



## AH Behavioral Health Charlotte

501 Billingsley Road

Charlotte, NC 28211-

---

Admit Date: 1/5/2019 13:54 EST  
Disch Date: 1/5/2019 14:17 EST  
Admitting:  
Attending: HENDRA ,JILL L DO  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6432944046  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HEMG  
Print ID: 476634771

**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6435933572  
Age: **38 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed.

- Last seen in EC by Dr. Richardson on 3/12/19.
- On Zyprexa, Celexa, Adderall. Stopped Depakote on his own. Never filled Saphris due to cost.
- Working for self - this has caused some financial issues. Looking for FT work.
- Mood - fair. Stress related to finances.
- Sleep fair - 8 hours per night. Appetite stable
- Energy good - exercising daily. Concentration variable.
- Short term memory has been poor. Has subscription to Cambridge Brain Services.
- No alcohol or illicit substances. No thoughts of harming others. No AH/VH

**Review of Systems**

**Constitutional:** Negative except as documented in history of present illness.

**Health Status**

**Allergies:**

Allergic Reactions (All)

No known allergies

**Current medications:** (Selected)

Prescriptions

*Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 0 Refill(s)

citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 0 Refill(s)

Admit Date: 4/2/2019 10:40 EDT  
Disch Date: 4/2/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6435933572  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634770

## Office/Clinic Visit Notes

### Documented Medications

#### *Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed  
metFORMIN: 500 mg, daily, 0 Refill(s)

### **Problem list:**

#### All Problems

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### **Histories**

#### **Past Medical History:**

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

##### Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

#### **Family History:**

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

#### **Procedure history:**

No active procedure history items have been selected or recorded.

#### **Social History**

##### Social & Psychosocial Habits

##### **Alcohol**

04/02/2019 **Use:** Denies

##### **Drug Abuse**

04/02/2019 **Use:** Denies

##### **Tobacco**

04/02/2019 **Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0.

### **Physical Examination**

#### **Mental Status Examination:**

Admit Date: 4/2/2019 10:40 EDT  
Disch Date: 4/2/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6435933572  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634770

## Office/Clinic Visit Notes

General appearance: Appropriately dressed and groomed.  
Gait & station: Normal.  
Strength & tone: Not tested.  
Attention & concentration: Normal.  
Orientation: Oriented X4.  
Language: Normal.  
Level of consciousness: Alert.  
Fund of Knowledge: Average.  
Recent & Remote Memory: No impairment in recent or remote.  
Speech: Rapid, Overproductive, Perseverative.  
Thought process: Perseverating.  
Mood and affect: Labile, Anxious.  
Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts.  
Perceptions+: No abnormalities.  
Insight: Fair.  
Judgment: Fair.

### VS/Measurements

#### Vital Signs

4/2/2019 10:41 EDT

<b>Peripheral Pulse Rate</b>	<b>103 BPM HI</b>
<b>Systolic Blood Pressure</b>	<b>148 mmHg HI</b>
<b>Diastolic Blood Pressure</b>	<b>91 mmHg HI</b>
Blood Pressure Location	Right arm
BP Instrument	Manual
Blood Pressure Position	Sitting

, Measurements from flowsheet : Measurements - Standard

4/2/2019 10:41 EDT

Height Contributor (ft)	5 ft
Height Contributor (inches)	11.5 inch

### Health Maintenance

#### Health Maintenance

**Pending** (in the next year)

##### OverDue

- Pneumococcal Vaccine due One-time only

##### Due

Body Mass Index Follow-Up Plan due 04/02/19 and every

HIV Screening due 04/02/19 One-time only

Influenza Vaccination due 04/02/19 and every

Tdap Vaccine due 04/02/19 One-time only

Tetanus Vaccine due 04/02/19 and every 10 year(s)

##### Due In Future

Body Mass Index not due until 03/11/20 and every 1 year(s)

**Satisfied** (in the past 1 year)

##### Satisfied

Diabetes Screening on 04/28/18. Satisfied by POWELL , CAROLYN B RTR

### Impression and Plan

Admit Date: 4/2/2019 10:40 EDT  
Disch Date: 4/2/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6435933572  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634770

## Office/Clinic Visit Notes

### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Summary: Doing fairly well.

### Plan

- 1) Medication: Zyprexa 5mg 2 tab at HS; Celexa 20mg daily. Adderall XR 20 BID.
- 2) Therapy - Patient is seeing a neurologist and plans to have neuropsych testing
- 3) Labwork Ordered - need updated labs - will order at next visit.
- 4) SA Treatment - Not indicated
- 5) RTC in 3 months for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.
- 9) Return to work written and given to patient.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**04/02/2019 11:30 AM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**04/03/19 01:59 PM**

Admit Date: 4/2/2019 10:40 EDT  
Disch Date: 4/2/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6435933572  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634770

**Behavioral Health Assessments**

DOCUMENT NAME: Behavioral Health Assessment  
 SERVICE DATE/TIME: 4/24/2019 12:37 EDT  
 RESULT STATUS: Auth (Verified)  
 PERFORM INFORMATION: RIALS ,LATASHA T NP (4/24/2019 12:38 EDT)  
 SIGN INFORMATION: LIVINGSTON ,RYAN EDWARD MD (4/24/2019 15:27 EDT);  
 RIALS ,LATASHA T NP (4/24/2019 12:38 EDT)

**WILLIAMS III, LEONARD CLINTON**

**DOB:** 11/01/1980  
**Sex:** Male

**MRN:** 0000642066  
**FIN:** 6437633200

**Relevant Clinical Documentation (last 24 hours)**

Universal Progress Note

04/24/19 06:36:00

**Night shift note 2300 - 0730: Patient rested quietly on bed with eyes closed, respirations slow and even. Q 15 minute checks maintained patient's safety. No acute distress noted. Will continue to monitor for safety and document behavior.**

Signed By: ROBINSON , JOSEPH H BH TECHNICIAN

\*\*\*\*\*

Universal Progress Note

04/23/19 14:41:00

P: SI/Delusional thoughts

I: Monitored behavior and safety. Encouraged patient come to staff if experiencing any symptoms. Offered food and fluids. Encouraged patient to attend group and interact with peers. Completed 15-minute rounds per protocol.

E: Patient spent a great amount of the day pacing in the halls. When talking with staff, his speech was rapid and pressured. His thoughts were tangential. He understood that he has paranoid thoughts, but said they were based in reality. He said people alienate him because of his mental illness and he does not know who tells people that he has been institutionalized. He said he is bipolar and knows how to regulate his own medication. He did not seem to find this dangerous. Patient appears manic. He did go to group. He ate well at meals and drank fluids. He also attended group. No other issues to report.

Admitted on: 04/22/2019

**Reason for Admission**

**Per initial Assessment/Plan on admission to ED:**

Pt is 38-year-old white male, previous diagnosis of bipolar 1 disorder (vs. schizoaffective d/o) and ADHD (? ASD), who presents to the emergency department in the early morning hours of 4/22 on a petition by his friend/former coworker for reports of delusional/paranoid and suicidal ideations. Upon initial evaluation, pt was noted to be hyperverbal with pressured, tangential speech, and did sound a bit paranoid when talking about how several of his coworkers turned against him. Given friend/coworker petition citing paranoia and recent text messages concerning for SI, pt was admitted to ED for observation until further collateral could be obtained. Initial review of EMR indicated pt stopped his Depakote, and initial examiner recommended pt either restart Depakote or increase nightly Zyprexa to 10 mg, but pt initially refused.

Therefore, pt continued Zyprexa 5 mg p.o. nightly; though he later requested increase to 10 mg, which was approved by ED physician in interim, prior to re-eval. Current meds: Adderall XR 40 mg and Celexa 20 mg p.o. nightly also continued. IVC/ERIC #1 completed on 4/22.

Per Clinton Krewson, PA on 4/23---Writer spoke w/ pt's OP psychiatrist via phone, who confirmed pt's history and that he is chronically hyperverbal but not delusional. We discussed current tx, meds, and plan for continued observation, additional collateral, and reevaluation w/ possible d/c tomorrow if pt maintains safety/stability and no immediate safety concerns are expressed by collateral. She was in agreement w/ this disposition and welcomed further questions/concerns from provider tomorrow, as needed.

Admit Date: 4/22/2019 03:35 EDT  
 Disch Date: 4/24/2019 12:30 EDT  
 Admitting: MORCIGLIO ,APRIL HARRELL MD  
 Attending: MORCIGLIO ,APRIL HARRELL MD  
 Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
 MRN: 0000642066 Acct#: 6437633200  
 DOB: 11/1/1980 Age: 38 years Sex: Male  
 Location: OUH  
 Print ID: 476634769

## Behavioral Health Assessments

Signed By: MURPHY , MARJORIE M BH TECHNICIAN

\*\*\*\*\*

### Universal Progress Note

04/23/19 11:20:00

Pt provided verbal consent to contact mother (Angie Haun) and friend / co-worker (Jennifer Cox) to obtain information on baseline functioning. See BH-Communication.

Signed By: SHIPP , SHAMIKKI R MSW

\*\*\*\*\*

### Universal Progress Note

04/23/19 10:16:00

D/C met with pt to follow up with disposition. Pt was cooperative however was speech was pressured. Pt spoke about triggers that led him to BH-Charlotte. PT processed his beliefs that his friends / co-workers were talking about him via Facebook that led to thoughts to harm self. Pt is aware of current disposition. He is currently linked to OMS clinic and he reported having an appointment on 4/25/19 with NP Peniston. Pt did not have any additional questions or concerns. D/C will continue to follow up with disposition.

Signed By: SHIPP , SHAMIKKI R MSW

\*\*\*\*\*

### Universal Progress Note

04/23/19 06:21:00

P: Substance abuse/psychosis  
I: Monitored behavior and safety. Encouraged patient come to staff if experiencing any symptoms. Offered food and fluids. Encouraged patient to attend group and interact with peers. Completed 15-minute rounds per protocol.  
E: Patient was sleep majority of the night only got up for snack. Slept without any interruptions.

Signed By: SIMMONS , ALEXIS

### Universal Progress Note

*Program :* BHC Adult Observation Unit  
*FARLEY , MICHAEL - 4/24/2019 11:39 EDT*  
*Universal Progress Note :* **LCSW met with patient and supported him in completion of safety plan. Patient did not have any questions or concerns about discharge plan. LCSW called transportation and arranged for yellow cab to pick up patient at 12:30.**

### Current Assessment

Observation day #2: Chart reviewed; BHC staff consulted; patient seen. No acute overnight events or behavior concerns. MAR reflects medication compliance and that the only prn med necessitated was acetaminophen. On assessment today, he is slightly anxious, talkative, but pleasant, polite, cooperative. He says that he is feeling good and is somewhat looking forward to discharge as he wants to maintain his outpatient appointment with NP Peniston on tomorrow. He goes on to explain how he and his Psych NP have been working well to establish a therapeutic rapport, and how his provider listens to his concerns--he is more than satisfied. He denies SI/HI/AI. He denies AVH, IOR, paranoia. No evidence of mania or delusional thought content. He is well composed and insightful. He did not appear distressed. Appropriate for discharge to outpatient--reportedly will f/u with OMS on 4/25 as scheduled.

### 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.

### Exam

#### Vitals & Measurements

**T:** 97.4 °F (Oral) **HR:** 90 (Peripheral) **RR:** 18 **BP:** 138/89  
**SpO2:** 98%

#### Mental Status Exam

**General appearance:** Appropriate grooming/hygiene. Fair eye contact. No major psychomotor abnormalities observed. No acute distress.

**Behavior:** Polite, cooperative.

**Gait & station:** Normal.

**Strength & tone:** Normal.

**Level of consciousness:** Alert.

**Orientation:** Oriented X 4.

**Attention & concentration:** Normal.

**Language:** Normal.

**Fund of knowledge:** Intelligent.

**Recent & remote memory:** No apparent deficits.

**Speech:** hyperverbal, over-productive, circumstantial.

**Thought processes:** Logical, Goal directed, Future oriented.

**Associations:** Intact.

**Mood:** "feeling good, just ready to go"

**Affect:** Restricted/blunted. Mildly anxious.

**Thought content:** Denies suicidal thoughts; denies homicidal thoughts; denies violent thoughts.

**Perceptions:** Denies auditory/visual hallucinations. No overt s/s psychosis.

**Insight:** Present.

**Judgment:** Intact.

### Risk Assessment

#### Suicide Risk Formulation

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

### Enduring Risk Factors :

**Strengths and protective factors :** Engaged in work or school,  
Identifies reasons for living

**Long-term risk factors :** Previous psychiatric diagnoses and  
treatments

Ineffective communication skills, Traumatic history, Financial  
concerns

**Past Suicidal behaviors :** Interrupted attempt lifetime

### Dynamic Risk Factors :

**Recent suicidal thoughts and behaviors :**

**Stressors :**

**Symptom and Recent Changes :** Mixed affective episode (Bipolar),  
Sexual abuse (lifetime)

**Columbia SSRS:** Reviewed / consistent with provider assessment

**Engagement:** good

**Risk Status (Specify low, Moderate or High based on normal  
population for care site):** Low

**Risk State (Relative to baseline for patient):** Low

**Protective factors:** Past positive response to treatment Motivated  
for treatment/ sobriety Supportive friend or family

**Resources:** Outpatient provider Stable home \_ \_

**Foreseeable Changes:** worsening mood \_ \_

**Contingency Plans:** safety plan, crisis numbers meds  
established close follow up

### Assessment and Plan/Disposition

1. ADHD

Ordered:

OBS, Discharge Day Management

### Discharge from BH ED or BH ED OBS to the community/ CSU:

**Assessment:** On assessment today, he is slightly anxious, talkative,  
but pleasant, polite, cooperative. He says that he is feeling good and is  
somewhat looking forward to discharge as he wants to maintain his  
outpatient appointment with NP Peniston on tomorrow. He goes on to  
explain how he and his OP MH team have been working well to establish  
a therapeutic rapport, and how his provider listens to his  
concerns--he is more than satisfied. He denies SI/HI/AI. He denies AVH,  
IOR, paranoia. No evidence of mania, acute psychosis, or delusional  
thought content. He is well composed and insightful. No overnight events.  
He did not appear distressed. At this time, he is appropriate for discharge  
to outpatient services--reportedly will f/u with OMS on 4/25 as  
scheduled. Says that he does not need Rx for the olanzapine "already  
have it". Further psychotropic management and diagnostic clarifications  
deferred to OP provider, however, pt is strongly encouraged to return to  
the ED in the event that he experiences any acute distress (medical or  
psychiatric), acute safety concerns, or worsening of symptoms.

