Abigail Chen
Rotation 4 – Psychiatry rotation at Elmhurst hospital
H&P 2
05/18/2026
Source of Referral: Brought in by NYPD
History obtained from: Patient, Chart review
Patient hearing: is not hard of hearing, deaf or mute.
Patient preferred to speak english for this assessment

Chief Complaint: “I came voluntarily to verify that I'm sane"

History of present illness:

AS is a 48-year-old undomiciled female with a past psychiatric history of schizoaffective disorder, bipolar type, and PTSD, with multiple prior CPEP visits and inpatient admissions (including three consecutive admissions since December 2025; most recently at Lincoln Hospital from 4/21/26–4/30/26). . Previously connected to Sun River Health (Inwood, 855-681-8700, provider: Henry Asideu, PNP, therapist: Samaria Harper). Medical history notable for seizures, DM2, OSA, Arthritis and obesity. She has a history of medication nonadherence and was discharged from her last admission without medications due to refusal. On 5/7/26, patient was BIB EMS after presenting to NYPD precinct 155 requesting help and appearing internally preoccupied. In CPEP, she was acutely agitated requiring stat medications and expressed grandiose delusions. She was admitted to AB-11 on 5/8/26 for further stabilization.

On evaluation today, patient was observed pacing, talking to herself, and responding to internal stimuli. She appeared loud, verbally disruptive, and intermittently agitated on the unit; however, on direct approach she became calm, cooperative, and amenable to interview. During interview patient is illogical expressing both grandiose and paranoid statements. She initially stated her “name at birth” was “Victoria Luce De Castillo” and claimed fluency in multiple languages including Japanese, Portuguese, Spanish, and Arabic, reporting employment as a language interpreter for the NYC Board of Elections and previously as a correction officer at Rikers. These statements are inconsistent with chart documentation. She laughed inappropriately, referred to other patients as “foolish entities,” and questioned her documented age, stating she “might be 43 or younger, definitely not 48.” Patient further explains she is currently in the hospital to do a “undercover job” as a correction officer and is not a patient. Speech was pressured and animated with exaggerated gestures and odd vocalizations. She that prior to admission she was walking “100 miles throughout the city” because God needed her to warn others of imminent catastrophic events, including a major earthquake and hurricane. She stated she presented to NYPD because her ex-husband was “coming after her” and came to the hospital to prove to “everyone” that she is sane.

Patient denied homelessness despite chart documentation indicating shelter residence, stating her apartments were “being leased or mortgaged.” She denied prior psychiatric diagnoses and described past hospitalizations as wrongful and endorsed some paranoid statements regarding hospital nurses working against her. She reported medication nonadherence due to belief that medications cause “metabolic syndrome” and states they prevent her from being able to do “her job” on the unit. Pt also described prior

IM medication as “40 mg of poison,” though she endorsed benefit from Thorazine 50 mg nightly for sleep.

She denied SI, HI, and AVH despite observed behavior suggestive of responding to internal stimuli. She denied substance use. Chart review notes a remote suicide attempt by ingestion of prescribed medications and trauma history of childhood sexual abuse. Prior records indicate illness onset in 2005, relative stability while medication adherent, and recurrent decompensations associated with nonadherence. Collateral attempts were unsuccessful.

Past Medical History: (obtained from chart)

- Diabetes mellitus
- Obesity
- Seizure disorder (02/18/2020).
- OSA
- Arthritis

Past Psychiatric History:

- Diagnosis: PTSD (post-traumatic stress disorders: Schizoaffective disorder- Bipolar 1 type, PTSD
- Hospitalizations: Many prior hospitalizations beginning 2006. 3 consecutive hospitalizations since December 2025, most recently Lincoln Hospital from 4/21/26–4/30/26.
- Outpatient treatment: Sunriver Health Inwood provider: Henry Asideu, PNP, therapist: Samaria Harper but states she stopped going.
- Violence/incarceration
- Trauma- endorsed sexual trauma history but did not want to provide detail (related to patients father according to chart)

Past Surgical History

- Denies past surgical history

Immunizations:

- Not reported

Allergies/Reaction:

