

DOMINION HOSPITAL

2960 Sleepy Hollow Road
Falls Church, Virginia 22044
Phone (703) 536-2000

WILLIAMS, LYNNAE D
J84090217483 ADM IN J.222-B
10/30/09 Roth, Richard L
DOB: 07/09/1976 F/33 MR# J000018122
Dominion Hospital

DISCHARGE PLAN FORM

Discharge Status _____
Admission Date: 10/30/09 Discharge Date: 10/31/09 Discharge To: Home EPHP on Mo.

FOLLOW-UP APPOINTMENTS

Name	Telephone	Appt Date	Appt Time	Date Faxed
Psychiatrist				
Fax Number	Address			
Therapist				
Fax Number	Address			
Other				

AFTERCARE PLAN

Mental Health/Social /Medical Issues

Patient has been advised of the potential for Metabolic Syndrome and the need for follow up with the Psychiatrist and Primary Care Physician.

DISCHARGE DIAGNOSIS:

Axis I:	Axis III:
Axis II:	Axis IV:
	Axis V:

Attending Physician: Dr. Roth Phone #: 703-821-2337

Physician Signature: R. Roth, M.D. Date: 10-31-09

Patient Signature: [Signature] Date: 10-31-09

Patient/Guardian Signature: _____ Date: _____

Social Worker Signature: [Signature] 10/31/09

- Return Patient's
- Medications
 - Belongings upon discharge
 - Valuables

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 1

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care INITIAL SAFETY ASSESSMENT: ADU

Coded Allergies/Adverse Reactions

Name	Category	Severity	Ver?	Date	Time	User
Reaction						

Allergies

Fluoxetine HCl	Drug	M	Y	10/30/09	1240	HEB
RASH						

Adult Partial Safety Assessmnt

11/04/09 1548 EMW

What are your goals for this hospitalization: "Adequately address any concerns about my : ability to return to work and cope with stress"

Any History of Abuse or Neglect: N

History of Aggressive/Assaultive Behavior: None

Access to Lethal Means: N

If Yes please explain:

Patients Social Worker notified: N

History of Suicide Attempts: N

Does the patient have any thoughts of suicide: DENIES

Does the patient have any intent of suicide: DENIES

Does the patient have a plan for suicide: DENIES

Does the patient have a history of self harm: N Types of Self Harm Behaviors:

Head Banging: N Scratching/Cutting: N Manipulating others to harm self: N

Fire Setting: N Hanging: N Overdosing: N Burning: N Self Strangulation: N

Jump in front of car, window, metro: N Poison: N Self Biting: N Other: N

Triggers: NA

Level of Impulsivity: Low

Admission history/symptoms indicate potential for self-harm: N

Commits to notify staff of self harm thoughts, intent, or plans: Y

Patient's Protective Barriers against Suicide/Self Harm: Coping Skills

Currently Employed/School

Positive Attitude

Social Supports

Ability Reality Test

Precipitating Factors: If applicable what does the pt identify as the cause of loss of control or acting out behavior? "MY JOB'S CONCERN AFTER THE ACCIDENT REPORT : FOLLOWING MY CAR ACCIDENT ON OCT 27, 2009"

Techniques used to help patient control behavior: "I HAVE BEEN IN CONTROL : OF MY MOOD, NOT OUT OF CONTROL, EXCEPT WHEN DISORIENTED FEW DAYS AFTER ACC."

<<NURSING ADMISSION NOTE>>

Oriented to unit: Y

Appearance: WELL GROOM : PT ADMITTED TO ADULT PARTIAL PROGRAM TODAY. STATES

Additional Comments: SHE WAS DISORIENTED AFTER HER CAR ACCIDENT FOR A FEW DAYS BUT DENIES : LOSS OF CONTROL OF MOOD OR BEHAVIOR RECENTLY. HAS AN INTERVIEW AT WORK

DOMINION HOSPITAL

**Admission Medical History
and Physical Examination**

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REVIEW OF SYSTEMS:

Head: No Abnormalities Identified Recent Trauma Other

Eyes: No Abnormalities Identified Corrective Lenses Other

Ears (hearing): No Abnormalities Identified Infection/Pain Other

Nose: No Abnormalities Identified Rhinitis Other

Mouth / Throat (with dental assessment): No Abnormalities Identified Sore Throat Other

Cardiovascular: No Abnormalities Identified Chest Pain Other

Respiratory: No Abnormalities Identified Cough Shortness of Breath Other

Gastrointestinal: No Abnormalities Identified Nausea Vomiting Diarrhea Other

Genito-urinary: No Abnormalities Identified Urinary Frequency Urgency Other

Gynecological: No Abnormalities Identified Vaginal Discharge Other

LMP: 1/1/09

Skeletomuscular (include motor development and functioning): No Abnormalities Identified Pain Other


Skin: No Abnormalities Identified Other

Neurological: No Abnormalities Identified Headaches Other

Weight Change / Dietary Habits: No Abnormalities Identified Weight Loss Weight Gain
 Appetite Loss Increased Appetite Other

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Patient Name:

Date:

10/3/09

MR #:

CHIEF COMPLAINT AND PRESENT ILLNESS (INCLUDE IDENTIFYING INFORMATION):

Ward dinner

CURRENT MEDICATIONS:

Adderall

PAST MEDICAL HISTORY:

ADDI D

(children include birth and maternal history, if available):

4 B Newborn

Surgery:

Illnesses:

0

Allergies:

NO FAC

Immunizations:

UP D

SOCIAL HISTORY:

Tobacco Use Yes No


Drug Use Yes No

Alcohol Use Yes No

FAMILY HISTORY:

DOMINION HOSPITAL

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ADMISSION PHYSICAL EXAMINATION


(Note: Examiner is to cross out any description of findings which do not apply to this patient. If any abnormality is noted during the examination, please describe under the "Specify otherwise" section.)

Pulse	Respirations	Blood Pressure
GENERAL APPEARANCE <input type="checkbox"/> Patient is a well-developed, well-nourished individual who does not appear to be acutely or chronically ill. Posture is appropriate; no visible disturbance or gait.		<input type="checkbox"/> Specify otherwise _____ _____ _____
SKIN <input type="checkbox"/> Palpation: warm, moist, elastic. Inspection: without significant eruptions or discoloration.		<input type="checkbox"/> Specify otherwise _____ _____ _____
HEAD <input type="checkbox"/> Scalp is clean. Hair is of normal distribution and color, is not significantly fine or course to touch.		<input type="checkbox"/> Specify otherwise _____ _____ _____
FACE <input type="checkbox"/> Facial contour, mobility and expression are normal. No marked asymmetry or sagging noted.		<input type="checkbox"/> Specify otherwise _____ _____ _____
EYES <input type="checkbox"/> Pupils are equal, round, regular and react to light and accommodation. Extraocular movements are normal. The sclera is white. Conjunctiva are free from infection. The cornea and lens are clear. The Fundoscopic examination reveals sharp disc margins. Vessels are of normal caliber. No hemorrhages or exudates are present.		<input type="checkbox"/> Specify otherwise _____ _____ _____ _____ _____ _____
NOSE <input type="checkbox"/> No obvious deformity. Mucous membranes are not inflamed. Turbinates are not swollen. Airways are patent. There is no septal perforation. There is no significant rhinitis.		<input type="checkbox"/> Specify otherwise _____ _____ _____
EARS <input type="checkbox"/> Canals are clear. Tympanic membranes are intact and noninjected. Hearing is adequate for normal conversation. External canals are free from tophi or other abnormalities.		<input type="checkbox"/> Specify otherwise _____ _____ _____