**Discharge from:** BH ED

**Discharge to:** Home

FARLEY , MICHAEL - 4/24/2019 11:47 EDT [1]

### Clinical Risk Assessment Data

Assaultive Ideations: No

History of Danger to others: No

Homicidal Ideations: No

Does Patient Have a Plan: No

Access to Firearms/Weapons: No

Recent Attempt to Harm Others: No

#### **-CSSRS Screen-**

CSSRS Screen Able to Assess: Yes (04/21/19 23:53:00)

CSSRS Screen Wish to be Dead: Past month, no  
(04/21/19 23:53:00)

CSSRS Screen Suicidal Thoughts: Past month, no  
(04/21/19 23:53:00)

CSSRS Screen Suicide Behavior: Lifetime, yes (04/21/19  
23:53:00)

CSSRS Screen Suicide Behavior Timeline: Over a year  
ago (04/21/19 23:53:00)

#### **-CSSRS Reassessment-**

CSSRS Reassess Able to Assess: Yes (04/24/19  
09:00:00)

CSSRS Reassess Able to Assess: Yes (04/23/19  
09:00:00)

CSSRS Screen Wish to be Dead ReAsses: Since last  
visit, no (04/24/19 09:00:00)

CSSRS Screen Wish to be Dead ReAsses: Since last  
visit, no (04/23/19 09:00:00)

CSSRS Screen Suicidal Thoughts ReAsses: Since last  
visit, no (04/24/19 09:00:00)

CSSRS Screen Suicidal Thoughts ReAsses: Since last  
visit, no (04/23/19 09:00:00)

CSSRS Screen Suicide Behavior ReAsses: Since last  
visit, no (04/24/19 09:00:00)

CSSRS Screen Suicide Behavior ReAsses: Since last  
visit, no (04/23/19 09:00:00)

### Medical History

#### Medications

##### Inpatient

acetaminophen, 650 mg, 2 tablet, ORAL, q4h, PRN  
Adderall XR, 40 mg, 2 capsule, ORAL, qAM (every  
morning)

aluminum hydroxide/magnesium hydroxide/simethicone  
200 mg-200 mg-20 mg/5 mL oral suspension, 30 mL,  
ORAL, q4h, PRN

benztropine, 2 mg, 2 mL, IM (INTRAMUSCULAR), Once,  
PRN

CeleXA, 20 mg, 1 tablet, ORAL, qHS (each night at  
bedtime)

glucagon, 1 mg, IM (INTRAMUSCULAR), Once, PRN  
metFORMIN, 500 mg, 1 tablet, ORAL, Daily

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769



## Behavioral Health Assessments

Discharge with: Self \_

### Patient Education

Community Resources (CHS) (CUSTOM)  
COPING SKILLS (CUSTOM)  
Healthy Sleep (CHS) (CUSTOM)  
Combat Stress with a Healthy Lifestyle  
Treating ADHD: Medication  
Treating ADHD: Learning New Behaviors  
Problems Linked to ADHD

### Follow Up

#### Discharge Follow Up Appointments

CMC Randolph OMS (med clinic) NP  
501 Billingsley Rd  
704-358-2990  
704-358-2832  
Charlotte NC 28211 (704)358-2889  
Follow Up On: 04/25/2019 13:40

Follow up with primary care provider  
Follow up within: A Day Call for Next Available Appt

### Attestation

#### Attestation-Brief

I participated in the following activities of this patient's care: medical decision making.  
I personally performed: supervision of the patient's care, the physical exam, the medical decision making.  
Personally reviewed: reason for visit, triage, current visit intake assessment, patient information sheet, family/collateral information sheet, patient's medical record as applicable.  
Reviewed documentation: congruent with exam: description provided in History, Impression, and Rationale.  
New/Changed medications: risks/benefits discussed with patient and/or legally responsible person.  
The case was discussed with: patient, BHC staff; Dr. Ryan Livingston, MD.  
Results interpretation: I agree with the study interpretation in this patient's care.  
CSSR reviewed.

nicotine 2 mg oral transmucosal gum, 2 mg, 1 gum,  
CHEWED, q1hr, PRN  
ZyPREXA, 10 mg, 1 tablet, ORAL, qHS (each night at bedtime)  
Home  
a.wallace rn  
Adderall XR 20 mg oral capsule, extended release, See Instructions  
Adderall XR 20 mg oral capsule, extended release, See Instructions  
Adderall XR 20 mg oral capsule, extended release, See Instructions  
citalopram 20 mg oral tablet, 20 mg, 1 tablet, ORAL,  
Daily, 3 refills, **Still taking, not as prescribed:** Takes at HS  
Goodys Extra Strength, See Instructions  
metFORMIN, 500 mg  
ZyPREXA 5 mg oral tablet, See Instructions, 3 refills

#### Problem List/Past Medical History

##### Ongoing

None

##### Historical

Obesity

##### Allergies

No known allergies

#### Lab Results

	<u>LAST</u>	<u>PRIOR</u>	<u>RANG</u>	<u>UNITS</u>
<u>Toxicology/The</u>	<u>RESULT</u>	<u>RESULT</u>	<u>E</u>	
<u>rapeutic Drug</u>				
<u>Monitoring</u>				
<b>Adulterants,</b>	04/21/19			
<b>Urine - POC</b>	Negative			
	04/21/19			
<b>Benzodiazepin</b>	Negative			
<b>es (BZO), Ur</b>				
<b>Cocaine</b>	04/21/19			
<b>(COC), Urine -</b>	Negative			
<b>PO</b>				
<b>Marijuana</b>	04/21/19			
<b>(THC), Urine -</b>	Negative			
	04/21/19			
<b>Methamphetam</b>	Negative			
<b>ine (MET), Ur</b>				
<b>Morphine</b>	04/21/19			
<b>(MOP), Urine -</b>	Negative			
<b>P</b>				
	04/21/19			
<b>Amphetamine</b>	Positive			
<b>(AMP), Urine</b>				
<b>Barbiturates</b>	04/21/19			
<b>(BAR), Urine</b>	Negative			

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

Oxycodone 04/21/19  
(OXY), Urine - Negative  
Methadone 04/21/19  
(MTD), Urine - Negative  
MDMA, Urine 04/21/19  
- POC Negative

[1] BH Universal Progress Note; FARLEY , MICHAEL 04/24/2019 11:39 EDT

**Electronically Signed By: RIALS, LATASHA T NP**  
**04/24/2019 12:38 PM**

**Electronically Signed By: LIVINGSTON, RYAN EDWARD MD**  
**04/24/19 03:27 PM**

---

---

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

DOCUMENT NAME:  
SERVICE DATE/TIME:  
RESULT STATUS:  
PERFORM INFORMATION:  
SIGN INFORMATION:

Behavioral Health Assessment  
4/23/2019 13:27 EDT  
Auth (Verified)  
KREWSON ,CLINTON PA C (4/23/2019 13:27 EDT)  
HARTZELL ,MATTHEW L MD (4/23/2019 19:39 EDT);  
KREWSON ,CLINTON PA C (4/23/2019 13:35 EDT)

**WILLIAMS III, LEONARD  
CLINTON**

**Location:** CHS CMC  
Behavioral Health

Admitted on: 04/22/2019

### Reason for Admission

#### **Per initial Assessment/Plan on admission to ED:**

Pt is 38-year-old white male, previous diagnosis of bipolar 1 disorder (vs. schizoaffective d/o) and ADHD (? ASD), who presents to the emergency department in the early morning hours of 4/22 on a petition by his friend/former coworker for reports of delusional/paranoid and suicidal ideations. Upon initial evaluation, pt was noted to be hypervocal with pressured, tangential speech, and did sound a bit paranoid when talking about how several of his coworkers turned against him. Given friend/coworker petition citing paranoia and recent text messages concerning for SI, pt was admitted to ED for observation until further collateral could be obtained. Initial review of EMR indicated pt stopped his Depakote, and initial examiner recommended pt either restart Depakote or increase nightly Zyprexa to 10 mg, but pt initially refused.

Therefore, pt continued Zyprexa 5 mg p.o. nightly; though he later requested increase to 10 mg, which was approved by ED physician in interim, prior to re-eval. Current meds: Adderall XR 40 mg and Celexa 20 mg p.o. nightly also continued. IVC/ERIC #1 completed on 4/22.

### Current Assessment

OBS#1

Chart reviewed, patient seen and assessed, case discussed with treatment team. No acute events yesterday or overnight. No PRN/stat psych medications or restrictive interventions required since admission. No acute aggression, agitation, or self-harm. CSSRS consistently negative for SI. Pt denies present or historical HI/bx. Denies current AVH. Pt remains compliant w/ current medications and denies adverse s/e. Pt accepting food/fluids normally. Slept overnight, per staff reports.

Upon reevaluation today, patient was found in the dayroom and agreeable to meeting with writer for assessment. He presented as polite and was fully cooperative with questioning. Patient reviewed his psychiatric history at length w/ writer, including recent sxs/events precipitating his IVC to ED. Pt acknowledges a history of experiencing mania w/ psychotic fts (primarily paranoia/delusions) and admits that recent social, occupational, and financial stressors have led to psychiatric

### Relevant Clinical Documentation (last 24 hours)

#### **Collateral Information**

*Name of Collateral :* Angie [REDACTED] (Mother)

*Collateral Phone Number :* 423-[REDACTED]

*Collateral Relationship :* Mother

*Information Provided by Collateral :* D/C spoke with mother to obtain collateral and discuss discharge planning. Mother indicated that pt is doing better and that she did not have any concerns. Mother reported that she will come for visitation today and provide feedback regarding baseline functioning. Mother is aware of anticipating discharge for 4/24/19. Mother did not report any safety concerns. D/C will continue to follow up with disposition.

[1]

#### **Collateral Information**

*Name of Collateral :* Jennifer Cox (Petitioner)

*Collateral Phone Number :* 704-[REDACTED]

*Collateral Relationship :* Other: Friend / Co-worker

*Information Provided by Collateral :* D/C spoke with Jennifer Cox (Petitioner) to obtain information on baseline functioning. Jennifer indicated that pt "sounded a lot more normal and erratic behaviors have not been witnessed" since BH-Charlotte admission to Observation Unit. She reported that pt has insight and is able to explain and acknowledge his behaviors. Jennifer stated that pt "promise" to follow up with provider recommendations for continued care once discharge. Jennifer claimed that pt resides alone and she will continue to provide support as needed. Jennifer did not report any safety concerns at this time.

[2]

### Clinical Risk Assessment Data

Assaultive Ideations: No  
History of Danger to others: No  
Homicidal Ideations: No  
Does Patient Have a Plan: No  
Access to Firearms/Weapons: No  
Recent Attempt to Harm Others: No

#### **-CSSRS Screen-**

CSSRS Screen Able to Assess: Yes (04/21/19 23:53:00)

CSSRS Screen Wish to be Dead: Past month, no (04/21/19 23:53:00)

CSSRS Screen Suicidal Thoughts: Past month, no

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

decompensation over the past 1-2 weeks. Pt is able to recount and describe his symptoms, acknowledging recent increase in paranoia/suspicion resulting in increased levels of distress and worsening manic sx's (racing thoughts, decreased sleep, increased energy, impulsivity) that he became evident of since his admission to ED. He fully admits to making impulsive and concerning statements via text message to his friend during this recent period of distress/mania, including suicidal statements; though he denies ever having any actual plan or intention to harm himself during that time. He also denies any present or historical HI/bxs, violence, or access to firearms.

Since admission to ED, pt has voluntarily requested/accepted increased dose of Zyprexa. He admits to sleeping poorly his first night due to his sx's as well as late admission/med administration time, but he reports sleeping well/normally last night. He also reports improved mood, describing currently feeling "content, even-keeled" and denies feeling depressed, irritable, or elevated. His affect is somewhat blunted/restricted. He denies any ongoing paranoia/suspicion and is able to discuss these thoughts with improved insight and clarity today. He further denies any ongoing acute sx's of mania or psychosis. His speech remains fast, overproductive, and circumstantial, which he reports is his baseline; his thoughts appear linear, goal-directed, and future-oriented. Thought content is logical and non-bizarre. No overt delusions, hallucinations, paranoia/suspicion, grandiosity, flight of ideas, or disorganization. No major psychomotor abnormalities.

Since his admission, pt reports talking w/ his friend/coworker/petitioner multiple times via phone, and he reports his mother intends to visit him in the ED later today. Pt is agreeable to signing ROI for EDSW to communicate w/ both these persons for collateral to better assess his current presentation/baseline. Writer recommended pt remain in ED/Obs today to ensure continued safety/stability and allow time for additional collateral to be obtained and possible discharge planning to occur. Pt was agreeable w/ this plan but expressed desire to be discharged soon due to upcoming job interview and other work obligations. He reported having his next f/u appt with OP psychiatrist, Kathleen Peniston, scheduled for this Thursday, which he plans to attend. And he also reports plan to stay with his mother for the following week while he completes some freelance work in that area.

Writer spoke w/ pt's OP psychiatrist via phone, who confirmed pt's history and affirmed that he is chronically hyperverbal but not delusional. We discussed current tx, meds, and plan for continued observation, additional collateral, and reevaluation w/ possible d/c tomorrow if pt maintains safety/stability and no immediate safety concerns are expressed by collateral. She was in agreement w/ this disposition and welcomed further questions/concerns from provider tomorrow, as needed.

### 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.

(04/21/19 23:53:00)

CSSRS Screen Suicide Behavior: Lifetime, yes (04/21/19 23:53:00)

CSSRS Screen Suicide Behavior Timeline: Over a year ago (04/21/19 23:53:00)

### -CSSRS Reassessment-

CSSRS Reassess Able to Assess: Yes (04/23/19 09:00:00)

CSSRS Reassess Able to Assess: Yes (04/22/19 09:00:00)

CSSRS Screen Wish to be Dead ReAsses: Since last visit, no (04/23/19 09:00:00)

CSSRS Screen Wish to be Dead ReAsses: Since last visit, no (04/22/19 09:00:00)

CSSRS Screen Suicidal Thoughts ReAsses: Since last visit, no (04/23/19 09:00:00)

CSSRS Screen Suicidal Thoughts ReAsses: Since last visit, no (04/22/19 09:00:00)

CSSRS Screen Suicide Behavior ReAsses: Since last visit, no (04/23/19 09:00:00)

CSSRS Screen Suicide Behavior ReAsses: Since last visit, no (04/22/19 09:00:00)

### Medical History

#### Medications

##### Inpatient

acetaminophen, 650 mg, 2 tablet, ORAL, q4h, PRN  
Adderall XR, 40 mg, 2 capsule, ORAL, qAM (every morning)

aluminum hydroxide/magnesium hydroxide/simethicone  
200 mg-200 mg-20 mg/5 mL oral suspension, 30 mL, ORAL, q4h, PRN

benztropine, 2 mg, 2 mL, IM (INTRAMUSCULAR), Once, PRN

CeleXA, 20 mg, 1 tablet, ORAL, qHS (each night at bedtime)

glucagon, 1 mg, IM (INTRAMUSCULAR), Once, PRN

metFORMIN, 500 mg, 1 tablet, ORAL, Daily

nicotine 2 mg oral transmucosal gum, 2 mg, 1 gum, CHEWED, q1hr, PRN

ZyPREXA, 10 mg, 1 tablet, ORAL, qHS (each night at bedtime)

##### Home

a.wallace rn

Adderall XR 20 mg oral capsule, extended release, See Instructions

Adderall XR 20 mg oral capsule, extended release, See Instructions

Adderall XR 20 mg oral capsule, extended release, See Instructions

citalopram 20 mg oral tablet, 20 mg, 1 tablet, ORAL,

Daily, 3 refills, **Still taking, not as prescribed:** Takes at HS

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

### Exam

#### Vitals & Measurements

**T:** 97.3 °F (Oral) **HR:** 80 (Peripheral) **RR:** 18 **BP:** 126/79  
**SpO2:** 96%

#### Mental Status Exam

**General appearance:** Appropriate grooming/hygiene. Fair eye contact. No major psychomotor abnormalities observed. No acute distress.

**Behavior:** Polite, cooperative.

**Gait & station:** Normal.

**Strength & tone:** Normal.

**Level of consciousness:** Alert.

**Orientation:** Oriented X 4.

**Attention & concentration:** Normal.

**Language:** Normal.

**Fund of knowledge:** Intelligent.

**Recent & remote memory:** No apparent deficits.

**Speech:** Rapid, hyperverbal, over-productive, circumstantial.

**Thought processes:** Logical, Goal directed, Future oriented.

**Associations:** Intact.

**Mood:** "Content, even-keeled"

**Affect:** Restricted/blunted. Mildly anxious.

**Thought content:** Denies suicidal thoughts; denies homicidal thoughts.

**Perceptions:** Denies auditory/visual hallucinations. No overt s/s psychosis.

**Insight:** Present.

**Judgment:** Intact.

#### Risk Assessment

CSSRS reviewed.

