Client Name: Test PatientAB **DOB:** 09/11/1950 **Facility:** Happy Home N&R **Room #:** 317
Gender: Male

DIAGNOSTIC INTERVIEW
INITIAL

Date of Service: 01/03/2021 **CPT:** 90791 **TOTAL Face Time Visit Minutes:** 43

Add-On CPT:
N/A

Diagnosis:
F33.2 - Major depressive disorder, recurrent severe without psychotic features

PART A/Skilled: Yes Hospice: No Telehealth: No Date Part A Initiated: 12/31/2020
Referred By: [X] Facility Staff [X] Physician [ ] Family [ ] Self [ ] Other:
MD Facility Order Date: 01/02/2021 Referring Physician (SNF setting only): Raj Singh, M.D.
Admitted to facility from: [ ] Community [X] Hospital [ ] Psychiatric Inpatient [ ] Other:

Reason for Referral

Attending physician ordered services for treatment of clinical depression and suicidal ideation. Symptoms at time of referral included: irritable, refusing meds, thoughts of self harm. Pt. showed marked agitation and is refusing medications since arriving at current placement. Stated moderate to high levels of despair over current health status with thoughts of self harm 2Xdaily the past 7 days. Distress level high and (+) correlated with bouts of acute physical pain secondary to recent amputation.

Mental Status (Select all that apply)

Appearance: [ ] Appropriate [ ] Well-groomed [ ] Bizarre [X] Disheveled [ ] Other:
Consciousness: [X] Alert [ ] Drowsy [ ] Comatose [ ] Other:
Orientation: [X] To Person [X] To Place [X] To Time [ ] Other: BIMS: Did not assess this visit.
Speech: [X] Clear [ ] Spontaneous [ ] Rapid [ ] Pressured [ ] Slow [ ] Slurred [ ] Absent [ ] Other:
Quality of Speech: Usually Understood
Activity Level: [ ] Appropriate [X] Agitated [ ] Psychomotor Retardation [ ] Tremulous [ ] Restless [ ] Slurred [ ] Absent [ ] Other:
Affect: [ ] Calm [X] Flat [ ] Blunted [ ] Sad [ ] Tearful [ ] Concerned [ ] Anxious [X] Agitated [ ] Angry [ ] Elated [ ] Inappropriate [X] Labile [ ] Other:
Mood: [ ] Euthymic [ ] Elevated [ ] Euphoric [ ] Dysphoric [X] Irritable [ ] Depressed [ ] Expansive [ ] Other: PHQ-9-OV Score: Did not assess this visit.
Concentration: Fair If other, please specify:
Thoughts: [ ] Appropriate [ ] Logical [ ] Coherent [X] Blocked [ ] Loose Association [ ] Hallucinations [ ] Delusions [ ] Circumstantial [ ] Tangential [ ] Other:
Memory: [X] Intact [ ] Short Term Deficits [ ] Long Term Deficits [ ] Other:
Judgment: Fair Other:

History of Current Mental Health Concern

Depressive symptoms exacerbated since recent amputation of left leg. GDS score this date = 9 out of 15. Patient reports reduced appetite, insomnia, and increased physical pain causing distractability and irritability since arriving at current placement.

Other Psychiatric/Mental Health History

Patient reported "off and on" couples counseling conducted by parish priest with wife of 40+ years in late 1990s. He said he has "suffered bouts" of depression most of his adult life secondary to Type 1 diabetes. Denies substance use disorder/addiction and reports negative history for psychiatric hospitalization. Of note, he stated his father attempted suicide (not completed) at age 55 during the patient's teenage years.

History of [ ] Serious Mental Illness [ ] Intellectual Disability *(Mental retardation in federal regulation)*
[ ] Intellectual Disability/Developmental Disability (ID/DD) [ ] Down Syndrome [ ] Autism [ ] Epilepsy
[ ] Other organic condition r/t ID/DD [ ] ID/DD w/o organic condition

MALADAPTIVE BEHAVIORS:

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Physical: (list)

Verbal: (list)

Repeated outbursts (yelling) at nursing staff with inappropriate language of an angry and bitter nature.

Other Behaviors not directed towards others: (list)

Refusing medications.

