Jeleeta Jolly
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Rotation #5: Psychiatry at Queens Hospital Center

H&P 2 - Psychiatry

Identifying Data:
Full name: M.K.
Address: Jamaica, NY
Location: Queens Hospital Center
Source of information: Self and Collateral
Source of referral: Patient's wife

Chief Complaint: Suicidal Ideations and Depression

History of Present Illness:

Patient M.K. is a 36 year old Guyanese male, employed at a Verizon store, domiciled with wife and son (11), with psychiatric history of depression on Zoloft 50 mg from PCP, and substance use disorder of cannabis who presents to CPEP brought in by EMS activated by wife for suicidal ideations. Wife reports patient has been sending texts over the past few days expressing thoughts of suicidal ideations. Patient reports having ongoing depression and expressed inability to function. Patient states "I just don't want to do anything now, Like I was tired, sleepy. I don't want to go to work. I don't even want to take care of myself."

Patient reports having depression since 2021, initially treated by his primary care physician with medication. Patient describes the current episode as characterized by profound fatigue, anhedonia, and difficulty facing the reality of recent life circumstances. Patient describes a psychiatric history with a cyclical pattern of depressive and possible manic episodes. A most recent acute episode began following a period of improvement in April 2025. Patient reports that after recovering from previous depressive episode lasting from June 2024 to April 2025, he experienced a period of significantly elevated mood and impulsive behaviors. During this time, he engaged in multiple high-risk activities, including spending all family savings, infidelity, giving away possessions, and abandoning his 20 year business partnership with a Verizon franchise store. Patient states "I couldn't even remember half of the things I was doing" during this period. Patient gave up his partnership in a Verizon franchise store and relocated his family to Atlanta with plans to open an independent store. Within one month, he lost the Atlanta store opportunity and subsequently started multiple failed business ventures including a music business and car rental company, purchasing cars he "couldn't even afford." Patient reports exhausting all finances during this period. Following this period of elevated activity, patient has experienced significant decline in mood and functioning. Patient is currently in his fourth week of employment at a Verizon store in Far Rockaway, working for a former business partner in a reduced capacity role. Over the past several days, patient reports complete inability to get out of

bed, missing work the previous day and today. Patient describes lying in bed since Sunday, unable to sleep but unable to engage in any activities, with "a thousand things going through my mind." Patient rates current distress as overwhelming, stating "I could barely live with myself, you know, deal with all the problems that I caused." Patient acknowledges significant guilt regarding the impact of behaviors on family, particularly wife and son. Patient describes feeling unable to face reality of situation and consequences of actions during elevated mood period. He denies HI, AH/VH, prior psychiatric hospitalizations, history of trauma or abuse, or any known family psychiatric history. He admits to daily cannabis use, but reports that he last used it 2 months ago, with intentions to quit. Denies alcohol or illicit drug use.

Collateral information obtained from patient's wife who states that she has been paying all the bills for the past seven to eight months and is "burnt out" from supporting the patient through multiple psychiatric episodes. She reports that they have been married for 12 years, together for 17 and have one son together. She reports knowing patient for many years and all of this behavior started after 2021. She states patient has been increasingly depressed and feels that he may have bipolar disorder. She re-affirmed history of patient's behavior. She states that she had reached out to mobile crisis in the past, however, was told that the patient could not be seen while working in a commercial business which he was reportedly located at the time. She states that at a subsequent attempt, the team told her he was stable (which wife reports he was at the time). She reports that patient has been hesitant to see a psychiatrist.

Medical History
No significant medical history.
Immunization: Up to date per chart review.

Past Surgical History
No significant past surgical history.

Medications
Sertraline 50 mg PO once daily
Wellbutrin 150 mg PO once daily in the morning (started in CPEP)
Depakote 250 mg PO twice daily (started in CPEP)
Olanzapine 5 mg PO at bedtime (started in CPEP)

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, alive at 67, HTN, diabetes
Father, alive at 72, HTN

Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 1 brother, living and well
1 son, 11, living and well

Social History
Patient is a married Guyanese male, lives with his wife and son (11) in a private home in Far Rockaway, Queens. He is currently employed at Verizon, working under his former business partner. Denies legal history. Admits to cannabis use (last used 2 months ago. Denies alcohol or illicit drug use. He endorses recent poor sleep, and decreased appetite.

Review of Systems:
General: **Admits to decreased appetite and inability to sleep**. 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 depression, feelings of helplessness, hopelessness, lack of interest in usual activities, and suicidal ideation/ thoughts.** Denies auditory or visual hallucinations, homicidal ideation, or obsessive/compulsive disorder.

Physical Exam

General: 36 y/o male, appeared disheveled, in no apparent distress. Patient was found dressed in hospital gown, sitting upright in hospital bed, A&O x 3.

Vital Signs:

BP:	128/85 mm/Hg
RR:	18 breaths/min, unlabored
P:	84 beats/min, regular
T:	97.7°F, oral
SpO2	98% room air

Ht: 5’8” Wt: 191 lbs BMI: 29.0

Skin: No scars, rashes, or bruises.
Psychiatric: Patient appears calm and cooperative but with good eye contact. Speech is pressured but coherent, with no latency. Mood is described as “ashamed” with labile affect. Thought process is linear and goal-directed. Thought content notable for suicidal ideation, with no plan or intent. Notable for somatic delusions and thought insertions/withdrawals. Denies homicidal ideation, auditory or visual hallucinations. Cognition is grossly normal. Insight and judgement are impaired with impulse control fair at this time.

