N282

MiraCosta College
Associate Degree Nursing Program
Mental Health Data Collection Tool (#3)

Student: Kendra Koenig **Date: March 9, 2012**

Client Initials: EF	**Room #:** 168 B	**Age:** 37	**Gender:** Male	**Date of Admission:** 3/8/12 (0.8 days)
Legal Status: Client was admitted voluntarily from the med-surg floor. The client was then placed on a 5150 hold.			**Level of Nursing Supervision and Rationale:** According to the chart, Q30 min; Pt has a Hx of MDD (with psychosis) and previous SI.	

Chief Complaint (Pt reason for admission): According to the client, he was admitted for, "having a nervous breakdown." He stated that he got into an altercation with one of his roommates and afterwards he began having SI. He mentioned holding a knife up to his throat and contemplating walking in front of a train.

Reason for Admission/Psychiatric Diagnosis (from Chart): "Worsening of depression with self-harm behavior. A 37 y/o male Pt was BIB the Sheriff's Department for SI and anxiety after his wife called 911. The Pt told his family that he wanted to walk in front of a train. He held a knife to his neck. The Pt calmed down but then around 10:00 PM his daughter walked into the kitchen to find him bleeding from his forehead. He reported that he hit his head against a wall. He was admitted with SI and AH in the past." The client had the following psychiatric diagnoses: MDD with psychosis, meth abuse and induced mood disorder, and r/o mood disorder secondary to medical condition (including head injury).

Etiology & Common Symptoms Associated with Psychiatric Diagnosis (from textbook): (Highlight or circle those you actually observed.)

MDD (with psychosis)

- Either a depressed mood or a loss of interest or pleasure in nearly all activities must be present for at least 2 weeks
- Markedly diminished interest or pleasure in all or most activities
- Four of seven additional symptoms must be present including
  - Disruption in sleep (insomnia or hypersomnia)
  -Disruption in appetite (or weight)- either increased or decreased
  -Disruption in concentration
  -Fatigue or loss of energy
  -Psychomotor agitation or retardation
  -Feelings of worthlessness or excessive or inappropriate guilt
  -Recurrent thoughts of death or SI
- Occupational problems
- Substance Abuse
- Loss of touch with reality (psychosis); usually includes delusions and hallucinations

Meth Abuse and Induced Mood Disorder

- Euphoria, initial CNS stimulation then depression, wakefulness, decreased appetite, insomnia, paranoia, aggressiveness, dilated pupils, tremors (Effects of Meth)
- Depression, psychomotor retardation that progresses into psychomotor agitation, fatigue then insomnia, severe dysphoria and anxiety, and unpleasant cravings (Effects of Meth Withdrawal)

Prior Psychiatric Treatment:

Hospitalizations: According to the client's chart, his psychiatric hospitalizations began in 2003. His first admission was at Bay View Hospital in 2003 following the death of his mother.

When: 2003, 2007, 2009, 2010

Where: 2003- Bay View Hospital; 2007/ 2009/ 2010- Tri City Medical Center

Partial Hospitalizations:

When_____Where_____

Out Patient Treatment: Not in client's chart

Therapist/Psychiatrist_____ Length of Time_____

DSM: Axis I: #1- MDD 'Major Depressive Disorder' with psychosis, #2- Meth Abuse and Induced Mood Disorder, and #3- r/o Mood Disorder secondary to medical condition (including head injury)

Axis II: Deferred

Axis III: Seizures, HTN, TBI 'traumatic brain injury', Type II DM, recurrent UTI's

