D346 Patient Case Studies

In order to respond to D346 Task 1, you must identify and review the case study that corresponds to the **first initial of your last name,** as follows:

Last Name	Case Study	Pages
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Case Study 1

Patient Name: Rob Taylor
Gender: Male
Date of Birth: 06/10/## (The patient is 55 years old)

Identifying Information: Rob Taylor is a 55-year-old male that appears older than his stated age. He arrived at the clinic unaccompanied.

Chief Complaint: "I have been feeling very depressed for the last two months."

History of Present Illness: Rob has been experiencing symptoms of sadness in the past two months. He has been married for 30 years to his wife, who separated from the client one month ago after she discovered that he resigned from his job. He worked as a criminal defense attorney for over 25 years. Per patient, his job demands had increased over the last year and a half, with the most recent case that started 13 months ago and had been requiring an average of 60- to 70-hour work weeks. Rob stated that he has always been a social drinker, but the increased work hours and stress related to this most recent case led to a progressive increase in alcohol intake. Approximately one year ago, he was drinking approximately one to two 2 oz glasses of whiskey on the rocks per week. His most recent intake is two to three 2 oz glasses of whiskey per day. Initially, Rob was able to manage his work demands and his drinking. After a few months, he started to experience effects related to the increased alcohol use. He found himself at times drinking more than he planned on drinking and spent weekends sleeping in and not being able to fulfill home and work obligations, so he tried to cut back but would crave the alcohol when his stress levels increased. His wife noticed a change in his behavior and alcohol consumption six months ago. She tried addressing her concerns with Rob. He would lash out at his wife and tell her that if she only knew how much stress he was experiencing, she would understand. Approximately two months ago, he started experiencing feelings of sadness, hopelessness, and guilt. He started secretly drinking since he promised his wife that he stopped drinking. He started showing up to work late, missing deadlines and appointments, and avoiding social gatherings with family and friends. His appetite had decreased, and he unintentionally lost 20 pounds over the past two months. He was placed on administrative leave from his job when he showed up highly intoxicated to work. The firm offered to send him for treatment. Rob was upset and embarrassed over the situation and resigned from his position. His wife discovered that he had never stopped drinking and decided to separate with plans to divorce him if he did not get help. Rob states that he does have suicidal ideations. He wishes he could fall asleep and not wake up again. He denies any plans or history of suicide attempts. He is hoping to get his life back on track and stop his alcohol use.

Medications/Drug Allergies: None, NKDA

Psychiatric History: Denied history of mental health problems. Denied any history of sadness, suicidal thoughts, or changes in mood prior to increase in alcohol consumption.

Substance Use: Denied any illicit use of drugs. Drinks two to three drinks per day seven days per week.

Social History: Married for 30 years and has no children. Denies history of legal troubles and incarcerations. Currently living on his own in a rental apartment.

Medical History: Denied medical or surgical history. His last physical exam was two weeks ago. His primary did state that he had mild elevated cholesterol and recommended dietary changes along with decreased alcohol consumption.

Neurodevelopmental History: He was born at term, with no delivery complications, and met all developmental milestones with no history of learning disabilities.

Medical Review of Systems: All ROS normal.

Psychiatric Family History: Dad had a history of alcohol use disorder and died of liver cirrhosis 20 years ago.

Mental Status Examination: Rob presented as a disheveled, poorly groomed, and malnourished 55-year-old male that looked older than his stated age. He appeared sad and tearful with poor eye contact throughout the interview. He was cooperative and answered all questions appropriately. He demonstrated some mild psychomotor retardation, but no tremors were noted. He described his mood as sad, and his affect was congruent. His speech was low volume but clear. His thought processes were logical and goal directed. He recognized that he has been experiencing a tremendous amount of stress and has been using alcohol to cope with his problems. He requested help to improve his overall mood and well-being with hopes of reconciling with his wife. There was no evidence of thought blocking, insertion, deletion, or ideas of reference. No perceptual abnormalities were noted. He has experienced suicidal ideations but denied any intent of self-harming and described his thoughts as wanting to go to sleep and not wake up. He does not own any firearms. He demonstrated good short-term and long-term memory.

