Farhana Chowdhury

Psychiatry Rotation at Queens Hospital Center (CPEP)

Due: October 6, 2020

**Identifying Data:**

Name: F.J.

Address: Jamaica, NY

Age: 39

Sex: Male

Race: African American

Religion: Christanity

Date &amp; Time: September 30, 2020 at 12:15pm

Location: CPEP-QHC

Source of Information: Self

Source of Referral: self

Reliability: Reliable

**Chief Complaint:** “I am feeling depressed and feel like hurting myself”

**HPI**

39 years old African American male, married, domiciled with family, unemployed, with no psychiatric history, present to the medical ER by himself secondary to feeling depressed and anxious due to multiple stressors at home for the past four months.

Patient was evaluated in MER and during the evaluation the patient appeared calm, cooperative, organized, poor eye contact, speaks in complete sentences with low volume and has a coherent thought process. Patient became teary while explaining the hard home condition due to COVID, lost his job and the pressure of the incoming baby in the family. Patient states, he was a bank manager and the job was stressful and working from home made the process more frustrating. Patient states for the past 2 months, he is experiencing difficulty concentrating and has to read the same instruction multiple times, which delayed his performance and as a result he lost his job. Without the job, the patient is feeling anxious about supporting his family as he has a 2 years old son and a baby girl is on its way. Patients expressed feeling helpless, hopeless and depressed, which is provoking suicidal thoughts. 2 months ago, the patient attempted to hang himself to the fan but he was able to stop himself. Patient is feeling really depressed today and getting thoughts of hurting himself; so he brought himself to the medical ER. Patient states, he used to love riding bikes and reading books but now thinking about it irritates him. Denies current homicidal ideation, auditory or visual hallucination or delusion. Denies alcohol abuse and illicit drug use.

Collateral information was collected from his wife who states her husband has been really depressed since the COVID started. Patient has not been eating, sleeping, communicating or taking care of himself. The wife states, “my husband has been really quiet, sad and not interested in activities that we both loved to do all the time.

**Past Medical History:**

None

**Past Surgical History:**

None

**Medications:**

none

**Allergies:**

NKDA, denies other environmental or food allergies.

**Family History:**

Patient states, his maternal aunt suffered from major depressive disorder and commited suicide around the age of 50. Patient denies family hx schizophrenia, bipolar disorder and any

other family hx of psychiatric disorders.

Patient admits to family history of HTN and colon cancer.

**Social History:** F.J. is a 39-year-old African American married male, who lives with his wife and 2 year old son. Patient’s wife is 7 months pregnant and they are expecting a baby girl. Patient completed his master’s degree in business from Baruch college and he was a bank manager. Patient is the sole earner of the family currently because the spouse was furlough from her job due to COVID. Patient and his partner are in the process of buying a house which they have signed and waiting for the loan process. Patient admits of drinking 2 glasses of wine daily after losing the job. Denies smoking or illicit drug use. Patient has been experiencing difficulty falling asleep as he only gets (3-4 hours of sleep per night) He admits to loss of appetite. Patient used to be physically active as he loved to bike, swim, run and hike but now he has no interest in any of the activity. Patient feels irritated and annoyed even thinking about the activities. Patient is currently sexually active with his wife. She denies any history of sexually transmitted illnesses.

**ROS:**

**General:** Admits to generalized weakness/fatigue, insomnia, and loss of appetite. She denies

fever, chills, or night sweats.

**Pulmonary system**: Denies dyspnea, cough, wheezing, hemoptysis, or paroxysmal nocturnal

dyspnea.

**Cardiovascular system:** Denies chest pain, HTN, palpitations, irregular heartbeat, syncope or

known heart murmur.

**Endocrine system:** Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive

sweating, hirsutism, or goiter.

**Psychiatric** – Admits to depression, hopelessness, helplessness, and sadness . Patient denies seeing a mental health professional for his depression.

**Physical**

Vital Signs:

BP: right seated 103/62

Pulse: 74

Temp: 98.3 °F (oral)

Resp: 16

SpO2: 96%

Height: 71 inches Weight: 170 Lbs BMI: 23.7

**General:** 39 year old male, Alert and Oriented x 3. Pt is of average build, laying down in medical ER hospital beds. Pt is well dressed, groomed and appears to be mild distressed.

**Skin:** Nonicteric, no lesions noted, or scan tissue noted or no tattoos.

**Mental Status Exam:**

**General**

1. **Appearance**: F.J. is a tall, average weight African American male with black dense curly hair in tidy fashion. He appeared well groomed, had good hygiene and was wearing clean black pants with a sky blue shirt. Patient had no scars, tattoos, body piercing or atypical body features. Appears to be stated age, well nourished and developed.
2. **Behavior and Psychomotor Activity:** F.J. was fidgeting for most of the interview while tears filled his eyes while talking. Patient appears alert and oriented x 3, calm but guarded and hesitant in sharing information. He had poor eye contact as he was looking at the ceiling or on the floor while speaking during the interview.
3. **Attitude Towards Examiner:** F.J. was cooperative, compliant and coherent thought process while answering the questions. Patient was answering in low volume and short sentences. However, I was able to establish a trust worthy rapport as I continued to speak to the patient for 3-4 minutes and the patient started to answer questions in complete sentences with details.