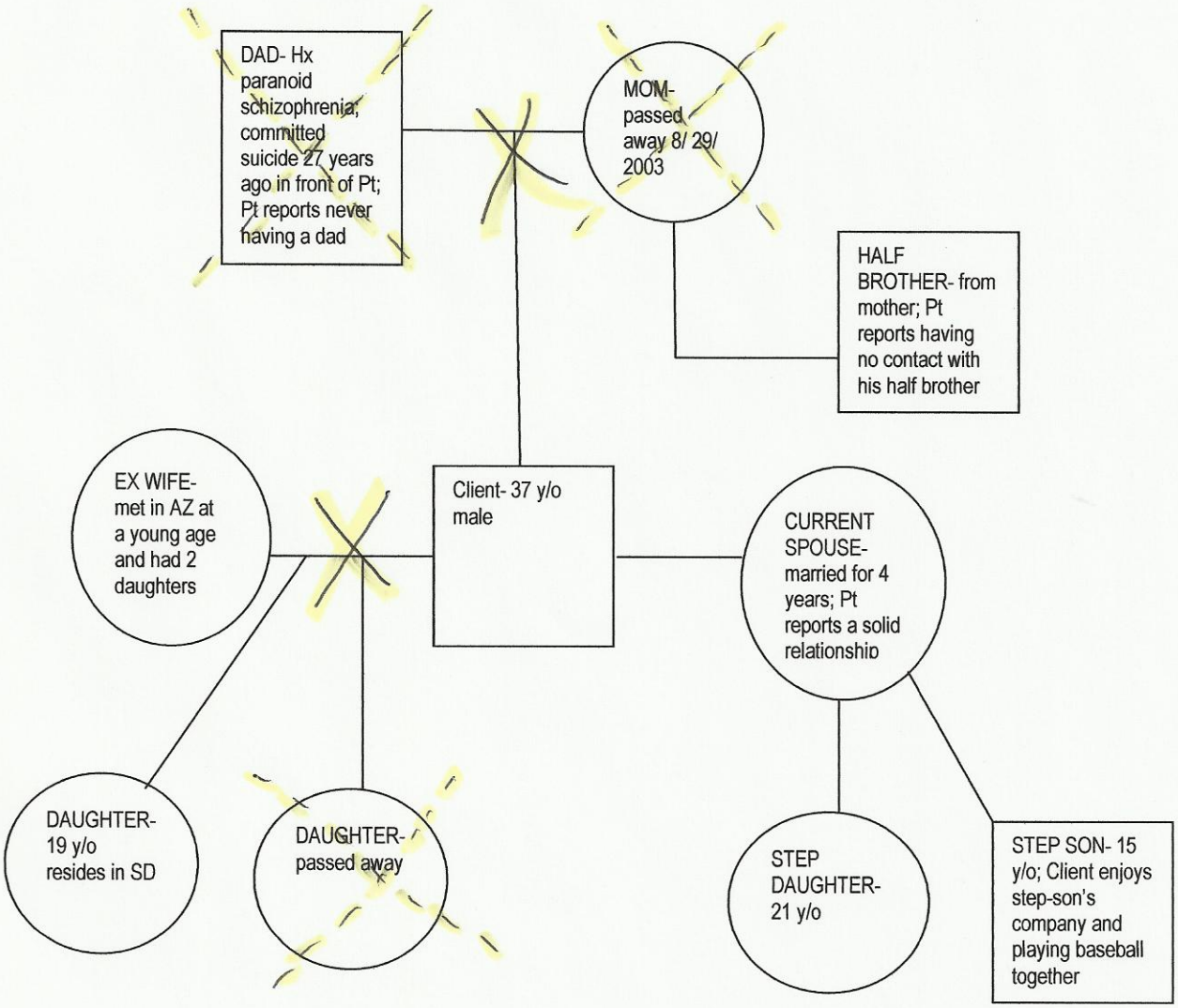
Axis IV: Moderate- inadequate finances, dysfunctional living situation, unemployment, inadequate social support, and functioning below academic performance level r/t TBI (reading & comprehension equivalent to the 4th grade level)

Axis V: current GAF 30-35

Medical or Surgical Conditions:

- **Hx of CP**
- **Seizures**
- **TBI**
- **HTN**
- **Hx of recurrent UTI's**
- **Type II DM**

Family History: According to the client's chart, his father committed suicide in front of him when he was 10 years old. His father had a Dx of paranoid schizophrenia. The client was sent to live in a group home for a year and then he was able to return home to his mother. When asking the client about his father, he stated that, "I never had a dad." The client was previously married to his ex wife whom he had two daughters with. One of his daughters passed away and the other one is 19 y/o residing in San Diego. The client remarried and has been with his spouse for over 4 years. He has a 21 year old step-daughter and a 15 year old step-son.



X = divorce

X = deceased

Laboratory Results

List the most recent lab value unless the client is admitted with a critical lab value. If no laboratory tests were ordered for this client, state which laboratory tests should be ordered and complete the table accordingly.

