Jeleeta Jolly
June 24, 2026
Rotation #5: Psychiatry at Queens Hospital Center

H&P 3 - Psychiatry

Identifying Data:
Full name: J.B.
Address: Jamaica, NY
Location: Queens Hospital Center
Source of information: Self, Chart review, and Collateral
Source of referral: EMS

Chief Complaint: Auditory and visual hallucinations

History of Present Illness:

Patient J.B. is a 47 year old African American male, domiciled at BRC shelter, unemployed, with psychiatric history of schizophrenia, brought in by EMS activated by self for auditory hallucinations and suicidal ideations. Patient states he occasionally gets intermittent hallucinations but that today, they became more overwhelming. He is hearing one voice speaking in a whisper, but cannot recall what it is saying. He states that the voice is not telling him to do anything specific. Patient also admits to seeing people that are not there, states that he sees shadows of figures. Patient admits to sometimes having suicidal ideations, but does not currently have a plan or intent. Per chart review, patient was admitted to Bellevue Hospital's inpatient psychiatric unit 8/4/2025-8/21/2025, and was then transferred to Manhattan Psychiatric Center for 6 months and was discharged one month ago for similar symptoms. Patient reports that he follows with an ACT team following discharge from the inpatient unit, where he receives outpatient care. He reports seeing them once weekly, with his most recent visit earlier that afternoon. Patient states he is compliant with prescribed medications. He currently takes Zyprexa and long acing Risperidone injection once every 2 weeks. He reports last taking medications today. Patient also endorses sleeping less over the past 6 weeks and poor appetite since this afternoon. He denies depression, feelings of hopelessness, helplessness, homicidal ideations, prior suicide attempts, history of trauma or abuse, substance use or abuse, or any known family psychiatric history.

Collateral information obtained from Jewish Board Shelter ACT team (patient's case manager) who states that patient was discharged from Manhattan Psychiatric Center in March 2026. She reports that patient last received Risperdal Consta 50 mg intramuscular injection on 5/29/26 by the ACT team. She states that patient was discharged back to the shelter. She states patient is compliant with his psychotropic medications and psychotherapy. She reports that patient is not a safety concern and when cleared, can be discharged back to the shelter.

Medical History
Congestive heart failure
Hypertension
Hyperlipidemia
Type II Diabetes
Immunization: Up to date per chart review.

Psychiatric History
Schizophrenia

Past Surgical History
No significant past surgical history.

Medications
Zyprexa 10 mg tablet at bedtime
Risperidal Consta 50 mg IM injection every 2 weeks
Aspiririn 81 mg PO once daily
Atorvastatin 10 mg PO once daily
Bumetanide 2 mg PO once daily
Carvedilol 3.125 mg PO BID
Empagliflozin 10 mg PO once daily
Metformin 500 mg PO once daily
Metoprolol succinate 25 mg PO once daily
Spironolactone 25 mg PO once daily

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, deceased 70, uncertain of PMH
Father, deceased 76, HTN
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, none

Social History
Patient is an African American male, lives at BRC shelter in Brooklyn. He is currently unemployed. Admits to history of arrest in the past. Denies alcohol or illicit drug use. He endorses recent poor sleep and appetite.

Review of Systems:
General: **Admits to poor sleep and appetite**. Denies fevers, chills, recent weight loss or weight gain, generalized weakness/fatigue, or night sweats.
Skin, hair, nails: Denies rashes or bruises.
HEENT: Denies headache, visual disturbances, deafness, nasal discharge, or sore throat.
Neck: Denies localized swelling/lumps or stiffness.
Pulmonary System: Denies cough or shortness of breath.
Cardiovascular System: Denies chest pain.
Gastrointestinal System: Denies abdominal pain, nausea, vomiting, constipation, or diarrhea.
Genitourinary System: Denies frequency, nocturia, urgency, hematuria, or dysuria.
Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances, or change in cognition/mental status/memory.
Musculoskeletal System: Denies muscle/joint pain or deformity.
Psychiatric: **Admits to auditory and visual hallucinations, and mild suicidal ideation/ thoughts.** Denies depression, feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, homicidal ideation, or obsessive/compulsive disorder.

Physical Exam

General: 47 y/o male, well groomed, in no apparent distress. Patient was found dressed in hospital gown, sitting on chair, A&O x 3.

Vital Signs:

BP:	121/82 mm/Hg	
RR:	18 breaths/min, unlabored	
P:	79 beats/min, regular	
T:	97.9°F, oral	
SpO2	98% room air	
Ht: 5’10”	Wt: 180 lbs	BMI: 25.8

Skin: No scars, rashes, or bruises.
Psychiatric: Patient appears calm and cooperative with good eye contact. Speech is soft, and slow but coherent, with some latency. Mood is described as “I feel fine” with blunted affect. Thought process is linear and goal-directed. Thought content notable for hallucinations and suicidal ideations, with no plan or intent. Denies homicidal ideation. Cognition is grossly normal. Insight, judgement, and impulse control are impaired at this time.

Mental Status Exam

General

1. **Appearance:** Patient is a 47 year old African American male, appearing as stated age. He is dressed in hospital gown, seated in chair, well-groomed, with good hygiene. No visible scars, lesions, or marks noted on face or hands. He appears in no acute distress.
2. **Behavior and Psychomotor Activity**: Patient remains calm throughout the interview, with no psychomotor slowing. Responses are at adequate speed and appropriate. No tremors or involuntary movements were present.
3. **Attitude towards Examiner**: Patient is cooperative and engaging in conversation. Rapport was established easily.