- Lamotrigine: Anaphylaxis
- Gabapentin: Headache and seizures
- Lithium: Swelling
- Fluphenazine: reaction not reported
- Lomitapide: reaction not reported
- Risperidone And Related: reaction not reported
- Haldol and Depakote: cause hives, and claritin helpse
- Ziprasidone: reaction not reported
- Latex: Rash (Non-Urticarial Bumps)

Current Medications :
(as per chart, pt denies taking any except chlorpromazine prn for sleep)

- Carbamazepine extended-release (Tegretol XR) 200 mg tablet: Administered every 12 hours.
- Chlorpromazine (Thorazine) 50 mg tablet: Administered orally at bedtime.
- Glucagon 1 mg injection: Administered intramuscularly every 15 minutes as required for hypoglycemia.
- Insulin lispro injection: 0 to 5 units administered subcutaneously three times daily with meals.

Family History:

- Unknown. Unable to assess family history of suicide or psychiatric illness

Social History:

- Undomiciled, living "here and there" as per patient and in The stadium women's shelter as per chart.
- Employment status: States "she works for homeland security and department of corrections at elmhurst hospital"
- Education: unclear
- Marital/ Relationship History: Divorced and remarried
- Children: states 11 year old triplets in custody of uncle
- Denies all substance use including cannabis, lsd, cocaine, alcohol, nicotine.

ROS:

- General – Denies fever, chills, weight loss, night sweats, or malaise.
- Head – Denies headache, dizziness, or trauma.
- Neck – Denies localized lumps or stiffness.
- Pulmonary system – Denies shortness of breath at rest or exertion, cough, wheezing or hemoptysis.
- Cardiovascular system – Denies chest pain, palpitations, leg swelling, syncope, or known heart murmur
- Gastrointestinal system – Denies abdominal pain, nausea, vomiting, diarrhea, constipation, change in bowel habit, or blood in the stool.
- Nervous system – Admits to seizures though states she has not had one since September 2019. Complains of "pinched nerve" in lower back causing pain radiating to her knee. Denies weakness, sensory disturbances (numbness, paresthesia, tingling)
- Musculoskeletal- lower back pain and bilateral knee pain from osteoarthritis that improve with Motrin.
- Psychiatric – Denies mania, depression, insomnia, or current hallucinations and delusion

Physical Exam

Vital Signs:

BP	132/82
Pulse	88
Temp	98.5 °F (36.9 °C) (Oral)
Resp	19
Ht	1.64 m (5' 4.57")
Wt	90.3 kg (199 lb)
SpO2	98%

BMI: 33.56 kg/m²
OB Status Unknown
Smoking Status Never
BSA 1.96 m²

General: Well appearing, in no acute distress
Pulmonary: Breathing comfortably on RA
Extremities: all joints with fROM
Neuro: Alert and interactive, gait intact, spontaneous movement in all extremitys
Skin: no visible rash, skin intact

Mental Status Exam
General
1. Appearance – AS is a 48 year old female who appears stated age, dressed in her own lounge wear. Well-nourished and casually groomed, appearing clean and appropriately dressed with red painted toenails.
2. Behavior and psychomotor activity – Patient appears restless and Hypervigilent, and loud throughout the interview and on observation on unit. Psychomotor agitation noted with pacing in hallway .
3. Attitude toward examiner – Generally calm and superficially cooperative and engaged. Avoidant eye contact. sharing most of personal history, concerns and beliefs.

Sensorium and Cognition
1. Alertness and Consciousness – Alert and awake throughout the interview.
2. Orientation – Oriented to person, place, and time.
3. Attention and Concentration – Fair. Able to sustain a meaningful interview and respond appropriately to questions with loose association.
4. Capacity to Read and Write – Not assessed.
5. Thought Process –Tangential with loose associations. Patient statements are illogical and responses are overly detailed with some non-essential information. Able to be redirected. No evidence of flight of ideas.
6. Abstract Thinking – Fair
7. Memory – Patient's remote and recent memory appears normal though not formally assessed
8. Fund of Information and Knowledge – Not assessed

Mood and Affect
1. Mood – "Great"
2. Affect –Full range and labile
3. Appropriateness –Mood and affet wecre consistent with topics discussed. Pt exhibit labile emotions between calm and angry