Laboratory	List values and indicates Normal/High or Low	Why is the lab abnormal for your client?	Nursing Concerns
RBC HgB Hct	L 3.8 L 12.3 L 35.2	Dietary deficiency and Keppra use. Keppra is an anticonvulsant that can cause pancytopenia (low RBC, WBC, and platelets).	Encourage intake of a well balanced diet (high in iron and folic acid); monitor H&H, assess for S/Sx's of anemia: weakness, pallor, SOB, etc.
Platelets	L 148	Keppra (anticonvulsant) use; can cause pancytopenia (anemia, leukopenia, and thrombocytopenia).	Avoid activities with the potential for causing trauma (risk for bleeding). Continue to monitor for a decrease in platelets. Assess the client for S/Sx of thrombocytopenia: ecchymosis, petechiae, bleeding gums, uncontrollable bleeding, etc.
Ca+	L 8.4	Poor dietary intake & hypoalbuminemia	Monitor for S/Sx of hypocalcemia (neuromuscular excitability): confusion, irritability, tachycardia, tingling, seizures, √ Chvostek/Trousseau; ↑ dietary intake of Ca/vitamin D
Total Protein Albumin	L 5.0 L 2.8	Malnutrition, imbalanced dietary intake	Monitor closely for drug-drug interactions since decreased levels of albumin. Monitor for delayed wound healing if wounds are present. Try to increase protein intake through diet.
Tox Screen	+ for amphetamines	According to the client, "his alcoholic beverage was spiked"	S/Sx of meth withdrawal: fatigue, irritability, disturbed sleep, increased appetite, anxiety, and psychotic reactions.
Glucose	N 102		
UA culture	No growth		
Blood culture	No growth		
WBC	N 5.1		
BUN	N 7		
Cr	N 0.83		

Medications: Name/Amount/Route nes only)	Classification	Mechanism of Action	Why is Your Client on this Med?
Aspirin (ASA)/ 81 mg/ PO/ daily	Antipyretics, nonopioid analgesics	Decreases platelet aggregation	Prophylaxis of TIA and MI (r/t HTN)
Pantoprazole (protonix) ER tablet/ 40 mg/ PO/ daily	Antiulcer agents, proton-pump inhibitor	Diminishes accumulation of acid in gastric lumen	Gastric ulcer prophylaxis
Carvedilol (Coreg) 25mg tab/ PO/ BID	Antihypertensive, beta blocker	↓ HR and BP by blocking stimulation of $beta_1$ and $beta_2$ adrenergic receptor sites	Pt has HTN
Atorvastatin (lipitor) 20mg tab/ PO/ QHS	Lipid lowering agent, HMG-CoA reductase inhibitor	Competitively inhibit HMG-CoA reductase in the liver; leads to ↓ total and LDL cholesterol, ↓ triglycerides	Pt has a Hx of HTN; hence Pt is at risk for CVA or MI r/t atherosclerosis and HTN
Ciprofloxacin (cipro) 500mg tab/ PO/ BID	Anti-infectives, fluoroquinolones	Inhibits bacterial DNA synthesis by inhibiting DNA gyrase. Causes death of susceptible bacteria	Infection? Pt's WBC is normal (5.1) and he displays no S/Sx's of infection. He was admitted to the med-surg floor for observation (r/t him repetitively banging his head and the subsequent sequelae and his Hx of a TBI)
Citalopram (celexa) 20mg tab/ PO/ Q PM	Antidepressant, SSRI	Selectively inhibits the reuptake of serotonin in the CNS resulting in antidepressant action	Pt has a Hx of MDD
Topiramate (topamax) 50mg tab/ PO/ BID	Anticonvulsants, mood stabilizers	Action may be due to: Blockade of Na+ channels in neurons, Enhancement of GABA (an inhibitory neurotransmitter), and Prevention of activation of excitatory receptors	Pt has a Hx of seizures
Insulin lispro (Humalog "High Risk") SS/ SubQ/ AC & HS *Rapid acting	Antidiabetic	Hormone lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat, inhibiting	Pt has Type II DM * Assess pt for signs and

