



# AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

PHYSICIAN FACESHEET - PATIENT DEMOGRAPHICS UPDATED: 10/21/2020 1541

NAME : WILLIAMS,LEONARD CLINTON ADM DATE/TIME: 10/21/2020 1500  
PT. TYPE : OP DIS DATE :  
SERVICE : VEA LOCATION : HOMS  
ADMIT SOURCE : 1

RACE : White or Caucasian  
PHONE (W) :  
PHONE (M) :

BIRTHDATE : 11/01/1980 SEX : MALE  
SS # :

ACCIDENT :  
ACCIDENT DATE:

ADMIT DX : Bipolar disorder, unspecified (CMS/HCC)  
WORKING DX : Post-traumatic stress disorder, unspecifiedPRI CARE MD : BRADNER,RICHARD  
ADMIT MD : UNKNOWN,ATTENDING  
ATTEND MD : MURRAY,PHILLIP MICHAEL  
REFER MD : MURRAY,PHILLIP MICHAEL  
ER MD : UNKNOWN,ATTENDING

EMPLOYER :  
ADDRESS #1 :  
ADDRESS #2 :  
CITY :  
ST/ZIP :

INSURANCE 1  
COMPANY : SELF PAY  
GROUP # :  
POL/SS # :  
INSURED : WILLIAMS,LEONARD CLINTON  
REL TO INS :  
MAIL TO :  
ADDRESS #1 :  
ADDRESS #2 :  
CITY/ST/ZIP:  
PHONE : EXT:  
APPROV/REF :  
INSURANCE  
COMPANY :  
GROUP # :  
POL/SS # :  
INSURANCE  
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PHONE : EXT:  
APPROV/REF :

Admit Date: 10/21/2020 15:00 EDT  
Disch Date: 10/21/2020 23:59 EDT  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 3/5/2021 14:03 EST

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6460501172  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 445014504

INSURED : ,  
REL TO INS :  
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ADDRESS #1 :  
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COMMENT :

EXT:

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## Office/Clinic Visit Notes

DOCUMENT NAME:

**WILLIAMS III, LEONARD  
CLINTON**

**DOB:** 11/01/1980 **MRN:** 0000642066  
**Sex:** Male **FIN:** 6460501172

### Patient Information:

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

### Chief Complaint

Phone second opinion visit

### History of Present Illness

39-year-old male presents today for second opinion. He usually sees Kathleen Keniston in OMS. Most recent visit was in July 2020. Since then, he has undergone IVC procedure for concerns about psychotic symptoms, suicidal ideation. Per records, patient will have history of misuse of Adderall prescription. I have reviewed care clinic records. Patient was changed to Invega monotherapy from prior regimen of citalopram, olanzapine, and Adderall XR. We complete the interview via phone. He consents to today's visit, confirms that he is at home. He denies current SI, HI, AH, VH. He has been stopped on the olanzapine and adderall. He states he is not sure about the medications that have been changed. He is hopeful about moving forward with EMDR therapy. He states he has acute PTSD and is lifelong disabled. He feels adderall helps with his concentration and he is hopeful to increase his current dosing. He states he is in profound, deep emotional pain "all of the time." He states he can become distressed to the point that he needs higher or extra doses of adderall. He feels it helps with mood, concentration and ability to get things done. He states he was stable on regimen of olanzapine, citalopram, and adderall. He states this was changed recently, reporting his medications were changed inappropriately. He states with his prior trauma he has constant thoughts about death, but does not have any intent or plan. He states this has been over a year, and a history of thinking about death as a relief for over 10 years. He denies current manic or psychotic symptoms. He denies any illicit substance use.

### Review of Systems

On interview denies current headache, chest pain, shortness of breath, abdominal pain, nausea vomiting. 10 point review of systems otherwise unremarkable.

### Exam

Cooperative, normal volume and rate of speech. Reports anxious mood with linear, goal-directed thought process. Nondelusional thought content. Currently denies SI, HI, AH, VH. Fair insight and judgment, with good impulse control.

### Assessment/Plan

ADD (attention deficit disorder), Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence  
Bipolar disorder, Bipolar disorder, unspecified

39-year-old man presents today for second opinion. He carries diagnoses of bipolar disorder, PTSD, and ADD. He is recently had an inpatient hospitalization due to concerns about paranoia and psychotic thought process. Some of this was in the context of concerns about increasing use of Adderall among other symptoms. He states with medication changes he

### Problem List/Past Medical History

#### Ongoing

None

#### Historical

Obesity

Obesity

### Medications

Adderall XR 20 mg oral capsule, extended release, 20 mg, 1 capsule, ORAL, qAM (every morning)  
citalopram 20 mg oral tablet, 20 mg, 1 tablet, ORAL, Daily  
Goodys Extra Strength, See Instructions  
Med List Status - Updated  
metFORMIN, 500 mg, **Not taking**  
Misc Medication  
ZyPREXA 5 mg oral tablet, See Instructions

### Allergies

No known allergies

### Social History

#### Abuse/Neglect

History of Abuse: Past. Abuse Type: Mental, Sexual. Comments: Sexual abuse by MGM, emotional abuse by step-father.