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<p>MOUTH</p> <p><input checked="" type="checkbox"/> Breath odor is within normal variation. There is not significant change in the color or texture of the lips, tongue or buccal membrane. Tongue protrudes in the midline without unusual tremor. Teeth are in good repair and the gums appear healthy.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>PHARYNX</p> <p><input checked="" type="checkbox"/> Mucosa is not inflamed. No evidence of swelling or exudate. Tonsils are present and not enlarged or inflamed.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>THYROID</p> <p><input checked="" type="checkbox"/> The thyroid is not enlarged. No nodules are present.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>NECK</p> <p><input checked="" type="checkbox"/> There is no increased jugular venous pressure. Carotid pulsations are equal. No bruits are heard.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>GLANDS</p> <p><input checked="" type="checkbox"/> There is no significant lymph gland enlargement in the neck, axillae, epitrochlear area, supraclavicular area or groin.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>CHEST</p> <p><input checked="" type="checkbox"/> Normal contour and movement on inspiration / expiration. No chest wall tenderness.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>LUNGS</p> <p><input checked="" type="checkbox"/> Auscultation: Breath sounds are audible. No rales, rhonchi, or wheezes are noted. Percussion: Resonant in all fields.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>BREASTS</p> <p><input checked="" type="checkbox"/> Free from masses and tenderness, discharge, dimpling, wrinkling or discoloration of the skin.</p>	<p><input type="checkbox"/> Specify otherwise _____</p> <p><i>not done</i></p>
<p>HEART</p> <p><input checked="" type="checkbox"/> Not enlarged. Heart sounds are normal regular in rhythm and of normal rate. No murmur, gallops, clicks or rub are heard.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>

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TANNER STAGES (Adolescents Only)

	FEMALE	MALE
<input type="checkbox"/> Stage 1	Preadolescent pubic hair and breasts.	Preadolescent penis and testes, no pubic hair
<input type="checkbox"/> Stage 2	Sparse, lightly pigmented straight pubic hair; breasts papilla elevated as small mound; areolas diameter increased.	Scanty pubic hair, slightly enlarged penis; enlarged scrotum, pink texture altered.
<input type="checkbox"/> Stage 3	Pubic hair darker, beginning to curl, increased amount; breast and areola enlarged, no contour separation.	Pubic hair darker and curly. Penis, scrotum larger.
<input type="checkbox"/> Stage 4	Pubic hair coarse, curly, more abundant; areola and papilla form secondary mound.	Adult-type pubic hair, penis larger, wider; scrotum larger, darker.
<input type="checkbox"/> Stage 5	Pubic hair is adult feminine triangle; mature breast, nipple projects, areola part of general breast contour.	Adult-type pubic hair distribution; full growth of penis and testes.

RECTAL

(All patients, age 45 or older, or if specific symptoms indicate need for examination.)


- No evidence of hemorrhoids, fissures, bleeding or masses. Prostate is smooth of normal size, is non-tender and free from nodules (male only.) No masses present. Sphincter tone normal.
- NOT PERFORMED**
- Patient less than age 45 and no specific symptoms indicating need for examination.
- Recent exam completed on _____ by _____
- Patient wishes to have own physician perform exam. Physician name _____
- Patient unable to cooperate because of psychiatric condition. Describe: _____
- Other _____

Specify otherwise _____

Specify otherwise _____

DOMINION HOSPITAL


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<p>ABDOMEN</p> <p><input type="checkbox"/> Normal contour - no masses to tenderness, no organomegaly (kidney, liver, spleen.) There is no costovertebral angle tenderness and no guarding. Peristaltic sounds are normal. No bruits are heard.</p>	<p><input type="checkbox"/> Specify otherwise _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>GENITALIA / PELVIC - FEMALE</p> <p><input type="checkbox"/> No hernias. No lesions of the labia or introitus are noted. The vaginal mucosa is moist and normally elastic. Uterus is normal size, shape, position, freely moveable. Cervix is without lesions. There is no significant vaginal discharge.</p> <p><i>NOT PERFORMED</i></p> <p><input type="checkbox"/> Patient less than 18 and not sexually active.</p> <p><input type="checkbox"/> Recent exam completed on _____ by _____</p> <p><input type="checkbox"/> Patient wishes to have own physician perform exam. Physician name _____</p> <p><input type="checkbox"/> Patient unable to cooperate because of psychiatric condition. Describe: _____</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Specify otherwise _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Specify otherwise _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>GENITALIA - MALE</p> <p><input type="checkbox"/> Both testes palpable. No abnormal masses. No hernias. No urethral discharge. No lesions of glans or shaft noted.</p> <p><i>NOT PERFORMED</i></p> <p><input type="checkbox"/> Patient less than 18 and not sexually active.</p> <p><input type="checkbox"/> Recent exam completed on _____ by _____</p> <p><input type="checkbox"/> Patient wishes to have own physician perform exam. Physician name _____</p> <p><input type="checkbox"/> Patient unable to cooperate because of psychiatric condition. Describe: _____</p> <p><input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Specify otherwise _____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Specify otherwise _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

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NOT PERFORMED


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- Other _____

Specify otherwise _____

Specify otherwise _____

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WILLIAMS, LYNNAE D 8
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 Dominion Hospital

NEUROLOGICAL EXAM (cond.)	
<input type="checkbox"/> Eyelid Elevation: Able to retract eyelid fully.	<input type="checkbox"/> Specify otherwise _____
<input type="checkbox"/> Fundi flat, discs not elevated; no arteriovenous nicking, no hemorrhages, no retinal pigmentation.	<input type="checkbox"/> Specify otherwise _____
III, IV, VI Movement of Eyes (oculomotor, trochlear and abducens nerves): <input type="checkbox"/> Smooth, symmetrical movement through all positions of gaze; no nystagmus present.	<input type="checkbox"/> Specify otherwise _____
V. Trigeminal (ophthalmic branch, maxillary branch, mandibular branch). <input type="checkbox"/> With eyes closed, indicates facial and aural tactile perception.	<input type="checkbox"/> Specify otherwise _____
Movement of muscles of mastication: <input type="checkbox"/> Symmetrical tension in muscles of clenched jaw; able to move jaw laterally against resistance; symmetrical muscle mass of temporalis and masseters; absence of lip tremors, involuntary chewing movements and trismus; chews symmetrically.	<input type="checkbox"/> Specify otherwise _____
VII. Facial <input type="checkbox"/> Normal facial inspection, frowns, and elevates eyebrows symmetrically (upper), tight closing of eyes (upper), adequate saliva production; able to show teeth; smiles symmetrically (lower).	<input type="checkbox"/> Specify otherwise _____
VIII. Acoustic <input type="checkbox"/> Cochlear branch: Hears finger rubbing and snapping equally in both ears.	<input type="checkbox"/> Specify otherwise _____
Vestibular branch <input type="checkbox"/> Finger to nose or finger to finger without past-pointing; normal tandem walk; stands with feet together without posture deviation (absent Romberg)	<input type="checkbox"/> Specify otherwise _____

DOMINION HOSPITAL

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Dominion Hospital

<p>CIRCULATION</p> <p><input type="checkbox"/> No significant varicosities. Pulses are palpable and regular in neck, wrist, groin, popliteal, and tibial arteries. No audible bruits.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>EXTREMITIES</p> <p><input type="checkbox"/> Full range of motion of joints. No discolorations, tenderness, edema or evidence of impaired function.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>BACK</p> <p><input type="checkbox"/> There is normal curvature of the spine. There is no tenderness of the cervical, dorsal and lumbar spines.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>

NEUROLOGICAL EXAMINATION	
<p>Level of Consciousness</p>	<p><input checked="" type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Stupor <input type="checkbox"/> Coma</p>
<p><u>Knowledge</u></p> <p><input type="checkbox"/> Appropriate to age, education, cultural background, life experiences.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><u>Speech and Language</u></p> <p><input type="checkbox"/> Clear articulation; no slurring, no stuttering, or other difficulties or impediments of speech; no bizarre intonation; able to use and interpret language with ease; no difficulty sending or receiving verbal or gestural messages.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><u>Examination of Cranial Nerves: II - XII</u></p> <p>II. Optic :</p> <p><input type="checkbox"/> Visual Fields: Full with no deficits on confrontation; able to distinguish number of fingers in central field; distinguishes movement in peripheral fields.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Pupillary Reactivity: Pupil size symmetrical; pupils neither widely dilated nor pinpoint in average room light; prompt constriction in reaction to direct light stimulus.</p>	<p><input type="checkbox"/> Specify otherwise _____</p>