Physical Exam

Vital Signs:

- Blood Pressure: 134/78
- Heart Rate: 78
- Respirations: 18

Height: 5'11"
Weight: 195 pounds

Labs/Diagnostics: (per primary medical records)

- Labs: Within acceptable limits; slightly elevated LDL
- EKG: Within normal limits
- Urine Toxicology: Positive for opioids

Case Study 2

Patient Name: Andrew Wilson
Gender: Male
Date of Birth: 03/25/19## (please state year that would make the patient 49 years old)

Identifying Information: Andrew Wilson is a 49-year-old male that appears his stated age. His wife accompanied him to the visit. He was sitting and wringing his hands with poor eye contact throughout the intake evaluation. He was well groomed with good hygiene. He is a real estate agent and works 40–50 hours per week. He has been married to his wife for 23 years, and they have two children, ages 18 and 16. Both Andrew and his wife are reliable historians.

Chief Complaint: "My wife talked me into coming. She said that I am very moody and irritable."

History of Present Illness: Per his wife, the client has experienced episodes of irritability and abnormal behavior. She noticed infrequent periods of strange and risky behavior for many years but has noticed that in the past year, his episodes have occurred with increased frequency. The first episode occurred 10 months ago. The patient experienced a change in behavior lasting five days that included excessive online gambling, not sleeping for four days, high energy levels, irritability, and high levels of distraction. The second episode occurred three weeks ago. His wife discovered a large purchase on one of their credit cards. The patient had spent over a thousand dollars on online adult sites. During this episode, the patient had not slept for five days and was energetic and irritable. The wife also noticed that he had pressured speech. The behaviors were noticeable to his family, but the client was working over 60 hours per week during both episodes and was convinced he was "the best realtor." The client denied triggers that precipitated these episodes and states that after a few days, the symptoms resolved on their own. For the past two weeks, he has experienced sadness, irritability, feelings of guilt, and hopelessness. He has also experienced suicidal ideations, saying that he would never hurt himself but would hope to go to sleep and not wake up. His guilt was associated with his erratic behaviors and how it caused his wife emotional distress. He denied any plans for self-harm, and there are no weapons in the home. Per his wife, the behaviors were out of character for her spouse, and after the second event, she gave him the option of seeking treatment or facing separation.

Medications/Drug Allergies: Metformin 500 mg BID; NKDA

Psychiatric History: History of major depressive disorder (diagnosed at the age of 16). Was placed on Prozac but stopped taking it after two weeks because it was causing insomnia and increased irritability. Refused to take medication after experience.

Substance Use: History of marijuana and cocaine use in 20s. Denies history of controlled substance misuse. Drinks an average of two to three beers two days per week. Denies history of other illicit or controlled substance use.

Social History: He has been married to his wife for 23 years. He has two children, a male, age 18, and female, age 16.

Medical History: Diabetes, type II

Neurodevelopmental History: He was born at term, with no delivery complications, and has met all developmental milestones with no history of learning disabilities.

Medical Review of Systems: All ROS normal.

Psychiatric Family History: Father has a history of a mental health condition, but his parents will not disclose diagnosis. Sister has a history of postpartum depression with psychosis.

Mental Status Examination: Andrew presented as a well-groomed, well-nourished client that appears stated age. He is awake and alert with poor eye contact and cooperative. He did not appear to have psychomotor agitation or retardation. His speech was clear, with normal rate and flow. His voice did crack, and he became tearful when he was describing his behavior during the recent episodes. His mood was depressed, and affect is congruent. His thought processes were linear and goal directed. His thought content was appropriate for his age. He denied any current thoughts of SI/HI. His last suicidal ideation was three days ago (wanting to sleep and not wake up). He denies any plans or history of attempts of suicide. He stated that he would never do that to his family. He does not own any firearms. Andrew was awake, alert, and oriented to person, place, time, and situation. Executive functioning appeared intact. He demonstrated good short- and long-term memory.

The client had fair insight. He recognized that he needed help and understood that his behavior was out of character for him. The client demonstrated fair judgment. He was open to receiving treatment and medications, if indicated.