**Sensorium and Cognition**

1. **Alertness and Consciousness**: F. J. was alert and his level of consciousness did not change throughout the interview.
2. **Orientation:** F.J was oriented to person, place of the exam, and the date.
3. **Concentration and Attention:** F.J demonstrated fair concentration and attention throughout the entire interview but sometimes he was distracted by the other patients. Also, sometime, I had to repeat the question a few times to get the answer.
4. **Capacity to Read and Write:** F. J.had normal reading and writing ability in English.
5. **Abstract Thinking:** F.J. was able to demonstrate adequate abstract thinking. For example, when the patient was asked, “what is the similarity between an orange and an apple?”, patient was able to answer “ they are fruits”
6. **Memory:** F. J’s recent, remote and immediate memory was intact as the patient was able to recall his wife and son’s name, graduation year, his wife’s phone number.
7. **Fund of Information and Knowledge:** F.J. has an adequate fund of knowledge as he completed his masters degrees from a well known business school.

**Mood and Affect**

1. **Mood:** F.J.’s mood was depressed, sad, teary and dysphoric. Patient was not smiling during the interview
2. **Affect:** F.J.’s affect was appropriate; it was congruent with his current mood.
3. **Appropriateness**: S.M.’s mood and affect were consistent throughout the interview.

**Motor**

1. **Speech:** F.J’s speech pattern was normal in its rate, rhythm and effort. He was soft spoken, in audible low volume but displayed no delayed response.
2. **Eye Contact:** F.J. had poor eye contact throughout the interview.
3. **Body Movements:** F.J had no extremity tremors, facial tics or other abnormal movements. His body movements were purposeful and not excessive.

**Reasoning and Control**

1. **Impulse Control:** F.J. impulse control seemed good as he was able to control his suicidal thoughts and brought himself to the hospital for medical intervention. Patient is still very depressed and has suicidal thoughts but no suicidal plans at the moment.
2. **Judgment:** F.J. has adequate judgment as he realizes that it is a wrong decision of hurting himself. He denies auditory/visual hallucinations, paranoia.
3. **Insight:** F.J has poor insight as the patient feels his life is purposeless and has no meaning to continue.

**Assessment:**

39 years old African American male, married, domiciled with family, unemployed, with no psychiatric history, present to the medical ER by himself secondary to feeling depressed and anxious due to multiple stressors at home for the past four months. Patient was evaluated in the medical ER, where the patient appears sad and depressed with suicidal ideation but no plan. Patient presentation is most consistent with suicidal ideation secondary to major depressive disorder .

**Differential Diagnosis:**

1. **suicidal ideation secondary to Major Depressive Disorder:** Patient is experiencing multiple stressors: COVID, unemployed, new family member and process of buying a house. He meets the diagnostic criteria as he has at least 5 symptoms: depressive mood, decreased appetite, insomnia, suicidal thoughts, and anhedonia for the past 2 weeks. He also has a risk factor of previous sucidal attempt, family history, major life changes, financial struggle and work stress
2. **Adjustment Disorder:** Patient is experiencing multiple stressors (financing a new home, new baby, unemployed, paying the bill and COVID) and as a response patient suffering from depression and suicidal thoughts. Patient is feeling overwhelmed, having difficulty sleeping, decreasing appetite, and feeling sad.

**Plan:**

1. Patient presentation of suicidal ideation warrants admission to CPEP for further monitoring and observation
2. Initiate medication
	1. Escitalopram (Lexapro) 10 mg, 1 tablet PO daily
3. Labs: CBC, CMP, THC, UA, urine toxicology, COVID- 19 PCR Test
4. Discuss with the patient about the importance of following up with an outpatient psychiatrist. The patient will be referred to outpatient psychiatry during discharge.
5. Counsel patient on importance of medication compliance and warn about abrupt cessation of medication
6. Discuss ways the patient can cope with the life stressor and offer therapist option
7. Reassess patient for suicidality and complete safety plan.

At this time, based on evaluation, the patient appears a threat to himself as he is having suicidal ideation. Patient is not handling the stress appropriately and has limited insight and judgement. Based on the presentation, the patient warrants further psychiatric evaluation and CPEP admission for observation, re-evaluation, and stabilization. Case was discussed with the PA and the attending physician. Also , the treatment plan was discussed with the patient and he is willing to adhere to the plan and treatment.