



AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

Phone:

Fax:

Provider: SENTER ,MEREDITH STACY

Date of Service: 10/6/2021

Visit #: 6486888614

Pt Name: WILLIAMS III, LEONARD CLINTON

Org MRN#: 0000642066

DOB: 11/1/1980

Sex: Male

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Office/Clinic Visit Notes

DOCUMENT NAME:

Psychiatric Visit Note

BH OP Note - Subsequent

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6486888614
Age: **40 years** Sex: **Male** DOB: **11/1/1980**
Associated Diagnoses: **None**
Author: **SENER , MEREDITH STACY**

Location: **AH BEHAVIORAL HEALTH CHARLOTTE****Visit Information**

Patient Location: NC

Provider licensed to provide medical care in the location/state of patient: Yes

Provider Location: Clinic/Hospital Encounter took place via 2-way audio visual technology

Video start time: 2:40 pm Video stop time: 3:00 pm

Consent:

- Patient's identity was confirmed.
- Medical condition or illness was discussed with the patient/personal representative.
- Current proposed treatment for medical condition or illness was explained to patient/personal representative along with the likely benefits, significant risks and complications associated with the treatment.
- The patient/personal representative verbally authorized treatment to be provided by audio/video, which may include a limited review of patient's current health status, medication or other treatment recommendations, patient education and an opportunity to ask questions about condition and treatment.

Verbal Consent granted: Yes

Chief Complaint

"You are ruining my life"

History of Presenting Illness

After 5min of waiting for patient I called him and he said he had not logged in b/c he was "fearful" of the appointment due to being subjected to "harassment and abuse" by our hospital. He then states he will in fact log in for the appointment.

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Logs in, reports feeling "absolutely miserable". States he is being evicted and is blaming us for that. Taking the Zyprexa 20mg qhs. States he is sleeping 12hrs/night. When awake does not feel oversedated. Reports he has always had suicidal ideation, due to "my life being destroyed" that he does not think will ever change and he describes as chronic baseline. He denies recent exacerbation of thoughts, and denies suicidal plan/intent. Denies HI. States he is eating fine.

I ask about his relationship w/ mother (who has been supportive in the past) and he becomes defenses, states he will not answer any questions about his family.

Zyprexa - denies side effects.

Feels he is under constant stress.

When asked about AH, replies "I have no signs of psychosis symptoms period. Anything on the record is deliberate fraud".

States he plans to find a new psychiatric provider b/c our clinic is not prescribing Adderall.

Review of Systems

A 10-point review of systems has been performed and found negative except for what was already stated in the HPI/Current Assessment.

Past Psychiatric History

Past diagnoses: Bipolar I disorder vs schizoaffective disorder bipolar type, PTSD, ADHD

Prior hospitalizations: yes, at least 1 in 2019 for psychosis

Outpatient treatment: has been in OMS for many years with various providers

Prior medication trials: Depakote (self-DC'd), Invega, Celexa

Suicide attempts: denies

Self-injurious behavior: denies

Violence toward others: denies

Medical History**Medication List****Active Medications**Prescribed

dextroamphetamine-amphetamine: 40 mg, 2 capsule, ORAL, qAM (every

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morning), for 30 day(s), 60 capsule, 0 Refill(s).
dextroamphetamine-amphetamine: 40 mg, 2 capsule, ORAL, qAM (every morning), for 30 day(s), 60 capsule, 0 Refill(s).
dextroamphetamine-amphetamine: 40 mg, 2 capsule, ORAL, qAM (every morning), for 30 day(s), 60 capsule, 0 Refill(s).
dextroamphetamine-amphetamine: 40 mg, 2 capsule, ORAL, qAM (every morning), for 30 day(s), 60 capsule, 0 Refill(s).
OLANzapine: 20 mg, 1 tablet, ORAL, qHS (each night at bedtime), for 30 day(s), 30 tablet, 2 Refill(s).

Documented

APAP/ASA/cafeine: See Instructions, 1 packet as needed.
metFORMIN: 500 mg, daily, 0 Refill(s).
misc medication: 5 hour energy shots prn, 0 Refill(s).

Medications Inactivated in the Last 72 Hours

No medications found.

ALLERGIES: no known allergies

Family Psychiatric/Medical History

Cancer: Father, GF, Paternal, GM, Maternal and GM, Paternal

HYPERTENSION: GM, Maternal.

Psych Hx--bipolar disorder, ADHD

Social History

Has previously reported history of sexual and emotional abuse

College grad

Single, lives alone

Unemployed, financial difficulties

Firearms: denies access

Substance Use History

Denies all

Exam

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Mental Status Exam

General Appearance: somewhat unkempt but healthy appearing (appears at healthy weight), apartment in disarray; patient appears comfortable, in no distress

Behavior: hostile, guarded

Orientation: Oriented to person, place, time.

Attention/Concentration: somewhat distractible

Psychomotor: no abnormal movements or tremor observed by video

Speech/Language: stuttered, pressured, loud, fast

Mood/Affect: Reports mood is "absolutely miserable"; Affect is irritable, anxious

Thought form/associations: linear, perseverative

Thought content: Paranoia as per HPI; reports chronic thoughts of death; Adamantly denies suicidal and homicidal plan or intent throughout interview.