Physical Exam

Vital Signs:

- Blood Pressure: 135/63
- Heart Rate: 73
- Respirations: 16

Height: 5'10"
Weight: 195 pounds
Labs/Diagnostics: (per primary medical records)

- Lab: Within acceptable limits
- EKG: Within normal limits

Case Study 3

Patient Name: Carrie Watson
Gender: Female
Date of Birth: 05/04/## (The patient is 34 years old)

Identifying Information: Carrie Watson is a 34-year-old female that appears older than her stated age. She arrived at the clinic accompanied by her mother, who remained in the waiting room.

Chief Complaint: Carrie was referred by her primary doctor for concerns related to medication overuse. Carrie appeared drowsy and sad. She stated, "I need help with my use of pain medication."

History of Present Illness: Carrie has been treated by her primary doctor for a back injury that she sustained at work. She was a warehouse inventory handler for nine years. Approximately two years ago, there was an accident at her place of employment where a heavy box fell from a shelf and landed on her back. She was diagnosed with lumbar disc herniations and prescribed oxycodone for pain. She is currently taking OxyContin 40 mg by mouth every 12 hours. Her primary doctor has attempted to decrease her dose for several months now, but Carrie has been hesitant due to the extreme pain she has felt when she has tried decreasing on her own.

Since the accident, Carrie has been unemployed and is currently living with her parents. She is married but has been separated for three months now. Her husband has voiced concern with her dependence on opioids. He had tried to get her the help she needs so that she could increase her level of functioning and resume working. When Carrie refused rehab, her husband decided to separate. Her parents have been supportive but have also voiced their concerns about her dependence on opioids. Over the last three months, she has experienced recurrent feelings of hopelessness, worthlessness, and guilt. She felt that her pain has impacted her ability to enjoy things she once enjoyed and has often thought that her family would be better off if she were dead. She denied any history of suicide attempts but sometimes wished she could go to sleep and not wake up. She has lost 25 pounds over the last 3 months. Past treatments included physical therapy and steroid injections to help with pain, but she felt that the only thing that had helped her with pain relief was the OxyContin. Carrie had tried decreasing her OxyContin doses but had experienced severe symptoms of withdrawal when she attempted to decrease her dose. Carrie started attending psychotherapy one month ago and has come to the realization that she needed help with her opioid dependency.

Medications/Drug Allergies: OxyContin 40 mg Q12 hours, prn severe pain.

Psychiatric History: Carrie has a history of major depressive disorder (early 20s). She was treated with Zoloft 100 mg daily and psychotherapy for over a year. She stopped taking meds and attending psychotherapy because she felt better. She experienced a second episode of depression at the age of 31 after struggles with infertility three years ago. Carrie and her husband attempted several courses of artificial insemination but stopped after the work-related accident. Her husband has refused to resume infertility treatment until she received help.

Substance Use: History of marijuana use in her teenage years. Denied any illicit use of drugs. Denied alcohol use but smokes two to three cigarettes per day.

Social History: Has been married for eight years. She was a warehouse inventory handler for nine years but has been unemployed since the accident two years ago. Her husband has been enlisted in the Air Force for 16 years and has been deployed overseas for the last six months. She has no children. She denied history of legal troubles and incarcerations.

Medical History: The patient had a history of lumbar disc herniations (L4–L5). Attempted physical therapy and alternative therapies (acupuncture/acupressure). Denied surgical history. LMP: one week ago.

Neurodevelopmental History: She was born at term, with no delivery complications, and had met all developmental milestones with no history of learning disabilities.

Medical Review of Systems: All ROS were normal with exception of lower back pain.

Psychiatric Family History: Mom had a history of MDD; Dad had a history of alcohol use disorder and had been sober for over 20 years.

Mental Status Examination: Carrie presented as a disheveled, poorly groomed, and malnourished 34-year-old woman that looked older than her stated age. She appeared drowsy, sad, and tearful with poor eye contact throughout the interview. She was cooperative but required repetition of questions due to drowsiness. She demonstrated psychomotor retardation. She described her mood as sad, and her affect was congruent. Her speech was low volume, and, at times, slurred. Her thought processes were logical and goal directed. She recognized that she is dependent on opioids and wanted to pursue outpatient treatment. There was no evidence of thought blocking, insertion, deletion, or ideas of reference. No perceptual abnormalities were noted. She had experienced thoughts of suicide. She denied any intent of self-harming and described her thoughts as wanting to go to sleep and not wake up. Her mother has been monitoring her use of her pain medication and kept the medication locked for safety. Carrie demonstrated poor attention and concentration and memory throughout the interview. Denied homicidal ideations, delusions, and hallucinations.