		hepatic glucose production	symptoms of hypoglycemia: anxiety, restlessness, nervousness, tremor, weakness, mood changes, tingling, chills, cold sweats, confusion, cool, pale skin, drowsy, difficult to concentrate, excessive hunger, tachycardia.	
Levetiracetam (Keppra) 500 mg tab/ PO/ TID	Anticonvulsant, pyrrolidines	Inhibits burst firing and may prevent hypersynchronization of epileptiform burst firing and propagation of seizure activity. ↓ incidence and severity of seizures	Pt has a Hx of seizure disorder	
Quetiapine (seroquel)/ 200mg tab/ PO/ QHS	Antipsychotics, mood stabilizers	Probably acts by serving as an antagonist of dopamine and serotonin, Also antagonizes histamine H1 receptors and alpha1-adrenergic receptors	Pt has MDD; this medication decreases manifestations of depression (fatigue, irritability, changes in appetite and sleep, etc)	
acetaminophen (Tylenol) 650 mg tab/ PO/ Q4H PRN	Antipyretic, nonopioid analgesic	Inhibits synthesis of prostaglandins that may serve as mediators of pain and fever, mostly in CNS	PRN for mild pain (1-3) *Cumulative dose not to exceed 4g/24hr Assess type, location, intensity of pain, assess fever, asses overall health status and alcohol use	
Mylanta II (magnesium hydroxide/ aluminum hydroxide)/ 15 mL/ solution/ PO/ Q4h PRN	Antiulcer agents, antacids	Neutralize gastric acid following dissolution of gastric contents. Inactivate pepsin if pH is raised to > or = to 4	PRN for indigestion	

Magnesium hydroxide (MOM) 30mL/ suspension/ PO/ PRN daily	Laxative, saline	Bowel evacuation by drawing water into lumen and causing peristalsis	PRN for constipation *Assess for abdominal distention, presence of bowel sounds, and bowel function, assess color, consistency, and amount of stool	
Temezepam (restoril) 15mg/ cap/ PO/ QHS PRN	Sedative/ hypnotic (benzodiazepine)	Acts at many levels in the CNS, producing generalized depression. Effects may be mediated by GABA, an inhibitory neurotransmitter	PRN for insomnia; may repeat X1	

Mental Status Assessment	**Assessment Findings** **(Describe in complete sentences and provide examples for your answers.)**
Appearance Grooming/dress Hygiene Eye contact Posture Identifying features Appearance versus stated age Overall appearance	The client was a 37 year old, American male who appeared years beyond his actual age. He appeared to not have shaven his beard for 1-2 weeks and he was over 50% bald on his head. He had several healing cuts on his forehead r/t him repeatedly banging his head when he was upset prior to his admission at the hospital. Many of the client's teeth were missing and the few that were remaining were brownish/ rust color and rotting. The client was wearing a pair of dark jeans and a green sweater; he also had the hospital slippers on as well as a pair of black slip-on sandals. He appeared to have showered recently and no malodors were noted. Although the client appeared somewhat shy or timid, he maintained good eye contact throughout the interview. The client was sitting on the edge of his bed in a slightly slumped position. He appeared nervous at times during the interview as he would fiddle with his fall risk armband. The client appeared well into his 50's compared to him being only 37 years old. Overall, the client appeared to be slightly disheveled and a bit shit, but very kind.

Behavior/Activity ☐ Hyperactive ☐ Agitated ☐ Psychomotor retardation ☐ Calm ☐ Tremors ☐ Tics ☐ Anxious	☐ Unusual movements/ gestures ☐ Catatonia ☐ Akathisia ☐ Rigidity ☐ Facial movements ☐ Other	Overall, the client was relatively calm. He agreed to the interview despite having a migraine HA. He answered every question and he always replied with more than 1 or 2 word phrases. He appeared a bit anxious as he would occasionally fiddle with his fall risk armband. By the client's slouched back posture, he appeared to be a bit shy and timid. The client didn't display any unusual or abnormal movements or gestures.
Speech (Describe tone, volume & fluency) ☐ Slow/rapid ☐ Pressured ☐ Tone ☐ Volume ☐ Fluency		The client spoke in a very soft nature with a low volume. His speech pattern was somewhat slow (may also be r/t his TBI). He spoke in a relaxed tone with slight inflections and deflections in tone noted. The client's words and sentences were coherent and easy to comprehend.
Attitude ☐ Cooperative ☐ Warm/friendly ☐ Suspicious ☐ Guarded ☐ Hostile ☐ Apathetic	☐ Uncooperative ☐ Distant ☐ Combative ☐ Aggressive ☐ Aloof ☐ Other	The client was calm and very cooperative. He agreed to the interview around lunch time as well as to meet sometime within the following hour to talk. When it was time for the interview, he was resting in his room in the dark. He revealed that he was experiencing a bad migraine HA. Even though he wasn't feeling good, he still agreed to the interview and answered every question to the best of his ability.
Mood ☐ Elated ☐ Irritable ☐ Fearful ☐ Worried ☐ Hopeless ☐ Mixed ☐ Appropriate for interview	☐ Sad ☐ Depressed ☐ Anxious ☐ Guilty ☐ Angry ☐ Labile	The client's mood was appropriate for the interview. Overall, the client appeared to be in a slightly depressed mood state. He reported attending group in the morning. During lunch, the client didn't interact with anyone; he ate and then went to back to his room. The client appeared to be slightly withdrawn and depressed.
Mental Status Assessment		**Assessment Findings** **(Describe in complete sentences and provide examples for your answers.)**
Affect ☐ Appropriate ☐ Flat ☐ Blunted or diminished ☐ Inappropriate/incongruent		The client's affect was appropriate throughout the interview. He displayed a range of emotions during the interview. He was very happy and smiling when talking about his dog and playing