#### Assessment and Plan/Disposition

##### **ASSESSMENT**

Pt is able to recount and describe recent symptoms, acknowledging recent increase in manic sx's including paranoia/suspicion resulting in distress, impulsive suicidal statements, and admission to ED. He denies ever having any plan or intention to harm/kill himself during that time. He acknowledges hx of passive SI during periods of distress but denies any suicidal behavior for past 20 yrs (Hx OD at age 18). Denies history of homicidality. Denies access to firearms.

Since admission to ED, pt has voluntarily requested/accepted increased dose of Zyprexa. He admits to sleeping poorly his first night due to his sx's as well as late admission/med administration time, but he reports sleeping well/normally last night. He also reports improved mood and denies feeling depressed, irritable, or elevated; affect is somewhat blunted/restricted. Denies ongoing paranoia/suspicion and is able to discuss these thoughts with improved insight and clarity. Denies any ongoing acute sx's of mania or psychosis. Speech remains fast, overproductive, and circumstantial, which appears to be his baseline (per collateral reports); thoughts appear linear, goal-directed, and future-oriented; thought content is logical and non-bizarre. No overt delusions, hallucinations, paranoia, grandiosity, flight of ideas, or

Goodys Extra Strength, See Instructions  
 metFORMIN, 500 mg  
 ZYPREXA 5 mg oral tablet, See Instructions, 3 refills

#### Problem List/Past Medical History

Ongoing

None

Historical

Obesity

#### Allergies

No known allergies

#### Lab Results

	<u>LAST</u>	<u>PRIOR</u>	<u>RANG</u>	<u>UNITS</u>
<u>Toxicology/The</u>	<u>RESULT</u>	<u>RESULT</u>	<u>E</u>	
<u>rapeutic Drug</u>				
<u>Monitoring</u>				
<b>Adulterants,</b>	04/21/19			
<b>Urine - POC</b>	Negative			
	04/21/19			
<b>Benzodiazepin</b>	Negative			
<b>es (BZO), Ur</b>				
<b>Cocaine</b>	04/21/19			
<b>(COC), Urine -</b>	Negative			
<b>PO</b>				
<b>Marijuana</b>	04/21/19			
<b>(THC), Urine -</b>	Negative			
	04/21/19			
<b>Methamphetam</b>	Negative			
<b>ine (MET), Ur</b>				
<b>Morphine</b>	04/21/19			
<b>(MOP), Urine -</b>	Negative			
<b>P</b>				
	04/21/19			
<b>Amphetamine</b>	Positive			
<b>(AMP), Urine</b>				
<b>Barbiturates</b>	04/21/19			
<b>(BAR), Urine</b>	Negative			
<b>Oxycodone</b>	04/21/19			
<b>(OXY), Urine -</b>	Negative			
<b>Methadone</b>	04/21/19			
<b>(MTD), Urine -</b>	Negative			
<b>MDMA, Urine</b>	04/21/19			
<b>- POC</b>	Negative			

Admit Date: 4/22/2019 03:35 EDT  
 Disch Date: 4/24/2019 12:30 EDT  
 Admitting: MORCIGLIO ,APRIL HARRELL MD  
 Attending: MORCIGLIO ,APRIL HARRELL MD  
 Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
 MRN: 0000642066 Acct#: 6437633200  
 DOB: 11/1/1980 Age: 38 years Sex: Male  
 Location: OUH  
 Print ID: 476634769

## Behavioral Health Assessments

disorganization.

Since his admission, pt reports talking w/ his friend/coworker/petitioner multiple times via phone, and he reports his mother intends to visit him in the ED later today. Pt is agreeable to signing ROI for EDSW to communicate w/ both these persons for collateral to better assess his current presentation/baseline. Writer recommended pt remain in ED/Obs today to ensure continued safety/stability and allow time for additional collateral to be obtained and dispo planning. Pt was agreeable w/ this plan. Reports next f/u appt with BHC OMS psychiatrist, Kathleen Peniston, scheduled for 4/25.

Writer spoke w/ pt's OP psychiatrist via phone, who confirmed pt's history and that he is chronically hypervocal but not delusional. We discussed current tx, meds, and plan for continued observation, additional collateral, and reevaluation w/ possible d/c tomorrow if pt maintains safety/stability and no immediate safety concerns are expressed by collateral. She was in agreement w/ this disposition and welcomed further questions/concerns from provider tomorrow, as needed.

### PLAN

#### 1. Disposition:

- Remain in ED/Obs, pending reevaluation.
- Possible d/c tomorrow.
- Next OMS appt 4/25.

#### 2. Medications:

- Continue current medication as prescribed.
- No med changes made today.

#### 3. Precautions:

- Continue routine (PL3) monitoring.

#### 4. Collateral:

- EDSW to contact petitioner/friend.
- Mother to visit, provide feedback.

### Attestation

I personally performed: the medical history, the exam, the medical decision making.

Personally reviewed: reason for visit, triage, current visit intake assessment, call center documentation, patient's medical record as applicable.

Reviewed documentation: congruent with exam.

New/Changed medications: risks/benefits discussed with patient and/or legally responsible person.

The case was discussed with: patient, nursing, social work, OP psychiatrist

[1] Collateral Information; SHIPP , SHAMIKKI R MSW 04/23/2019 13:19 EDT

[2] Collateral Information; SHIPP , SHAMIKKI R MSW 04/23/2019 11:28 EDT

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

Electronically Signed By: KREWSON, CLINTON PA C  
04/23/2019 01:35 PM

Electronically Signed By: HARTZELL, MATTHEW L MD  
04/23/19 07:39 PM

---

---

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

DOCUMENT NAME: Behavioral Health Assessment  
SERVICE DATE/TIME: 4/22/2019 02:56 EDT  
RESULT STATUS: Auth (Verified)  
PERFORM INFORMATION: MORCIGLIO ,APRIL HARRELL MD (4/22/2019 03:15 EDT)  
SIGN INFORMATION: MORCIGLIO ,APRIL HARRELL MD (4/22/2019 03:34 EDT)

**WILLIAMS III, LEONARD  
CLINTON**

**DOB:** 11/01/1980  
**Sex:** Male

**MRN:** 0000642066  
**FIN:** 6437633200

**Location:** CHS CMC  
Behavioral Health

### Clinical Risk Assessment Data

Assaultive Ideations: No  
History of Danger to others: No  
Homicidal Ideations: No  
Does Patient Have a Plan: No  
Access to Firearms/Weapons: No  
Recent Attempt to Harm Others: No  
**-CSSRS Screen-**  
CSSRS Screen Able to Assess: Yes (04/21/19 23:53:00)  
CSSRS Screen Wish to be Dead: Past month, no (04/21/19 23:53:00)  
CSSRS Screen Suicidal Thoughts: Past month, no (04/21/19 23:53:00)  
CSSRS Screen Suicide Behavior: Lifetime, yes (04/21/19 23:53:00)  
CSSRS Screen Suicide Behavior Timeline: Over a year ago (04/21/19 23:53:00)

### History of Present Illness

38-year-old white male, previous diagnosis of bipolar 1 disorder, ADHD, presents to the emergency department on a petition by his friend/former coworker.

The petition reads as follows: Respondent has recently exhibited delusional behaviors and suicidal ideations. He believes that coworkers are "out to get" him and that he is in immediate danger from them. His speech is pressured and incoherent and his apartment is unkempt and neglected. He sent petitioner (friend/coworker) numerous texts outlining his intention to self-harm. Respondent has previous diagnosis of schizoaffective disorder. Unknown meds. Petitioner fears for his ultimate safety.

Nursing attempted to reach petitioner for collateral information but was unable to reach her.

Patient has been followed for several years at the OMS clinic and has most recently been followed by NP Peniston. He has been seen at OMS since 2011. His most recent OMS visit was 2 weeks ago when he saw NP Peniston on April 2. Review of that clinic note shows that patient was currently on Zyprexa, Celexa and Adderall. He had previously been on Depakote but he stopped that on his own. He had also previously been prescribed Saphris but he never filled it secondary to cost. At the end of that visit patient was to continue taking Zyprexa 5 mg 2 tablets at night, Celexa 20 mg daily and Adderall XR 20 mg twice daily. Review of his first clinic visit in November 2011 shows that patient was diagnosed with bipolar disorder at age 18 when he was hospitalized at Broughton State Hospital for 72 days. Dr. Gleditsch also documented in his clinic note from that visit that patient had a brief hospitalization at Woodridge in TN for 4 days. Tonight patient told nursing that he has a diagnosis of autism spectrum disorder. However, review of clinic notes over the past 8 years showed no evidence of an autism diagnosis.

On interview patient is hypervocal with pressured, tangential speech. He denied information on the petition and stated that his friend, who is also a former coworker, did this out of spite because they have been arguing lately. He says that she just did this because they've been in a power struggle. Patient also explained that he currently has no coworkers. He works as a freelance web designer. When I asked more questions, he did admit that he previously worked in Wells Fargo for 4 years up until June 2018. When talking about working at Wells Fargo he

### Medical History

#### Problem List/Past Medical History

Ongoing  
None  
Historical  
Obesity

### Psychiatric History/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.  
Diabetes mellitus: Negative: Mother, Father, Sister, Brother, GF, Maternal, GF, Paternal, GM, Maternal, GM, Paternal and Grandparent.  
HYPERTENSION: GM, Maternal.  
Psych Hx--bipolar disorder, ADHD

### Social History/Substance Use 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

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769



## Behavioral Health Assessments

did sound a bit paranoid when talking about how several of his coworkers turned against him. He does not know exactly why, but he believes it was because of something related to Facebook. Discussed with patient that the fact that his friend and coworker petition him for paranoia and sending text messages outlining how he is going to harm himself, is very worrisome. Explained to him that from reviewing his clinic notes it appears that he stopped his Depakote on his own and I recommended that we either restart Depakote or increase Zyprexa to 10 mg at night. Patient adamantly refused. I then recommended a overnight observation stay for further monitoring of symptoms and to also get additional information from the petitioner. Explained to him that nursing called her, I called her and no one has been able to reach her as of yet. Given the allegations on the petition I would like to speak with her and also see the text messages she is referring to before we consider discharge.

Plan to admit to observation for safety and further evaluation; continue Zyprexa 5 mg p.o. nightly, Adderall XR 20mg BID and Celexa 20 mg p.o. nightly; continue to try to reach the petitioner for collateral information and to also see if she can bring the text messages to the hospital. Reevaluate on April 23 and at that time we will be able to make a better informed decision about inpatient treatment versus discharge after we get additional information from the petitioner.

### 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.

### Exam

#### Vitals & Measurements

**T:** 98.5 °F (Oral) **HR:** 105 (Peripheral) **RR:** 18 **BP:** 131/97  
**SpO2:** 97%

#### Mental Status Exam

**General appearance:** Appropriately dressed and groomed Normal eye contact Cooperative Not internally preoccupied or responding to internal stimuli No psychomotor retardation or agitation Normal body habitus for age

**Gait & Station:** Normal

**Strength & tone:** Normal

**Attention & concentration:** Normal

**Orientation:** Oriented x4

**Language:** Normal

**Fund of knowledge:** Average

**Recent and remote memory:** No impairment in recent or remote

**Speech:** Pressured

**Thought process:** Tangential

**Associations:** Tangential

**Mood:** Anxious

**Affect:** Appropriate to stated mood/ thought content

**Thought content related to harm to self or others:** Denies suicidal thoughts Denies suicidal intent Denies having a plan for suicide Denies homicidal ideation

**Thought content (not related to dangerousness):** No disturbance in

Highest Education: College graduate.

Freelance graphic art

Home/Environment

Marital Status: Single. lives in an apartment by himself

Nutrition/Health

Home Diet: Diabetic.

Tobacco

Never smoker, 0 Yrs Smoker. 0 Avg # Packs Per Day.

### Medications

#### Inpatient

No active inpatient medications

#### Home

a.wallace rn

Adderall XR 20 mg oral capsule, extended release, See Instructions

Adderall XR 20 mg oral capsule, extended release, See Instructions

Adderall XR 20 mg oral capsule, extended release, See Instructions

citalopram 20 mg oral tablet, 20 mg, 1 tablet, ORAL, Daily, 3 refills, **Still taking, not as prescribed:** Takes at HS

Goodys Extra Strength, See Instructions

metFORMIN, 500 mg

ZyPREXA 5 mg oral tablet, See Instructions, 3 refills

### Allergies

No known allergies

### Lab Results

	<u>LAST</u>	<u>PRIOR</u>	<u>RANGE/UNITS</u>
<u>Toxicology/Therapeutic Drug Monitoring</u>	<u>RESULT</u>	<u>RESULT</u>	
<b>Adulterants,</b>	04/21/19		
<b>Urine - POC</b>	Negative		
	04/21/19		
<b>Benzodiazepines (BZO), Ur</b>	Negative		
<b>Cocaine</b>	04/21/19		
<b>(COC), Urine - PO</b>	Negative		
<b>Marijuana</b>	04/21/19		
<b>(THC), Urine -</b>	Negative		
	04/21/19		
<b>Methamphetamine (MET), Ur</b>	Negative		
<b>Morphine</b>	04/21/19		
<b>(MOP), Urine - P</b>	Negative		
<b>Amphetamine (AMP), Urine</b>	04/21/19		
	Positive		
<b>Barbiturates</b>	04/21/19		
<b>(BAR), Urine</b>	Negative		

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Behavioral Health Assessments

thought content \_ \_

**Perceptions:** No perceptual disturbances No auditory hallucinations Paranoid thoughts (see HPI) No visual hallucinations

**Insight:** Limited

**Judgment:** Limited

**Oxycodone** 04/21/19  
**(OXY), Urine -** Negative  
**Methadone** 04/21/19  
**(MTD), Urine -** Negative  
**MDMA, Urine** 04/21/19  
**- POC** Negative

### Risk Assessment

#### Suicide Risk Formulation

#### Enduring Risk Factors :

**Strengths and protective factors :** Engaged in work or school, Identifies reasons for living

**Long-term risk factors :** Previous psychiatric diagnoses and treatments

Ineffective communication skills, Traumatic history, Financial concerns

**Past Suicidal behaviors :** Interrupted attempt lifetime

#### Dynamic Risk Factors :

#### Recent suicidal thoughts and behaviors :

#### Stressors :

**Symptom and Recent Changes :** Mixed affective episode (Bipolar), Sexual abuse (lifetime)

**Columbia SSRS:** Reviewed / consistent with provider assessment

#### Engagement:

**Risk Status (Specify low, Moderate or High based on normal population for care site):** Medium

**Risk State (Relative to baseline for patient):** Medium

**Protective factors:** Past positive response to treatment \_ \_

**Resources:** Outpatient provider \_ \_

**Foreseeable Changes:** worsening mood \_ \_

**Contingency Plans:** Admit to OBS \_ \_

### Assessment and Plan/Disposition

1. Bipolar 1 disorder

2. ADHD

**Admission to ED Observation/Inpt Tx IS NOT RECOMMENDED at this time:**

#### **Assessment:**

38-year-old white male, previous diagnosis of bipolar 1 disorder, ADHD, presents to the emergency department on a petition by his friend/former coworker.

The petition reads as follows: Respondent has recently exhibited delusional behaviors and suicidal ideations. He believes that coworkers are "out to get" him and that he is in immediate danger from them. His speech is pressured and incoherent and his apartment is unkempt and neglected. He sent petitioner (friend/coworker) numerous texts outlining his intention to self-harm. Respondent has previous diagnosis of schizoaffective disorder. Unknown meds. Petitioner fears for his ultimate safety.

