Sirat Zafar
Psychiatric Rotation
CPEP-QHC (Jamaica, Queens)
January 31, 2026

Site Evaluation #2: Case 1

Source of Referral:
Source of Referral: Emergency Medical Services (EMS)
History Obtains from: Patient, Chart review, and additional information from friend (collateral)
Patient is hearing, is not hard of hearing, deaf or mute
Patient is English speaking
No interpretation needed, the patient spoke in preferred language.

Chief Complaint: suicidal ideations

History of Present Illnesses:
J.C. is a 20 yo English speaking Asian female, in a relationship, domiciled with family (father and 14 yo brother), unemployed, recently withdrawn from Mount St. Mary's University, with no reported significant PMHx, reported hx of non-suicidal self injurious behavior of cutting and suicidal attempt of ingestion of tylenol x 1 month ago, BIBEMS activated by boyfriend for suicidal ideation. Upon evaluation, the patient is calm, superficially cooperative, with mild bilateral hand tremor, avoidant eye contact, slow and reduced speech, dysphoric mood and constricted affect. Patient reports expressing SI to her boyfriend which prompted him to call 911. She endorses experiencing SI for a long period of time (over the course of the past 8 years). Patient reports a recent increase in the intensity and frequency of suicidal ideations, triggered by intense emotional distress, most recently following an argument with her boyfriend. Patient reports having active SI with vague plans of ingesting medications and drowning in water. Patient admits to suicidal gesture of ingesting 5-6 pills of Tyelenol with intent to end her life. She states she has intense SI when thinking of past trauma from childhood of family scandals and being physically disciplined by grandmother and mother. She endorses hx of self-harm, admitting to cutting arms, over shoulders, and thighs (last episode 2 days ago) with a knife. Today, patient denies active SI with intent/plan. The main protective factor against suicide was responsibility to her family. She denies access to weapons or lethal means.

She endorses dysphoric mood, anhedonia and lack of sleep due to nightmares, poor concentration, poor appetite associated with binge eating, and decreased level of energy throughout the day for the past two weeks. She states having difficulty maintaining stable romantic relationships. Denies hx of psychiatric admissions, taking psychiatric medications, hx of diagnosed mental illness and outpatient counseling. She admits to pertinent family history of brother having ADHD. Admits to alcohol use as a means to sleep better; denies any other substance use.

Past Medical History:
Present Illness- None

Past Surgical History:
Denies surgeries, past injuries, or transfusions.

Medications:
No medications, holistic preps, birth control or vitamins.

Allergies: Denies any food allergies, NKDA, no environmental allergies. No known allergies to anesthesia.

Family History: Mother and father alive; no reported psychiatric history. Brother with ADHD.

Social History: Patient is in a relationship, unemployed female living with father and 14 yo brother in a house. She has no children. Denies tobacco or illicit drug use. Admits to occasional alcohol use, typically 1 drink several nights per week, primarily to aid sleep onset. Reports difficulty falling asleep with frequent nightmares. Endorses disordered eating patterns characterized by binge-eating behavior. Identifies family as primary support system.

Review of Systems:

1. General: **Reports chronic binge-eating behavior.** Denies changes in appetite, fatigue, fevers, chills or night sweats.
2. Skin: Denies changes in texture, excessive dryness, or sweating. No evidence of self-inflicted wounds, intravenous drug use, or skin picking.
3. Head: Denies headache, vertigo, or head trauma.
4. Neck: Denies localized swelling/lumps or stiffness/decreased range of motion.
5. Pulmonary System: Denies cough, dyspnea, wheezing, hemoptysis, cyanosis, or orthopnea.
6. Cardiovascular System: Denies chest pain, palpitations, syncope, feet or ankle edema, and known heart murmur.
7. Gastrointestinal System: Denies abdominal pain, nausea, and vomiting, dysphagia, jaundice.
8. Nervous System: Denies seizures, loss of consciousness, changes in cognition, change in memory, weakness, and sensory disturbances such as numbness, paresis, dysesthesias, and paresthesia.
9. Musculoskeletal system: Denies muscle/joint pain. Denies weakness, swelling, or recent trauma.
10. **Psychiatric**: Admits to insomnia, depressed mood, anhedonia, poor concentration, low energy, poor appetite with binge-eating behavior, nightmares, and chronic suicidal ideation. Admits to prior suicide attempt via Tyelenol ingestion one month ago and recent non-suicidal self-injurious behavior (cutting). Endorses interpersonal instability and emotional distress triggered by relationship conflict. Denies current HI, psychotic symptoms, mania, phobias, memory loss, or disorientation. Today, denies active suicidal intent or plan.

Vital Signs:

- Temperature: 98.5F (Oral)
- Heart Rate: 86
- Respiratory Rate: 18
- Blood pressure: 112/76 mmHg Right Arm (Seated)

- Oxygen Saturation: 96% on room air
- Height: 5’3’’
- Weight: 104 lbs
- BMI: 18.40 kg/m2

Physical Exam:

- General: 20 y/o female who appears his stated age- good posture, in hospital gown. Patient was found sitting in the CPEP hallway, A&O x 4, and in NAD.
- Neurological: A&O ×4. Calm, superficially cooperative. Speech slow, soft, and coherent. Thought process linear and goal-directed. Attention and concentration variable. Memory grossly intact. Mild bilateral hand tremor noted. No focal neurological deficits appreciated. Insight poor; judgment grossly impaired.

