Sirat Zafar
Psychiatric Rotation
CPEP-QHC (Jamaica, Queens)
January 15, 2026

Site Evaluation #1

Source of Referral:
Source of Referral: Emergency Medical Services (EMS)
History Obtains from: Patient, Chart review, and additional information from family (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 and acute alcohol intoxication

History of Present Illnesses:
J.S. is a 22 yo Guyanese male, single, housed with roommate in brooklyn, employed as an HVAC technician, with a significant past medical history of ADHD and hx of alcohol use, brought in by EMS (BIBEMS)/NYPD (not arrested) activated by mother for acute alcohol intoxication and suicidal ideations (SI) with no intent/plan. Blood alcohol level is 387 mg/dL upon arrival. The patient was reevaluated the following morning after becoming clinically sober. Patient states that he was heavily drinking with friends and came home to his mother's house last night. He does not recall making statements that he wants to harm himself. Denies current or ongoing SI, homicidal ideations, or auditory/visual hallucinations. Patient admits to daily alcohol use and denies any illicit drug use or past psychiatric hospitalizations. Spoke to V (Aunt) who states the patient has chronic alcohol abuse and has had similar episodes of heavy drinking with agitation in the past. She states witnessing grandmother's traumatic death in 2022 has affected the patient negatively, and he has "not been the same since." Endorses significant psychiatric family history of uncle having schizophrenia and bipolar disease and mother's cousin having schizophrenia. Spoke to S (Mother) for additional information. Mother states that patient has expressed suicidal ideations with no intent/plan. Patient was taking Ritalin and Adderall for ADHD but has stopped since junior high school due to side effects. Mother reports patient complains of trouble sleeping, with "constant thoughts rushing through his mind", using alcohol as a means to fall asleep and "calm his mind." She also reports intermittent marijuana use, which the patient did not clearly endorse during evaluation. Patient denies paranoia, history of suicide attempts, tremors, diaphoresis, nausea, or vomiting.

Past Medical History:
Present Illness- Attention-Deficit/Hyperactivity Disorder (ADHD), Alcohol use disorder (history of heavy alcohol use)

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

Medications:
Thiamine 100 mg PO QD, last dose yesterday (hospital administered)
Folic acid 1 mg PO QD, last dose yesterday (hospital administered)
Multivitamin 1tab PO QD, last dose yesterday (hospital administered)
Nicotine Polacrilex 2 mg PO PRN, last dose yesterday (hospital administered)

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

Family History: Mother alive, no psychiatric history. Father status unknown. Mothers brother has schizophrenia and bipolar disease. Mothers cousin has schizophrenia.

Social History: Patient is a single, unemployed male living with a roommate in an apartment in Brooklyn. He has no children and is employed as an HVAC technician. Denies tobacco or illicit drug use and admits to daily alcohol use. He reports drinking half a pint of alcohol 3-4x per week for the past few months. Reports poor sleep with difficulty falling asleep and uses alcohol to aid sleep.

Review of Systems:

1. General: 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**: Endorses a first-time alcohol-related blackout; denies prior episodes of memory loss. Admits to insomnia. Denies nervousness, depression, phobia, mania, disorientation, past suicide attempts, homicidal behaviors, and active plan.

Vital Signs:

- Temperature: 98.3F (Oral)
- Heart Rate: 71
- Respiratory Rate: 18
- Blood pressure: 109/69 mmHg Right Arm (Seated)
- Oxygen Saturation: 100% on room air
- Height: 5’3”
- Weight: 135 lbs
- BMI: 23.91 kg/m2

Physical Exam:

- General: 22 y/o male who appears his stated age- good posture, in hospital gown. Patient was found sitting in CPEP eating breakfast, A&O x 4, and in NAD.
- Neurological: A&O x4, cooperative, thoughts & speech coherent. Conversation progresses logically. Attention variable. Memory acutely impaired in the setting of recent heavy alcohol use. Insight poor; judgement grossly impaired.