Resisting Care: (list)

See above.

Wandering:

Impact of Maladaptive Behaviors on Resident:

Did any of the above behaviors put the resident or others at risk for physical illness or injury? No

Did any of the above behaviors interfere with the resident's care? Yes

Did any of the above behaviors interfere with the resident's participation in activities or social interaction? No

Did any of the above behaviors significantly intrude on privacy or activity of others? No

Did any of the above behaviors disrupt care or living environment? Yes

Current Psychotherapeutic Medications

Lyrica, Lisinopril for pain and hypertension. Pain meds given PRN. No current medication for depression. *Psychiatry consult recommended.

Abuse/Neglect/Trauma History:

Physical: No Explain:

Sexual: Yes Explain:

Possible history: Mr. PatientAB stated his parents told him when his son was born that he himself he had been molested by a teenage neighbor/babysitter at age 3 but he reported zero recall of the person of the incident. Staff should be mindful of possible increased paranoia or sensitivity around male "neighbors" or care takers in facility or other possible triggers. He minimizes long term impact of this trauma history on his daily life and functioning.

Mental / Emotional: No Explain:

Any History of Neglect of Any Kind? No Explain:

Pertinent Medical History

Diabetes Mellitus Type 1, onset at age 13. Recent amputation of left leg above knee. Hypertension.

Cultural/Ethnic Influences

White, European American raised Roman Catholic (no longer practices, but believes in a higher power). Heterosexual.

Family/Social History

69 year old, married 44 years, 3 adult children, 5 grandchildren, nuclear family all local and involved in his care, 3Xweek visits. Some ongoing conflict and lack of trust of adult son.

Vocational History:

Worked for US Postal Service for 38 years prior to retirement.

Sources of History:

[X] Clinician Observation [X] Chart Review [X] Pt Report [X] Staff Report [X] Family / Guardian
[X] Assessment Measures [ ] Psychological Testing [ ] Other: ____

Current Patient Functional Strengths/Abilities (check all that apply): [X] Motivated for Therapy [X] Intelligent [ ] Verbal
[X] Insight into symptoms [ ] Judgment adequate [X] Memory Intact [X] Other: Very supportive spouse and two adult daughters.

Patient Liabilities (possible barriers to making progress toward change; check all that apply): [ ] Weak social support system
[X] Vision difficulties [ ] Hearing difficulties [ ] Low Energy [X] Mobility Impairment: recent leg amputation
[X] At Risk for Decompensation w/out Intervention [ ] Other: ____

Quality of Life Subjective Rating 1-10 Scale: Extremely Poor = 1 Excellent = 10

[ ] Patient Self Rating: Current Estimate: 3 Highest Estimate in Past Year: 8
[ ] Staff Rating: Current Estimate: ____ Highest Estimate in Past Year: ____
[ ] Family Rating: Current Estimate: ____ Highest Estimate in Past Year: ____

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Overall Prognosis: Other Gaurded

If previously diagnosed with dementia, please indicate type: N/A

Need for assessment due to marked mental status change: No

Need for assessment due to change in baseline functioning: Yes

Patient can benefit from behavior modifying interventions: Yes

QUALITY MEASURES Required:

A) Measure 283 Dementia Associated Behavioral & Psychiatric Symptoms Screen & Recommendations

a) "N/A" Patient not known to have a dementia diagnosis at this time

General recommendations for patient management found at end of document.

B) Measure 431 Unhealthy Alcohol Use Screen & Brief Counseling.

HOW MANY TIMES IN PAST 12 MONTHS DID YOU HAVE MORE THAN 5 (men) or 4 (women) DRINKS IN A DAY?UNHEALTHY USER IF >/= 1 DAY.

a) "G2197, G9622" Patient NOT identified as an unhealthy alcohol user by systematic screener above

C) Measure 128 Body Mass Index (Normal parameters: BMI > or = 18.5 and <25)

"G8420" BMI w/in normal parameters, no f/up needed.

