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

Chief complaint: “I emailed my teacher that I was having suicidal thoughts.”

HPI: Pt is a 16 year old African American female, high school student, domiciled with family, with reported past psychiatric history of major depressive disorder, who initially presented to pediatric ER, BIBEMS/NYPD for suicidal ideations. Per initial triage report, pt allegedly emailed her school staff that she was going to run away from home and end her life.

Pt reports a fight at school last week with a girl that she used to date romantically. The altercation was broken up by the dean of the school and led to her suspension. The next day she emailed a trusted teacher who she has opened up to about her past mental health struggles, saying "sorry I can't go on.” The pt's uncle confronted her about it and accused her of sending the email for attention. This caused patient to walk out from home. She wandered to different places until she reached Queens Hospital. She said she came into the hospital because she used to visit a counselor here, and requested to speak with her upon arrival; staff informed her that who she was looking for does not work there.

Pt endorses previous suicidal attempt two years ago, when she tried to overdose on Ibuprofen, which led to her hospitalization (she is unsure how long she was hospitalized for). She saw a therapist after the incident and claimed that it helped however, was not able to continue with the counseling because no one was able to take her to the appointments. Pt struggles with depression and copes by cutting her wrists which she claims provides relief. She denies being on any medication. Pt expresses a strong desire to talk to someone about her mental health struggles. She says that her family makes her feel "different" and "crazy" and claims that her mother also struggles with depression. Pt states she sent that email to her teacher as a “cry for help” because she “just wants someone to acknowledge that I am struggling.” Pt denies active SI, HI, hallucinations, or delusions.

Pt is domiciled in a multifamily unit. In her direct unit she lives with her mother and sister, upstairs is her maternal uncle and grandma, and in the basement lives her paternal uncle and grandma. She admits to a history of marijuana and nicotine use.

Collateral information from mother was obtained. She shared that the patient has suffered from depression for 2-3 years but is not currently seeing a psychiatrist. She also confirms prior suicide attempt 2 years ago. Mom declines to answer any more questions.

Past Medical History
- None

Psychiatric History
- Major depressive disorder
- Inpatient psychiatric hospitalization secondary to suicide attempt in 2024

Past Surgical History
- None

Immunizations:
- Pfizer COVID vaccine (3) in 2025
- Influenza vaccine yearly, last in 2025

Medications

- None

Allergies
No known drug, food, or environmental allergies

Family History
- Mother alive; history of depression
- Father alive, no psychiatric history
- Sister alive (15), no psychiatric history

Social History
Habits: endorses daily marijuana use and nicotine via vape; denies alcohol or other illicit drug use.
Diet: endorses healthy diet.
Occupation: does not work; goes to school.
Exercise: does not exercise.
Travel: no recent travel.
Sleep habits: endorses 6-7 hours of sleep per night.
Marital status/living situation: not married; lives with family.

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: multiple scars noted on bilateral wrists; denies rash, itching, excessive sweating or dry skin
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: endorses depressed mood; denies current suicidal ideations, homicidal ideations, auditory or visual hallucinations, delusions, or paranoia

Physical Exam
General: 16 year old female, well developed, well nourished and well groomed. Pt appears stated age and is tearful during the interview.

Vital Signs:
Blood pressure: 101/69 mmHg
Respiratory rate: 18 breaths per minute, unlabored
Pulse: 70 BPM, regular rate and rhythm
Temperature: 98.1 F
SpO2: 100% on RA
Height: 5 feet 5 inches
Weight: 126 pounds
BMI: 20.97

Skin: about 8-10 scars on each bilateral wrists, 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 and maintains eye contact throughout the conversation; speech with normal rate, rhythm, and volume. Mood is sad and affect is tearful. Thought process and content is logical. No overt hallucinations noted. Poor insight and judgement.

Mental status exam:
Appearance and attitude:
- Pt is a 16 year old AA female who is well groomed and appears stated age. Pt is tearful during the interview. She is cooperative and engaged, answers questions appropriately and maintains eye contact.