Nursing attempted to reach petitioner for collateral information but was

Admit Date: 4/22/2019

03:35 EDT

Disch Date: 4/24/2019

12:30 EDT

Admitting: MORCIGLIO ,APRIL HARRELL MD

Attending: MORCIGLIO ,APRIL HARRELL MD

Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6437633200

DOB: 11/1/1980

Age: 38 years

Sex: Male

Location: OUH

Print ID: 476634769

## Behavioral Health Assessments

unable to reach her.

Patient was hypervocal with pressured, tangential speech. He denied information on the petition and stated that his friend, who is also a former coworker, did this out of spite because they have been arguing lately. He says that she just did this because they've been in a power struggle. Patient also explained that he currently has no coworkers. He works as a freelance web designer. When I asked more questions, he did admit that he previously worked in Wells Fargo for 4 years up until June 2018. When talking about working at Wells Fargo he did sound a bit paranoid when talking about how several of his coworkers turned against him. He does not know exactly why, but he believes it was because of something related to Facebook.

Discussed with patient that the fact that his friend and coworker petition him for paranoia and sending text messages outlining how he is going to harm himself, is very worrisome.

Explained to him that from reviewing his clinic notes it appears that he stopped his Depakote on his own and I recommended that we either restart Depakote or increase Zyprexa to 10 mg at night. Patient adamantly refused.

I then recommended a overnight observation stay for further monitoring of symptoms and to also get additional information from the petitioner. Explained to him that nursing called her, I called her and no one has been able to reach her as of yet. Given the allegations on the petition I would like to speak with her and also see the text messages she is referring to before we consider discharge.

Plan to admit to observation for safety and further evaluation; continue Zyprexa 5 mg p.o. nightly, Adderall XR 20mg BID and Celexa 20 mg p.o. nightly; continue to try to reach the petitioner for collateral information and to also see if she can bring the text messages to the hospital. Reevaluate on April 23 and at that time we will be able to make a better informed decision about inpatient treatment versus discharge after we get additional information from the petitioner.

**Reason for Admission:** Suicidal ideation/ attempt **Disposition**

**Plan:** Admission to OBS is current recommendation, but if rapid improvement is not seen in the next 24-48hrs, the plan will be to proceed to inpt level of care.

**Legal Status:** Involuntary; PIC/ ERIC #1 completed **Collateral information:** \_ \_

**Monitoring Status:** PL-3 **Specific Monitoring Needs:** None

**Suicide Risk Monitoring:** Daily **Specific Order Set(s) for Care**

**Management:** None \_

**Medication:** see above

### Follow Up

No Follow Up Appointments documented.

### Attestation

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

**Reviewed Documentation:** Congruent with exam

Admit Date: 4/22/2019

03:35 EDT

Disch Date: 4/24/2019

12:30 EDT

Admitting: MORCIGLIO ,APRIL HARRELL MD

Attending: MORCIGLIO ,APRIL HARRELL MD

Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6437633200

DOB: 11/1/1980

Age: 38 years

Sex: Male

Location: OUH

Print ID: 476634769

## Behavioral Health Assessments

**New/Changed medications:** Not applicable to this assessment

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

**Electronically Signed By: MORCIGLIO, APRIL HARRELL MD**  
**04/22/2019 03:34 AM**

---

---

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

**Behavioral Health Assessments**

DOCUMENT NAME: Psychiatric Assessment  
SERVICE DATE/TIME: 4/22/2019 11:04 EDT  
RESULT STATUS: Auth (Verified)  
PERFORM INFORMATION: ELLIS ,CHARLI DO (4/22/2019 11:06 EDT)  
SIGN INFORMATION: ELLIS ,CHARLI DO (4/22/2019 11:06 EDT)

**WILLIAMS III, LEONARD CLINTON**

**DOB:** 11/01/1980  
**Sex:** Male

**MRN:** 0000642066  
**FIN:** 6437633200

Pt's an after midnight case and therefore will not be assigned to any dayshift docs. The pt has been asking the RN if his Zyprexa can be for 10 mg qhs; his previous dose. I read his eval from Dr. Morciglio and her plan was to start him on 5 mg qhs of Zyprexa. Since he's been here he received a scheduled Zyprexa 5 mg and a 1x dose so he received 10 mg and has tolerated this. Will change Zyprexa to 10 mg qhs.

**Electronically Signed By: ELLIS, CHARLI DO**  
**04/22/2019 11:06 AM**

**Chemistry****Accession Number:**

<b>Orderable Name:</b>	<b>Collected Date/Time:</b> 4/21/2019 23:45 EDT	<b>Result Date/Time:</b> 4/22/2019 00:22 EDT
------------------------	---	--

Procedure	Result	Units	Reference Range
Breathalyzer Results	0.00		
Adulterants,Urine -POC	Negative		
Benzodiazepines (BZO),Urine -POC	Negative		
Cocaine (COC),Urine -POC	Negative		
Marijuana (THC),Urine -POC	Negative		
Methamphetamine (MET), Urine -POC	Negative		
Morphine (MOP),Urine -POC	Negative		
Amphetamine (AMP),Urine - POC	Positive		
Barbiturates (BAR),Urine - POC	Negative		
Oxycodone (OXY),Urine - POC	Negative		
Methadone (MTD),Urine - POC	Negative		
MDMA,Urine -POC	Negative		

<b>Orderable Name:</b> Urine Drug Screen POC (BH ED) (POC Urine Drug Screen (BH ED))	<b>Collected Date/Time:</b> 4/22/2019 03:57 EDT	<b>Result Date/Time:</b>
--	---	--------------------------

Procedure	Result	Units	Reference Range
Breathalyzer Results	Not Done: Task duplication		

Admit Date: 4/22/2019 03:35 EDT  
Disch Date: 4/24/2019 12:30 EDT  
Admitting: MORCIGLIO ,APRIL HARRELL MD  
Attending: MORCIGLIO ,APRIL HARRELL MD  
Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437633200  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: OUH  
Print ID: 476634769

## Chemistry

<b>Orderable Name:</b> Urine Drug Screen POC (BH ED) (POC Urine Drug Screen (BH ED))		<b>Collected Date/Time:</b> 4/22/2019 03:57 EDT	<b>Result Date/Time:</b>
<b>Procedure</b>	<b>Result</b>	<b>Units</b>	<b>Reference Range</b>
ED Urine Pregnancy Test	Not Done: Task duplication		

## Point of Care

**Accession Number:**

<b>Orderable Name:</b>		<b>Collected Date/Time:</b> 4/21/2019 23:45 EDT	<b>Result Date/Time:</b> 4/22/2019 00:22 EDT
<b>Procedure</b>	<b>Result</b>	<b>Units</b>	<b>Reference Range</b>
Breathalyzer	Yes		
Breathalyzer Results	0.00		
Adulterants,Urine -POC	Negative		
Marijuana (THC),Urine -POC	Negative		
Cocaine (COC),Urine -POC	Negative		
Morphine (MOP),Urine -POC	Negative		
Amphetamine (AMP),Urine - POC	Positive		
Methamphetamine (MET), Urine -POC	Negative		
Barbiturates (BAR),Urine - POC	Negative		
Benzodiazepines (BZO),Urine -POC	Negative		
MDMA,Urine -POC	Negative		
Methadone (MTD),Urine - POC	Negative		
Oxycodone (OXY),Urine - POC	Negative		
Caregivers Name -Nsg	MERRITT , KENNETH BH TECHNICIAN		
Result Read Date/Time	4/21/2019 23:45 EDT		

<b>Orderable Name:</b> Urine Drug Screen POC (BH ED) (POC Urine Drug Screen (BH ED))		<b>Collected Date/Time:</b> 4/22/2019 03:57 EDT	<b>Result Date/Time:</b>
<b>Procedure</b>	<b>Result</b>	<b>Units</b>	<b>Reference Range</b>
ED Urine Pregnancy Test	Not Done: Task duplication		
Breathalyzer	Not Done: Task duplication		
Breathalyzer Results	Not Done: Task duplication		
Caregivers Name -Nsg	Not Done: Task duplication		
Result Read Date/Time	Not Done: Task duplication		

Admit Date: 4/22/2019 03:35 EDT  
 Disch Date: 4/24/2019 12:30 EDT  
 Admitting: MORCIGLIO ,APRIL HARRELL MD  
 Attending: MORCIGLIO ,APRIL HARRELL MD  
 Printed: 7/8/2021 06:59 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
 MRN: 0000642066 Acct#: 6437633200  
 DOB: 11/1/1980 Age: 38 years Sex: Male  
 Location: OUH  
 Print ID: 476634769

**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6437855822  
Age: **38 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed. Last seen in OMS by this writer on 4/25/19. On Zyprexa, Celexa, Adderall.

- Patient was seen one week ago. Missed Celexa x 2 days. Some low mood.
- Sleep: good. Appetite: fair Energy: good Concentration: fair
- Turned down for job in South Carolina - said there was a better fit.
- Still working on own business - trying to get business started.
- No SI/HI/Psychosis. Patient denies any ETOH or drug use.
- Patient has a lot of confidence in professional abilities. Does not like corporate.

**Review of Systems**

**Constitutional:** Negative except as documented in history of present illness.

**Health Status**

**Allergies:**

Allergic Reactions (All)

No known allergies

**Current medications:** (Selected)

Prescriptions

*Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 3 Refill(s)

Admit Date: 5/1/2019 10:40 EDT  
Disch Date: 5/1/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437855822  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634768

## Office/Clinic Visit Notes

citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 3 Refill(s)

### Documented Medications

#### *Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed

Med List Status - Updated: KKP NP, 0 Refill(s)

metFORMIN: 500 mg, daily, 0 Refill(s)

### **Problem list:**

#### All Problems

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### **Histories**

#### **Past Medical History:**

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

#### **Family History:**

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

#### **Procedure history:**

No active procedure history items have been selected or recorded.

#### **Social History**

##### Social & Psychosocial Habits

##### **Home/Environment**

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

##### **Alcohol**

04/25/2019 **Use:** Denies

##### **Drug Abuse**

04/25/2019 **Use:** Denies

##### **Employment/School**

Admit Date: 5/1/2019 10:40 EDT  
Disch Date: 5/1/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437855822  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634768



## Office/Clinic Visit Notes

04/22/2019 **Description:** Frelance graffic art

04/22/2019 **Highest Education:** College graduate

### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

### Tobacco

04/25/2019 **Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0

### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father.

## Physical Examination

### Mental Status Examination:

General appearance: Appropriately dressed and groomed.

Gait & station: Normal.

Strength & tone: Not tested.

Attention & concentration: Normal.

Orientation: Oriented X4.

Language: Normal.

Level of consciousness: Alert.

Fund of Knowledge: Average.

Recent & Remote Memory: No impairment in recent or remote.

Speech: Rapid, Overproductive, Perserverative.

Thought process: Perseverating.

Mood and affect: Anxious.

Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts, patient has fixed beliefs surrounding the situation with friend. Cannot confirm or refute validity of the situation. .

Perceptions+: No abnormalities.

Insight: Fair.

Judgment: Fair.

### VS/Measurements

#### Vital Signs

5/1/2019 11:00 EDT

Peripheral Pulse Rate

98 BPM

Systolic Blood Pressure

133 mmHg

Diastolic Blood Pressure

82 mmHg

, Measurements from flowsheet : Measurements - Standard

5/1/2019 11:00 EDT

Height Contributor (ft)

5 ft

Height Contributor (inches)

11.5 inch

## Health Maintenance

Admit Date: 5/1/2019

10:40 EDT

Disch Date: 5/1/2019

23:59 EDT

Admitting: PENISTON ,KATHLEEN KELLY NP

Attending: CASTRO ,MANUEL A MD

Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6437855822

DOB: 11/1/1980

Age: 38 years

Sex: Male

Location: HOMS

Print ID: 476634768

## Office/Clinic Visit Notes

### Health Maintenance

#### Pending (in the next year)

##### OverDue

Pneumococcal Vaccine due One-time only

##### Due

Body Mass Index Follow-Up Plan due 05/01/19 and every

HIV Screening due 05/01/19 One-time only

Influenza Vaccination due 05/01/19 and every

Tdap Vaccine due 05/01/19 One-time only

Tetanus Vaccine due 05/01/19 and every 10 year(s)

##### Due In Future

Body Mass Index not due until 04/24/20 and every 1 year(s)

#### Satisfied (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Summary: Doing fair since last visit 1 week ago.

#### Plan

- 1) Medication: Zyprexa 5mg 1-2 tab at HS; Celexa 20mg daily. Adderall XR 20 BID.
- 2) Therapy - Patient is seeing a neurologist and plans to have neuropsych testing
- 3) Labwork Ordered - need updated labs -
- 4) SA Treatment - Not indicated
- 5) RTC in 2 months for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.
- 9) Return to work written and given to patient.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**05/01/2019 11:18 AM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**05/01/19 02:32 PM**

Admit Date: 5/1/2019 10:40 EDT  
Disch Date: 5/1/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6437855822  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634768

**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6439620101  
Age: **38 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed. Last seen in OMS by this writer on 5/1/19. On Zyprexa, Celexa, Adderall.

- Called 1 week ago and reported being emotionally distraught and had increased dose of Adderall.
- Patient presents angry, irritable, agitated. He cusses and voice volume is elevated. He is not threatening or aggressive.

Situation: Pt reports a situation that continues to cause him emotional distress. He believes that his friend/co-worker got information regarding his history that he wanted to remain private and shared this with his employer. He states that people started to treat him differently and he noticed that people no longer wanted to be as friendly with him. He left the job over a year ago and did not tell me at that time that was the reason for his departure. He states that people from his past were out to get him and knew about his history of mental health treatment as well as some social struggles that he did not want others to know about. He feels betrayed and has been trying to get this person to admit this belief but she is not been willing to acknowledge this is indeed true. She was the person who also completed the INVOL paperwork when he was brought to the ED and states this was done in "bad faith" as he was not a danger. He asked to have her removed as a contact. Unfortunately, this seems to not have been completed and she was contacted when someone from our financial department contacted could not get in touch with the patient. He had a conversation with the person from the hospital and was angry and refused to give her his SS# because he did not feel that was appropriate and suspected that there was some nefarious reasons for her asking for this information.

- Patient eventually calms down and is willing to consider the unlikely role of our financial department colluding with this friend of his.
- He admits to spending time focussed on this situation daily and it does cause distress.
- At one point he talks about it disrupting his ability to work but then later on, downplays other symptoms stating goof sleep and appetite as well as energy and concentration

Admit Date: 6/13/2019 13:40 EDT  
Disch Date: 6/13/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439620101  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634767

## Office/Clinic Visit Notes

- Patient is fixed in the belief he has surrounding this situation and I have no confirmation it is true. It does not appear he has specific evidence but interprets conversations and situations to confirm his suspicion
- He reports that he is not paranoid and knows this is true and will not consider that this is not the case. Again, I have no first hand knowledge of the situation and am unable to verify the information given.
- He states he believes his rights and privacy impeded and therefore is looking for legal council to bring a lawsuit against the people involved.
- He denies any recent SI. No HI. He denies AH/VH. The patient does seem to have some ideas of relating things back to himself when it is unlikely there is a connection.