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<p>NEUROLOGICAL EXAM (cond.)</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><i>IX, X. Glossopharyngeal and Vagus Nerves:</i></p>	
<p><input type="checkbox"/> Normal midline elevation of uvula and palate; laryngeal contour rising with swallowing; phonates without hoarseness or articulation difficulty.</p>	
<p><i>XI. Accessory Nerve:</i></p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Normal strength and symmetry on turning head and elevation of shoulders.</p>	
<p><i>XII. Hypoglossal Nerve:</i></p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Tongue protrudes in midline with absence of fasciculations, tremors or atrophy, normal muscle strength of tongue; normal lingual speech.</p>	
<p><u>Cerebellar Function:</u></p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p>Balance:</p>	
<p><input type="checkbox"/> No abnormalities of gait (tandem and heel-toe.)</p>	
<p>Coordination:</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Able to touch finger to nose and heel to shin and vice versa rapidly and accurately with no past pointing; able to perform rapid alternating movements (supination and pronation of forearms) quickly and symmetrically.</p>	
<p><u>Motor Functions:</u></p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Symmetrical on inspection; good tone without spasticity or rigidity; no contractures or hypotonus; no atrophy.</p>	
<p>Muscle Strength:</p>	<p><input type="checkbox"/> Specify otherwise _____</p>
<p><input type="checkbox"/> Adequate and symmetrical muscle strength (5/5) on resistance to opposing force for upper and lower body muscle group on flexion and extension, abduction and adduction.</p>	

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Involuntary Movements: <input type="checkbox"/> Absence of tremors, twitches, tics, fibrillations, fasciculations, athetoid or choreiform movements, myoclonus or myotonia.	<input type="checkbox"/> Specify otherwise _____ _____ _____ _____
Range of Motion: <input type="checkbox"/> Full range of motion with no restrictions in upper and lower extremities, spine.	<input type="checkbox"/> Specify otherwise _____ _____ _____
<u>Sensory System:</u> <input type="checkbox"/> Normal and symmetrical response to touch.	<input type="checkbox"/> Specify otherwise _____ _____ _____
<u>Other Reflexes and Signs:</u> Babinski's sign: <input type="checkbox"/> Absent (great toes downgoing on right and/or left.) <input type="checkbox"/> Present (toes upgoing on right and/or left.) <input type="checkbox"/> Non-reactive or equivocal.	<input type="checkbox"/> Specify otherwise _____ _____ _____ _____
Meningeal Signs: <input type="checkbox"/> Present: <input type="checkbox"/> Kernig <input type="checkbox"/> Brudzinski	<input type="checkbox"/> Specify otherwise Absent _____ _____

Deep Reflexes:

Please note results of tests of biceps, triceps, radial, quadriceps, and Achilles' reflexes.

0 = Absent 1 = Diminished 2 = Normal 3 = Increased 4 = Hyperactive 5 = Hyperactive with clonus

	LEFT	RIGHT
Biceps		
Triceps		
Radial	1+2	1+2
Quadriceps		
Achilles		



PARTIAL HOSPITALIZATION PROGRAM
ADMISSION SUMMARY

To be completed by attending physician at the time of discharge from inpatient level of care to the partial hospitalization program.

Current Diagnosis: Axis 1: Psychosis, NOS
Axis 2: defence
Axis 3: no diagnosis
Axis 4: none known
Axis 5: GAF: 60

Presenting Problem (target symptoms and behaviors): 3 separate incidents of
bizarre behaviour during the few days prior to her
in-pt adm 10/30/09

Mental Status: since admission no overt evidence of
psychosis noted

Treatment Planning:
Treatment Problem Statement: The behavior/relationship difficulties, which require change in order for the patient to function in a less restrictive setting, require that the patient will: show stable mood
thinking and behavior

PHYSICIAN TREATMENT PLANNING INTERVENTIONS

Therapeutic Interventions: therapy: individual, group,
possibly family

Other: _____

Estimated Length of Stay 4 to 8 days in PHD

Discharge Plan home, out pt TX

R. Rothman
ATTENDING PHYSICIAN

10-31-09
DATE:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 1

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J.3PA-

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Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

11/04/09 1533 MXS

Reason For Admission^:

Patient was admitted to DH on 10/30/09 and left AMA on 10/31/09. In days/weeks prior to admission patient had reportedly been behaving in a bizarre way at work (State Dept) and was then in a road traffic accident which she is reported to have deliberately caused. Today patient presents stating that she is not sure why she has been admitted to PHP except "that the State Department has ordered this".

- Dr. Roth stated to me that I was being discharged & I specifically asked if it would be AMA, a friend whose mother works for VA advised it was best to comply even if I knew I did not belong there.

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:

Patient is one of two sibs born to middle class parents, raised in suburb of Atlanta, attended Spellman College for undergrad, progressed to grad school at Georgetown SFS, was then employed by DOD, sent to Iraq for four months (2007), returned to DOD where she reports having exceeded work performance expectations, then moved to State Dept in March 09. Patient has supportive parents (retired educators) Patient lives alone in apt in DC and currently works for State Dept as an analyst.

- I was born & raised in Mesa, AZ, I did not go to Atlanta until undergrad. My parents bought a home in Atlanta in 2006 (Fairburn, GA). I told them I started at State in July 2009. They failed to include other work history - 1998-1999 Countrywide Financial, Peace Corps - 1999-2001, Japan Exchange & Teaching Program 2001-2003, Studied Japanese at Sophia University for 6 mos from fall 2003 to 2004. I was an analyst at DoD and told them I was an FSO at the State Dept.

---FAMILY HISTORY----

Family Psych Hx: Y

Family Psych Relationship: Aunt

Describe Family Psych Hx^:

Schizophrenia in maternal aunt.

Family Hx of Suicide: N

Family Suicide Relationship:

Describe Family Hx of Suicide^:

Family CD Hx: N

Family CD Relationship:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 3

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

11/04/09 1533 MXS

Religion: CHR CHRISTIAN

Spiritual Practices: Church

Pt Believes in Higher Power: Y
Describe Higher Power^:

Last Grade Completed: Graduate degree
Degrees/Certificates: Masters in Foreign Relati

Current Student: N
Where:

Change in School Performance:
Describe Change In School Performance^:

Problems with Behavior at School:
Truancy:

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:

-----EMPLOYMENT HISTORY-----

Currently Employed: Y
Pt Occupation: Analyst
Time at Current Job: 4.5 years
Job Satisfaction: High
Longest Time at One Job: 4.5 years
Frequent Job Changes: N
Reason for Job Changes^:

*I have only been employed at current employer since July 2009.
↳ ~ 2.6 years.*

Unemployed in Last Year: N
Reason for Unemployment^:

Parent Occupation:
Spouse Occupation:
Financial Needs: Denies any stressors
Denies debts
Denies compulsive spendin
States she manages money "very well and I have good savings"

Military Hx: N
Branch(es):

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 4

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

of Years:
Military Reserve:
Discharge Type:

Year:

Discharge R/T Substance Abuse:
Discharge R/T Psych Condition:

-----ARREST HISTORY-----

Arrest or Pending Litigation/Civil Charges Hx: Y
Number of Arrests: 1
Reason for Arrest: leaving scene of accident
Arrests Involving Violence: N
DUI/DWI: N
When:
Public Intoxication: N
When:
Probation Hx: N
Why/When:
Parole Hx: N
Why/When:

Describe Pending Litigation/Civil Charges^:

above note re. recent charges.
Patient has retained an attorney

-----CAFFEINE HISTORY-----

Pt Use Caffeine: Y
Types of Caffeine: Coffee
Amt per Day: 1-2
I rarely drink caffeine, only time is Starbucks maybe a couple times a month. I will usually get a caramel frappuccino when I do go to Starbucks.
I have never drank this amount of caffeine except once or twice in college when I was staying up late to study for an exam.

