

# Focused Exam: Bipolar Disorder Shadow Health; Lucas Callahan - Complete Winter 2020 solution guide.

written by

proficient



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## Focused Exam: Bipolar Disorder (Part 2 of 2)

Therapeutic Intervention III - Winter 2020, NUR 304

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### Reflections

**Activity Description:** Reflective writing develops your clinical reasoning skills as you grow and improve as a clinician and gives your instructor insight into your learning process. This reflection activity will help you think more deeply about your performance in the assignment. Use your documentation as you respond to the prompts at the bottom of the page.

### Documentation Review

#### ED Nursing Note

#### Mental Status Note

#### SBAR

#### ED Nursing Note

#### Student Response

#### Model Documentation

#### Chief Complaint

Patient was brought in by police due to erratic behavior  
-bouts of depression a 'couple' times of the year

Lucas Callahan is a 25-year-old man who was brought to Shadow General Hospital at 11:30 PM; he was taken here by policemen who found his behavior erratic. He denies having illness or a need to be in the hospital.

#### History of Present Illness

-Patient reports not sleeping for past 4 days, sleeps only for a 'couple of hours' when patient does sleep  
-Diagnosed with depression 3 years ago

Presents to the ED today after being brought in by local law enforcement. He was found in a grocery store parking lot looking into car windows for what he believes are "government agents chasing him due to his enlightenment and knowledge of government secrets." Mr. Callahan states he is feeling extremely energetic and reports this level of energy for the past week. States he has not slept for the past four nights well. He does occasionally use cocaine, but states he has needed it in the past four days due to his current energy level. Denies any exacerbating or relieving factors. Denies taking any medications to aid in sleep or lower his energy level.

Mr. Callahan says he currently feels euphoric and extremely energetic, and he has felt this way for a week. He has not used any substances in four days. Mr. Callahan reports frequently having extremely low energy and mood, while at other times having extremely high energy and mood; he reports these changes happening a couple of times a year, with his last depressive period ending a couple months ago after lasting a long time.

#### Past Medical History

-Previous hospitalization 3 years ago from suicide attempt

The patient received a diagnosis of depression 3 years ago following a suicide attempt. The psychiatrist who diagnosed him prescribed him antidepressants (patient cannot recall name or dose).

No known allergies to food, medication, latex, or environmental allergens

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	Student Response	Model Documentation
Home Medications	-antidepressants (patient doesn't remember name of medication and is not currently taking them)	No current home medications. Previously was on an antidepressant (can not recall name or dose), but stopped to inefficacy and side effects. He reports stopping his regir without consulting a psychiatrist.
Ask Suicide-Screening (ASQ)	<ul style="list-style-type: none"> <li>-previous suicide attempt (3 years ago); no longer has suicidal ideations</li> <li>-previous ideas of wanting to be dead; patient claims no longer feeling this way and 'love[s] being alive'</li> <li>-doesn't believe that other people would be better off without them</li> <li>-no homicidal urges</li> </ul>	<p>Mr. Callahan reports that his suicide attempt occurred 3 ye ago but that he doesn't wish to discuss the details. He der having attempted suicide other times or planning to do so currently. He reports that during depressive periods, he dc typically experience thoughts of suicide and wanting to be dead; however, he is not worried about these thoughts returning, as he feels his depression is behind him.</p> <p>The patient denies feeling like others would be better off without him, but he also reports not wanting to delve into t subject.</p> <p>He denies ever having experienced homicidal urges.</p>
Mood Disorder Questionnaire (MDQ)	<ul style="list-style-type: none"> <li>-Patient was previously depressed and says he goes through depressive states a 'couple' times throughout the year</li> <li>-Patient claims they are no longer depressed and currently have no suicidal ideations</li> <li>-Patient is unsure of claims others have not noticed his mood changes</li> <li>-'Occasionally' gets into arguments but claims no physical violence ever</li> <li>-Sees self as a 'visionary poet' who will change the world through his work.</li> <li>-Self-concept seems to be overly positive</li> <li>-Patient moves and talks very quickly</li> <li>-Claims no difficulty in concentrating</li> <li>-Engages in potentially dangerous sexual activity with friends and strangers alike</li> <li>-Spends money on cocaine and on friends</li> </ul>	<p>Mr. Callahan perceives his overall mental health to be exceptional, especially given his feeling that his depressio permanently over. He reports having an exceptionally high view of himself, enjoying life to the fullest, and not knowing caring about others' opinions of his mental health.</p> <p>The patient reports irritability that can often culminate in arguments but never physical fights.</p> <p>He reports typically only sleeping two hours a night.</p> <p>Mr. Callahan reports knowing he is typically a very fast tall and mover and says he has racing thoughts. He denies difficulty concentrating on activities that matter to him, suc writing poetry, at which he has been especially productive past week. In that time frame, he has also had an increas social activity, libido, and sexual activity.</p> <p>The patient reports spending most of his money on drugs, books, and donations to his friends; he admits his parents express frustration over these spending habits.</p>

Student Response	Model Documentation
Social History	<p>-Uses cocaine regularly on weekends, last used 4 days ago            -Drinks alcohol (whiskey, vodka) 2-3x a week, a 'couple of glasses'            -No current job and not looking for one; parents support patient financially            -Patient owns his own car            -Patient eats one meal a day            -Doesn't consume caffeine            -Completed one year of college, didn't finish            -Doesn't have a stable home; patient sleeps in car or stays at a friend's house            -Claims no history of abuse from family            -Doesn't have good relationship with family but they support him financially and have him on their insurance</p> <p>Marital status: single</p> <p>Occupation: unemployed; reports being fired from previous jobs but not wanting to discuss the details. his income comes from allowances given by his parents</p> <p>Living situation: no permanent residence, he typically sleeps in his car or at a friend's house</p> <p>Education: attended college for one year, after which he was expelled for poor attendance</p> <p>Sexual history: currently sexually active, multiple partners, contraceptive use, no history of STIs</p> <p>Alcohol: regular use 2-3 times a week starting at 18 years</p> <p>Illicit drug use: cocaine usually 2-3 times a week starting 8 months ago</p> <p>Nutrition: reports having a typically low appetite and usually eating only 1 small meal a day; he does not typically track fluid intake but reports drinking water</p>
Family Medical History	<p>-Adopted; adoptive parents have no history of mental illness            -Patient is unsure of history of birth parents</p> <p>Mr. Callahan is adopted and does not know any medical details of his biological family; he also denies a history of mental illness in his adoptive family.</p>
Review of Systems	<p>-HEENT: no abnormal findings            -Cardiovascular: No abnormal findings            -Skin, hair, nails: no abnormal findings            -GI: no abnormal findings</p> <p>General: Denies fatigue, fever, chills, night sweats, swelling, changes in weight</p> <p>HEENT: Denies headaches, eye problems, ear problems, problems including nosebleeds or congestion, and throat problems</p> <p>Cardiovascular: Denies abnormal heart rate, chest pain, leg pain</p> <p>Skin, hair, and nails: Reports recent scratches on back from sex; denies other skin changes; denies changes in hair or nails</p> <p>Gastrointestinal: Denies abdominal pain, nausea or vomiting or changes to bowel movements; reports bowel movements occur every 3 days</p>

1. Explicitly describe the tasks you undertook to complete this exam.

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2. Explain the clinical reasoning behind your decisions and tasks.

Enter your response here...

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3. Identify some challenges that you encountered during the patient interview. How did you overcome these challenges? What techniques would you explore to mitigate these challenges in your future practice?

Enter your response here...

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