### Review of Systems

**Constitutional:** Negative except as documented in history of present illness.

### Health Status

#### Allergies:

Allergic Reactions (All)

No known allergies

#### Current medications: (Selected)

##### Prescriptions

###### *Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 3 Refill(s)

citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 3 Refill(s)

##### Documented Medications

###### *Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed

Med List Status - Updated: KKP NP, 0 Refill(s)

metFORMIN: 500 mg, daily, 0 Refill(s)

#### Problem list:

##### All Problems

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### Histories

#### Past Medical History:

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

Admit Date: 6/13/2019 13:40 EDT  
Disch Date: 6/13/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439620101  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634767

## Office/Clinic Visit Notes

### Family History:

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

### Procedure history:

No active procedure history items have been selected or recorded.

### Social History

#### Social & Psychosocial Habits

##### Home/Environment

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

##### Alcohol

06/13/2019 **Use:** Denies

##### Drug Abuse

06/13/2019 **Use:** Denies

##### Employment/School

04/22/2019 **Description:** Freelance graphic art

04/22/2019 **Highest Education:** College graduate

##### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

##### Tobacco

06/13/2019 **Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0

##### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father.

### Physical Examination

#### Mental Status Examination:

General appearance: Appropriately dressed and groomed.

Gait & station: Normal.

Strength & tone: Not tested.

Admit Date: 6/13/2019 13:40 EDT  
Disch Date: 6/13/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439620101  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634767

## Office/Clinic Visit Notes

Attention & concentration: Fluctuating.  
Orientation: Oriented X4.  
Language: Normal.  
Level of consciousness: Alert.  
Fund of Knowledge: Average.  
Recent & Remote Memory: No impairment in recent or remote.  
Speech: Rapid, Overproductive, Perseverative.  
Thought process: Distractible, Tangential, Perseverating.  
Mood and affect: Labile, Irritable, Anxious.  
Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts, patient has fixed beliefs surrounding the situation with friend. Cannot confirm or refute validity of the situation. .  
Perceptions+: No abnormalities.  
Insight: Fair.  
Judgment: Fair.

### VS/Measurements

#### Vital Signs

6/13/2019 13:32 EDT	Peripheral Pulse Rate	91 BPM
	Systolic Blood Pressure	117 mmHg
	Diastolic Blood Pressure	78 mmHg
	Blood Pressure Location	Right arm
	BP Instrument	Machine
	Blood Pressure Position	Sitting

, Measurements from flowsheet : Measurements - Standard

6/13/2019 13:32 EDT	Height Contributor (ft)	5 ft
	Height Contributor (inches)	11.5 inch

### Health Maintenance

#### Health Maintenance

##### Pending (in the next year)

###### Due

Body Mass Index Follow-Up Plan due 06/13/19 and every  
HIV Screening due 06/13/19 One-time only  
Pneumococcal Vaccine due 06/13/19 One-time only  
Tdap Vaccine due 06/13/19 One-time only  
Tetanus Vaccine due 06/13/19 and every 10 year(s)

###### Due In Future

Body Mass Index not due until 04/30/20 and every 1 year(s)

##### Satisfied (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Admit Date: 6/13/2019 13:40 EDT  
Disch Date: 6/13/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439620101  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634767

## Office/Clinic Visit Notes

Summary: Remains consumed with situation regarding old job and work colleague. Unclear the amount of validity as cannot confirm. Patient is distraught and agitated during the assessment. Recently increased his own Adderall.

### Plan

- 1) Medication: Zyprexa 10mg at bedtime; Celexa 20mg daily. Adderall XR 20 BID (do not change meds or increase or decrease doses).
- 2) Therapy - not seeing currently
- 3) Labwork Ordered - need updated labs -
- 4) SA Treatment - Not indicated
- 5) RTC in 1-2 weeks for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**06/13/2019 04:47 PM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**06/18/19 10:23 AM**

Admit Date: 6/13/2019 13:40 EDT  
Disch Date: 6/13/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439620101  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634767



## AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

### Office/Clinic Visit Notes

DOCUMENT NAME:

Behavioral Health Physician Progress Rpt

#### PSYCH OMS NP WITH NURSE

Patient: **WILLIAMS III, LEONARD CLINTON**

MRN: 0000642066

FIN: 6439957311

Age: **38 years** Sex: **Male** DOB: **11/1/1980**

Associated Diagnoses: **None**

Author: **PENISTON , KATHLEEN KELLY NP**

#### Visit Information

Visit type

Accompanied by

History limitation

#### History of Present Illness

Nursing assessment reviewed. Last seen in OMS by this writer on 6/13/19. On Zyprexa, Celexa, Adderall.

- Patient was seen 10 days ago and was struggling with feeling overwhelmed and "emotionally devastated" due to situation described below.
- He had increased his own Adderall and I suggested we decrease the dose back down and that he take a consistent dose of Zyprexa each night.
- After a few days of following this plan he started to feel better. Still struggling with feeling overwhelmed but improved since last visit.
- Patient is fixed in the belief he has surrounding this situation and I have no confirmation it is true. It does not appear he has specific evidence but interprets conversations and situations to confirm his suspicion
- He reports that he is not paranoid and knows this is true and will not consider that this is not the case. Again, I have no first hand knowledge of the situation and am unable to verify the information given.
- He denies any recent SI. No HI. He denies AH/VH. The patient does seem to have some ideas of relating things back to himself when it is unlikely there is a connection.
- Overall, patient is much improved since last visit. More easily redirected and able to answer questions more directly.

*Per last visit on 6/13/19: Pt reports a situation that continues to cause him emotional distress. He believes that his friend/co-worker got information regarding his history that he wanted to remain private and shared this with his employer. He states that people started to treat him differently and he noticed that people no longer wanted to be as friendly with him. He left the job over a year ago and did not tell me at that time that was the reason for his departure. He states that people from his past were out to get him and knew about his history of mental health treatment as well as some social struggles that he did not want others to know about. He feels betrayed and has been trying to get this person to admit this belief but she is not been willing to acknowledge this is indeed true. She was the person who also completed the INVOL paperwork when he was brought to the ED and states this was done in "bad faith" as he was not a danger. He asked to have her removed as a contact. Unfortunately, this seems to not have been*

Admit Date: 6/24/2019

13:40 EDT

Disch Date: 6/24/2019

23:59 EDT

Admitting: PENISTON ,KATHLEEN KELLY NP

Attending: CASTRO ,MANUEL A MD

Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6439957311

DOB: 11/1/1980

Age: 38 years

Sex: Male

Location: HOMS

Print ID: 476634766



## Office/Clinic Visit Notes

*completed and she was contacted when someone from our financial department contacted could not get in touch with the patient. He had a conversation with the person from the hospital and was angry and refused to give her his SS# because he did not feel that was appropriate and suspected that there was some nefarious reasons for her asking for this information.*

### Review of Systems

**Constitutional:** Negative except as documented in history of present illness.

### Health Status

#### Allergies:

Allergic Reactions (All)

No known allergies

#### Current medications: (Selected)

Prescriptions

*Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 3 Refill(s)  
citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 3 Refill(s)

Documented Medications

*Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed  
Med List Status - Updated: KKP NP, 0 Refill(s)  
metFORMIN: 500 mg, daily, 0 Refill(s)

#### Problem list:

All Problems

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### Histories

#### Past Medical History:

Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

#### Family History:

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

Admit Date: 6/24/2019 13:40 EDT  
Disch Date: 6/24/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439957311  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634766

## Office/Clinic Visit Notes

### Procedure history:

No active procedure history items have been selected or recorded.

### Social History

#### Social & Psychosocial Habits

##### Home/Environment

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

##### Alcohol

06/13/2019 **Use:** Denies

##### Drug Abuse

06/13/2019 **Use:** Denies

##### Employment/School

04/22/2019 **Description:** Frelance graffic art

04/22/2019 **Highest Education:** College graduate

##### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

##### Tobacco

06/13/2019 **Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0

##### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father.

### Physical Examination

#### Mental Status Examination:

General appearance: Appropriately dressed and groomed.

Gait & station: Normal.

Strength & tone: Not tested.

Attention & concentration: Fluctuating.

Orientation: Oriented X4.

Language: Normal.

Level of consciousness: Alert.

Fund of Knowledge: Average.

Recent & Remote Memory: No impairment in recent or remote.

Speech: Rapid, Overproductive, Perserverative.

Thought process: Distractible, Tangential, Perseverating.

Admit Date: 6/24/2019 13:40 EDT  
Disch Date: 6/24/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439957311  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634766

## Office/Clinic Visit Notes

Mood and affect: Labile, Irritable, Anxious.

Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts, patient has fixed beliefs surrounding the situation with friend. Cannot confirm or refute validity of the situation. .

Perceptions+: No abnormalities.

Insight: Fair.

Judgment: Fair.

### VS/Measurements

Vital Signs

6/24/2019 14:07 EDT

#### Peripheral Pulse Rate

**116 BPM HI**

Systolic Blood Pressure

117 mmHg

Diastolic Blood Pressure

77 mmHg

Blood Pressure Location

Left arm

BP Instrument

Machine

Blood Pressure Position

Sitting

, Measurements from flowsheet : Measurements - Standard

6/24/2019 14:07 EDT

Height Contributor (ft)

5 ft

Height Contributor (inches)

11.5 inch

### Health Maintenance

#### Health Maintenance

**Pending** (in the next year)

##### Due

Body Mass Index Follow-Up Plan due 06/24/19 and every

HIV Screening due 06/24/19 One-time only

Pneumococcal Vaccine due 06/24/19 One-time only

Tdap Vaccine due 06/24/19 One-time only

Tetanus Vaccine due 06/24/19 and every 10 year(s)

##### Due In Future

Body Mass Index not due until 06/12/20 and every 1 year(s)

**Satisfied** (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Summary: Improved from last visit though still distressed and ruminative regarding situation with ex-employer.

#### Plan

1) Medication: Zyprexa 10mg at bedtime; Celexa 20mg daily. Adderall XR 20 BID

2) Therapy - not seeing currently

3) Labwork Ordered - need updated labs -

4) SA Treatment - Not indicated

5) RTC in 6 weeks for further evaluation of medication.

Admit Date: 6/24/2019 13:40 EDT  
Disch Date: 6/24/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439957311  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634766

## Office/Clinic Visit Notes

- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**06/24/2019 02:46 PM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**06/28/19 10:42 AM**

Admit Date: 6/24/2019 13:40 EDT  
Disch Date: 6/24/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6439957311  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634766

**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6441913522  
Age: **38 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed. Last seen in OMS by this writer on 6/24/19. On Zyprexa, Celexa, Adderall.

- Doing fair. Good sleep and appetite. Energy and concentration are well.
- Patient continues to have concerns about his medical record being compromised and information shared with unauthorized persons.
- Less focussed and distraught about situation at work and with friends that has been causing him distress over the past several months.
- He denies any recent SI. No HI. He denies AH/VH. No ETOH or drugs.

**Review of Systems**

**Constitutional:** Negative except as documented in history of present illness.

**Health Status**

**Allergies:**

Allergic Reactions (All)

No known allergies

**Current medications:** (Selected)

Prescriptions

*Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 0 Refill(s)

citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 0 Refill(s)

Documented Medications

*Documented*

Admit Date: 8/15/2019 11:00 EDT  
Disch Date: 8/15/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6441913522  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634765

## Office/Clinic Visit Notes

Goodys Extra Strength: See Instructions, 1 packet as needed  
Med List Status - Updated: KKP NP, 0 Refill(s)  
metFORMIN: 500 mg, daily, 0 Refill(s)

### Problem list:

#### All Problems

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### Histories

#### Past Medical History:

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

#### Family History:

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

#### Procedure history:

No active procedure history items have been selected or recorded.

#### Social History

##### Social & Psychosocial Habits

##### **Home/Environment**

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

##### **Alcohol**

06/13/2019 **Use:** Denies

##### **Drug Abuse**

06/13/2019 **Use:** Denies

##### **Employment/School**

04/22/2019 **Description:** Frelance graffic art

04/22/2019 **Highest Education:** College graduate

Admit Date: 8/15/2019 11:00 EDT  
Disch Date: 8/15/2019 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6441913522  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634765

## Office/Clinic Visit Notes

### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

### Tobacco

08/15/2019 **Currently Using Any Form of Tobacco:** No

**Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0

### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father.

### Physical Examination

#### Mental Status Examination:

General appearance: Appropriately dressed and groomed.

Gait & station: Normal.

Strength & tone: Not tested.

Attention & concentration: Fluctuating.

Orientation: Oriented X4.

Language: Normal.

Level of consciousness: Alert.

Fund of Knowledge: Average.

Recent & Remote Memory: No impairment in recent or remote.

Speech: Rapid, Overproductive, Perseverative.

Thought process: Distractible, Tangential, Perseverating.

Mood and affect: Anxious.

Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts.

Perceptions+: No abnormalities.

Insight: Fair.

Judgment: Fair.

#### VS/Measurements

##### Vital Signs

8/15/2019 10:37 EDT

##### Peripheral Pulse Rate

**105 BPM HI**

##### Systolic Blood Pressure

**104 mmHg LOW**

Diastolic Blood Pressure

75 mmHg

Blood Pressure Location

Right arm

BP Instrument

Machine

Blood Pressure Position

Sitting

, Measurements from flowsheet : Measurements - Standard

8/15/2019 10:37 EDT

Height Contributor (ft)

5 ft

Height Contributor (inches)

11.5 inch

### Health Maintenance

Admit Date: 8/15/2019

11:00 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

Disch Date: 8/15/2019

23:59 EDT

MRN: 0000642066

Acct#: 6441913522

Admitting: PENISTON ,KATHLEEN KELLY NP

DOB: 11/1/1980

Age: 38 years

Sex: Male

Attending: CASTRO ,MANUEL A MD

Location: HOMS

Printed: 7/8/2021 06:58 EDT

Print ID: 476634765

## Office/Clinic Visit Notes

### Health Maintenance

#### Pending (in the next year)

##### Due

Body Mass Index Follow-Up Plan due 08/15/19 and every  
HIV Screening due 08/15/19 One-time only  
Influenza Vaccination due 08/15/19 and every  
Pneumococcal Vaccine due 08/15/19 One-time only  
Tdap Vaccine due 08/15/19 One-time only  
Tetanus Vaccine due 08/15/19 and every 10 year(s)

##### Due In Future

Body Mass Index not due until 08/14/20 and every 1 year(s)

#### Satisfied (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits  
Medical Diagnoses: diabetes, elevated cholesterol and triglycerides  
Psychosocial Stressors: finances

Summary: Improved from last visit.

#### Plan

- 1) Medication: Zyprexa 5-10mg at bedtime; Celexa 20mg daily. Adderall XR 20 BID
- 2) Therapy - not seeing currently - plans to see Karen Crane.
- 3) Labwork Ordered - need updated labs - needs to f/u with PCP.
- 4) SA Treatment - Not indicated
- 5) RTC in 3 months for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**08/15/2019 11:11 AM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**08/21/19 02:06 PM**

Admit Date: 8/15/2019 11:00 EDT  
Disch Date: 8/15/2019 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6441913522  
DOB: 11/1/1980 Age: 38 years Sex: Male  
Location: HOMS  
Print ID: 476634765



**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6446109019  
Age: **39 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed. Last seen in OMS by this writer on 8/15/19. On Zyprexa, Celexa, Adderall.

- Doing fair. Sleeping well. Appetite unchanged but some weight gain. Energy fair and concentration varies.
- Has some stressors. Financial issues and not steadily employed. States mom has been helping with bills.
- Patient continues to voice being traumatized by situation at Wells Fargo. Concerned about the security of his identity and MH history.
- He is much calmer today and able to discuss other things without the entire time being consumed with situation above.
- He denies any SI. No HI. He denies AH/VH. No ETOH or drugs. Believes meds are helpful.