Physical Exam

Vital Signs:

- Blood Pressure: 92/53
- Heart Rate: 113
- Respirations: 14

Height: 5'9"
Weight: 125 pounds

Labs/Diagnostics: (per primary medical records)

- Lab: Within acceptable limits
- EKG: Within normal limits
- Urine Toxicology: Positive for opioids
- Urine Hcg: Negative

COWs Score: negative

Case Study 4

You are a PMHNP on call to provide inpatient mental health consultations. You received a consult from the medical-surgical unit to assess a patient and determine the decision-making capacity and treatment recommendations.

Patient Name: Hugo Hernandez
Gender: Male
Date of Birth: 05/13/19## (The patient is 68 years old)

Identifying Information: Hugo is a 68-year-old male that appears older than his stated age. His wife was at his bedside. He was lying in his hospital bed, drowsy, irritable, and responsive to verbal stimuli. He was alert and oriented to person only. He maintained poor eye contact and whispered when speaking. He frequently drifted off to sleep throughout interview. The patient was a poor historian, but his wife was a reliable historian. He was admitted to the medical-surgical unit for a urinary tract infection five days ago.

Chief Complaint: "I don't know."

History of Present Illness: Per the admission assessment, the patient experienced sudden onset confusion at home three days ago. His wife stated that the patient had been experiencing increased urinary urgency and frequency for several weeks. He refused to go to the doctor. He denied any awareness of his hospitalization and his current surroundings. Per his wife, the patient's behavior was not his baseline behavior, and prior to the episode three days ago, he had no history of cognitive deficits. He had been experiencing disruptive sleep patterns since his admission and significant levels of irritability. The patient received a full workup and was diagnosed with a urinary tract infection (UTI) and benign prostatic hyperplasia (BPH). He was started on antibiotics for his UTI and alpha blockers for BPH.

Medications/Drug Allergies: Levofloxacin (Levaquin) 750 mg IV daily; Flomax 0.4 mg by mouth daily; NKDA

Psychiatric History: No past psychiatric history

Substance Use: History of social alcohol use in the past but stopped over 20 years ago. Denied history of illicit drug use.

Social History: Married for 48 years. Has four adult children, ages 45, 43, 42, and 40. He was a construction worker for 35 years and has been retired for 13 years after sustaining a work-related back injury.

Medical History: Hyperlipidemia. Denied surgeries.

Neurodevelopmental History: Wife was unsure if husband met developmental milestones. She denied any history of known learning disabilities.

Medical Review of Systems: All ROS normal.

Psychiatric Family History: Wife stated his mother was diagnosed with dementia and died at the age of 82.

Psychiatric Review of Systems: Per his wife, the patient was demonstrating signs of acute confusion with some episodes of lucidity in between. He appeared drowsy and irritable. Per his wife, the patient had not demonstrated any signs of mental health problems in the weeks leading up to admission. She described Hugo as a kind and cheerful individual.

Mental Status Examination: Hugo appeared older than his stated age. He was awake and alert to person at the time of assessment. Per his wife and nurses, his level of consciousness fluctuated throughout the day. His speech was at times incoherent. He spoke only a few words at a time. His mood was irritable, and his affect was congruent. He was unable to assess thought process and thought content since he was confused and was not responding to questions asked. Hugo was sleepy but arousable and oriented to person only. He was confused, with his level of attention fluctuating throughout the interview. Unable to assess memory. The patient had poor insight and poor judgment.