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 5

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

11/04/09 1533 MXS

----NICOTINE HISTORY----

Nicotine Hx: N

Kind of tobacco:

Age First Used:

Packs/tins per day:

How many years:

Any Consequences:

Quit:

When:

Does Patient Drink Alcoholic Beverages: Y

Type of Alcohol: WINE

How Often: 1 - 2 times/month

How Long: 10 years

How Much: glass

Last Drink:

Type of Alcohol:

How Often:

How Long:

How Much:

Last Drink:

Type of Alcohol:

How Often:

How Long:

How Much:

Last Drink:

Alcohol Comment^:

Patient denies any abuse of alcohol and states she seldom drinks

Pt Believes ETOH Use a Problem: N

Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:

When:

Sober Support System:

Who:

AA/NA:

Last Contact:

Sponsor:

Last Contact:

ETOH Sobriety/Support/Treatment Comments^:

None

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 6

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Additional Drugs or Chemical Use: N

Type of Drug:
 How Often:
 How Long Used:
 How Much:
 Last Used:
 Type of Drug:
 How Often:
 How Long Used:
 How Much:
 Last Used:
 Type of Drug:
 How Often:
 How Long Used:
 How Much:
 Last Used:

Drug Use Comment^:

Believes Drug Use a Problem: N
 Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
 When:
 Sober Support System:
 Who:
 AA/NA:
 Last Contact:
 Sponsor:
 Last Contact:

CD Sobriety/Support/Treatment Comments^:
 Patient denies any CD recent or past

~~~~ABUSE HISTORY~~~~

(Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:  
 Describe Physical Abuse^:

Emotional:  
 Describe Emotional Abuse^:

Sexual:  
 Describe Sexual Abuse^:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 7

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Neglect:

Describe Neglect^:

Patient Has Hx of Abuse to Others: N

Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N

Describe CPS/APS Report^:

Describe CPS/APS Involvement^:

Abuse Comments^:

~~~~STRENGTHS/WEAKNESSES~~~~

Stability of Home Environment: Strength

Motivation for Tx: Weakness

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:

Weakness

Stability and Support of Employment:

Strength

Function of Marriage/Family System:

Strength

Support System in and Beyond Family:

Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:

Mostly exercise

- I stated in group & during impatent that exercise, socializing w/ friends, talking on the phone, studying Jpn were regular parts of my social activities.

Type of Recent Leisure Activities^:

Running, working out in gym

Also stated in daily worksheets & during groups that I had several leisure activities, including exercise, talking/socializing w/ friends, studying foreign language, watching TV.

What Do You Do When Bored/Lonely^:

Go running on the mall

- I said I call friends/meet w/ friends

Psychosocial Assessment ~std

11/04/09 1533 MXS

Does Your Work Schedule Interfere With Your Leisure Activities: N
Do You Belong to Any Social Groups/Community Organizations: N

Improvement Needed in ANY of the following areas:
Patient denies

Pt Perception of Illness^:

Patient is bewildered as to why she is here.
Patient states that her co-worker who reported her
bizarre behavior at work is disgruntled, leaving
his job and moving to California. She contends that
she has had a conflictual relationship with this co-
worker.

Contradicts what they said earlier in
the report. I told them I was here
because Dr. Newman believed a
single, uncorroborated source.

Pt Perception of Needs^:

Patient states she will "do whatever you tell me here
and whatever I need to get back to my job"

Pt's Goals for Treatment^:

Return to work
Have attorney advocate that legal charges be dropped
Be able to convince her boss that she is stable

Community Resources Current/Needed:
Unable to assess

Anticipated Treatment Mgr Role in TX/DC Planning:
FAMILY CONTACT
COORDINATION OF CARE/OPP
DISCHARGE PLANNING
REFERRAL TO COMM. RESOURC

Goals of Treatment: STABILIZE MOOD - never discussed w/ me
IMPROVE COPING SKILLS - not an issue,
never discussed with me.

I never stated this. Initially
I told Dr. Newman that I did
not think coworker would spread
rumors, by process of elimination
I determined that
coworker was only source because
of my positive relationship w/
supervisor, people during training
etc.

I have never made a
statement like this. As I
have stated repeatedly,
if my employer chooses to
dismiss me due to false
allegations, I have the
skillset to be successful
in the private sector or
another field of my choice.

Table with 4 columns: Monogram Initials, Name, Nurse Type. Row 1: MXS, J.NUR.MFS1 SANDIFORD, MARY, SW

Age/Sex: 33 F
Unit #: J000018122
Account#: J84090218118
mitted:

WILLIAMS, LYNNAE D (DIS RCR)
J.3PA-
Roth, Richard L
Dominion Hospital Patient Care

Page: 1
Printed 11/12/09 at 0701
Period ending 11/12/09 at 0701
ADMINISTRATIVE DATA SCREEN

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT ft in cm
CONDITION VISITORS ALLOWED WT lb oz kg
CMT
VISIT REASON PHP
--- Observation Patient ---
Dt in Tm in
Dt out Tm out

Coded Allergies/Adverse Reactions

| Name | Category | Severity | Ver? | Date | Time | User |
|------|----------|----------|------|------|------|------|
|------|----------|----------|------|------|------|------|

| | | | | | | |
|----------------|------|---|---|----------|------|-----|
| Fluoxetine HCl | Drug | M | Y | 10/30/09 | 1240 | HEB |
| RASH | | | | | | |

| Monogram | Initials | Name | Nurse Type |
|----------|----------|------|------------|
|----------|----------|------|------------|

| | | | |
|-----|-----------|------------------|----|
| HEB | J.NUR.HEB | BLACK, ELIZABETH | RN |
|-----|-----------|------------------|----|

DISCHARGE - Patients Medication List
MEDICATION RECONCILIATION

WILLIAMS,LYNNAE D

ATTENDING: Roth, Richard L
ALLERGIES: Fluoxetine HCl (From Prozac)
ADRs: ***NO ADRs ENTERED***

WEIGHT: 60.78 kg 134 lbs

ACCOUNT: J84090217483

***** Home Medications *****

| DRUG NAME | DOSE/ROUTE | FREQUENCY |
|-----------|------------|-----------|
|-----------|------------|-----------|

No Home Medications Documented

*** This is a complete list of your medications. Bring this list to your next ***
 *** doctor's appt. ()Prescriptions provided to patient/guardian at discharge ***
 *** ()No prescriptions required ()Prescriptions called into pharmacy ***
 *** Patient/Guardian Signature: *Lynnae Williams* Date: 10/31/09 ***

WILLIAMS,LYNNAE D
 AC# J84090217483 ADM IN J.222 B
 MR# J000018122 ADM 10/30/09 SCH
 Roth, Richard L
 AGE 33 DOB 07/09/76 SEX F

***** This is a permanent part of the record. Please do not discard. *****

RUN DATE: 11/11/09
RUN TIME: 1217
RUN USER: J.NUR.EMW2

DOMINION HOSP ADMISSIONS
PARTIAL HOSPITALIZATION DISCHARGE LIST

WILLIAMS, LYNNAE D

DOCTOR: Roth, Richard L

Allergies: Fluoxetine HCl (From Prozac)
ADRS: ***NO ADRS ENTERED***

Patient Medication List

| Medication | Dose | Frequency | Route |
|---------------------------------------|------|-----------|-------|
| * no psychiatric medication ordered * | | | |
| | | | |
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I have reviewed the Medications listed above and understand that this is the list of Medications to be taken after Discharge.

Patient/Family/Guardian Signature: Lynnae Williams Date: 11/11/09 Time: 12:20

Nurse Signature: Richard M. H., RN Date: 11/11/09 Time: 12:25

MD Signature: R. Rothman Date: 11/17/09 Time: _____

Copy to Patient. Original to Chart

DOMINION HOSPITAL

**PHYSICIAN ADMISSION INSTRUCTION SHEET
 ADULT PARTIAL PROGRAM**

(CIRCLE THE ANSWER, YES OR NO)

- Y N Admit to the Partial Hospitalization Program
- Y N Regular Diet (specify other: _____)
- Y N Medical History and Physical Examination (ONLY FOR A DIRECT ADMISSION)
- Y N Vital Signs (B.P., TPR x1) Other: _____

DUAL DIAGNOSIS EDUCATION GROUPS

- Y N Assessment
- Y N Groups

I certify that the services identified as "partial hospitalization" are medically necessary to prevent further decompensation and subsequent admission to inpatient treatment.

