Source of information: Self and mother
Reliability: Not reliable
Mode of transport: EMS

Chief complaint: “I had thoughts about killing myself last week.”

HPI: Patient is a 36 year old Caucasian male with past medical history of HTN, HLD, sleep apnea and diabetes insipidus and past psychiatric history of depression, anxiety, bipolar type II, and borderline personality disorder who was BIBEMS and NYPD escort for suicidal ideations. It was unknown who activated EMS, but per EMS report, “caller states patient mentioned having items such as a steak knife, rope, and firearm during potential suicidal ideations.” Pt states he spoke to his psychiatrist today and told her he was having suicidal thoughts last week which lasted 2 days and self resolved. He states he had no plan at that time, despite referencing potential means during suicidal statements. He states it was a “silly thing to say” and did not actually mean it. He reports being stressed and frustrated with fighting with his insurance company for the past 2 years in order to get medication (Zepbound) for his sleep apnea approved. Pt states he tried cutting himself on the arms recently without success (no scarring or lacerations noted).

Pt states in December 2025, he had mentioned to one of his doctors that his mom had a revolver in the house, and had said that he will use that on himself (reports mother was notified and bullets were thrown out and gun locked up). Pt follows up with his psychiatrist and therapist regularly. He is adherent to his medications. When asked about things that make him happy, he states writing, broadway shows with his parents, and watching the Red Sox. Pt denies any current suicidal ideations, homicidal ideations, auditory/visual/tactile hallucinations, delusions, or paranoia however cannot contract to safety, stating, “I don’t know what I’d do if I’m sent home,” admitting to having some passive suicidal ideations. No evidence of pressured speech, grandiosity, decreased need for sleep, flight of ideas, or increased goal-directed activity.

Per collateral from the patient’s mother, pt has been very upset and frustrated with his insurance company regarding medication coverage for his sleep apnea. She states pt has devoted a significant amount of time to getting this medication covered, as he has been on it for over 6 months. Mother states he has been compliant with psychiatric medications since his last psychiatric hospitalization 8 years ago at for 10 days, after he tried to kill himself by hanging. Mother denies observing any suicidal or risky behaviors lately. Pt lives alone but occasionally returns to stay with his parents and spend time with them. Mother also reports that she has a firearm passed down from her father who was a hunter. However, it has not been used for a long time and there has been no ammunition kept in the home for years.

Past Medical History
- Hypertension
- Hyperlipidemia
- Diabetes insipidus
- Sleep apnea

Psychiatric History
- Depression
- Anxiety
- Bipolar II disorder
- Borderline personality disorder

Previous suicidal attempt: 2018; tried to hang himself but “rope was too long”
    - Was hospitalized: 2018 at psychiatric hospital for 10 days

Past Surgical History
- None

Immunizations:
- COVID-19 Pfizer vaccine 4/8/21 and 4/29/21
- COVID-19 Moderna vaccine 11/5/21
- Influenza CCIV3 IM, single dose vaccine, last in 10/20/25
- TDAP vaccine 2/22/23

Medications
- Wellbutrin XL 300 mg; take 300 mg by mouth every morning
- Lithium 300 mg capsule; take 600 mg by mouth in the morning and 600 mg in the evening; take with meals
- Lamotrigine 150 mg and 25 mg tablets; take one 150 mg and three 25 mg tablets by mouth in the morning, for a total of 225 mg
- Fluoxetine 20 mg capsule; take 20 mg by mouth in the morning
- Amiloride 5 mg tablet; take 5 mg by mouth in the morning
- Zepbound injection once a week (unknown dose)

Allergies
Allergy to Penicillin; reaction- breaks out in hives
No known food or environmental allergies

Family History
- Mother alive, no psychiatric history.
- Father alive, no psychiatric history.
- No siblings

Social History
Habits: endorses social marijuana and alcohol on weekends (Friday-Sunday); denies illicit drug use.
Diet: endorses healthy diet for the most part, but sometimes indulges in fast food such as McDonalds.
Occupation: works as freelance attorney (documentation reviewer; works from home).
Exercise: does not exercise.
Travel: no recent travel.
Sleep habits: endorses 5-7 hours of sleep per night; history of sleep apnea for which he takes Zepbound.
Marital status/living situation: not married; lives alone.

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: denies rash, itching, excessive sweating or dry skin; no evidence of self inflicted wounds such as scarring or lacerations, or IV drug use
Head: denies headaches or vertigo
Neck: denies swelling, lumps, stiffness, or decreased ROM
Gastrointestinal: denies nausea, vomiting, diarrhea, constipation, or abdominal pain
Musculoskeletal: denies acute muscle or joint swelling or pain, deformity, or trauma
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, palpitations, or swelling of legs or feet
Neurology: denies dizziness, changes in speech, seizures, LOC, weakness, headaches, or sensory disturbances
Psychiatry: denies active depressed mood, current suicidal ideations, homicidal ideations, auditory or

visual hallucinations, delusions, or paranoia; **endorses occasional passive SI**

Physical Exam
General: 36 year old male, well nourished and well groomed; obese appearing. Pt appears stated age and is in no acute distress.

Vital Signs:
Blood pressure: 120/82 mmHg
Respiratory rate: 18 breaths per minute, unlabored
Pulse: 71 BPM, regular rate and rhythm
Temperature: 97.7 F
SpO2: 96%
Height: 5 feet 9 inches
Weight: 244 pounds
BMI: 36

Skin: no signs of self inflicted wounds, including lacerations or scars. No active bleeding.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rales, wheezes, or rhonchi auscultated.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Psych: patient is cooperative but avoids eye contact throughout the conversation; speech with normal rate, rhythm, and volume. Mood appears mildly irritated and affect is flat. Thought process and content is logical. No overt hallucinations noted. Poor insight and judgement.