		baseball with his step-son. He even laughed when we lightheartedly talked (and joked) about DM. The client became very sad when talking about his mother who passed away in 2003. It was evident that they were very close and she meant a lot to him. The client's affect was appropriate to the particular topic being discussed.
Thought Process ☐ Intact ☐ Concrete thinking ☐ Circumstantiality ☐ Tangentiality ☐ Loose associations ☐ Echolalia ☐ Slow	☐ Flight of ideas ☐ Perserveration ☐ Clang associations ☐ Blocking ☐ Word salad ☐ Ideas of reference	The client's thought processes were clear, intact, and easy to follow. He answered questions appropriately and within a timely manner. No clang associations, word salad, echolalia, loose associations, flight of ideas, or tangentiality noted.
Thought Content ☐ Delusions ☐ Suicidal/homicidal thoughts ☐ Obsessions ☐ Paranoia	☐ Phobias ☐ Magical thinking ☐ Poverty of speech ☐ Other ☐ None	The client's thought content was intact and appropriate. He denied any SI or HI. No delusions, paranoia, phobias, or obsessions were noted.
Perceputal Disturbances ☐ Visual hallucinations ☐ Auditory hallucinations ☐ Other hallucinations ☐ Illusions ☐ Depersonalization ☐ None		The client didn't exhibit any S/Sx's of a perceptual disturbance. No VH, AH, or illusions were noted.
Memory/Cognition Orientation Memory Level of alertness		The client was alert and oriented X4 (person, place, time, and event). Both the client's short and long-term memory were intact. The client was able to recall events from the previous week indicating that his short-term memory was intact. The client was also able to recall events from his youth indicating that his long-term memory was intact.
Insight & Judgment (Give brief explanation & provide examples) Insight Judgment Impulse control		Overall, the client had a good level of insight. He knew a lot about DM and depression. He was aware of the fact that he has been suffering from depression for many years. The client displayed an adequate sense of judgment. He knew

	that he needed some additional help right now; he felt as if he were having a nervous breakdown. He also realized that he and his family need to move as soon as possible due to their dysfunctional living situation with the roommate. The client has poor impulse control. When someone upsets him, he hurts himself. He said he wouldn't hurt anyone else but he does inflict harm upon himself when he is frustrated or upset.

Risk Assessment:

Suicide Assessment: (suicidal ideation, intent, plan, access) When I interviewed the client, he had no SI. He stated that he didn't have weapons (i.e. guns) in his house.

Recent suicide attempt (describe): The client reports getting into a verbal altercation with his roommate over a petty issue. Words were exchanged as well as the roommate shoving the client. The client reported wanting to walk in front of a train. The client also reported holding a knife to his throat. He said he was "serious" and that he really wanted to "do it."

History of suicide of family member or close friend: According to the client's chart, the client's father committed suicide in front of him when he was just 10 y/o. The chart also stated that the client's father had a Hx of paranoid schizophrenia. When I asked the client about his father, he stated, "I never had a dad"; there was no further elaboration on this topic.

Homicide Assessment: Thoughts of harming another (who, intent, plan, access) The client denies any HI. He reported that he has never thought of hurting someone else and he'd rather hurt himself instead when he's upset.

History of violence: recent (past year) Describe including precipitating factors and severity: The client was very reserved and had no Hx of violence directed towards others. He stated that when he's upset, he thinks of hurting himself and that he has no desire to hurt anyone else. On Monday, the client's roommate got violent/ physically aggressive with the client. Words were exchanged and the roommate proceeded with repeatedly shoving the client. This event was a precipitating factor involved with the client's admission. The client denies any other recent Hx of violence.