**Review of Systems**

**Constitutional:** Negative except as documented in history of present illness.

**Health Status**

**Allergies:**

Allergic Reactions (All)

No known allergies

**Current medications:** (Selected)

Prescriptions

*Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)  
Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)  
Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Admit Date: 11/5/2019 14:40 EST  
Disch Date: 11/5/2019 23:59 EST  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6446109019  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634764

## Office/Clinic Visit Notes

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 2 Refill(s)  
citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 2 Refill(s)

### Documented Medications

#### *Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed  
Med List Status - Updated: KKP NP, 0 Refill(s)  
metFORMIN: 500 mg, daily, 0 Refill(s)

### **Problem list:**

#### All Problems

Obesity / SNOMED CT 2535065012 / Confirmed  
This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).  
Resolved: Obesity / SNOMED CT 2535065012  
This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).  
This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### **Histories**

#### **Past Medical History:**

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

##### Comments:

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

#### **Family History:**

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

#### **Procedure history:**

No active procedure history items have been selected or recorded.

#### **Social History**

##### Social & Psychosocial Habits

##### **Home/Environment**

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

##### **Alcohol**

11/05/2019 **Use:** Denies

##### **Drug Abuse**

Admit Date: 11/5/2019 14:40 EST  
Disch Date: 11/5/2019 23:59 EST  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6446109019  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634764

## Office/Clinic Visit Notes

11/05/2019 **Use:** Denies

### Employment/School

04/22/2019 **Description:** Frelance graffic art

04/22/2019 **Highest Education:** College graduate

### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

### Tobacco

11/05/2019 **Currently Using Any Form of Tobacco:** No

**Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Avg # Packs Per Day (20 cigs/pack):** 0

### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father.

## Physical Examination

### Mental Status Examination:

General appearance: Discheveled, Malodorous.

Gait & station: Normal.

Strength & tone: Not tested.

Attention & concentration: Fluctuating.

Orientation: Oriented X4.

Language: Normal.

Level of consciousness: Alert.

Fund of Knowledge: Average.

Recent & Remote Memory: No impairment in recent or remote.

Speech: Rapid, Overproductive, Perserverative.

Thought process: Tangential, Perseverating.

Mood and affect: Anxious.

Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts.

Perceptions+: No abnormalities.

Insight: Fair.

Judgment: Fair.

### VS/Measurements

#### Vital Signs

11/5/2019 14:45 EST	Peripheral Pulse Rate	96 BPM
	Systolic Blood Pressure	127 mmHg
	Diastolic Blood Pressure	85 mmHg

, Measurements from flowsheet : Measurements - Standard

11/5/2019 14:45 EST	Height Contributor (ft)	5 ft
	Height Contributor (inches)	11.5 inch

Admit Date: 11/5/2019 14:40 EST  
Disch Date: 11/5/2019 23:59 EST  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6446109019  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634764

## Office/Clinic Visit Notes

### Health Maintenance

#### Health Maintenance

**Pending** (in the next year)

Due

Tdap Vaccine due 11/05/19 One-time only

Tetanus Vaccine due 11/05/19 and every 10 year(s)

**Satisfied** (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Summary: Improved from last visit.

Plan

- 1) Medication: Zyprexa 5-10mg at bedtime; Celexa 20mg daily. Adderall XR 20 BID
- 2) Therapy - not seeing currently - plans to see Karen Crane.
- 3) Labwork Ordered - need updated labs - needs to f/u with PCP.
- 4) SA Treatment - Not indicated
- 5) RTC in 3 months for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**11/05/2019 04:45 PM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**11/13/19 03:55 PM**

Admit Date: 11/5/2019 14:40 EST  
Disch Date: 11/5/2019 23:59 EST  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6446109019  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634764

**Office/Clinic Visit Notes**

DOCUMENT NAME: Behavioral Health Physician Progress Rpt

**PSYCH OMS NP WITH NURSE**

Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6449507368  
Age: **39 years** Sex: **Male** DOB: **11/1/1980**  
Associated Diagnoses: **None**  
Author: **PENISTON , KATHLEEN KELLY NP**

**Visit Information**

**Visit type**  
**Accompanied by**  
**History limitation**

**History of Present Illness**

Nursing assessment reviewed. Last seen in OMS by this writer on 11/5/19. On Zyprexa, Celexa, Adderall.

Patient has made many call center calls and sent several messages to this writer over the past week. He has attached several letters including one that was sent today. I have read all the letter in their entirety. He reports a lot anxiety and agitation and has had yelled and used profane language in his communication with the staff. I have expressed to him directly this was unacceptable and could lead to dismissal from the clinic. He has expressed interest in considering treatments specific for PTSD such as EMDR and other meds (Zoloft).

- Patient presents in a similar manner to previous visits. Rapid speech and remains focussed on the situation with Wells Fargo, his former employer.
- He is currently in the process of applying for bankruptcy. AS part of this process, he plans to report Wells Fargo. He reports they are legally liable for his loss of employment and his pain and suffering.
- WE have discussed this situation at several visits. He reports he has proof that they were getting his private health information and disseminate this to other employees.
- The patient reports a previous trauma in the past when he states he was stigmatized due to his mental illness. States he left western NC in an attempt to start fresh. Now, feels like he is reliving the trauma.
- Discussed that I was concerned about the potential adverse effect of stimulants for anxiety and PTSD symptoms and that is the reason I would not suggest an increase in the dose.
- Attempted to refocus on his symptoms but patient is not interested in changing medications today. Discussed possibly switching to Zoloft but he would rather stick with Celexa.
- Patient adamantly denies any thoughts of harming self or others. H does report that when he is "shell shocked" he will sometimes wish he was dead to escape the feeling. Denies plan, intent, prep action.
- Patient denies any drug or alcohol use. Again, discussed that increased dose of Adderall is not recommended and wold not be in his best interest given the reports of anxiety and severe PTSD.
- Discussed with patient that my goal is to provide safe effective care and I am very sorry he is not feeling well lately. I empathize with his PTSD symptoms and recent struggles due to finances.

Admit Date: 2/4/2020 13:40 EST  
Disch Date: 2/4/2020 23:59 EST  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6449507368  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634763

## Office/Clinic Visit Notes

- Patient also reports that a phone number for someone he does not know somehow ended up on in his medical record. I checked his emergency contact which had his phone number only.
- He reports having spoken to the privacy department several times about situations with his medical records and his concerns about privacy. They have done an investigation regarding his complaints.

Considerations: Patient clearly anxious at times during the evaluation. Some deep breaths at times to calm himself down. I did feel the need to reiterate the expectations of behavior for all patients and asked that he be respectful of the staff. I empathized that I realize he reports this verbal aggression is secondary to his PTSD. Patient became very angry and his demeanor changed. He raised his voice and said that if they could not deal with the symptoms of mental health patients, they should get another job. I allowed him to express self but as he started posturing in a way that indicated he was getting physically agitated I ended the session expressing that I was not comfortable with him yelling at me and I asked him to leave the office.

### Review of Systems

**Constitutional:** Negative except as documented in history of present illness.

### Health Status

#### Allergies:

##### Allergic Reactions (All)

No known allergies

#### Current medications: (Selected)

##### Prescriptions

##### *Prescribed*

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

Adderall XR 20 mg oral capsule, extended release: See Instructions, 2 capsules each am, 60 capsule, 0 Refill(s)

ZyPREXA 5 mg oral tablet: See Instructions, 1-2 tablets at bedtime, 60 tablet, 2 Refill(s)

citalopram 20 mg oral tablet: 20 mg, 1 tablet, ORAL, Daily, 30 tablet, 2 Refill(s)

##### Documented Medications

##### *Documented*

Goodys Extra Strength: See Instructions, 1 packet as needed

Med List Status - Updated: KKP NP, 0 Refill(s)

metFORMIN: 500 mg, daily, 0 Refill(s)

#### Problem list:

##### All Problems

Obesity / SNOMED CT 2535065012 / Confirmed

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

Resolved: Obesity / SNOMED CT 2535065012

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### Histories

#### Past Medical History:

##### Resolved

Obesity (2535065012): Resolved on 3/12/2019 at 38 years.

Comments:

Admit Date: 2/4/2020

13:40 EST

Disch Date: 2/4/2020

23:59 EST

Admitting: PENISTON, KATHLEEN KELLY NP

Attending: CASTRO, MANUEL A MD

Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6449507368

DOB: 11/1/1980

Age: 39 years

Sex: Male

Location: HOMS

Print ID: 476634763

## Office/Clinic Visit Notes

7/2/2018 EDT 13:23 EDT - SYSTEM

This Problem was set by a rule (CHS\_EKS\_BMI\_PROB).

3/12/2019 EDT 11:24 EDT - SYSTEM

This Problem was resolved by a rule (CHS\_EKS\_BMI\_PROB).

### Family History:

HYPERTENSION

GM, Maternal

Cancer

Father

GM, Paternal

GF, Paternal

GM, Maternal

### Procedure history:

No active procedure history items have been selected or recorded.

### Social History

#### Social & Psychosocial Habits

#### Home/Environment

04/22/2019 **Marital Status:** Single

**Family Comments:** lives in an apartment by himself

#### Alcohol

11/05/2019 **Use:** Denies

#### Drug Abuse

11/05/2019 **Use:** Denies

#### Employment/School

04/22/2019 **Description:** Frelance graffic art

04/22/2019 **Highest Education:** College graduate

#### Nutrition/Health

04/22/2019 **Home Diet:** Diabetic

#### Tobacco

11/05/2019 **Currently Using Any Form of Tobacco:** No

**Smoking Status:** Never smoker

**# Years Active Cigarette Smoker:** 0

**Current or Former Smoking History - Avg # Packs/Day (20 cigs** 0

#### Abuse/Neglect

04/22/2019 **History of Abuse:** Past

**Abuse Type:** Mental, Sexual

**Abuse/Neglect Comments:** Sexual abuse by MGM, emotional abuse by step-father

Admit Date: 2/4/2020 13:40 EST  
Disch Date: 2/4/2020 23:59 EST  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: CASTRO ,MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6449507368  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634763

## Office/Clinic Visit Notes

### Physical Examination

#### Mental Status Examination:

General appearance: Discheveled, Malodorous.  
Gait & station: Normal.  
Strength & tone: Not tested.  
Attention & concentration: Fluctuating.  
Orientation: Oriented X4.  
Language: Normal.  
Level of consciousness: Alert.  
Fund of Knowledge: Average.  
Recent & Remote Memory: No impairment in recent or remote.  
Speech: Rapid, Overproductive, Perseverative.  
Thought process: Tangential, Perseverating.  
Mood and affect: Anxious.  
Thought content: No violent thoughts, No suicidal thoughts, No homicidal thoughts.  
Perceptions+: No abnormalities.  
Insight: Fair.  
Judgment: Fair.

### Health Maintenance

#### Health Maintenance

##### Pending (in the next year)

###### OverDue

Tobacco Use Screening and Cessation due and every

###### Due

Body Mass Index Follow-Up Plan due 02/04/20 and every

HIV Screening due 02/04/20 One-time only

Influenza Vaccination due 02/04/20 and every

Tdap Vaccine due 02/04/20 One-time only

###### Due In Future

Body Mass Index not due until 11/04/20 and every 1 year(s)

##### Satisfied (in the past 1 year)

There are no satisfied recommendations within the defined date range

### Impression and Plan

#### Dx/Order Association Plan

Psychiatric Diagnoses: Bipolar, type I MRE mixed; ADD; cluster A traits

Medical Diagnoses: diabetes, elevated cholesterol and triglycerides

Psychosocial Stressors: finances

Summary: Patient was able to stay calm for the majority of the session but after I expressed the expectations for the clinic regarding behavior he started yelling and was physically agitated. He has previously been told that continued verbal assault to staff will result in discharge from the clinic.

Admit Date: 2/4/2020 13:40 EST  
Disch Date: 2/4/2020 23:59 EST  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6449507368  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634763



## Office/Clinic Visit Notes

### Plan

- 1) Medication: Zyprexa 5-10mg at bedtime; Celexa 20mg daily. Adderall XR 20 BID
- 2) Therapy - not seeing currently - does speak with a psychologist John Monguillot.
- 3) Labwork Ordered - need updated labs - needs to f/u with PCP.
- 4) SA Treatment - Not indicated
- 5) RTC in 3 months for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is aware to contact OMS for any needed medication adjustments.

### Professional Services

Amount of time spent with patient - Minutes

Greater than 50% of the time spent with patient was devoted to counseling and coordination of care.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**

**02/04/2020 06:08 PM**

**Electronically Signed By: CASTRO, MANUEL A MD**

**02/05/20 12:26 PM**

Admit Date: 2/4/2020 13:40 EST  
Disch Date: 2/4/2020 23:59 EST  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: CASTRO, MANUEL A MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6449507368  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634763

**Office/Clinic Visit Notes**

DOCUMENT NAME: Psychiatric Visit Note

**WILLIAMS III, LEONARD CLINTON**

**DOB:** 11/01/1980 **MRN:** 0000642066  
**Sex:** Male **FIN:** 6454918570

**Problem List/Past Medical History**

Ongoing  
None  
Historical  
Obesity  
Obesity

**Patient Information:**

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

**History of Present Illness**

Patient is a 39 year old male with diagnoses of Bipolar D/O, PTSD and ADD.  
Last visit: 4/29/20. Meds: Zyprexa, Celexa, and Adderall.

- Patient reports overall he is feeling better and attributes this improvement to his case was successful with Discovery CC.
- He is going through the process of applying for disability which is also very stressful and he is struggling to complete the process.
- He describes waves of being overtaken by traumatic feelings that paralyze him and make it difficult to function.
- he reports that he called because he would like to have an increase in his Adderall as "it is the only thing that helps".
- Discussed reasons why this would not be a good long term strategy including any lack indication for Adderall in PTSD.
- The patient is very talkative and speech is rapid. I am able to get all needed questions answered and he answers appropriately.
- He reports good sleep. Appetite is regular and energy level is unchanged. He states his concentration remains poor especially when stressed.
- He reports that he is able to complete ADLs and take care of his home even though it is a struggle at times. Mom is financially supportive.
- No SI/HI/Psychosis. Patient denies any ETOH or drug use. Has not seen PCP regular. Does still speak with therapist (john) by phone.

**Review of Systems**

Constitutional: Negative for chills, fever, and flushing  
Musculoskeletal: Negative except as documented in HPI.  
Neurologic: Negative for abnormal balance, confusion, headache, or tremors.  
Psychiatric: Negative except as documented in HPI.  
ROS reviewed as documented in chart

**Exam**

**Psychiatric:**

Attention and Concentration: Normal, patient is able to follow and interact through interview.  
Orientation: Oriented x4.  
Fund of Knowledge: Average  
Recent & Remote Memory: Normal  
Insight: Fair

**Medications**

Adderall XR 20 mg oral capsule, extended release,  
See Instructions  
Adderall XR 20 mg oral capsule, extended release,  
See Instructions  
Adderall XR 20 mg oral capsule, extended release,  
See Instructions  
citalopram 20 mg oral tablet, 20 mg, 1 tablet,  
ORAL, Daily, 2 refills  
Goodys Extra Strength, See Instructions  
metFORMIN, 500 mg, **Not taking**  
Misc Medication  
ZyPREXA 5 mg oral tablet, See Instructions, 2  
refills

**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**

Admit Date: 6/9/2020 17:00 EDT  
Disch Date: 6/9/2020 23:59 EDT  
Admitting: PENISTON ,KATHLEEN KELLY NP  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6454918570  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634762

## Office/Clinic Visit Notes

Judgment: Fair  
Mood and Affect: Anxious, intense. Affect congruent (per phone call)  
Thought Process: Ruminative.  
Associations: Intact  
Thought Content: Denies any homicidal ideation. Denies suicidal ideation.  
Perceptions: Denies any auditory or visual hallucinations. Denies any symptoms of paranoia.  
Language: Normal  
Speech: Rapid

### Assessment/Plan

ADD (attention deficit disorder)

Ordered:

Est OV Level 4 - 99214

Follow-Up Appt

Bipolar disorder

Ordered:

Est OV Level 4 - 99214

Follow-Up Appt

1) Medication: Explained that patient has a buffer to take one or two extra Adderall if needed (based on fill dates) but I am not comfortable with increasing daily dose of this medication. Gave multiple reasons and explained that he is welcome to seek another opinion if he would like.