Sensorium and Cognition

1. **Alertness and Consciousness**: Patient is alert and conscious throughout the interview.
2. **Orientation**: Patient is oriented to person, place, and time.
3. **Concentration and Attention**: Attention and concentration were intact. Responses were goal directed.
4. **Capacity to Read and Write**: Not assessed during this interview.
5. **Abstract Thinking**: Patient appears intact, ability to interpret proverbs was not tested.
6. **Memory**: Patient's recent and remote memory remains intact.
7. **Fund of Information and Knowledge**: Fund of knowledge appeared appropriate for age, education, and background.

Mood and Affect

1. **Mood**: Patient described his mood as "I feel fine".
2. **Affect**: Patient's affect is blunted, with reduced emotion throughout the interview.
3. **Appropriateness**: Mood and affect were appropriate to the content discussed. No labile emotions or inappropriate affect was observed.

Motor

1. **Speech**: Patient's speech is slow, soft, and quiet, with some latency in responses. Speech is coherent, understandable, and goal-oriented.
2. **Eye Contact**: Patient maintained good eye contact throughout the interview.
3. **Body Movements**: Patient exhibited no psychomotor slowing. No abnormal involuntary movements were observed.

Reasoning and Control

1. **Impulse Control**: Patient's impulse control is impaired due to ongoing psychosis and suicidal thoughts, increasing the risk of acting on symptoms or impulses despite currently denying plan or intent.
2. **Judgement**: Patient has impaired judgement in the context of active psychotic symptoms and intermittent suicidal ideation.

3. **Insight**: Patient has impaired insight as he demonstrates limited awareness of the severity and impact of his symptoms, including persistent auditory and visual hallucinations despite ongoing treatment.

Problem List:

- Auditory and visual hallucinations
- Suicidal ideation
- Schizophrenia

Assessment: 47 year old African American male, domiciled at BRC shelter, with psychiatric history of schizophrenia, brought in by EMS activated by self for auditory hallucinations and suicidal ideations. Patient states he occasionally gets intermittent hallucinations but that today, they became more overwhelming. He is hearing one voice speaking in a whisper, but cannot recall what he is hearing. He also admits to seeing people that are not there, states that he sees shadows of figures. Patient endorses sometimes having suicidal ideations, but does not currently have a plan or intent. Patient had prior hospitalization at Bellevue Hospital's inpatient psychiatric unit 8/4/2025-8/21/2025, and was then transferred to Manhattan Psychiatric Center for 6 months and was discharged one month ago for similar symptoms. He denies any history of prior suicide attempts. On evaluation, patient appeared cooperative, but with a blunted affect. He had good eye contact, spoke soft and slowly, with impaired judgement and insight. Given patient's auditory and visual hallucinations and psychotic features along with suicidal ideation, and recent prolonged hospitalization for similar symptoms, patient will be admitted to CPEP for observation and stabilization and for continued safety monitoring.

Differential Diagnoses:

1. Schizophrenia

   This is the most likely diagnosis given the patient's history of schizophrenia, recent prolonged psychiatric hospitalization, and current presentation with worsening auditory and visual hallucinations. Despite reported medication adherence with both oral olanzapine and long acting risperidone, he continues to experience psychotic symptoms including hearing whispering voices and seeing shadow-like figures. This seems likely to be an acute exacerbation of his schizophrenia.
2. Schizoaffective disorder

   This should be considered because the patient presents with psychotic symptoms and intermittent suicidal ideation. However, there is insufficient evidence of a sustained mood episode occurring concurrently with psychotic symptoms. While suicidal ideation can occur in schizoaffective disorder, the absence of clear manic or major depressive episodes makes this diagnosis less likely than schizophrenia.

3. Major depressive disorder

   MDD with psychotic features remains a possible differential because the patient endorses suicidal ideation, poor appetite, and decreased sleep. However, this diagnosis is less likely because the patient denies depressed mood, hopelessness, helplessness, and other depressive symptoms. Additionally, his psychotic symptoms appear chronic, which is more consistent with schizophrenia.

4. Substance induced psychotic disorder

   This diagnosis should always be considered in patients presenting with hallucinations and suicidal thoughts. However, since the patient denies current substance use and collateral information does not suggest recent use, and given that he was hospitalized for similar symptoms a few months ago, this diagnosis is less likely.

5. Psychotic disorder due to another medical condition

   Medical causes of psychosis such as neurologic disorders, endocrine abnormalities, or metabolic disturbances should be considered. However, this patient has a longstanding history of schizophrenia with previous psychiatric hospitalizations with similar symptoms. He is alert and oriented, without evidence of acute medical illness, making this less likely, though routine labs remain warranted.

Workup/Plan:

- Admit to CPEP under New York Mental Hygiene Law 9.40 for observation and stabilization given suicidal ideation with impaired judgement and safety concerns.
- Start Q15 safety checks in CPEP to monitor for suicidal ideation or other behavioral changes
- Provide supportive therapy, psychoeducation, and crisis intervention as indicated.
- Encourage participation in individual, group, and milieu therapy while in CPEP
- Medication management
  - Continue patient on Zyprexa 10 mg at bedtime.
  - Assess patient's response to medication (improvment in sleep, suicidal ideation, hallucinations)
- Obtain ongoing collateral information from ACT team as needed
- Obtain labs (CBC, BMP, serum ethanol, UA, and TSH) to rule out medical causes of symptoms - normal
- Obtain urine toxicology screen (5-panel) to rule out substance induced symptoms - negative
- Follow up labs and medical follow up as needed
- Re-evaluate patient in the morning - patient reported feeling much better the next day, denies any hallucinations or suicidal ideations with improved sleep and appetite. Patient

did not receive any STAT medications. Patient was safely cleared for discharge back to shelter.

Patient Education

- Encouraged participation in individual and group therapy while staying in CPEP
- Encouraged continued medication adherence
- Continue following up with outpatient ACT team and psychotherapy after discharge

/s/ Jeleeta Jolly, PA Student