#### Alcohol

Denies

#### Drug Abuse

Denies

#### Employment/School

Highest Education: College graduate.

Freelance graphic art

#### Home/Environment

Marital Status: Single. lives in an apartment by himself

#### Nutrition/Health

Home Diet: Diabetic.

#### Tobacco

Smokeless Tobacco Use: Never. Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day.

#### Vape/E-Cigarette

Use: Never.

### Family History

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

Coronary artery disease (CAD): Negative: Mother, Father, Sister, Brother, GF, Maternal, GF, Paternal, GM, Maternal, GM, Paternal and Grandparent.

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has not been feeling well, while he has been stable on most recent medications. He focuses on Adderall use, and reports this helps with both focus, and ability to cope. He is asking for higher doses. With patient's long history of stability, it is reasonable to go back to prior medications. He also has a history of taking lower doses of Adderall without abuse for a long amount of time. I agree with his primary provider's thoughts that he would not benefit from higher doses of stimulant medications as this can lead to worsening irritability, paranoia, and symptoms that led to hospitalization. I will defer to primary provider for further medication changes. He has been counseled on potential side effects emergency emergency services.

Diabetes mellitus: Negative: Mother, Father, Sister, Brother, GF, Maternal, GF, Paternal, GM, Maternal, GM, Paternal and Grandparent.  
HYPERTENSION: GM, Maternal.

–Resume citalopram and olanzapine

–Resume Adderall at prior lower dose of 20 mg daily, do not recommend higher doses that patient is requesting

–Counseled on potential side effects and reasons seek emergency services

–She will follow-up with regular provider

Post-traumatic stress disorder, unspecified, PTSD (post-traumatic stress disorder)

### Patient Education

**Personally reviewed:** Current visit triage/intake/medical record as applicable

**Reviewed Documentation:** Congruent with exam

**New/Changed medications:** Risks/benefits discussed with patient and/or legally responsible person

**This assessment/plan of care was discussed with:** patient \_ \_ \_

### 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 telephone, 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

**Time spent in coordination of care and phone time:** A total of 15 minutes was spent in review of pertinent medical records, evaluation of the patient problem, and coordination of a care plan as part of this phone visit. 19 minutes was spent on the phone portion of visit.

**Electronically Signed By: MURRAY, PHILLIP MICHAEL MD**  
**10/29/2020 01:19 PM**

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## Medication Compliance Status

### Admission Medication Reconciliation

#### Med Name

acetaminophen/aspirin/caffeine (Goodys Extra Strength)

**Display Line** See Instructions, 1 packet as needed, 0, 11/03/11 16:02:00 EDT

**Compliance Status:** **Compliance Comments:**

Still taking, as prescribed

OLANzapine (ZyPREXA 5 mg oral tablet)

**Display Line** 5 mg per 1 tablet, ORAL, BID (2 times a day), 60 tablet, 1, 1, 02/15/21 12:56:00 EST

**Compliance Status:** **Compliance Comments:**

dextroamphetamine-amphetamine (Adderall XR 20 mg oral capsule, extended release)

**Display Line** 40 mg per 2 capsule, ORAL, qAM (every morning), 60 capsule, 0, 0, 02/15/21 12:56:00 EST

**Compliance Status:** **Compliance Comments:**

metFORMIN (metFORMIN)

**Display Line** 500 mg per, daily, 0, 04/15/16 15:22:00 EDT

**Compliance Status:** **Compliance Comments:**

Not taking

misc medication (Misc Medication)

**Display Line** 5 hour energy shots prn, 0, 04/29/20 9:24:00 EDT

**Compliance Status:** **Compliance Comments:**

Still taking, as prescribed

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## Electronic Orders

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

<b>Order: Virtual Check-in (Phone) Est Pt 11-20 Min AMB -I4115</b>		
Ordering Physician: MURRAY ,PHILLIP MICHAEL MD (National Provider Identifier: 1154646487)		
Electronically Signed By: MURRAY ,PHILLIP MICHAEL MD		
Order Details: 10/21/20 3:41:00 PM EDT Modifier: CR OFC   VVI Office/Hospital, ADD (attention deficit disorder)   PTSD (post-traumatic stress disorder)   Bipolar disorder		
Order Comment:		
Action Type: Order	Action Date/Time: 10/21/2020 15:41 EDT	Entered By: MURRAY ,PHILLIP MICHAEL MD
Ordering Provider: MURRAY ,PHILLIP MICHAEL MD	Supervising Provider:	
Order Details: 10/21/20 15:41:00 EDT Modifier: CR VVI   OFC Office/Hospital, Bipolar disorder   PTSD (post-traumatic stress disorder)   ADD (attention deficit disorder)		
Review Information:		
Doctor Cosign: Not Required		

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## Allergy History

Substance **No known allergies**

Recorded Date/Time

11/3/2011 16:19 EDT

**Allergy Type** Allergy; **Recorded On Behalf Of** FERRARO,NICHOLAS P RN; **Reaction Status** Active; **Reviewed Date/Time** 6/9/2020 16:36 EDT; **Reviewed By** PENISTON , KATHLEEN KELLY NP;

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