N/A

Score: 22 **Date Calculated:** 01/03/2021 **Calculated by:** Susie Sunshine

D) Measure 134 Depression Screen (e.g. PHQ9, BDI, GDS) **Scale Used:** GDS **Score:** 9

"G8431" Positive screen for clinical depression, f/up plan noted as:

b) will provide ongoing treatment to reduce/relieve depressive symptoms

E) Measure 226 Tobacco Use Screen & Cessation Intervention

"G9903", "1036F" Pt screen for tobacco use and is currently NOT a tobacco user.

F) For ages 65+: Measure 181 Elder Maltreatment Screen (Elder Abuse Suspicion Index)

"G8734" Negative screen, no f/up required.

N/A

G) Measure MBHR1 Anxiety Utilization of GAD-7.

a) "PRO2000.4Y" Patient was administered GAD-7

GAD-7 Score: 5 **Date Measured:** 01/03/2021

VIOLENCE RISK

History of Violence Risk to Others in past 6 months:

N/A

Lifetime History of Violence Risk to Others prior to past 6 months:

Patient recalls one fist fight on flag football field at age 15. Denies any other history of violence.

SBQ-R Suicide Behaviors Questionnaire-Revised (check only one response per item)

Have you ever thought about or attempted to kill yourself: 3 - I have had a plan at least once to kill myself and really wanted to die

How often have you thought about killing yourself in the past year? 4 - Often (3-4 times)

Have you ever told someone that you were going to commit suicide, or that you might do it? 2 - Yes, at one time, but did not real

How likely is it that you will attempt suicide someday? 0 - Never

SBQ-R Total Score = 9 **[range is from 3-18; cutoff ≥7 general adult population or ≥8 psych inpatient]**

Current Risk of Harm to Self or Others: ☐ None ☒ Self ☐ Others **Explain:**

Thoughts increase in (+) correlation to physical pain.

Ideation: ☐ No Ideation ☒ Ideation **Explain:**

Desires relief from physical pain and worries will never walk again.

Plan/Means: ☐ Plan ☒ No Plan ☐ Means ☒ No Means **Explain:**

Fully and consistently denies plan and means.

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Estimated Current Risk Level: Low **Explain:**

Risk is low given protective factors of religious beliefs, family support, ability to respond to behavioral treatment and psychiatric medications, and currently no plan or means noted along with stated future orientation (grandson's graduation pending May 2021).

Did you Baker Act this client this date of service? No

Disposition of Case (check all that apply):

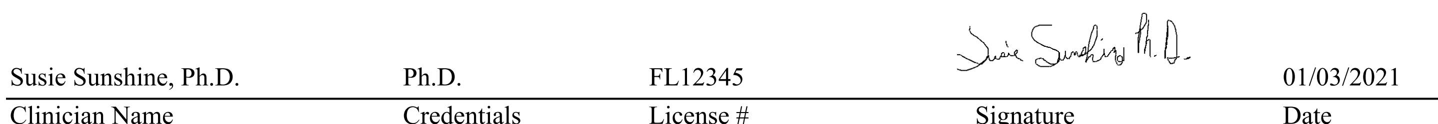
- [ ] Patient unlikely to benefit from therapy or behavior modifying interventions due to: ______________________
- [x] Patient has the capacity to benefit from psychotherapy: baseline functioning is altered (including sudden change in pts w/dementia)
- [x] Patient requesting/willing to participate in psychology services/psychotherapy and proposed treatment plan
- [x] Treatment to be initiated; Individualized Master Treatment plan to be completed
- [x] Other:

Will work on non-pharmaceutical approaches to pain management in treatment along with reduction of depression symptoms.

RECOMMENDATIONS to CARE TEAM:

Patient shows remorse over loosing temper with staff; do not take his maladaptive behaviors personally. Mr. PatientAB's thoughts of self-harm and outbursts are (+) correlated to his level of physical pain. Offer PRN meds if numerical rating score for pain is 5 or greater (5/10). Show genuine interest in his work history at the US Postal Service. Offer hope that he WILL succeed in Skilled PT and walk again. Offer gentle reminders that proper diet and medication adherence will increase his strength and speed his successful return home.

I hereby certify the above information is true and correct and that psychotherapy is medically necessary to treat the identified Dx/condition:



Susie Sunshine, Ph.D.	Ph.D.	FL12345		01/03/2021
Clinician Name	Credentials	License #	Signature	Date