Motor
1. Speech – Loud and hyperverbal
2. Eye contact – Avoidant.
3. Body Movements – No abnormal movements or tremors during interview. Thought Content and

Perception
1. Suicidality – Denies current suicidal ideations, plan, or intent.
2. Homicidality – Denies current homicidal ideation, plan or intent.
3. Hallucinations – Denies current auditory or visual hallucinations. However seems internally preoocupied
4. Delusions/Paranoia – Delusions elicited: Paranoid, Grandiose
5. Internal preoccupation – Patient denied, however appeared internally pre-occupied

Reasoning and Control
1. Impulse control – Poor
2. Judgement - Impaired
3. Insight – Poor

Assessment:

48-year-old undomiciled female with a chronic psychiatric history of schizoaffective disorder, bipolar type and PTSD, multiple prior psychiatric hospitalizations (including three consecutive admissions since December 2025), and longstanding medication nonadherence, presenting with acute psychiatric decompensation. Current presentation is characterized by prominent manic and psychotic symptoms, including grandiose, religious, and persecutory delusions; pressured and hyperverbal speech; tangential thought process with loose associations; labile affect; hyperactivity; and poor insight and judgment. She denies SI, HI, and AVH, though she appears internally preoccupied and has been observed responding to internal stimuli. Symptoms emerged in the setting of medication refusal following recent discharge.

Given her chronic psychotic illness beginning in 2005, repeated hospitalizations, and documented stability with medication adherence, presentation is most consistent with an acute exacerbation of schizoaffective disorder, bipolar type, likely precipitated by medication nonadherence.

Differential Diagnosis:

1. Schizoaffective disorder, bipolar type – Most likely
Most consistent with patient's longitudinal history of chronic psychotic illness with superimposed mood episodes. She demonstrates clear manic symptoms (elevated mood, pressured speech, hyperactivity, decreased need for sleep) along with persistent psychosis. History of recurrent decompensation in the setting of medication nonadherence further supports this diagnosis.

2. Bipolar I disorder, current episode manic with psychotic features
Considered given prominent manic features and psychosis. However, given her longstanding psychotic history and multiple hospitalizations predating current episode, schizoaffective disorder remains more likely unless psychotic symptoms are confirmed to occur exclusively during mood episodes.

3. Substance-induced psychotic disorder
Less likely as patient denies substance use and there is no clear evidence of intoxication or withdrawal. However, toxicology screening is warranted given acute agitation and severity of presentation.

Plan

Medications

- Continue Chlorpromazine 50 mg PO nightly – for psychosis and sleep (patient reports benefit)
- Restart Carbamazepine XR 200 mg PO BID – mood stabilization (monitor serum levels)
- Insulin lispro sliding scale TID with meals – DM2 management
- Glucagon IM PRN – hypoglycemia protocol
- PRN antipsychotic for acute agitation (avoid documented allergens)

Given significant history of medication refusal and recurrent decompensation with nonadherence:

- Provide structured psychoeducation regarding risks of untreated psychosis and mania
- Assess capacity to refuse medications
- If persistent refusal and continued clinical instability, consider pursuing treatment over objection per hospital protocol
- Evaluate candidacy for long-acting injectable (LAI) antipsychotic if an agent is identified that patient tolerates and is not contraindicated

Avoid due top allergy:

- Lamotrigine (anaphylaxis)
- Lithium (swelling)
- Haloperidol and Valproate (hives)
- Gabapentin (reported seizures/headache)

Psychiatric Management

- Continue inpatient psychiatric admission for stabilization
- Close monitoring of psychosis, mania, agitation, and behavioral dysregulation
- Monitor for emergence of SI/HI given remote overdose attempt
- Encourage participation in group and structured milieu therapy
- Reattempt collateral contact with outpatient providers (Sun River Health), family and shelter staff

Medical Management

- Monitor blood glucose TID AC
- Seizure precautions
- Monitor weight and metabolic parameters
- NSAIDs PRN for osteoarthritis pain

Labs and Diagnostics

- CBC, CMP – baseline and for carbamazepine monitoring
- Carbamazepine level after steady state
- -HbA1c
- Fasting lipid panel
- Urine toxicology screen
- EKG prior to antipsychotic titration

Q15-minute checks

- Monitor for agitation or escalation