Mental status exam:
Appearance and attitude:
- Pt is a 36 year old, Caucasian male of obese build but well groomed; appears stated age. Dressed appropriate for weather. Neutral facial expression, engaging in conversation. He is cooperative and engaged, answers questions appropriately but avoids eye contact.

Motor activity:
- Pt sits quietly in the chair, responding appropriately to questions, with no signs of agitation or distress.

Thought and speech:
- Pt speaks at a normal rate and volume with clear articulation. His thoughts are logical, coherent, and goal-directed. Pt denies active suicidal ideations; no homicidal ideations. No delusions, obsessions, or paranoia noted.

Mood and affect:
- Pt reports feeling irritated about constant back and forth with insurance company but denies hopelessness. Affect is flat with minimal eye contact.

Perception:
- Pt denies hallucinations or perceptual disturbances.

Orientation:
- Pt is alert and fully oriented to person, place, time, and situation.

Memory:
- Grossly intact; no impairment during interview. Pt is able to recall past events.

Attention:

- Grossly intact; pt is not easily distractible.

Insight and judgement:
- Insight is limited and judgement is impaired regarding severity of suicidal risk. Pt does not think he should have been brought to the hospital.

Assessment

Pt is a 36 YOM with history of bipolar II disorder, depression, anxiety, borderline PD, and prior suicide attempt requiring hospitalization, who was BIBEMS/NYPD for suicidal ideation after making statements involving potential means of self harm. Pt reports stress related to insurance issues and recent attempt of self harm with cutting. Although he denies current SI with intent or plan, he endorses passive SI and is unable to contract for safety. Mental status exam notable for flat affect, limited insight, and impaired judgement. No evidence of psychosis or acute mania/hypomania. Given prior suicide attempt, recent self harm behavior, and inability to contract for safety, pt remains at high risk for self harm and requires psychiatric stabilization.

Differential Diagnoses:

1. Major depressive episode in setting of bipolar II disorder
    A. Patient has a known history of bipolar II disorder and presents with recent suicidal ideation, passive SI, flat affect, impaired judgement regarding suicidal risk, and recent self-harm behavior. Although he denies active depressed mood and hopelessness, his presentation remains concerning for an underlying depressive episode, particularly given his minimization of suicidal statements and prior suicide attempt requiring psychiatric hospitalization. Pt's frustration with his insurance company may represent a precipitating stress event worsening his mood symptoms rather than the primary etiology. There is no evidence of acute mania.
2. Borderline personality disorder with acute suicidal behavior
    A. Patient has a history of borderline personality disorder and presents with previous suicidal statements (and minimization of the seriousness of these statements), recent attempts of cutting, and emotional reactivity to stress. Borderline PD is commonly associated with chronic or recurrent SI, impulsive self harm, and difficulty coping with interpersonal or situational stresses. In this case, pt's inability to contract for safety and statement, "I don't know what I'd do if I'm sent home," raises concern for poor coping skills and increased risk of self harm if discharged. The lack of psychosis, logical thought process, and intact orientation fits better with a personality-related crisis rather than a primary psychotic disorder.
3. Persistent depressive disorder
    A. This should be considered because pt appears to have a chronic underlying mood disturbance rather than an isolated acute episode. He has a history of depression, anxiety, bipolar II disorder, and previous suicide attempt with psychiatric hospitalization, suggesting longstanding emotional dysfunction and persistent depressive symptoms. Further, he presents for recurrent suicidal thoughts and self harm behaviors. Although he denies active depressed mood during the interview, patients with PDD may minimize symptoms or view chronic low mood as their baseline. However, pt's presentation seems to be reactive to psychosocial stressors, particularly frustration with his insurance company, which is more consistent with the presentation seen in borderline PD rather than PDD.
4. Substance/medication induced mood disorder
    A. Although least likely, this should be considered because the pt reports social marijuana and alcohol use every weekend, and substance use can worsen mood symptoms, judgement, and suicidal ideation. Although he denies illicit drug use and there is no clear evidence of intoxication or withdrawal on exam, it is still reasonable to include this until urine tox and labs are obtained. Medication effects should also be considered, as pt is on multiple psych medications including lithium, lamotrigine, fluoxetine, and bupropion. A lithium level is especially appropriate to assess adherence or toxicity, and basic labs can help rule out metabolic contributors.

Plan/Workup

- Will admit to Comprehensive Psychiatric Emergency Program (CPEP) for further psychiatric observation and stabilization due to passive suicidal ideation; pt may be an acute threat to self and/or others if discharged at this time. He is in need of further psychiatric observation and stabilization with reevaluation in the morning.
- Collateral contact (mom) was already contacted for evaluation of baseline functioning and additional history.
- Will restart home medications, including Wellbutrin 300 mg, Lithium 600 mg in the morning and 600 mg at night, Lamotrigine 225 mg, Fluoxetine 20 mg, and Amiloride 5 mg. Will consider stat medications for stabilization
- Will obtain urine tox to evaluate if this is a drug induced presentation
- Will obtain labs including CBC with differential, CMP, hemoglobin A1C, lithium level, and POC glucose to medically clear pt, evaluate for metabolic or hematologic abnormalities contributing to psychiatric symptoms, assess renal function and therapeutic lithium levels, and monitor glycemic control and acute glucose abnormalities.

Patient safety:
Prior to discharge, will inform patient to call 911 if feelings of self harm arises, and to call his mother and use deep breathing/calming exercises if feeling anxious. Will stress the importance of medication adherence and diabetes control. Will advise pt to follow up with his PCP for sleep apnea, and to continue attending his regularly scheduled appointments with therapist and psychiatrist.