MENTAL STATUS EXAM

General

1. **Appearance**: J.C. is a 20 yo Asian female, appears stated age, slender build. She was dressed in a hospital gown and appeared mildly disheveled. Hair is long, straight and slightly unkempt. Grooming and hygiene are fair. Patient endorses recent non-suicidal self-injurious behavior; no acute injuries observed on visible areas. Patient is in no acute distress.
2. **Behavior and Psychomotor Activity:** Behavior is calm with mild psychomotor slowing. No agitation noted. Mild bilateral hand tremor observed.
3. **Attitude Towards Examiner**: Superficially cooperative with avoidant eye contact. Rapport established gradually.

Sensorium and Cognition

1. **Alertness and Consciousness**: Patient was awake, alert, and able to sustain consciousness throughout the interview without fluctuation.
2. **Orientation**: Oriented to person, place, time and situation.
3. **Concentration and Attention**: Attention and concentration were variable and mildly impaired, though sufficient to participate in the interview and provide relevant, goal-directed responses.
4. **Capacity to Read and Write**: Patient had fair reading ability.
5. **Abstract Thinking**: Patient was able to understand abstract concepts.
6. **Memory**: Immediate, recent, and remote memory grossly intact.
7. **Fund of Information and Knowledge:** Fund of knowledge appeared appropriate for age, education and occupational background.

Mood and Affect

1. **Mood**: J.C. described her mood as “depressed and anxious” which she attributes to ongoing interpersonal stressors and recent interpersonal conflict with her boyfriend.
2. **Affect**: Anxious, constricted and congruent with stated mood.
3. **Appropriateness**: Mood and affect were appropriate to the content discussed. No emotional lability or inappropriate affect was observed.

Motor

1. **Speech**: Speech is slow and soft with prolonged latency but coherent and goal-directed.
2. **Eye Contact**: Eye contact was avoidant and intermittent.
3. **Body Movements**: No psychomotor abnormalities observed.

Reasoning and Control

1. **Impulse Control**: Impulse control appeared impaired in the context of recent self-injurious behavior and maladaptive coping strategies.
2. **Judgment**: Judgment was grossly impaired, particularly related to recent behaviors of suicide attempt x 1 month ago.
3. **Insight**: Insight into her psychiatric symptoms and maladaptive coping behaviors is limited and grossly impaired.

Assessment: J.C. is a 20 yo Asian female with no prior psychiatric treatment, BIBEMS activated by her boyfriend for suicidal ideations in the setting of chronic mood symptoms, history of trauma, and recent interpersonal conflict. She reports a long-standing history of suicidal ideation with recent escalation in intensity and frequency, including a recent suicidal gesture involving acetaminophen ingestion and ongoing non-suicidal self-injurious behavior (cutting via knife). Although she currently denies active suicidal intent or plan, she endorses persistent depressive and anxiety symptoms, impaired impulse control, limited insight, maladaptive coping strategies (including alcohol use for sleep), and emotional blunting. Psychosocial stressors include childhood trauma, unstable interpersonal relationships, unemployment, and recent withdrawal from college, and lack of daily routine. Given the long-term suicidal ideations, recent self-harm behaviors, impaired coping skills and limited protective factors, she remains at elevated risk for self-harm and will benefit from continued observation, stabilization, and medical management in CPEP.

Differential Diagnosis:

1. Major Depressive Disorder – Considered given chronic depressed mood, anhedonia, sleep disturbance, low energy, impaired concentration, suicidal ideation, lack of appetite, and functional impairment x 8 years.
2. Borderline Personality Disorder – Considered due to chronic suicidal ideation, non-suicidal self-injurious behavior, emotional dysregulation, and interpersonal instability; however, insufficient longitudinal data to confirm diagnosis, must be monitored.
3. Post-Traumatic Stress Disorder – History of childhood trauma with associated nightmares, emotional blunting, dysphoria, and affective blunting raises concern for trauma-related pathology.

Plan:

- Place on **NY Mental Hygiene Law 9.40** for emergency psychiatric evaluation due to suicidal statements made in the setting of worsening depressive symptoms and psychosocial stressors.
- **Maintain on q15-minute safety checks** in CPEP for safety and unpredictable behavior.
- Consider **basic labs (CBC, CMP)** if clinically indicated. **Urine pregnancy test** ordered prior to medication prescription.
- **SAFE-T** suicide risk assessment *(Moderate suicide risk)*

- Obtain **urine toxicology screening** to assess substance use, **serum acetaminophen level** and **salicylate levels** to assess for co-ingestion and obtain **serum ethanol level** to assess for alcohol.
- Initiate **Mirtazapine 15 mg PO QHS** for depressive symptoms and sleep disturbance; patient counseled on sedation and potential weight gain, which she reports is not a current concern
- **Means restriction counseling** provided; patient denies access to firearms or other lethal means.
- Discuss higher levels of care, including **AOPD**; (Patient declined due to plans to relocate to Maryland.)
- Patient expresses preference for **outpatient psychotherapy** and agrees to pursue outpatient mental health follow-up after discharge.
- **Future-oriented goals** discussed, including returning to and completing college, relocating to Maryland, and obtaining employment (similar to previous employment at Bubble tea shop as barista) prior to resuming school.
- Encourage **family involvement** as appropriate to support outpatient follow-up and safety planning.