Elizabeth Walsh RN per Dr. Roth 11/4/09 1200 (RW) EW
 Telephone Order Received By: Physician Name Date Time Read Back
 (RN Signature) (RN Initials)

Elizabeth Walsh RN 11/4/09 1553
 Transcribed By: (RN Signature) Date Time

[Signature] 11/4/09
 Physician Signature Date Time

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.


| Date | Time | Complete top portion with each Level of Care change. Indicate order with a Check Mark. |
|------|------|---|
| | | <input type="checkbox"/> Outpatient Procedure: _____ (procedure) for _____ (medical reason) |
| | | <input type="checkbox"/> Place in Outpatient Observation Services for _____ (medical reason). |
| | | <input type="checkbox"/> Admit as Inpatient for _____ (medical reason). |

Physician Signature: _____

| Date | Time | Additional Orders: (Dates/Times required) |
|----------|------|--|
| 11/4/09 | 1200 | T.O. Dr. Roth / Elizabeth Miller, RN (S) Admit pt to adult partial program noted E. Miller, RN 11/4/09 1200 <i>Stoetum 11/4/09</i> |
| 11/9/09 | | Pt. will not attend this P/T "11/10/09 due to a court appearance in DC court noted 11/9/09 1000 <i>Stoetum</i> |
| 11/11/09 | | Discharge Today <i>Stoetum</i>
noted E Miller, RN 1200 11/11/09 |

Allergies & Sensitivities NKA

| Weight | Height | Diagnosis |
|--------|--------|-----------|
| | | |

WILLIAMS, LYNNAE D
 J84090218118 REG RCR J.3PA
 11/04/09 Roth, Richard L
 DOB: 07/09/1976 F/33 MR# J000018122
 Dominion Hospital



PARTIAL HOSPITALIZATION PROGRAM
ADMISSION SUMMARY

To be completed by attending physician at the time of discharge from inpatient level of care to the partial hospitalization program.

Current Diagnosis: Axis 1: Psychosis, NOS - I was never asked for my opinion of this diagnosis, or not told this was my diagnosis until they (Mary + Elizabeth) attempted to get me to sign off on diagnosis the last day of treatment
Axis 2: defence (?)
Axis 3: no diagnosis
Axis 4: none known
Axis 5: GAF: 60

Presenting Problem (target symptoms and behaviors): 3 separate incidents of bizarre behaviour during the few days prior to her inpt adm 10/30/09 (Nobody specified what the 3 incidents were, reportedly gave conflicting stories of events in an attempt to confuse me)

Mental Status: since admission no overt evidence of psychosis noted

Treatment Planning: Was not discussed with me, Dr. Roth told me I was being dismissed / said it would not be. show stable mood thinking and behaviour

Treatment Problem Statement: The behavior/relationship difficulties, which require change in order for the patient to function in a less restrictive setting, require that the patient will:

PHYSICIAN TREATMENT PLANNING INTERVENTIONS
Dr. Roth said this after speaking w/ Dr. Hoiles who said the only reason I was there was because of the car accident

Therapeutic Interventions: therapy: individual, group, possibly family (This was not discussed, again, I asked for a copy of discharge + he refused to provide or only provided paperwork stating no medication was provided.)

Other: _____
Estimated Length of Stay 4 to 8 days in PHD

Discharge Plan home, out pat TX

R. Roth MD
ATTENDING PHYSICIAN

10-31-09
DATE:

I spoke to CSW Anita Zulk who was assigned to me + she said she could not imagine Dr. Roth would refuse to discharge me because it was clear I was not experiencing any symptoms, was coherent, and most likely needed a neurological exam to explain memory loss following the accident. She was the first person on Dominion's staff to express concern about the accident, everyone else focused on the alleged incident w/ my coworker. Ms. Zulk also met w/ my family when they arrived.

Age/Sex: 33 F
Unit #: J000018122
Account#: J84090218118
Admitted:

WILLIAMS, LYNNAE D (DIS RCR)
J.3PA-
Roth, Richard L
Dominion Hospital Patient Care

Page: 1
Printed 11/12/09 at 0701
Period ending 11/12/09 at 0701
ADMINISTRATIVE DATA SCREEN

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT ft in cm
CONDITION VISITORS ALLOWED WT lb oz kg
CMT
VISIT REASON PHP
--- Observation Patient ---
Dt in Tm in
Dt out Tm out

Coded Allergies/Adverse Reactions

| Name | Category | Severity | Ver? | Date | Time | User |
|------|----------|----------|------|------|------|------|
|------|----------|----------|------|------|------|------|

| | | | | | | |
|----------------|------|---|---|----------|------|-----|
| Fluoxetine HCl | Drug | M | Y | 10/30/09 | 1240 | HEB |
| RASH | | | | | | |

Monogram Initials Name Nurse Type

| | | | |
|-----|-----------|------------------|----|
| HEB | J.NUR.HEB | BLACK, ELIZABETH | RN |
|-----|-----------|------------------|----|

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care INITIAL SAFETY ASSESSMENT: ADU

Coded Allergies/Adverse Reactions

| Name | Category | Severity | Ver? | Date | Time | User |
|----------------|----------|----------|------|----------|------|------|
| Fluoxetine HCl | Drug | M | Y | 10/30/09 | 1240 | HEB |
| RASH | | | | | | |

Adult Partial Safety Assessmnt

11/04/09 1548 EMW

What are your goals for this hospitalization: "Adequately address any concerns about my : ability to return to work and cope with stress"

I did not make any statements regarding stress. I was told by a nurse when I was discharged that I had to list something under safety plan & I complied, saying/writing job stress.

Any History of Abuse or Neglect: N

History of Aggressive/Assaultive Behavior: None

Access to Lethal Means: N

If Yes please explain:

Patients Social Worker notified: N

History of Suicide Attempts: N

Does the patient have any thoughts of suicide: DENIES

Does the patient have any intent of suicide: DENIES

Does the patient have a plan for suicide: DENIES

Does the patient have a history of self harm: N Types of Self Harm Behaviors:

Head Banging: N Scratching/Cutting: N Manipulating others to harm self: N

Fire Setting: N Hanging: N Overdosing: N Burning: N Self Strangulation: N

Jump in front of car, window, metro: N Poison: N Self Biting: N Other: N

Triggers: NA

Level of Impulsivity: Low

Admission history/symptoms indicate potential for self-harm: N

Commits to notify staff of self harm thoughts, intent, or plans: Y

Patient's Protective Barriers against Suicide/Self Harm: Coping Skills

I repeatedly told staff I wrote on paperwork that this had never been an issue.

Currently Employed/School

Positive Attitude

Social Supports

Ability Reality Test

Precipitating Factors: If applicable what does the pt identify as the cause of loss of control or acting out behavior? "MY JOB'S CONCERN AFTER THE ACCIDENT REPORT : FOLLOWING MY CAR ACCIDENT ON OCT 27, 2009"

Techniques used to help patient control behavior: "I HAVE BEEN IN CONTROL : OF MY MOOD, NOT OUT OF CONTROL, EXCEPT WHEN DISORIENTED FEW DAYS AFTER ACC.

Never made this statement.. I made no statement about my mood.

<<NURSING ADMISSION NOTE>>

Oriented to unit: Y

Appearance: WELL GROOM : PT ADMITTED TO ADULT PARTIAL PROGRAM TODAY. STATES

Additional Comments: SHE WAS DISORIENTED AFTER HER CAR ACCIDENT FOR A FEW DAYS BUT DENIES

: LOSS OF CONTROL OF MOOD OR BEHAVIOR RECENTLY. HAS AN INTERVIEW AT WORK

Can be done

Age/Sex: 33 F
Unit #: J000018122
Account#: J84090218118
Admitted:

WILLIAMS, LYNNAE D (REG RCR)

J.3PA-
Roth, Richard L
Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: Y

Describe Treatment Hx^:

Outpatient treatment at Georgetown Univ Counseling Center for depression, anxiety, sleep disturbance in 2006. Overnight in DH on 10/30/09 and then AMA discharge.