Motor activity:
- Pt sits quietly in the stretcher, 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. Her thoughts are logical, coherent, and goal-directed. Pt denies active suicidal ideations; no homicidal ideations. No delusions, obsessions, or paranoia noted.

Mood and affect:
- Mood appears sad and affect is tearful.

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 fair given pt acknowledges her depression and expresses desire for psychiatric treatment. Judgement is limited given the suicidal statements sent to staff and impulsive decision to leave home.

Assessment

Pt is a 16 YOF with PPHx of MDD and prior suicide attempt who presented after sending suicidal statements to school staff in the setting of worsening depression and recent interpersonal stressors. Pt endorses ongoing self-harm behaviors through cutting and depressed mood, though currently denies active SI/HI, hallucinations, or delusions. Presentation is concerning for acute worsening of depressive symptoms with impaired coping mechanisms and poor outpatient psychiatric follow up.

Differential Diagnoses:

1. Worsening major depressive disorder
    A. This is the strongest diagnosis given the pt's known history of major depressive disorder, depressed mood, prior suicide attempt, and ongoing self-harm behavior through cutting. Pt's symptoms appear to have acutely worsened after recent psychosocial stressors, including a fight with an ex-girlfriend, suspension from school, and feeling invalidated by her family. She is tearful during the interview and admits to feeling depressed. Further, pt is not seeing a

therapist or psychiatrist for her depression, as she has no way of making her appointments; pt is also not on any medications. Although she currently denies active SI, her email sent to the school stating “sorry I can’t go on” and then later admitting that it was a cry for help, indicates that her depressive symptoms are severe enough to impair coping mechanisms and raises concern for ongoing suicide risk despite current denial.

2. Persistent depressive disorder
    A. This should be considered given that patient and collateral from mother describe depression lasting approximately 2 years, suggesting a chronic depressive pattern rather than only a brief acute episode. Pt’s longstanding emotional distress, prior suicide attempt in 2024, repeated cutting behavior, and lack of consistent outpatient therapy support a persistent mood disorder. However, PDD alone may not fully explain the acute suicidal statements, so it may coexist with or be complicated by a major depressive episode.
3. Adjustment disorder with depressed mood
    A. Adjustment disorder should be considered because pt’s acute presentation is closely tied to identifiable stressors including the school fight, suspension, conflict with her uncle, and feeling unsupported by her family. After these events, pt sent a concerning email to her teacher and left home, suggesting emotional distress in response to recent life stress. Adjustment disorder is less likely as the primary diagnosis because she has a longer history of depression, prior suicide attempt, and self harm behaviors, which point to an underlying mood disorder rather than purely a situational reaction.
4. Cannabis use disorder contributing to mood disorder
    A. Pt endorses daily marijuana use, which can worsen depressive symptoms and impair coping skills. In adolescents, frequent cannabis use can also contribute to mood instability and poorer psychiatric outcomes. However, this is least likely because cannabis use disorder would not fully explain the chronic depression, prior suicide attempt, or self-harm behavior, therefore it is better understood as a contributing factor that may worsen her underlying depressive disorder.

Plan/Workup

Plan while in hospital:

- Labs including CBC, CMP, TSH, urine toxicology and urine pregnancy test obtained
- Will monitor vitals
- Patient was transferred from pediatric ED to Emergency Extended Length of Stay (EELOS)
    - Will place on 1:1 observation given recent suicidal statements and history of prior suicide attempt and self harm
    - Suicide precautions in place including removal of harmful objects
    - Patient will require in-patient psychiatric admission, pending bed availability
        - Social work following for placement and disposition planning
- Pt was counseled on marijuana cessation, as cannabis may worsen mood symptoms and emotional regulation.

Plan during inpatient psychiatric unit:

- Daily psychiatric evaluation and reassessment of suicidal ideation
- Consider initiation of antidepressants such as SSRI therapy for depressive symptoms after psychiatric evaluation
- Encourage participation in therapy
    - Upon discharge, will try to set up online therapy sessions so patient is able to make her appointments virtually
    - Potentially initiate family meeting to improve communication and support system
- Develop safety plan prior to discharge