Student reported suicidal and/or homicidal assessment findings to: NA

Substance Abuse:

Current use of: Tobacco, Caffeine, Alcohol, Cocaine, Amphetamines, Marijuana, Hallucinogens, PCP, Sedatives, Opiates, Inhalants, Rave drugs, others, misuse of prescribed or OTC medications. Describe the following: The client's Tox Screen was + for amphetamines. The client stated that his "alcoholic beverage was spiked" and that he didn't know there were amphetamines in his drink

Pattern (daily, weekends, bender): Client stated that he rarely drinks ETOH and he smokes cigarettes daily.

Quantity (day, weekend, bender): Client reported smoking 10-15 cigarettes/ day; previously the client would smoke up to 2 packs of cigarettes/ day. The client rarely drinks ETOH, only on special occasions. He reported (greatly) cutting down on his drinking habit the

past 3-4 months.

Age (use started): Client reported that he began smoking cigarettes and drink ETOH in high school.

When problematic: According to the client, his wife drinks ETOH. Sometimes this can be problematic the client is trying to refrain from ETOH.

Past History of substance abuse: According to the client, he used to smoke and sell a lot of marijuana. He was incarcerated for a year and a half in 2003 for distributing marijuana. He rarely drinks ETOH (for the past 3 or 4 months) due to realization of excessive use and abuse.

Past Treatment (AA, Detox, Rehab, etc.): Client denies any past Tx for substance abuse and no information was found in the chart.

Cultural Considerations:

The client has impaired communication r/t his TBI. When the client was 23 y/o he was in a horrible MVA that left him fighting for his life. He was in a coma for 19 months and when he arose he had significant neurologic and motor deficits. He mentioned that his reading and comprehension level is comparative to the 4th grade. He also stated that he had to re-learn to write following his injury. The client was alert and oriented X4 (person, place, time, and event). The client had a thin frame and evidently impaired nutrition as evidenced by his laboratory values (low RBC, H&H, Ca+, protein, and albumin). While in the hospital, he has been on a 1800 ADA diet. Both of the client's parents are deceased. It was obvious that the client had a very close relationship with his mother and that he missed her dearly by the way he talked of her and the change in his tone of voice. He stated that he has a solid relationship with his wife and step-children. He talked of his step-son on multiple occasions and how he enjoyed playing baseball with him. The client also has a daughter of his own from his first marriage; she resides in San Diego. The client mentioned that he had another daughter as well but she passed away. Although when inquired about his support system, he said that he probably didn't have anyone besides his mother and father in law. He enjoys spending time with his in-laws and said that they both reciprocally would do anything for one another. The client is knowledgeable about his disorder (MDD) and is compliant with follow up appointments and medication administration. He is also knowledgeable about diabetes; he is compliant with medication but not with the diet (he reported not being too fond of the food choices). The client graduated from high school but didn't attend college. The client reported having a Baptist faith. He mentioned not attending a church service in several years but that it's definitely something he'd consider getting back into.

Communication Orientation Nutrition Family Relationships Health & Health Beliefs Education Religion

3 Nursing Diagnoses (Written in 3 part statement):

I. Risk for suicide
R/T: Major Depressive Disorder
AEB: the client's recent SI (wanting to walk in front of a train as well as holding a knife up to his throat), the client was placed on a 5150 with Q30min observation, and the client has a past Hx of SI with multiple inpatient psychiatric admissions

II. (Risk for) Loneliness
R/T: Social isolation associated with feelings of sadness, hopelessness
AEB: the client not talking about any friends, the client reported being at home most of the time (he leaves to walk the dog or visit his in-laws), and the client feels as if his support system consists of only two people (his mother and father in law)

III. Self neglect

R/T: Depression and cognitive impairment
AEB: the client's diagnosis of MDD and Hx of TBI, the client's physical characteristics- unshaven with rotted and missing teeth, and the client appeared much older (around 55 y/o) compared to his actual age (37 y/o)

