Name: Rakesh Kukatla | DOB: 10/31/1972 | MRN: 8082383 | PCP: DEBORAH J GIANNONE, FNP | Legal Name: Rakesh Kukatla

Appointment Details

Notes

ED Provider Notes

at 1/13/2023 11:27 AM

ED Provider Signout/Progress Note

Patient seen and evaluated by the CPEP team. Per Derek McKenna, the on-call CPEP nurse practitioner, patient can be discharged home at this time. Diagnosis is "no psychiatric disorder found after evaluation." Patient can follow-up with his PCP

Plan

Encounter for psychiatric assessment 1.

Jeffrey A Orzell, DO 01/13/23 1127

Dr. James E Stoughton, MD at 1/11/2023 8:56 PM

------PATIENT IDENTIFICATION -----

Rakesh Kukatla 10/31/1972 MRN: 8082383

PCP: DEBORAH J GIANNONE, FNP

------ HISTORY OF PRESENT ILLNESS ------

Chief Complaint

Patient presents with

Psychiatric Evaluation

Will not communicate with anyone

Rakesh Kukatla is a 50 y.o. male with PMHx not on file presenting to the ED via BCSD for CPEP evaluation. Patient refuses to speak and cooperate with history and physical exam. Police reports patient has been incarcerated but department does not have psych evaluation on patient. Denies any trauma or injuries. Requesting CPEP evaluation.

History provided by: Police

History limited by: patient refusing to speak.

Language interpreter used: No

------ REVIEW OF SYSTEMS ------

Review of Systems

Reason unable to perform ROS: refuses to speak.

All other systems reviewed and are negative.

----- PAST HISTORY ------

No past medical history on file. No past surgical history on file.

Social and Family History: **Social History**

Tobacco Use

 Smoking status: Never Smokeless tobacco: Never

Vaping Use

 Vaping Use: Never used

Substance Use Topics

 Alcohol use: Yes • Drug use: Never

Family History

Family history unknown: Yes

The patient's home medications and allergies have been reviewed.

No current outpatient medications

Allergies: Patient has no known allergies.

----- PHYSICAL EXAM -----

Visit Vitals

BP (!) 157/105 (BP Location: Lt

Upper Arm, Patient Position:

Sitting)

Pulse

36.5 °C (97.7 °F) (Oral) Temp

Resp 18 SpO₂ 100% **Smoking Status** Never

Physical Exam

Vitals and nursing note reviewed. Exam conducted with a chaperone present.

Constitutional:

General: He is not in acute distress.

Appearance: Normal appearance. He is not ill-appearing.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal. Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat:

Mouth: Mucous membranes are dry.

Pharynx: Oropharynx is clear.

Eyes:

General: No scleral icterus.

Extraocular Movements: Extraocular movements intact.

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulses: Normal pulses.

Heart sounds: Normal heart sounds. No murmur heard.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing, rhonchi or rales.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness.

Musculoskeletal:

General: No swelling or tenderness. Normal range of motion.

Cervical back: Normal range of motion and neck supple. No rigidity or tenderness.

Right lower leg: No edema. Left lower leg: No edema.

Skin:

General: Skin is warm and dry.

Capillary Refill: Capillary refill takes less than 2 seconds.

Coloration: Skin is not jaundiced or pale.

Findings: No bruising or rash.

Neurological:

General: No focal deficit present.

Mental Status: He is alert. Mental status is at baseline.

Psychiatric:

Mood and Affect: Tearful: refuses to speak.

------ ORDERS & RESULTS ------

ORDERS:

Orders Placed This Encounter

Procedures

- CPEP Consult for ED Patients
- Flight risk
- Suicide precautions

EKG:

No orders to display

LABORATORY RESULTS: Labs Reviewed - No data to display

IMAGING STUDIES:

No orders to display

------ ED COURSE ------

MEDICATIONS:

Medications - No data to display

ED COURSE:

Clinical Impressions as of 01/12/23 0134

Encounter for psychiatric assessment

Procedures

------ MEDICAL DECISION MAKING ------

Medical Decision Making

Rakesh Kukatla is a 50 y.o. male with PMHx not on file presenting to the ED via BCSD for CPEP evaluation. Patient refuses to speak and cooperate with history and physical exam. Police reports patient has been incarcerated but department does not have psych

evaluation on patient. Denies any trauma or injuries. Requesting CPEP evaluation.

2051: Patient assessed at bedside. Patient is awake, alert, and refusing to cooperate and speak with history. Patient exam is otherwise unremarkable. Plan of care that includes CPEP evaluation, discussed with police who is agreeable.

Patient medically cleared for CPEP evaluation at this time.

0200: Patient signed out to Dr. Holland due to shift change, pending CPEP evaluation and disposition.

Encounter for psychiatric assessment: acute illness or injury Amount and/or Complexity of Data Reviewed Independent Historian:

Details: entire history obtained from BCSD

<u>Medication sent to patient's pharmacy:</u>

ED Prescriptions

None

Medication Counseling: Risks and benefits of new medication(s) discussed. Patient verbalized understanding.

----- IMPRESSION -----

Encounter for psychiatric assessment

James E Stoughton, MD 01/12/23 0134

Nursing Note

Nurse Jon C at 1/12/2023 9:23 AM

Pt upset he has not been seen by CPEP

NAD otherwise

Breakfast at bedside

Nurse Jon C at 1/12/2023 1:48 AM

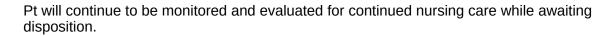
Pt is resting comfortably in room at this time. Pt has no s/s of acute distress noted at this time. Pt is not complaining of any issues to be addressed medically or socially at this time other than wanting a bed to sleep in

Color pink. No signs of respiratory distress noted. VSS.

No abdominal distention or emesis this shift. Patient ambulating adequately.

Voiding spontaneously.

No BM this shift.



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