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Children's Specialized Hospital

Fax

To:	Dr Yassim	**From:**	Kelly Cope
Fax:	9,1,609-242-1906	**Pages:**	5
Phone:		**Date:**	11/10/2011
Re:	patient-Landon Watson		

report 9-14-11

COMMENTS:
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CHILDREN'S SPECIALIZED HOSPITAL
(888)-CHILDREN (244-5373)

PSYCHIATRIC EVALUATION

09/14/11

NAME: WATSON, LANDON
DATE OF BIRTH: 05/17/2004
MEDICAL RECORD #: M000309595

HISTORY OF PRESENT ILLNESS
Landon is a 7-year-old in a self-contained classroom being brought in by his mother and her boyfriend after the school recommended assessment and treatment for ADHD. They describes the primary problem as he is very hyperactive and cannot sit still (in school). He is more in play mode than work mode. This has the consequence, "I can't get him to do anything, he does not listen" and subsequently he is not doing well in school. His mother is concerned that he will fall behind, "He is very smart, if he was calm he would be able to do very well (in life). I don't want to see him work at McDonalds the rest of his life or get into trouble." Accordingly, the goal is for him to be calmer so that he can do better in school and also to make it easier to manage at home. His mother is hoping that treatment will help at that "I'm hoping that there is some sort of medication to calm him down." They are bringing him specifically now as he is about to start first grade and the Child Study Team has diagnosed him as ADHD.

BEHAVIOR
"He is very hyper, he would not stay in his seat. He likes to bother other student by touching them. He is the class clown, he wants all eyes on him." He is hyperactive, inattentive and impulsive in all settings and all situations without any particular waxing or waning. He has been like this his entire life, though it has not become noticeable until starting preschool. He does not deliberately try to annoy people so much as refuse to do what they say when it involves controlling his impulsiveness or sitting still. Accordingly, other than the impulsiveness and hyperactivity, there are no other signs of oppositional defiant or conduct disorder behavior.

COGNITIVE/COMMUNICATION
He communicates well with others. He is able to relate well to the feelings of others. He likes making friends and is social and outgoing without any significant issues with shyness. He has a full, wide range of interest. His mother describes him as intelligent, possibly even more so than most children without any issues with frustration tolerance as long as he is not being made to sit still or control his impulsiveness. There are no other signs of PDD.

In term of his mood, he generally appears happy and confident, both are described by his case manager (Ms. Coppola) and his mother, never given indication of harming himself or anybody else. No signs of a mood disorder. He sleeps well once they get him settled down to go to bed and has a good appetite. He was traumatized or abused and there is no history of symptoms consistent with PTSD or worrying other than getting worried or scared of storms and natural disasters in the past few months after seeing a TV episode on natural disasters at his father's house. There is no issues with separation anxiety though he does tend to be manipulative and whinny with his mother to get her attention. According to Ms. Coppola and his mother he is not like this in school or with his peers and he tries being like this with Mr. Buchta (the mother's boyfriend), yet he does not accommodate the behavior and it is controlled accordingly.

PSYCHIATRIC HISTORY

Psychiatric history is as above. Hyperactivity and impulsiveness first became a problem when he was 4 years old, when he was being screened for kindergarten. At that point he was not cooperative for the test so he was later on placed in a developmental kindergarten before going to regular kindergarten. We spoke with Carol Coppola (Child Study Team case manager at Forked River Elementary School) who reported a child neurological assessment by Dr. Pietrucha several months ago diagnosing him with ADHD with ODD and a WISC FSIQ of 97 (individual IQs ranging from 89 to 104 with this test being determined to be a good estimation of his intelligence as he put in good effort despite being hyperactive and unfocused). Woodcock-Johnson showed particular difficulty with letter identification. Otherwise, there is no prior history of treatment or assessment.

SOCIAL HISTORY

He lives with his mother who for the past 2 years has been living with her best friend and their children. One of those children has ADHD. He lives with his 11-year-old sister as well. The house is unstructured and they would like to have their own place. With being a single mother she is unable and being out of work (normally working as a barber), they are unable to get their own place. He mother wonders if the lack of structure and the current setting and the fact that the other child in the house with ADHD teases him is a contributing factor in Landon's symptoms. He has never been traumatized or abused in any way though. His father has been involved in his life for the past 2 years, having him about 1 weekend a month, but his mother has full residential and legal custody with his father turning down offer by the judge to have custody when DNA testing confirmed paternity. He has a 13-year-old sister who recently went to live with her father.

He is in a self-contained classroom in first grade at Forked River Elementary where he is doing well per, Ms. Coppola who confirms the above mentioned history, reports that the behaviors do not present themselves to a significant

degree to date this year, although they are evident to a less minor degree. Her goal will be to have him mainstreamed. He is in regular classes. He is self-contained for only half of his classes and her goal is to have him completely mainstreamed over the long term.

DEVELOPMENTAL HISTORY
He was born full term, spontaneous vaginal delivery. All milestones were on time to early. He was exposed to Paxil in utero, but there are no other complicating factors. Two years ago his mother left her husband who had been in her life from the age of 1 to 4 years old, but now her boyfriend is a father figure to him.

FAMILY PSYCHIATRIC HISTORY
His mother suffers from anxiety and PTSD. Has a half sister with bipolar disorder. The maternal grandmother has schizophrenia. Nothing is known of the father's side of the family. There is no known history of learning disorders and there is no known history of learning disorder or ADHD.

MEDICAL HISTORY
There is no personal cardiac history nor any significant cardiac history at a young age in anyone in the family or any sudden unexplained death in the family. There is no history of seizures, loss of consciousness, fainting or head trauma. He sees Dr. Mahmud Yassn his pediatrician. He prescribed melatonin 1 mg at night for sleep. No other medication. No known drug allergies. No surgical history.

MENTAL STATUS EXAMINATION
Landon appears his stated age. He speak somewhat non-spontaneously, but appears intelligent. His 3 wishes are primarily for toys, but he is clearly trying to win his mother sympathy and act more childish than he really is, to go off on his own while he speak with her. However, once he is on his own, he has no problem staying by himself. He draws pictures, his pictures are age appropriate, primarily drawing pictures of sharks. He is somewhat hyperactive and not that well focused, but is polite and friendly though he does refuse to speak with me even though he is not outrightly rude.

ASSESSMENT
Landon is a 7-year-old boy in self-contained classes due to behavioral problems being brought in by his mother for consideration of medication to help calm him down. His hyper diagnosis in all respect is consistent attention-deficit hyperactivity disorder with no signs of mood disorder, neglect, organic impairment or anxiety. His mother wonders if having more structured home environment would help. While it may control his behavior at home, it would have little to no effect on his ability to focus in school. Medication to help him focus would almost certainly be indicated and after discussing the risks and the benefits of different medications (including long-

acting medications which could be less helpful with attention versus a stimulant medication), we felt that stimulant medication would be best choice as it has the best effect with focusing and could be used only on the days that are needed.

DIAGNOSES
Axis I: Attention-deficit hyperactivity disorder, combined type.
Axis II: None identified.
Axis III: No acute issues.
Axis IV: Academic.
Axis V: 65.

PLAN
1. Initiate Concerta 18 mg.
2. Followup in about 2 weeks.

Moshe Rose, MD

D:09/14/2011 14:22 T:09/14/2011 16:39
Job# 650346 / Int# 481609575
<Electronically signed by Moshe Rose MD>
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