Mental Status Exam

General

1. **Appearance:** Patient is a 36 year old Guyanese male, overweight, appearing as stated age. He is dressed in hospital gown, seated on hospital bed, with a disheveled appearance. 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 abnormalities. Responses are at mildly increased speed, but 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 remain 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 “ashamed”.
2. **Affect**: Patient’s affect is labile, shifting between sadness, dysphoric, and anxious throughout the evaluation.
3. **Appropriateness**: Despite affective variability, emotional responses remained appropriate and congruent with the topics discussed.

Motor

1. **Speech**: Patient's speech is pressured, rapid, and difficult to interrupt at times. He responded immediately to questions without noticeable latency in responses. Despite an increased rate of speech, his speech remained understandable and goal-oriented.
2. **Eye Contact**: Patient maintained good eye contact throughout the interview and was engaged in the conversation.
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 fair at this time, as he denies intent to act on suicidal thoughts at this time and is not displaying any active manic episodes.
2. **Judgement**: Patient has impaired judgement in the context of ongoing depressive symptoms, with suicidal ideation.
3. **Insight**: Patient has impaired insight into the severity of his condition and the consequences of his actions and the need for appropriate treatment.

Problem List:

- Depression
- Suicidal ideations
- Anxiety
- Insomnia

Assessment: 36 year old Guyanese male, domiciled with family, with psychiatric history of depression on Zoloft 50 mg from PCP, and substance use disorder of cannabis presents to CPEP brought in by EMS activated by wife for suicidal ideations. Wife reports patient has been sending texts and messages over the past few days expressing thoughts of suicidal ideations. Patient reports having ongoing depression and expressed inability to function. At this time, he endorses suicidal ideation but with no plan or intent. He denies any history of prior suicide attempts. Patient's history is significant for a prior manic episode following a prolonged depressive period. He describes a period of impulsive spending, elevated mood, and poor judgement resulting in significant financial losses and disruption of family functioning. On evaluation, patient appeared cooperative, but with a mood described as "ashamed" and labile affect. He had good eye contact, with pressured speech, and impaired judgement and insight. Given patient's suicidal ideation, severe depressive symptoms, marked functional decline, collateral concern from family, and history concerning for bipolar disorder, patient will be admitted to CPEP for observation, stabilization, and for continued safety monitoring.

Differential Diagnoses:

1. Bipolar I Disorder

This is the most likely diagnosis given the patient's history of distinct episodes of depression alternating with a probable manic episode. During the elevated mood period, the patient demonstrated multiple symptoms of mania, including excessive spending resulting in financial debt, impulsive business decisions, grandiose plans to relocate and start multiple businesses, hyperactivity, poor judgement, and decreased insight into his behavior. He reports limited recollection of some actions during this period, suggesting impaired reality and severity of symptoms. The current presenation is characterized by severe depressive symptoms including hypersomnia, anhedonia, impaired functioning, excessive guilt, and suicidal ideations. The presence of a clear manic episode followed by a major depressive episode strongly supports this diagnosis.

2. Major depressive disorder

   The patient meets criteria for a severe major depressive episodes, as seen by his depressed mood, fatigue, anhedonia, feelings of worthlessness, and suicidal ideations. His symptoms have significantly impaired his ability to function both socially and occupationally. While MDD could explain the current presentation, the history of a distinct period of elevated mood with impulsive and high risk behaviors is more suggestive of a bipolar disorder.

3. Cannabis induced mood disorder

   The patient's history of daily cannabis use raises consideration of a substance induced mood disorder. Chronic cannabis use has been associated with mood instability, worsening depressive symptoms, and in some individuals may precipitate manic or psychotic symptoms. Although the patient reports abstinence for the past two months and his mood symptoms appear to persist beyond the expected period of intoxication or withdrawal, cannabis may have contributed to the severity or expression of his mood symptoms.

4. Persistent depressive disorder

   The patient reports experiencing depressive symptoms dating back to 2021, suggesting the possibility of a chronic depressive disorder. Persistent depressive disorder could explain his prolonged periods of low mood and impaired functioning. However, this diagnosis alone would not adequately account for the significant period of elevated mood, impulse behaviors, and grandiosity.

5. Adjustment disorder

   The patient's recent financial losses, occupational decline, damaged business relationships, and guilt regarding the impact of his actions on his family are significant psychosocial stressors that could contribute to emotional distress. His current depressive symptoms may be exacerbated by these consequences and difficulty coping with recent life changes. However, the severity of symptoms, presence of suicidal ideation, marked functional impairment, and documented

history of recurrent mood episodes extending back several years make this diagnosis less likely as the primary diagnosis.

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
    - Start patient on Wellbutrin 150 mg orally daily.
    - Start patient on Depakote 250 mg twice daily, and Zyprexa 5 mg at bedtime.
    - Assess patient's response to medication (improvment in sleep, suicidal ideation, depressive symptoms)
- Obtain ongoing collateral information from wife as needed
- Obtain labs (CBC, CMP, serum ethanol, UA, and TSH) to rule out medical causes of symptoms - labs were within normal limits
- Obtain urine toxicology screen (5-panel) to rule out substance induced symptoms - positive for THC
- Follow up labs and medical follow up as needed and substance abuse counseling

Patient Education

- Educated patient regarding the diagnosis of Bipolar 1 disorder, including the nature of his depressive and manic episodes
- Educated on the importance of medication adherence to minimize symptoms and reduce risk of future mood episodes
- Encouraged abstinence from cannabis, as substance use may worsen symptoms and complicate treatment
- Encouraged health lifestyle habits, including regular exercise, balanced nutrition, stress management, and consistent daily routines.
- Arrange outpatient psychiatry and therapy follow up prior to discharge

/s/ Jeleeta Jolly, PA Student