Physical Exam

Vital Signs:

- Blood Pressure: 142/56
- Heart Rate: 82
- Respirations: 18

Height: 5'6"
Weight: 125 pounds

CAM Assessment Score: Positive for features 1, 2, 3 and 4

Recent Labs/Diagnostics: (per primary medical records)

- CT: Head—negative for infarct
- Labs: Within acceptable limits with exception of elevated WBC
- EKG: Within normal limits
- CXR: Negative

Neurology—CVA ruled out
Cardiology—Cardiac disease ruled out
Urology—Diagnosed UTI secondary to BPH and started on Flomax during hospitalization. Scheduled for follow-up visit once discharged.

Case Study 5

Patient Name: Kelly Taylor
Gender: Female
Date of Birth: 10/25/19## (please state year that would make the patient 43 years old)

Identifying Information: Kelly Taylor is a 43-year-old female that appears her stated age. She appeared sullen and poorly groomed, she was malodorous, and she maintained poor eye contact throughout the interview. She was a reliable historian.

Chief Complaint: "I haven't been feeling like myself for the past month. I feel sad and don't leave my house much."

History of Present Illness: Per the client, symptoms started approximately one month ago. She complained of sadness, feelings of hopelessness, worthlessness, and guilt. In addition to these symptoms, Kelly had experienced decreased energy levels and decreased appetite. Kelly stated that she had experienced occasional thoughts of going to sleep and not waking up but denied thoughts of wanting to hurt herself. Her last suicidal thought was four days ago. She expressed guilt and stated that her friends and family would be better off without her. She denied current thoughts of wanting to die. She had been working remotely since the pandemic started. She stated that initially working from home was a good experience for her, but in recent months, she had started feeling lonely and somewhat isolated. She is a customer service representative for an online car dealership and has been at her place of employment for 10 years. She is currently single but was married for 15 years and has been divorced for two years. She has no children and lives alone with her cat. She has a few close friends and a sister who lives nearby. Her parents died 20 years ago in a car accident. She had always been a high-performing employee but in recent weeks has started to call in sick more often than usual. She is showering one to two times per week and eating one to two times per day. She denied any weight loss. She has been spending less times with friends. She stated that she feels low energy levels and does not find joy in going out with her friends. She has been experiencing insomnia, finding it difficult to fall asleep, and in the morning, she feels tired and unrested. She had not received treatment for her current symptoms prior to her appointment.

Medications/Drug Allergies: Multivitamins. Denies drug allergies.

Psychiatric History: History of major depression in high school for six months with a relapse after her parents' death in car accident 20 years ago. She attended psychotherapy both times and stopped attending therapy because she "felt better."

Substance Use: Denies current or past use of illicit or controlled substances. Drinks a small glass of red wine with her dinner one to two days per week.

Social History: She was married for 15 years to her college boyfriend and divorced two years ago when she discovered that he was unfaithful. She has dated but has not had a serious relationship since her divorce. She has a sister who lives nearby and a few close friends. She used to participate in a bowling league but decided to take a break from the league three weeks ago. She has no history of legal problems.

Medical History: She denied any history of medical problems. She had an appendectomy at the age of eight with no complications. Last menstrual period: two weeks ago.

Neurodevelopmental History: She was born at term, with no delivery complications, and met all developmental milestones with no history of learning disabilities.

Medical Review of Systems: All ROS normal.

Psychiatric Family History: Sister—history of MDD and GAD. Mom—history of GAD. Dad—history of alcoholism.

Mental Status Examination: Kelly is a female that appeared her stated age. She was poorly groomed, disheveled, and malodorous. She was awake, alert with poor eye contact, but cooperative. Her speech was clear with a normal rate, flow, and tone and normal for her age and orientation, with occasional pauses midsentence. Her mood was sad, and her affect was congruent. Her thought processes were linear and goal directed. Her thought content was appropriate for her age. She denied any thoughts of SI/HI. Kelly was awake, alert, and oriented to person, place, time, and situation. Her executive functioning appeared intact. She demonstrated good short-term and long-term memory. She had fair insight and judgment.

Physical Exam

Vital Signs:

- Blood Pressure: 115/63
- Heart Rate: 63
- Respirations: 17

Height: 5'4"
Weight: 154 pounds

Labs/Diagnostics: (per primary medical records labs six months ago)

- Lab: Within normal limits
- EKG: Within normal limits
- Recent urine pregnancy—negative