- Continue Zyprexa and Celexa

2) Therapy - Patient talks to counselor John by phone

3) Labwork Ordered - Not indicated

4) SA Treatment - Not indicated

5) RTC in 1-2 month for further evaluation of medication.

6) Patient was provided with education regarding medication and treatment plan.

7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.

8) Patient is fully aware to contact OMS for any changes in symptoms, medication adjustments, development of side effects, or if in crisis.

### Patient Education

Patient counseled on risks/benefits of current medication regimen and diagnosis, as well as the importance of consistently taking medications as prescribed.

Patient counseled on the usefulness of therapy in conjunction with medications to help with symptoms.

Patient was also counseled on sleep hygiene techniques and the importance of physical activity in health and wellness.

### 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

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.

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

HYPERTENSION: GM, Maternal.

Admit Date: 6/9/2020 17:00 EDT  
Disch Date: 6/9/2020 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: MURRAY, PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6454918570  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634762

## Office/Clinic Visit Notes

current health status, medication or other treatment recommendations, patient education and an opportunity to ask questions about condition and treatment.

Verbal Consent Granted: select one

**Time spent in coordination of care and phone time:** A total of 60 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. 45 minutes was spent on the phone portion of visit.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**  
**06/09/2020 06:22 PM**

Admit Date: 6/9/2020 17:00 EDT  
Disch Date: 6/9/2020 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: MURRAY, PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6454918570  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634762

**Office/Clinic Visit Notes**

DOCUMENT NAME: Psychiatric Visit Note

**WILLIAMS III, LEONARD CLINTON**

**DOB:** 11/01/1980 **MRN:** 0000642066  
**Sex:** Male **FIN:** 6456338225

**Problem List/Past Medical History**

Ongoing  
 None  
 Historical  
 Obesity  
 Obesity

**Patient Information:**

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

**History of Present Illness**

Patient is a 39 year old male with diagnoses of Bipolar D/O, PTSD and ADD.  
 Last visit: 6/9/20. Meds: Zyprexa, Celexa, and Adderall.

- Patient reports taking medication as prescribed.
- States that he still has a lot of distress secondary all the trauma he has been through.
- Has started using Kasina mind machine which has helped significant.
- The hypnosis provide helps him relax . Has been doing daily. Wants to increase to twice daily.
- Notable improvement in amount and level of distress. Not having thoughts of wanting to die.
- He reports sleeping 7-10 hours per night. Appetite is normal for him.
- The patient also reports significant improvement in focus and states energy is fair.
- No psychosis, SI or HI reported. No reports of drugs or ETOH use.
- In the midst of applying for disability.

**Medications**

Adderall XR 20 mg oral capsule, extended release,  
 See Instructions  
 Adderall XR 20 mg oral capsule, extended release,  
 See Instructions  
 Adderall XR 20 mg oral capsule, extended release,  
 See Instructions  
 citalopram 20 mg oral tablet, 20 mg, 1 tablet,  
 ORAL, Daily, 2 refills  
 Goody's Extra Strength, See Instructions  
 Med List Status - Updated  
 metFORMIN, 500 mg, **Not taking**  
 Misc Medication  
 ZYPREXA 5 mg oral tablet, See Instructions, 2  
 refills

**Allergies**

No known allergies

**Review of Systems**

Constitutional: Negative for chills, fever, and flushing  
 Musculoskeletal: Negative except as documented in HPI.  
 Neurologic: Negative except as documented in HPI.  
 Psychiatric: Negative except as documented in HPI.  
 ROS reviewed as documented in chart

**Exam**

**Psychiatric:**

Attention and Concentration: Normal, patient is able to follow and interact through interview.  
 Orientation: Oriented x4.  
 Fund of Knowledge: Average  
 Recent & Remote Memory: Normal  
 Insight: Fair  
 Judgment: Fair  
 Mood and Affect: Anxious. Affect congruent (per phone call)  
 Thought Process: Circumstantial

**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**

Admit Date: 7/21/2020 14:20 EDT  
 Disch Date: 7/21/2020 23:59 EDT  
 Admitting: PENISTON, KATHLEEN KELLY NP  
 Attending: MURRAY, PHILLIP MICHAEL MD  
 Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
 MRN: 0000642066 Acct#: 6456338225  
 DOB: 11/1/1980 Age: 39 years Sex: Male  
 Location: HOMS  
 Print ID: 476634761

## Office/Clinic Visit Notes

Associations: Intact  
Thought Content: Denies any homicidal ideation. Denies suicidal ideation.  
Perceptions: Denies any auditory or visual hallucinations. Denies any symptoms of paranoia.  
Language: Normal  
Speech: hypertalkative, rapid

### Assessment/Plan

ADD (attention deficit disorder)

Bipolar 1 disorder

PTSD (post-traumatic stress disorder)

- 1) Medication: Continue meds - no changes made today.
- 2) Therapy - Patient reports speaking with therapist/advocate named John.
- 3) Labwork Ordered - Not indicated
- 4) SA Treatment - Not indicated
- 5) RTC in 3 month for further evaluation of medication.
- 6) Patient was provided with education regarding medication and treatment plan.
- 7) Patient is aware of emergency services availability including Psychiatric ED and Mobile Crisis.
- 8) Patient is fully aware to contact OMS for any changes in symptoms, medication adjustments, development of side effects, or if in crisis.

### Patient Education

Patient counseled on risks/benefits of current medication regimen and diagnosis, as well as the importance of consistently taking medications as prescribed. Patient counseled on the usefulness of therapy in conjunction with medications to help with symptoms. Patient was also counseled on sleep hygiene techniques and the importance of physical activity in health and wellness.

### 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 30 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. 20 minutes was spent on the phone portion of visit.

**Electronically Signed By: PENISTON, KATHLEEN KELLY NP**  
**07/21/2020 03:04 PM**

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.

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

HYPERTENSION: GM, Maternal.

Admit Date: 7/21/2020 14:20 EDT  
Disch Date: 7/21/2020 23:59 EDT  
Admitting: PENISTON, KATHLEEN KELLY NP  
Attending: MURRAY, PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6456338225  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634761



## AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

---

Admit Date: 9/4/2020 15:00 EDT  
Disch Date: 9/5/2020 01:56 EDT  
Admitting: ADAMS ,SCOTT D DO  
Attending: ADAMS ,SCOTT D DO  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6458940290  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634760



## AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

---

Admit Date: 10/21/2020 13:19 EDT  
Disch Date: 10/21/2020 23:59 EDT  
Admitting:  
Attending:  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#:  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634759





## AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

---

Admit Date: 9/4/2020 15:00 EDT  
Disch Date: 9/5/2020 01:56 EDT  
Admitting: ADAMS ,SCOTT D DO  
Attending: ADAMS ,SCOTT D DO  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6458940290  
DOB: 11/1/1980 Age: 39 years Sex: Male  
Location: HOMS  
Print ID: 476634760

**Office/Clinic Visit Notes**

DOCUMENT NAME:

Virtual Health Care Visit Note

**WILLIAMS III, LEONARD  
CLINTON**

**DOB:** 11/01/1980 **MRN:** 0000642066  
**Sex:** Male **FIN:** 6461878763

**Problem List/Past Medical History**

Ongoing  
None  
Historical  
Obesity  
Obesity

**Patient Information:**

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

**Chief Complaint**

Follow-up

**History of Present Illness**

40-year-old man presents today for follow-up phone visit. Consents to today's visit and denies current SI, HI, AH, VH. He confirms current location. He states he evaluates his day based on the hours that he is productive during the day.

He states this can vary depending on his stressors. He feels that Adderall has been helpful, but feels it would be better at the 20 mg twice daily dosing. He states he is not usually able to be around people due to irritability and poor frustration tolerance. He states he becomes agitated when faced with stimuli, and wants to leave situations. He states he is trying to navigate this to maximize his daily activities and employment. He states he is interested in a brain scan for PTSD for his disability hearings. I informed him that brain scans do not usually use to diagnose PTSD as this is primarily a clinical diagnosis. He otherwise denies side effects from medications. He currently denies 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 irritable 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)

Bipolar disorder

PTSD (post-traumatic stress disorder)

40-year-old man presents today for follow up visit. 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 has not been feeling well,

**Medications**

Adderall XR 20 mg oral capsule, extended release, 40 mg, 2 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 graffiac 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.

Admit Date: 11/24/2020 16:00 EST  
Disch Date: 11/24/2020 23:59 EST  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6461878763  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634758

## Office/Clinic Visit Notes

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. In the past with higher doses of stimulant medications he has a history of worsening irritability, paranoia, and symptoms that led to hospitalization.

He continues to report some irritability, difficulty tolerating external environments. There are shared decision making we agreed to go back to total dose of Adderall 40 mg daily. We will continue to monitor this as this was a factor in recent hospitalization. He will also continue citalopram and olanzapine.

–Continue citalopram and olanzapine at current doses

–Continue Adderall 40 mg daily

–Counseled on potential side effects and reasons seek emergency services

–Follow-up in 1 month

### 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 5 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. 16 minutes was spent on the phone portion of visit.

**Electronically Signed By: MURRAY, PHILLIP MICHAEL MD**  
**12/01/2020 07:25 PM**

### 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.

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

HYPERTENSION: GM, Maternal.

Admit Date: 11/24/2020 16:00 EST  
Disch Date: 11/24/2020 23:59 EST  
Admitting: MURRAY, PHILLIP MICHAEL MD  
Attending: MURRAY, PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6461878763  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634758



# AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

PHYSICIAN FACESHEET - PATIENT DEMOGRAPHICS UPDATED: 05/04/2021 1031

NAME : WILLIAMS,LEONARD CLINTON ADM DATE/TIME: 02/15/2021 1240  
PT. TYPE : OP DIS DATE : 02/15/2021 2359  
SERVICE : VEA LOCATION : HOMS

ADMIT SOURCE : 1  
ADDRESS #1 : [REDACTED] MED REC# : 000064-20-66  
ADDRESS #2 : [REDACTED] ACCOUNT # : [REDACTED]  
CITY : CHARLOTTE PHONE (H) : (704) [REDACTED]  
CO/ST/ZIP : NC 28273 PHONE (W) : [REDACTED]  
RACE : White or Caucasian PHONE (M) : (980) [REDACTED]

BIRTHDATE : 11/01/1980 SEX : MALE  
SS # : XXX-XX-4844

ACCIDENT :  
ACCIDENT DATE:

ADMIT DX : Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

WORKING DX : Bipolar disorder, unspecified (CMS/HCC) PRI CARE MD : BRADNER,RICHARD

ADMIT MD : UNKNOWN,ATTENDING

ATTEND MD : MURRAY,PHILLIP MICHAEL

REFER MD : MURRAY,PHILLIP MICHAEL

ER MD : UNKNOWN,ATTENDING

GUARANTOR : WILLIAMS,LEONARD CLINTON III, RELATIVE : WILLIAMS,LEONARD

ADDRESS #1 : [REDACTED] REL ADDRESS 1: [REDACTED]

ADDRESS #2 : [REDACTED] REL ADDRESS 2:

CITY : CHARLOTTE REL CITY : CHARLOTTE

ST/ZIP : NC 28273 REL ST/ZIP : NC 28212

PHONE (W) : [REDACTED] REL PHONE (H): (980) [REDACTED]

REL TO PT : SELF REL PHONE (W): [REDACTED]

REL TO PT : FRIEND

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 # :

INSURED : ,

REL TO INS :

MAIL TO : ,

ADDRESS #1 :

ADDRESS #2 :

CITY/ST/ZIP :

PHONE :

EXT:

APPROV/REF :

## INSURANCE

COMPANY :

GROUP # :

## INSURANCE

COMPANY :

GROUP # :

Admit Date: 2/15/2021 12:40 EST  
Disch Date: 2/15/2021 23:59 EST  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6466717620  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634757

POL/SS # :		POL/SS # :	
INSURED :	,	INSURED :	,
REL TO INS :		REL TO INS :	
MAIL TO :	,	MAIL TO :	,
ADDRESS #1 :		ADDRESS #1 :	
ADDRESS #2 :		ADDRESS #2 :	
CITY/ST/ZIP :		CITY/ST/ZIP :	
PHONE :		PHONE :	
	EXT :		EXT :
APPROV/REF :		APPROV/REF :	
COMMENT :		COMMENT :	

## Office/Clinic Visit Notes

DOCUMENT NAME: Virtual Health Care Visit Note

**WILLIAMS III, LEONARD  
CLINTON**

**DOB:** 11/01/1980 **MRN:** 0000642066  
**Sex:** Male **FIN:** 6466717620

**Problem List/Past Medical History**

Ongoing  
ADD (attention deficit disorder)  
Bipolar disorder  
PTSD (post-traumatic stress disorder)  
Historical  
Obesity  
Obesity

**Patient Information:**

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

**Chief Complaint**

Follow-up phone visit

**History of Present Illness**

40-year-old male presents today for follow-up phone visit. He consents to today's visit and confirms he is at home. He denies current SI, HI, AH, VH. He states he has been having traumatic distress symptoms for the past hour. He states he worries about irritability. He states overall he feels that the day was a good day as far as his symptoms. He states he is not had many symptoms, states that these could occur recently. He states he has been doing EMDR, and measures his day based on the amount of usable hours that he has. He speaks about his daily work activities, and how this interacts with some of his difficulty with focusing. In fatigue that can come from extending more effort and times and he feels this leads to more subsequent symptoms. He feels that EMDR is helping him quite a bit. He plans to follow-up with a neurologist about his PTSD symptoms. He states he also plans to speak with a neurologist, and see if he can appeal for disability. He states he can have tenderness during the day with cleaning his home, completing his daily tasks and stressors. He states this can also occur when he does not feel that he is having significant symptoms. He states he can have significant psychological symptoms, but people are not able to tell it by just looking at him. He feels that this can be a part of his difficulties, he relates this to a significant case of PTSD, stating that he is in the top 1% of severity. He states that he does better with a smaller dose of olanzapine, but if it is split during the day. He states he stopped taking citalopram after his most recent hospitalization. He feels he continues to require stimulant medication that will focus. He currently denies 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.

**Medications**

Adderall XR 20 mg oral capsule, extended release, 40 mg, 2 capsule, ORAL, qAM (every morning)  
Goodys Extra Strength, See Instructions  
Med List Status - Updated  
metFORMIN, 500 mg, **Not taking**  
Misc Medication  
ZyPREXA 5 mg oral tablet, 5 mg, 1 tablet, ORAL, BID (2 times a day), 1 refills

**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.

Frelance graffic art

Home/Environment

Marital Status: Single. lives in an apartment by himself

Nutrition/Health

Home Diet: Diabetic.

Tobacco

Admit Date: 2/15/2021 12:40 EST  
Disch Date: 2/15/2021 23:59 EST  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6466717620  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634757

## Office/Clinic Visit Notes

### 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

1. ADD (attention deficit disorder)  
2. Bipolar disorder  
3. PTSD (post-traumatic stress disorder)  
40-year-old man presents today for follow up visit. 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 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. In the past with higher doses of stimulant medications he has a history of worsening irritability, paranoia, and symptoms that led to hospitalization.