Inaccurate, never reported this information.

Additional Suicide Risk Elements: Hx of risky behavior

I was told by Dr. Roth that the discharge was not AMA, he repeatedly threatened my job saying he could "clear me" and if I did not do what he said (remain inpatient) I likely would not go back to work.

homicidal/Violence Risk Factors:
patient denies

Marital Status: Single
Sexual Orientation:

of Marriages: 0 How Long/Current: 0

Long Previous Marriages^:

Number of Children: 0 Ages: 0

Living Arrangement: Own Place

Needs Alt Living Arrangement: N

Social Support Network: Good

Support Person(s): Family
Friends

Treatment Participants: Patient's parents
who are in town

Support Comments^:

"My parents came because my cousin in Baltimore called them. My cousin took me to the ER at Georgetown two days after my accident because ..I did not receive any medical treatment ..I was just taken by the police and put in a cell, finger printed.. and then charged with leaving the scene of an accident"

When it was clear that Dr. Roth had no intentions of releasing me, I told my parents this was serious & I needed them to come here immediately. My mom asked my cousin to take me to the hospital after my employer called (mistake) asking for my whereabouts following the accident. My cousin's BF picked me up & took me to the hospital. My cousin met us at the hospital. My cousin went to buy 5 Gays for me while we were in the waiting room.

Describe Typical Day: Wake at 7.0 am
Work by 8.30 - 5.30
Evening - outdoor running or work out in gym
Dinner alone or with a friend
Bed 11.0 pm

Hobbies/Interests: Exercise

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's name: Lynnae Williams

Birth Date: 7/9/1976

Social Security Number: 6001091112

Phone Number: 202-577-6474

Date(s) of Service: 10/30 - 10/31 & 11/4 to 11/11

I authorize: Dominion Hospital
to release or disclose the following information to:

Lynnae Williams
Name of person, physician or agency to receive information

202-577-6474
Phone Number of receiver

70 I. St Apt. 1210
Street Address

Washington
City

DC
State

20003
Zip Code

Information to be Released/Disclosed:

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Admission History | <input type="checkbox"/> Medication Records | <input checked="" type="checkbox"/> Psychological Evaluation |
| <input checked="" type="checkbox"/> Discharge Summary | <input checked="" type="checkbox"/> Nursing Assessment | <input type="checkbox"/> Psycho-Educational Reports |
| <input checked="" type="checkbox"/> History & Physical | <input checked="" type="checkbox"/> Nursing Progress Notes | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Transfer Forms | <input type="checkbox"/> Medical Abstract |
| <input checked="" type="checkbox"/> Consultation | <input checked="" type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Itemized Bill/UB-92 |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Labs/EKG's/X-rays | | |

Purpose:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Medical Follow-up | <input checked="" type="checkbox"/> Individual Use | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Disability | <input type="checkbox"/> Other _____ |

Patient advised of charges: Yes No N/A

I prefer to pick up records I wish to review records (by appointment only) Please mail

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. YLW (Initial)

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee

I have read the above and authorize the disclosure of the protected health information as stated

Lynnae Williams
Signature of Patient (must be signed if age 14 years or older for Psychiatric records)

11/11/09
Date (authorization will expire 6 months after date signed)

Signature of Parent/Guardian (if applicable)

Relationship to Patient

2960 SLEEPY HOLLOW ROAD; FALLS CHURCH, VA 22044; PHONE: 703-536-2000 FAX: 703-536-6139
FOR HOSPITAL USE ONLY

Completed by _____ Date _____

DOMINION HOSPITAL

Admission Medical History
and Physical Examination

WILLIAMS, LYNNAE D
J84090217483 ADM IN J.222-B
10/30/09 Roth, Richard L
DOB: 07/09/1976 F/33 MR# J000018122



Dominion Hospital

No Restrictions on Physical Activity

Physical Activity restricted due to: _____

Impressions / Recommendations:

1) Mod obs
2) HT+D
2) & med med prob
only

10/21/09

Signature

Date

Age/Sex: 33 F
Unit #: J000018122
Account#: J84090218118
Admitted:

WILLIAMS, LYNNAE D (REG RCR)

J.3PA-
Roth, Richard L
Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Reason For Admission^:

Patient was admitted to DH on 10/30/09 and left AMA on 10/31/09. In days/weeks prior to admission patient had reportedly been behaving in a bizarre way at work (State Dept) and was then in a road traffic accident which she is reported to have deliberately caused. Today patient presents stating that she is not sure why she has been admitted to PHP except "that the State Department has ordered this".

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:

Patient is one of two sibs born to middle class parents, raised in suburb of Atlanta, attended Spellman College for undergrad, progressed to grad school at Georgetown SFS, was then employed by DOD, sent to Iraq for four months (2007), returned to DOD where she reports having exceeded work performance expectations, then moved to State Dept March 09. Patient has supportive parents (retired educators) Patient lives alone in apt in DC and currently works for State Dept as an analyst.

---FAMILY HISTORY----

Family Psych Hx: Y

Family Psych Relationship: Aunt

Describe Family Psych Hx^:

Schizophrenia in maternal aunt.

Family Hx of Suicide: N

Family Suicide Relationship:

Describe Family Hx of Suicide^:

Family CD Hx: N

Family CD Relationship:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 2

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: Y

Describe Treatment Hx^:

Outpatient treatment at Georgetown Univ Counseling Center for depression, anxiety, sleep disturbance in 2006. Overnight in DH on 10/30/09 and then AMA discharge.

Additional Suicide Risk Elements: Hx of risky behavior

Micidal/Violence Risk Factors:

Patient denies

Marital Status: Single

Sexual Orientation:

of Marriages: 0 How Long/Current: 0

Long Previous Marriages^:

Number of Children: 0 Ages: 0

Living Arrangement: Own Place

Needs Alt Living Arrangement: N

Social Support Network: Good

Support Person(s): Family

Friends

Treatment Participants: Patient's parents who are in town

Support Comments^:

"My parents came because my cousin in Baltimore called them. My cousin took me to the ER at Georgetown two days after my accident because ..I did not receive any medical treatment ..I was just taken by the police and put in a cell, finger printed.. and then charged with leaving the scene of an accident"

Describe Typical Day: Wake at 7.0 am

Work by 8.30 - 5.30

Evening - outdoor running

or work out in gym

Dinner alone or with

a friend

Bed 11.0 pm

Hobbies/Interests: Exercise

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 2

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care INITIAL SAFETY ASSESSMENT: ADU

Adult Partial Safety Assessmnt

11/04/09 1548 EMW

: TODAY; VERY ELEGANTLY AND NEATLY DRESSED IN BUSINESS SUIT. DENIES SI/HI/SIB

: GIVES SL=10

:

:

:

| Monogram Initials | Name | Nurse Type |
|-------------------|------|------------|
|-------------------|------|------------|

| | | | |
|-----|------------|--------------------|----|
| EMW | J.NUR.EMW2 | WITTING, ELIZABETH | RN |
| HEB | J.NUR.HEB | BLACK, ELIZABETH | RN |

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 3

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Religion: CHR CHRISTIAN

Spiritual Practices: Church

Pt Believes in Higher Power: Y

Describe Higher Power^:

Last Grade Completed: Graduate degree

Degrees/Certificates: Masters in Foreign Relati

Current Student: N

Where:

Change in School Performance:

Describe Change In School Performance^:

Problems with Behavior at School:

Truancy:

Learning Problems/Special Education: N

Describe Learning/Behavioral Problems^:

~~~~EMPLOYMENT HISTORY~~~~

Currently Employed: Y

Pt Occupation: Analyst

Time at Current Job: 4.5 years

Job Satisfaction: High

Longest Time at One Job: 4.5 years

Frequent Job Changes: N

Reason for Job Changes^:

Unemployed in Last Year: N

Reason for Unemployment^:

Parent Occupation:

Spouse Occupation:

Financial Needs: Denies any stressors

Denies debts

Denies compulsive spendin

States she manages

money "very well and

I have good savings"

Military Hx: N

Branch(es):

Age/Sex: 33 F  
Unit #: J000018122  
Account#: J84090218118  
Admitted:

WILLIAMS, LYNNAE D (REG RCR)

J.3PA-  
Roth, Richard L  
Dominion Hospital Patient Care  
PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std 11/04/09 1533 MXS

# of Years:  
Military Reserve:  
Discharge Type:

Year:

Discharge R/T Substance Abuse:  
Discharge R/T Psych Condition:

----ARREST HISTORY----

Arrest or Pending Litigation/Civil Charges Hx: Y  
Number of Arrests: 1  
Reason for Arrest: leaving scene of accident  
Arrests Involving Violence: N  
DUI/DWI: N  
When:  
Public Intoxication: N  
When:  
Probation Hx: N  
Why/When:  
Parole Hx: N  
Why/When:

Describe Pending Litigation/Civil Charges^:  
above note re. recent charges.  
Patient has retained an attorney

----CAFFEINE HISTORY----

Pt Use Caffeine: Y  
Types of Caffeine: Coffee  
Amt per Day: 1-2

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 5

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

11/04/09 1533 MXS

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Does Patient Drink Alcoholic Beverages: Y

Type of Alcohol: WINE
How Often: 1 - 2 times/month
How Long: 10 years
How Much: glass

Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:

Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:

Last Drink:

Alcohol Comment^:
Patient denies any abuse of alcohol and states she seldom drinks

Pt Believes ETOH Use a Problem: N

Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:

Sober Support System:
Who:

AA/NA:
Last Contact:

Sponsor:
Last Contact:

ETOH Sobriety/Support/Treatment Comments^:

None

Age/Sex: 33 F
Unit #: J000018122
Account#: J84090218118
Admitted:

WILLIAMS, LYNNAE D (REG RCR)

J.3PA-
Roth, Richard L
Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std 11/04/09 1533 MXS

Additional Drugs or Chemical Use: N

- Type of Drug:
- How Often:
- How Long Used:
- How Much:
- Last Used:
- Type of Drug:
- How Often:
- How Long Used:
- How Much:
- Last Used:
- Type of Drug:
- How Often:
- How Long Used:
- How Much:
- Last Used:

Drug Use Comment^:

Believes Drug Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

- Longest Sobriety:
- When:
- Sober Support System:
- Who:
- AA/NA:
- Last Contact:
- Sponsor:
- Last Contact:

CD Sobriety/Support/Treatment Comments^:
Patient denies any CD recent or past

~~~~ABUSE HISTORY~~~~

(Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:  
Describe Physical Abuse^:

Emotional:  
Describe Emotional Abuse^:

Sexual:  
Describe Sexual Abuse^:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 7

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Neglect:

Describe Neglect^:

Patient Has Hx of Abuse to Others: N

Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N

Describe CPS/APS Report^:

Describe CPS/APS Involvement^:

Use Comments^:

----STRENGTHS/WEAKNESSES----

Stability of Home Environment: Strength

Motivation for Tx: Weakness

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:  
Weakness

Stability and Support of Employment:  
Strength

Function of Marriage/Family System:  
Strength

Support System in and Beyond Family:  
Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:  
Mostly exercise

Time of Recent Leisure Activities^:  
Running, working out in gym

What Do You Do When Bored/Lonely^:  
Go running on the mall



Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 8

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

11/04/09 1533 MXS

Does Your Work Schedule Interfere With Your Leisure Activities: N

Do You Belong to Any Social Groups/Community Organizations: N

Improvement Needed in ANY of the following areas:

Patient denies

Pt Perception of Illness^:

Patient is bewildered as to why she is here.

Patient states that her co-worker who reported her bizarre behavior at work is disgruntled, leaving his job and moving to California. She contends that she has had a conflictual relationship with this co-worker.

Pt Perception of Needs^:

Patient states she will "do whatever you tell me here and whatever I need to get back to my job"

Pt's Goals for Treatment^:

Return to work

Have attorney advocate that legal charges be dropped  
able to convince her boss that she is stable

Community Resources Current/Needed:

Unable to assess

Anticipated Treatment Mgr Role in TX/DC Planning:

FAMILY CONTACT

COORDINATION OF CARE/OPP

DISCHARGE PLANNING

REFERRAL TO COMM. RESOURC

Goals of Treatment: STABILIZE MOOD

IMPROVE COPING SKILLS

| Monogram Initials | Name | Nurse Type |
|-------------------|------|------------|
|-------------------|------|------------|

|     |                            |    |
|-----|----------------------------|----|
| MXS | J.NUR.MFS1 SANDIFORD, MARY | SW |
|-----|----------------------------|----|

**DOMINION HOSPITAL**

WILLIAMS, LYNNAE D  
J84090217483 ADM IN J.222-B  
10/30/09 Roth, Richard L  
DOB: 07/09/1976 F/33 MR# J000018122  
Dominion Hospital

**Physician' Admission Instruction Sheet  
Adult Services (Inpatient)**

(CIRCLE THE ANSWER, YES OR NO)

- Y  N ADMIT TO THE ADULT UNIT
- Y  N REGULAR DIET (SPECIFY OTHER: \_\_\_\_\_)
- Y  N MEDICAL HISTORY AND PHYSICAL EXAMINATION
- Y  N PATIENT MAY SMOKE:  
Rationale:  
 Poly-Drug Withdrawal Treatment Complications  
 Exacerbates Psychiatric Symptoms  
 Deviates Focus of Inpatient Treatment Goals

**DUAL DIAGNOSIS SERVICES:**

Y  N DUAL DIAGNOSIS EDUCATION GROUPS

**PRECAUTIONS: ALL APPLY YES OR NO**

- LOCKED UNIT
- 15 MINUTE CHECKS
- BELONGINGS/CLOTHES SEARCH
- SHARPS RESTRICTIONS

**LABS:**

- Y  N CBC with differential
- Y  N CMP (fasting)
- Y  N TSH
- Y  N LIPID PANEL (fasting)
- Y  N URINE DRUG SCREEN
- Y  N SERUM BETA HCG (women of childbearing potential)
- Y  N OTHER: \_\_\_\_\_

**OTHER:**

I certify that Inpatient psychiatric services are medically necessary to prevent further decompensation.

|                                                |                             |          |         |                            |
|------------------------------------------------|-----------------------------|----------|---------|----------------------------|
| Telephone Order Received by:<br>(RN Signature) | per _____<br>Physician Name | Date     | Time    | Read Back<br>(RN Initials) |
| <i>C Stanton RN</i>                            |                             | 10/30/09 | 1723    |                            |
| Transcribed By: (RN Signature)                 |                             | Date     | Time    |                            |
| <i>R Slotnick</i>                              |                             | 10/30/09 | 5:00 PM |                            |
| Physician Signature                            |                             | Date     | Time    |                            |

Authorization is hereby given to dispense the generic equivalent unless otherwise indicated by the physician.

| Date | Time | Complete top portion with each Level of Care change. Indicate order with a Check Mark.     |
|------|------|--------------------------------------------------------------------------------------------|
|      |      | <input type="checkbox"/> Outpatient Procedure: _____ (procedure) for _____ (medical reaso  |
|      |      | <input type="checkbox"/> Place in Outpatient Observation Services for _____ (medical reaso |
|      |      | <input type="checkbox"/> Admit as Inpatient for _____ (medical reaso                       |

Physician Signature: \_\_\_\_\_

Date Time Additional Orders: (Dates/Times required)

10/30/09 @ 1135 Please admit pt to Admit Unit and call MD for admission p 1135 assessment  
 T. C. Dr Roth / HEB Black, EN, RBV  
 @ 1135 10/30/09  
 Note to 1440 [Signature] 10/30/09 [Signature]

10/31/09 Discharge Today  
 Obtain approval for PTP [Signature]  
 Note to [Signature] 10/31/09 1330

Allergies & Sensitivities  NKA

298.9

WILLIAMS, LYNNAE D  
 J84090217483 ADM IN J.222-B  
 10/30/09 Roth, Richard L  
 DOB: 07/09/1976 F/33 MR# J000018122