Perceptions: Denies auditory and visual hallucinations.

Insight and judgment: Insight is fair-poor; Judgement is fair-poor

Lab/Diagnostic Results

none new

Assessment

Mr. Williams is a 40y/o man w/ Bipolar I vs SAD, PTSD, ADHD, possible ASD per prior notes.

At 8/12/21 appt he was experiencing symptoms of mania including irritability, distractibility, pressured speech being very difficult to interrupt, tangential thought process/flight of ideas. He was also quite paranoid, perseverating on several paranoid delusions. Hospitalization was considered, however after conferring with colleagues who have known the patient over the past few years, his state was judged to be not far off baseline.

He was performing basic self care (seen eating on camera), reported sleeping 6hrs/night, and persistently/adamantly denied suicidal and homicidal ideation/plan/intent throughout assessment. He became increasingly irritable and hostile when told about Adderall discontinuation, but this did not rise to the level of threats. After careful consideration we agreed on plan for police wellness check so someone could see him in person to ensure safety. He was hesitant about this but agreed after we explained we were not planning on an involuntary hospitalization and did not want the police visit to surprise him.

Between 8/12/21 and 9/1/21 appts, he called/messaged our clinic numerous times requesting Adderall refills. During this time period I staffed the case with department chair Dr. Rachal, who agrees stimulants are inappropriate at this time. We discussed the case with director of AIC clinic, and together decided a stimulant

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would only be considered if patient was maintained on a long-acting injectable antipsychotic given adherence issues.

9/1/21: I explained this to the patient, and he states he will consider LAI, but is hesitant because Zyprexa has been the most effective antipsychotic for him. Notably symptoms of mania and psychosis are markedly improved after increasing Zyprexa from 10mg qhs to 20mg qhs. He remains irritated/agitated, yelling at times when not getting his way about Adderall, speaking rapidly but improved compared to last appt. Today he does not perseverate on paranoid conspiracy theories about Wells Fargo as he was on 8/12/21. Will keep Zyprexa at current dose. Stimulant remains contraindicated.

10/6/21: remains very paranoid, continues to contact clinic requesting Adderall. Adderall remains inappropriate for this patient given his level of paranoia, though he remains somewhat improved on increased Zyprexa dose of 20mg. He would continue to benefit from hospitalization for stabilization but is not in agreement with this.

Patient is at chronically elevated risk of harm to self and others due to age, prior psych admissions and diagnoses, reported history of trauma, limited social support, and history of difficulty with med adherence. Acutely, risk is elevated based on current manic and psychotic symptoms (though these are now greatly improved on increased Zyprexa dose). Fortunately he has no known history of suicide attempts, self injury or violence. Patient would still benefit from hospitalization for LAI initiation, however is declining and at this time does not meet criteria for involuntary hospitalization, as he is demonstrating ability to meet basic self care needs, and denies suicidal and homicidal plan/intent throughout assessment. He does not display any symptoms or behaviors during interview that would indicate imminent threat to self or others.

Plan

- will not re-initiate stimulant
- continue Zyprexa 20mg qHS
- considering transfer to AIC as patient would benefit from long acting injectable due to history of med non-adherence and decompensation when off antipsychotic meds. Would also consider mood stabilizer if patient amenable, but he is refusing at this time

-Contingency plans discussed: call center, national hotline, mobile crisis, BHC ED, 911.

-Medical: should have antipsychotic monitoring workup (lipid and DM screening, weight); will prioritize as soon as psychiatrically stable enough to comply. As of now he is not in agreement.

COVID-19 VACCINE STATUS: not vaccinated, stated is considering; encouragement provided.

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- Patient was provided with education regarding medication and treatment plan.
 - Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis, agrees to utilize these services if needed.
 - Patient is aware to contact clinic as needed
- RTC 1 mo or sooner if needed (patient states he does not wish to f/u with this writer due to my not prescribing Adderall; however, I explained to the patient that I am still happy to see him if he wishes; order for f/u placed incase he changes his mind).

Attestation

35min spent on this case, including at least 50% in direct patient counseling and coordination of care.
Meredith Senter, MD

Electronically Signed By: SENTER, MEREDITH STACY MD
10/10/2021 11:18 AM

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Electronic Orders

The current National Provider Identifier value is displayed with the ordering physician

Order: Virtual E&M Visit (Video);MOD MDM or 30-39 min – Est Pt Level 4 – I4123 AMB		
Ordering Physician: SENTER ,MEREDITH STACY (National Provider Identifier: 1407204530)		
Electronically Signed By: SENTER ,MEREDITH STACY		
Order Details: 10/6/21 2:55:00 PM EDT Modifier: CR OFC VVI Office/Hospital, Bipolar disorder		
Order Comment:		
Action Type: Order	Action Date/Time: 10/6/2021 14:56 EDT	Entered By: SENTER ,MEREDITH STACY
Ordering Provider: SENTER ,MEREDITH STACY	Supervising Provider:	
Order Details: 10/06/21 14:55:00 EDT Modifier: CR VVI OFC Office/Hospital, Bipolar disorder		
Review Information:		
Doctor Cosign: Not Required		

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