Discharge Summary

Patient Name: John Doe 1

MRN: 000012 Age: 20 Sex: M

Admit Date: 01/15/2023 Discharge Date: 01/17/2023

REASON FOR HOSPITALIZATION:
John Doe is a 20-year-old male with history of ADHD, was admitted to San Diego Psychiatric Hospital after patient jumped off the moving vehicle when he had an argument with his mother.

RELEVANT HISTORY:
The patient had a previous episode when he wanted to jump off the moving vehicle about 5-6 months ago, but his aunt stopped him. The patient has no history of inpatient psychiatric hospitalization. The patient was admitted involuntary on 72-hour hold for danger to self.

DIAGNOSIS: 2
1. Adjustment disorder with mixed disturbance of emotions and contact
2. Rule out bipolar disorder
3. Homelessness

DISCHARGE MEDICATION:
The patient was discharged with no medication as the patient declined medication.

HOSPITAL COURSE:
The patient was transferred from 5th floor where he was treated under Trauma Team after he was brought on 72-hour hold for danger to self after patient impulsively jumped off the moving vehicle when he had an argument with his mother in the car. The patient did not have any serious injury, but according to the mother, the patient had a seizure like episode and he lost consciousness at the scene. He had extensive medical workup at the 5th floor under Trauma Team and he was medically cleared. The patient was started on small dose of Zoloft, but he declined medications as he denies feeling hopeless, helpless. The patient denies feeling suicidal, homicidal. Denies thoughts of harming self or others; denies auditory or visual hallucination. The patient was calling his brother from the hospital and his family visited him and he slept about 6 hours. The patient was offered voluntary hospitalization, but he preferred to be discharged. The patient was discharged home with the brother.

LAB RESULTS:
UDS was negative. TSK was within normal limits. Blood alcohol level not detected. CBC within normal limits. Basic metabolic panel within normal limits. Head CT scan without contrast, no intracranial hemorrhage or any fracture. CT cervical without contrast. No fracture.

VITAL SIGNS ON DISCHARGE DAY:
Temperature 36.6, pulse rate 97, respirations 16, blood pressure 126/86, O2 saturation 98% on room air.

MENTAL STATUS EXAMINATION:
General Appearance: John Doe is 20-year-old male who looks as stated age, dressed casual, groomed fair, okay personal hygiene. Alert and oriented x3. Independent in ADLs.

Attitude: Pleasant, cooperative.

Eye contact: Fair

Musculoskeletal: Gait steady. No spasticity. No tremor was noticed.

Psychomotor activity: Within range.

Speech: Normal rate, rhythm, volume.

Language: No aphasia.

Mood: I feel okay.

Affect: Euthymic affect.

Thought process: No thought blocking was noticed.

Thought content: Denies feeling hopeless, helpless, worthless. Denies suicidal ideation, homicidal ideation. The patient is future oriented and was looking forward to getting discharged. No paranoia. No delusion.

MAJOR DIAGNOSTIC PROCEDURE: None

RENDING LAB RESULTS: None

PLAN:

1. Case was discussed with the patient, patient's nurse, social worker, the treatment team did not find patient is eligible for involuntary observation at this point as the patient does not appear to be danger to self, danger to others, or gravely disabled. The patient was discharged home with brother after his 72-hour hold expired this morning. The patient was offered voluntary observation, but he preferred to be discharged at this time.
2. The patient was referred to San Diego Wellness Center. Appointment is scheduled on January 19, 2023. The patient declined any psychotropic medications at this time and he was discharged with no medication.
3. Suicide risk re-evaluation and treatment recommendation per our unit protocol.
4. The patient agrees to discuss any concerns of hurting self or others with psychiatric staff, emergency room staff or call 911.
5. Safety plan, crisis plan was discussed with the patient. The patient denies having any active access to lethal means including fire guns or stockpile of medication.

DISCHARGE INSTRUCTION: Diet, regular.

DISCHARGE DESTINATION: Home with brother.

CONDITION OF DISCHARGE: Stable. The patient is able to perform ADLs.

PROGNOSIS: Fair as the patient is young and he is future oriented and has no substance abuse problem and this is his first inpatient psychiatric hospitalization.

Total discharge time was 50 minutes that include face-to-face evaluation discussing safety plan, crisis plan, discharge plan with the patient, patient's nurse, and social worker. **3**

Signed electronically by: Caring Provider, MD **4** Date/time signed: 01/17/2023 11:34 pm

1. Client name or identifier is present on the progress note.
2. The diagnosis is indicated.
3. The progress note supports the code billed. Time is indicated on the progress note.
4. Provider identifier is present on the progress note.