Nursing Interventions: **(List at least 3 interventions for each diagnosis.)**

I.
1. Assess for SI when the history reveals the following: depression, substance abuse, stressful life events, past SI, etc.
2. Develop a positive therapeutic relationship with the client; do not make promises that cannot be kept.
3. Maintain increased surveillance of the client when the Prozac is initiated. Antidepressant medications take anywhere from 2 to 6 weeks to achieve full efficacy.
4. Involve the client in treatment planning and self-care management of psychiatric disorder (MDD).
5. Explore with the client all circumstances and motivations related to the suicidality. Listen to the client's own views about his problems.
6. Discuss plans for dealing with SI in the future (i.e. how to identify precipitating factors, whom to contact, where to go for help, and how to respond to desire for self-harm)

II.
1. Assess the client's perception of loneliness.
2. Use active listening skills and spend time with the client.
3. Explore ways to increase the client's support system and participation in groups and organizations.
4. Encourage the client to be involved in meaningful social relationships and provide support of one's personal attributes.

III.
1. Monitor individuals with acute or chronic mental and complex physical illness for defining characteristics of self-neglect.
2. Assist individuals with complex mental and physical health issues to adopt positive health behaviors so that they may maintain their health status.
3. Utilize behavior modification as appropriate to bring about client changes that lead to improvement in personal hygiene, environmental hygiene, and adherence to medical regimen.
4. Assess persons with complex health issues for adequate coping abilities and assist those with coping problems to maintain their health and well being in the community.

Patient Teaching:

- The importance of complying with medications (the client has a Hx of poor compliance with medications)
- The importance of following the ADA's dietary recommendations (Pt doesn't follow a diabetic diet because he doesn't like the food choices)
- Appropriate coping skills (so that the Pt doesn't contemplate or inflict self-harm when he's upset)
- The importance of regular exercise (at least 30 minutes 3-5 times per week)
- The importance of keeping follow up appointments (i.e. psychiatrist and PCP)
- Getting about 30 minutes of sunlight daily to help reduce depressive S/Sx's
- Recognizing the S/Sx's of depression

Health Promotion:

The client is compliant in regards to his DM. He checks his blood sugars 4 times per day and administers insulin PRN. The client does not follow a diabetic diet due to his distaste for the food selections. The client does get physical exercise by walking his dog or walking to his in-laws house; he also reports playing baseball with his step-son on the weekends. The client quit drinking heavily in January and reports that he rarely drinks anymore. The client also cut down smoking cigarettes. He used to smoke at least 2 packs per day; now, he's down to 15 cigarettes per day. The client struggles with reading and writing due to his MVA and resultant brain damage. He said that his reading and writing capabilities are comparable to the 4th grade level. The client graduated from high school in Arizona. When asking the client about his support system, he said that he "probably had no one." Upon further exploration, he reveled having strong support from his in-laws. He said that he can always call them or go to their house whenever he needs them. The client reports that he likes to walk and play with his dog when he is feeling stressed or overwhelmed. The client has willingness and wants to accept help to manage his depression.

Diet Exercise Vaccinations Lifestyle Choices Provider Follow-up Age-related Needs Education Social Support Stress Reduction Techniques

Discharge Planning Needs:

The client will be started on Prozac during his admission. The Professor educated the client about the various side effects of the medication such as weight gain and priapism. The client reported that he has a local pharmacy that he uses to obtain his various other Rx medications. The client is able to complete ADL's independently. His daily routine usually consists of cleaning the house, walking the dogs, and (eventually) yard work. The client lives with his wife and step-son, as well as roommates. He said that they will begin looking for a new place once he's out of the hospital (his expected discharge was in 3-5 days). The client reports that this wasn't the first altercation that has occurred with this particular roommate (hence the decision to find a new place to live). The client will need to follow up with a psychiatrist on an outpatient basis. The client stated that he will be following up with Dr. Chavalya at Gray Bill following his discharge.

Medication –education, supply, access ADL's Housing Mental Health Aftercare Medical Care Follow-up

Appropriate Referrals:

- **PRN 911 or ED**
- **Outpatient services that may assist the client with medication management, support groups, substance abuse counseling, and social support services**
- **Family counseling**
- **Psychiatrist & Psychologist**
- **Suicide Prevention hotline (1-800-273-TALK); I gave the client a card to keep in his wallet (he stated that if he had this card the other day (Monday), the situation at his house may not have escalated to the same extent (him contemplating SI); his eyes appeared teary when given the card and talking about the surrounding events)**
- **Tri City Medical Center Outpatient Behavioral Health; M-F 0830-1600; 510 Vista Way in Oceanside; phone # 760-940-5050**
- **Reading and writing assistance**