MENTAL STATUS EXAM

General

1. **Appearance**: J.S. is a 22 yo Guyanese male of short stature and average build, appearing his stated age. He was dressed in a hospital gown and appeared mildly disheveled. Hygiene was fair. Hair was short and slightly unkempt. No visible scars, track marks, or signs of self-injurious behavior were observed. Physical appearance was consistent with recent alcohol intoxication without acute medical distress.
2. **Behavior and Psychomotor Activity:** Behavior was calm with mild irritability and anxiety noted. Psychomotor activity was within normal limits. No agitation, retardation, tremors, or abnormal movements observed.
3. **Attitude Towards Examiner**: Patient was cooperative with the examiner and engaged appropriately. Rapport was established easily.

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 was variable but 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**: Recent memory was acutely impaired in the context of recent heavy alcohol use; remote memory appeared 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.S. described his mood as “okay” and stated that he felt ready to return to work. He attributed the current presentation to an alcohol-related blackout and reported that this had not occurred previously.
2. **Affect**: 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**: Coherent and fluent with slightly increased rate, easily interruptible; normal volume and tone.
2. **Eye Contact**: Eye contact was intermittent but appropriate.
3. **Body Movements**: No psychomotor abnormalities observed.

Reasoning and Control

1. **Impulse Control**: Impulse control appeared impaired in the context of alcohol use.
2. **Judgment**: Judgment was grossly impaired, particularly related to substance use and recent behaviors.
3. **Insight**: Insight into substance use and its consequences was limited and grossly impaired.

Assessment: J.S. is a 22-year-old Guyanese male with a history of ADHD and chronic alcohol use, BIBEMS/NYPD activated by mother for suicidal ideations and acute alcohol intoxication (BAL 387 mg/dL). Following clinical sobriety, he denied current suicidal or homicidal ideation, intent, or plan and attributed the incident to an alcohol-related blackout. Urine toxicology was positive for cannabis, indicating concurrent substance use. Psychosocial stressors include the traumatic death of his grandmother, who served as his primary caretaker. Although he denies current suicidal ideation, the severity of intoxication, amnestic episode, ongoing substance use, limited insight, and collateral concerns suggest continued risk to self, and further evaluation and support in CPEP are warranted.

Differential Diagnosis:

1. Alcohol use with Alcohol-Induced Mood Disorder (with depressive features) – Suicidal statements occured during acute intoxication (BAL 387 mg/dL) and resolved with sobriety, with ongoing daily alcohol use and blackout history.
2. Substance use disorder (Alcohol and Cannabis) – History of daily alcohol use with urine toxicology positive for marijuana and collateral support of ongoing substance use
3. Adjustment disorder with depressed mood – Emotional distress related to a significant psychosocial stressor (witnessing grandmother's traumatic death, who was his primary caretaker)
4. Major Depressive Disorder – Considered given reported suicidal statements and psychosocial stressors, though current presentation lacks persistent depressive symptoms and SI resolved with sobriety.

Plan:

- Place on **NY Mental Hygiene Law 9.40** for emergency psychiatric evaluation due to suicidal statements made in the setting of acute alcohol intoxication.
- **Maintain on q15-minute safety checks** in CPEP for safety and unpredictable behavior.
- **SAFE-T** suicide risk assessment *(Moderate suicide risk)*
- Obtain **urine toxicology screening** to confirm substance use *(positive for THC)*
- **CIWA-Ar assessment** performed to evaluate for alcohol withdrawal, *with a score of 0 indicating no current withdrawal symptoms*
- Initiate **Bupropion HCl 150 mg PO QD** for mood symptoms. Discuss risks, benefits, and seizure risk in the context of ongoing alcohol use with patient.
- **Nicotine polacrilex 2 mg PO PRN** provided for nicotine cravings during CPEP stay

- **Thiamine, folic acid, and multivitamin administered** for alcohol-related nutritional support and deficiency prevention
- **Motivational interviewing** used to explore substance use patterns, increase insight, and assess readiness for change
- Substance use counseling: **CAGE screening and harm-reduction strategies**
- Discussing and scheduling outpatient treatment options, including **QHCD and AOPD programs**
- **Continued evaluation and support in CPEP to complete risk assessment and ensure safe disposition**
- **Family meeting** to engage family in treatment planning and reinforce medication adherence
- Consider basic labs (CBC, CMP) if clinically indicated to evaluate for alcohol-related metabolic abnormalities