He reports some difficulty since most recent visit, but reports feeling better after stopping citalopram. At this time we will discontinue citalopram, continue olanzapine and Adderall. We will increase olanzapine to 5 mg twice daily dosing to maximize effect and minimize potential side effects per his report. We will continue to monitor, with a goal of safely maximizing stimulant medications for underlying focus issues, while maximizing appropriate treatment for prior trauma symptoms. He has been counseled on potential side effects and reasons to seek emergency services. He will follow-up in 1 month.

- Discontinue citalopram
- Continue Adderall at current doses
- Increase olanzapine to 5 mg BID
- Counseled on potential side effects and reasons seek emergency services
- Follow-up in 1 month

### 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.

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.

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

HYPERTENSION: GM, Maternal.

Admit Date: 2/15/2021 12:40 EST  
Disch Date: 2/15/2021 23:59 EST  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6466717620  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634757

## Office/Clinic Visit Notes

- 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 5 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. 9 minutes was spent on the phone portion of visit.

**Electronically Signed By: MURRAY, PHILLIP MICHAEL MD**  
**02/18/2021 08:34 AM**

Admit Date: 2/15/2021 12:40 EST  
Disch Date: 2/15/2021 23:59 EST  
Admitting: MURRAY ,PHILLIP MICHAEL MD  
Attending: MURRAY ,PHILLIP MICHAEL MD  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6466717620  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634757



# AH BH Charlotte OMS Medication

501 Billingsley Rd

Charlotte, NC 28211-

PHYSICIAN FACESHEET - PATIENT DEMOGRAPHICS UPDATED: 05/08/2021 626

NAME : WILLIAMS,LEONARD CLINTON ADM DATE/TIME: 05/04/2021 900  
PT. TYPE : OP DIS DATE : 05/04/2021 2359  
SERVICE : VEA LOCATION : HOMS  
ADMIT SOURCE : 1  
ADDRESS #1 : [REDACTED] MED REC# : 000064-20-66  
ADDRESS #2 : [REDACTED] ACCOUNT # : CHS64733-56000  
CITY : CHARLOTTE PHONE (H) : (980) [REDACTED]  
CO/ST/ZIP : NC 28273 PHONE (W) :  
RACE : White or Caucasian PHONE (M) : (980) [REDACTED]  
BIRTHDATE : 11/01/1980 SEX : MALE  
SS # : XXX-XX-4844

ACCIDENT :  
ACCIDENT DATE:

ADMIT DX : Reserved for concepts with insufficient information to code with codable

children

WORKING DX : PRI CARE MD : BRADNER,RICHARD  
ADMIT MD : UNKNOWN,ATTENDING  
ATTEND MD : WRIGHT,AYOFEMII  
REFER MD : MURRAY,PHILLIP MICHAEL  
ER MD : UNKNOWN,ATTENDING  
GUARANTOR : WILLIAMS,LEONARD CLINTON III, RELATIVE : WILLIAMS,LEONARD  
ADDRESS #1 : [REDACTED] REL ADDRESS 1: [REDACTED]  
ADDRESS #2 : [REDACTED] REL ADDRESS 2:  
CITY : CHARLOTTE REL CITY : CHARLOTTE  
ST/ZIP : NC 28273 REL ST/ZIP : NC 28212  
PHONE (W) : REL PHONE (H): (980) [REDACTED]  
REL TO PT : SELF REL PHONE (W):  
REL TO PT : FRIEND

EMPLOYER :  
ADDRESS #1 : CITY :  
ADDRESS #2 : 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 # :

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

Admit Date: 5/4/2021 09:00 EDT  
Disch Date: 5/4/2021 23:59 EDT  
Admitting: WRIGHT ,AYOFEMI I DO  
Attending: WRIGHT ,AYOFEMI I DO  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6473356000  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634756



POL/SS # :		POL/SS # :	
INSURED :	,	INSURED :	,
REL TO INS :		REL TO INS :	
MAIL TO :	,	MAIL TO :	,
ADDRESS #1 :		ADDRESS #1 :	
ADDRESS #2 :		ADDRESS #2 :	
CITY/ST/ZIP :		CITY/ST/ZIP :	
PHONE :		PHONE :	
	EXT :		EXT :
APPROV/REF :		APPROV/REF :	
COMMENT :		COMMENT :	

## Office/Clinic Visit Notes

DOCUMENT NAME: Psychiatric Visit Note

**WILLIAMS III, LEONARD CLINTON**

**DOB:** 11/01/1980  
**Sex:** Male

**MRN:** 0000642066  
**FIN:** 6473356000

**Location:** AH BH Charlotte  
OMS Medication

### Chief Complaint

Follow-up

### History of Present Illness

Leonard is a 40 y.o. male with the following diagnoses:

1. Bipolar disorder
2. ADD (attention deficit disorder)
3. PTSD (post-traumatic stress disorder)

Today's visit occurs through 2 way audio and video technology. He confirms that she is in NC.

### **At last visit, the plan was as follows:**

- Continue Adderall at current doses
- Continue olanzapine to 5 mg BID
- Continue Trazodone, no new script sent, pt purchasing otc
- Counseled on potential side effects and reasons seek emergency services

Since last visit the has been experiencing some weakness. He is sleeping more. He states that he has been running out of Adderall because of this. He states that the 16 hour/day schedule vs 24 hour/day schedule causes him to run out early? When provider attempts to clarify, he because agitated yelling "fuck!" Patient requires redirection that if the profanity and yelling continue then appointment will need to be concluded early. Patient calms himself enough to continue the remainder of the visit. This provider expressed concern for worsening irritability with Adderall. He is adamant that this in not the case. He insists that it helps PTSD. He states that his Zyprexa is "fine." He takes 5-10 mg at night. For the past few months, he has been taking 10 mg. He intermittently has passive thoughts of not wanting to be alive. He

### Medical History

#### Problem List/Past Medical History

Ongoing  
ADD (attention deficit disorder)  
Bipolar disorder  
PTSD (post-traumatic stress disorder)

#### Historical

Obesity  
Obesity

### Medications

#### Inpatient

No active inpatient medications

#### Home

Adderall XR 20 mg oral capsule, extended release, 40 mg, 2 capsule, ORAL, qAM (every morning)  
Adderall XR 20 mg oral capsule, extended release, 40 mg, 2 capsule, ORAL, qAM (every morning)  
Adderall XR 20 mg oral capsule, extended release, 40 mg, 2 capsule, ORAL, qAM (every morning)  
Goodys Extra Strength, See Instructions  
Med List Status - Updated  
metFORMIN, 500 mg, **Not taking**  
Misc Medication  
ZyPREXA 5 mg oral tablet, 5 mg, 1 tablet, ORAL, BID (2 times a day), 1 refills

### Allergies

No known allergies

### Family Psychiatric/Medical 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.  
Diabetes mellitus: Negative: Mother, Father, Sister, Brother, GF, Maternal, GF, Paternal, GM, Maternal, GM, Paternal and Grandparent.  
HYPERTENSION: GM, Maternal.

Admit Date: 5/4/2021 09:00 EDT  
Disch Date: 5/4/2021 23:59 EDT  
Admitting: WRIGHT ,AYOFEMI I DO  
Attending: WRIGHT ,AYOFEMI I DO  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6473356000  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634756

## Office/Clinic Visit Notes

states the last time these thoughts happened was about 3 days ago. He has thoughts that it would be a relief, but he denies active plan or intent. He sleeps well. Zyprexa helps with this. He is no longer using Trazodone.

Most days, he has been feeling "weak."

He states that he has been criminally victimized x 2 years and this wears him down.

He declines to elaborate on details other than to state that it is documented.

He denies other manic symptoms.

He has intrusive memories and not flashbacks.

He plays video games or reads to cope.

### Exam

#### Mental Status Exam

General: Appears stated age. Dressed appropriately. Well nourished. Alert.

Orientation: Oriented to person, place, situation, and time.

Eye contact: Good.

Motor: No psychomotor agitation, retardation. No Parkinson movements, tics. No tremors.

Attitude: hostile

Speech: Normal rate, rhythm, volume, and prosody.

Attention and concentration: Fair, given the ability to follow the interview process appropriately.

Memory: Grossly intact

Thought process: Linear and goal directed

Mood: irritable

Affect: Congruent.

Thought content: Denied SI, HI at this time.

Associations: Non-bizarre

Perception: Denied auditory or visual hallucinations or paranoia.

Cognition: Grossly intact.

Insight: Limited

Judgment: Fair

### 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.

Frelance 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.

### Assessment and Plan

1. Bipolar disorder
2. PTSD (post-traumatic stress disorder)
3. ADD (attention deficit disorder)

*40-year-old man presents today for follow up visit. 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 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*

Admit Date: 5/4/2021

09:00 EDT

Disch Date: 5/4/2021

23:59 EDT

Admitting: WRIGHT ,AYOFEMI I DO

Attending: WRIGHT ,AYOFEMI I DO

Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066

Acct#: 6473356000

DOB: 11/1/1980

Age: 40 years

Sex: Male

Location: HOMS

Print ID: 476634756

## Office/Clinic Visit Notes

*medications. He also has a history of taking lower doses of Adderall without abuse for a long amount of time. In the past with higher doses of stimulant medications he has a history of worsening irritability, paranoia, and symptoms that led to hospitalization.*

Since last visit, he continues to report ongoing PTSD sx's. Patient is also very irritable on exam at times yelling and using profanity towards provider. This provider expresses concern for worsening irritability with use of Adderall. He denies this. He is med compliant. He declines an increase in Olanzapine. Will continue current meds as prescribed. However, if irritability/agitation worsening, then recommend d/c stimulant

–Continue Adderall XR 40 mg qam

–Continue olanzapine to 5 mg BID

--Continue Benadryl otc

–Counseled on potential side effects and reasons seek emergency services

**Electronically Signed By: WRIGHT, AYOFE MI DO**  
**05/04/2021 10:11 AM**

Admit Date: 5/4/2021 09:00 EDT  
Disch Date: 5/4/2021 23:59 EDT  
Admitting: WRIGHT, AYOFE MI DO  
Attending: WRIGHT, AYOFE MI DO  
Printed: 7/8/2021 06:58 EDT

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6473356000  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 476634756

**AH BH Charlotte OMS Medication****501 Billingsley Rd****Charlotte, NC 28211-**

PHYSICIAN FACESHEET - PATIENT DEMOGRAPHICS UPDATED: 10/10/2021 125

NAME : WILLIAMS, LEONARD CLINTON ADM DATE/TIME: 10/06/2021 1440  
PT. TYPE : OP DIS DATE : 10/06/2021 2359  
SERVICE : VEA LOCATION : HOMS

ADDRESS #1 : 13009 YORKRIDGE DRIVE MED REC# : 000064-20-66  
ADDRESS #2 : APT 214 ACCOUNT # : CHS64868-88614  
CITY : CHARLOTTE PHONE (H) : (980) 613-2196  
CO/ST/ZIP : NC 28273 PHONE (W) :  
RACE : White or Caucasian PHONE (M) : (980) 613-2196

BIRTHDATE : 11/01/1980 SEX : MALE  
SS # : XXX-XX-4844

ACCIDENT :  
ACCIDENT DATE:

ADMIT DX : Bipolar disorder, unspecified (CMS/HCC)

WORKING DX : Reserved for concepts with insufficient information to code with codable childrenPRI

CARE MD : BRADNER, RICHARD  
ADMIT MD : UNKNOWN, ATTENDING  
ATTEND MD : SENTER, MEREDITH STACY

REFER MD :  
ER MD : UNKNOWN, ATTENDING

GUARANTOR : WILLIAMS, LEONARD CLINTON III, RELATIVE : WILLIAMS, LEONARD  
ADDRESS #1 : 13009 YORKRIDGE DRIVE REL ADDRESS 1: 7235 CITY VIEW DRIVE  
ADDRESS #2 : APT 214 REL ADDRESS 2:  
CITY : CHARLOTTE REL CITY : CHARLOTTE  
ST/ZIP : NC 28273 REL ST/ZIP : NC 28212  
PHONE (W) : REL PHONE (H) : (980) 613-2196  
REL TO PT : SELF REL PHONE (W) :  
REL TO PT : FRIEND

EMPLOYER :  
ADDRESS #1 : CITY :  
ADDRESS #2 : 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 # :  
INSURED :  
REL TO INS :  
MAIL TO :  
ADDRESS #1 :  
ADDRESS #2 :  
CITY/ST/ZIP :  
PHONE : EXT :  
APPROV/REF :

INSURANCE  
COMPANY :  
GROUP # :

INSURANCE  
COMPANY :  
GROUP # :

Admit Date: 10/6/2021 14:40 EDT  
Disch Date: 10/6/2021 23:59 EDT  
Admitting: SENTER, MEREDITH STACY  
Attending: SENTER, MEREDITH STACY  
Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6486888614  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 509861891

POL/SS # :		POL/SS # :	
INSURED :	,	INSURED :	,
REL TO INS :		REL TO INS :	
MAIL TO :	,	MAIL TO :	,
ADDRESS #1 :		ADDRESS #1 :	
ADDRESS #2 :		ADDRESS #2 :	
CITY/ST/ZIP:		CITY/ST/ZIP :	
PHONE :	EXT:	PHONE :	EXT:
APPROV/REF :		APPROV/REF :	
COMMENT :		COMMENT :	

**Office/Clinic Visit Notes**

DOCUMENT NAME: Psychiatric Visit Note

**BH OP Note - Subsequent**Patient: **WILLIAMS III, LEONARD CLINTON** MRN: 0000642066 FIN: 6486888614Age: **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.

Admit Date: 10/6/2021 14:40 EDT  
Disch Date: 10/6/2021 23:59 EDT  
Admitting: SENTER ,MEREDITH STACY  
Attending: SENTER ,MEREDITH STACY  
Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN:0000642066 Acct#: 6486888614  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 509861891

**Office/Clinic Visit Notes**

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 defensive, 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 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

Admit Date: 10/6/2021 14:40 EDT

Disch Date: 10/6/2021 23:59 EDT

Admitting: SENTER, MEREDITH STACY

Attending: SENTER, MEREDITH STACY

Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066 Acct#: 6486888614

DOB: 11/1/1980 Age: 40 years Sex: Male

Location: HOMS

Print ID: 509861891

**Office/Clinic Visit Notes**

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****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**

Admit Date: 10/6/2021 14:40 EDT

Disch Date: 10/6/2021 23:59 EDT

Admitting: SENTER, MEREDITH STACY

Attending: SENTER, MEREDITH STACY

Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON

MRN: 0000642066 Acct#: 6486888614

DOB: 11/1/1980 Age: 40 years Sex: Male

Location: HOMS

Print ID: 509861891

**Office/Clinic Visit Notes**

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/messed 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 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

Admit Date: 10/6/2021 14:40 EDT  
Disch Date: 10/6/2021 23:59 EDT  
Admitting: SENTER, MEREDITH STACY  
Attending: SENTER, MEREDITH STACY  
Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6486888614  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 509861891



**Office/Clinic Visit Notes**

-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.

-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**

Admit Date: 10/6/2021 14:40 EDT  
Disch Date: 10/6/2021 23:59 EDT  
Admitting: SENTER, MEREDITH STACY  
Attending: SENTER, MEREDITH STACY  
Printed: 11/12/2021 16:23 EST

Pt Name: WILLIAMS III, LEONARD CLINTON  
MRN: 0000642066 Acct#: 6486888614  
DOB: 11/1/1980 Age: 40 years Sex: Male  
Location: HOMS  
Print ID: 509861891