Dominion Hospital

| Weight | Height | Diagnosis                 |
|--------|--------|---------------------------|
| 134    | 5'8"   | Mood Disorder & Psychoses |

DR Roth

Rm 222B

Physician's Orders T4003 Rev 4/00 (RC# 0914041)

DO NOT WRITE ORDERS UNLESS RED # APPEARS

Age/Sex: 33 F

WILLIAMS, LYNNAE D (DIS IN)

Page: 1

Unit #: J000018122

J.2A-J.222-B

Printed 11/02/09 at 0633

Account#: J84090217483

Roth, Richard L

Period ending 11/02/09 at 0633

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

ADMINISTRATIVE DATA SCREEN

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT 5 ft 8 in 172.72 cm  
 CONDITION VISITORS ALLOWED WT 134 lb 0.02 oz 60.782 kg  
 CMT  
 VISIT REASON IP SERVICES  
 --- Observation Patient ---  
 Dt in Tm in  
 Dt out Tm out

| Coded Allergies/Adverse Reactions |          |          |      |      |               |      |
|-----------------------------------|----------|----------|------|------|---------------|------|
| Name                              | Category | Severity | Ver? | Date | Time          | User |
| Reaction                          |          |          |      |      |               |      |
| Allergies                         |          |          |      |      |               |      |
| Fluoxetine HCl                    | Drug     |          | M    | Y    | 10/30/09 1240 | HEB  |
| RASH                              |          |          |      |      |               |      |

| Monogram Initials | Name                       | Nurse Type |
|-------------------|----------------------------|------------|
| HEB               | J.NUR.HEB BLACK, ELIZABETH | RN         |

Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 1

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

10/31/09 0948 AXZ

Reason For Admission^:

Pt is psychotic.

Does Patient Meet Criteria for Current Level of Care: Y

Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:

Pt works in the State Department. She graduated from GTU from the School of Foreign Services. She was in a car accident 10/27/09. She reported to police that she wanted to know what it would feel like to be in a car accident. Later she did not recall saying that. Pt suspicious, talking to herself, and is exhibiting anxiety. Pt denies A/V hallucinations.

- According to police report that I have discussed.

~FAMILY HISTORY~

Family Psych Hx: Y

Family Psych Relationship: MA AUNT C SCHIZOPHRENIA

Describe Family Psych Hx^:

SEE ABOVE

Family Hx of Suicide: N

Family Suicide Relationship: N/A

Describe Family Hx of Suicide^:

N/A

Family CD Hx: N

Family CD Relationship: N/A

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: N

Describe Treatment Hx^:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (REG RCR)

Page: 2

Unit #: J000018122

J.3PA-

Account#: J84090218118

Roth, Richard L

Admitted:

Dominion Hospital Patient Care INITIAL SAFETY ASSESSMENT: ADU

Adult Partial Safety Assessmnt

11/04/09 1548 EMW

: TODAY; VERY ELEGANTLY AND NEATLY DRESSED IN BUSINESS SUIT. DENIES SI/HI/SIB  
: GIVES SL=10  
:  
:  
:

Monogram Initials      Name      Nurse Type

|     |            |                    |    |
|-----|------------|--------------------|----|
| EMW | J.NUR.EMW2 | WITTING, ELIZABETH | RN |
| HEB | J.NUR.HEB  | BLACK, ELIZABETH   | RN |

Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 2

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

10/31/09 0948 AXZ

N/A

Additional Suicide Risk Elements: Hx of risky behavior  
Sev. anxiety/panic/agitat  
IDS WORK AS STRESSOR

Homicidal/Violence Risk Factors:  
N/A

Marital Status: Single  
Sexual Orientation:

# of Marriages: 0 How Long/Current: N/A

How Long Previous Marriages^:  
N/A

Number of Children: 0 Ages: N/A

Living Arrangement: Own Place ? I live alone

Needs Alt Living Arrangement: Y ?

Social Support Network: Excellent

Support Person(s): Family  
Friends

Treatment Participants: Parents

Support Comments^:

Pt states that she expects to be d/c today, but if she  
were to stay, she would like her parents to be  
involved in her tx here.

Describe Typical Day: work, shower, eat, talk  
with friends on the phone

Hobbies/Interests: Reading  
Exercise  
Watching movies  
Studying languages

Religion: CHR CHRISTIAN

Spiritual Practices: None

Pt Believes in Higher Power: Y

Describe Higher Power^:

God

Last Grade Completed: MS  
Degrees/Certificates: FOREIGN SERVICE FROM  
GTU

Current Student: N

Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 3

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

10/31/09 0948 AXZ

Where: N/A

Change in School Performance: N

Describe Change In School Performance^:

Problems with Behavior at School: N

Truancy: N

Learning Problems/Special Education: N

Describe Learning/Behavioral Problems^:

N/A

~~~~EMPLOYMENT HISTORY~~~~

Currently Employed: Y

Pt Occupation: Foreign Service

Time at Current Job: 5 months

Job Satisfaction: High

Longest Time at One Job: 2.5 years

Frequent Job Changes: N

Reason for Job Changes^:

Unemployed in Last Year: N

Reason for Unemployment^:

Parent Occupation:

Spouse Occupation:

Financial Needs: Finances are not a problem for pt.

Military Hx: N

Branch(es):

of Years:

Military Reserve:

Discharge Type:

Year:

Discharge R/T Substance Abuse:

Discharge R/T Psych Condition:

~~~~ARREST HISTORY~~~~

Arrest or Pending Litigation/Civil Charges Hx: N



Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 4

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

10/31/09 0948 AXZ

Number of Arrests:  
Reason for Arrest:  
Arrests Involving Violence:  
DUI/DWI:  
When:  
Public Intoxication:  
When:  
Probation Hx:  
Why/When:  
Parole Hx:  
Why/When:

Describe Pending Litigation/Civil Charges^:

~~~~CAFFEINE HISTORY~~~~

Pt Use Caffeine: N

Types of Caffeine: None

Amt per Day:

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:

Packs/tins per day:

How many years:

Any Consequences:

Quit:

When:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 5

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment ~std

10/31/09 0948 AXZ

Does Patient Drink Alcoholic Beverages: N

Type of Alcohol:

How Often:

How Long:

How Much:

Last Drink:

Type of Alcohol:

How Often:

How Long:

How Much:

Last Drink:

Type of Alcohol:

How Often:

How Long:

How Much:

Last Drink:

Alcohol Comment^:

Pt Believes ETOH Use a Problem: N

Negative Effects on Life: N/A

Medical Problems from CD Use: N/A

Longest Sobriety:

When:

Sober Support System:

Who:

AA/NA:

Last Contact:

Sponsor:

Last Contact:

ETOH Sobriety/Support/Treatment Comments^:

N/A

Additional Drugs or Chemical Use: N

Type of Drug:

How Often:

How Long Used:

How Much:

Last Used:

Type of Drug:

How Often:

How Long Used:

How Much:

Last Used:

Type of Drug:

How Often:

How Long Used:

How Much:

Last Used:

Age/Sex: 33 F

WILLIAMS, LYNNAE D (ADM IN)

Page: 6

Unit #: J000018122

J.2A-J.222-B

Account#: J84090217483

Roth, Richard L

Admitted: 10/30/09 at 1158

Dominion Hospital Patient Care

PSYCHOSOCIAL ASSESSMENT

Psychosocial Assessment -std

10/31/09 0948 AXZ

Drug Use Comment^:

Pt Believes Drug Use a Problem: N  
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:  
When:  
Sober Support System:  
Who:  
AA/NA:  
Last Contact:  
Sponsor:  
Last Contact:

CD Sobriety/Support/Treatment Comments^:  
N/A

-----ABUSE HISTORY-----

Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:  
Describe Physical Abuse^:

Emotional:  
Describe Emotional Abuse^:

Sexual:  
Describe Sexual Abuse^:

Neglect:  
Describe Neglect^:

Patient Has Hx of Abuse to Others: N  
Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N  
Describe CPS/APS Report^:

Describe CPS/APS Involvement^:  
N/A