fAisef Ahmed
Rotation 5 – Psychiatry rotation
H&P 1
06/12/2026

Location: Elmhurst Hospital
Religion: Islam
Source of Information: patient and Family: sister
History obtained from: Patient, Chart review, and collateral (sister)
Mode of transport: Brought in by EMS & NYPD
Race: Bengali
Marital status: single
Patient hearing: is not hard of hearing, deaf, or mute.
Patient preferred to speak English for this assessment

Chief complaint: “I am God, and everyone worships me.”

History of present illness:

TA is a 28-year-old domiciled male with a past psychiatric history of Type 1 bipolar disorder with psychotic features, and cannabis use disorder with multiple inpatient psychiatric admissions in the past, first hospitalization in 2018, and his most current hospitalization was at Elmhurst Hospital Center from 10/14/2025 - 10/25/2025 following post manic episodes with multiple prior CPEP visits in the past. Patients sister activated 911 for the Patient because he was becoming verbally and physically aggressive at home with his sibling and parents. As per the sister patient stated he is a god and everyone is serving him. The patient was brought in by EMS and NYPD and was in physical restraint however, he was not under arrest. During the course of CPEP, the patient was acutely agitated and physically aggressive with other patients and staff, requiring multiple stat IM medications. He was admitted to AB-11 on 6/08/2026 for involuntary admission to the inpatient psychiatry unit.

Additional information was obtained, and the patient provided consent for contact with the collateral (Sister). As per the sister patient was previously calm and cooperative prior to today. Patient regularly follows up at Elmhurst Outpatient Psychiatry Clinic. However, over the last 2 weeks, the patient has become agitated and irritable towards family and fiancée. According to the sister, the patient appeared disorganized in his speech, saying, “I am God, and everyone worships me.” The patient was becoming more grandiose in his statements, believing that television broadcasts contained messages specifically directed toward him.

The patient had previously been stabilized on lithium and olanzapine. During outpatient follow-up, lithium was being tapered due to dermatologic side effects, and paliperidone palmitate (Invega Sustenna) was initiated. Family reports worsening symptoms during this medication transition. He received the first long-acting injectable on 4/26/2026 and his second dose on 5/28/2026. Patient was stabilized well with Invega monotherapy in the past

Patient was found in the hallway arguing with staff regarding his medications, stating “DO NOT GIVE ME HALDOL I WILL DIE” and proceeded to harass staff members and make sexual remarks towards them. The patient was able to be redirected during the interview. When encountering the patient, he was initially calm and cooperative with the writer. Patient expressed he was upset with the staff since they were trying to poison him with Haldol and stated that he is a king and you all work for me. He claims that he wants to learn all about psychiatry and become a psychiatrist because he is the smartest being in the world. Patient is currently unemployed; however, they will soon work in finance and make billions and billions of dollars. Patient further explained that he doesn't need medications, feels amazing without them, and can unlock his third eye to have the spirits of Donald Trump and Elon Musk manifest in him.

Patient acknowledged his previous psychiatric diagnoses in the past and is aware of his prior hospitalizations, where the hospital gave him medications to gain weight and treat acne. Patient stated that the medication Haldol is harmful to him, which will kill him immediately, and would rather take Ativan 5 mg when he feels anxious.

Patient denies any active suicidal ideations, denies any homicidal ideations; however, would verbally threaten staff and other patients but denies intent or plan to execute. Denies any auditory, visual, and tactile hallucinations. Patient denies any current chest pain, shortness of breath, headache/dizziness/lightheadedness. No signs of EPS/tremors/akathisia reported or observed

Past Medical History
- Excezma
- Nodularcystic acne

Past psychiatric history
- Type 1 bipolar disorder
- Cannabis abuse disorder

Allergies
- No known allergies

Current medications
- benzoyl peroxide (BENZAGEL) 10 % gel Topical
- haloperidol (HALDOL) tablet 5 mg every 6 hours PRN
- Lithium capsule 600 mg twice a day
- LORazepam (ATIVAN) tablet 2 mg every 6 hours PRN
- nicotine (NICORETTE) gum 2 mg Mouth/Throat
- OLANZapine (ZyPREXA ZYDIS) 10 mg Sublingual Nightly
- OLANZapine (ZyPREXA ZYDIS) 5 mg Sublingual once daily

Family History:

- Notable for psychiatric illness on the maternal side.

- Maternal uncle carries a diagnosis of Bipolar Disorder and has a history of psychiatric hospitalization for manic episodes.
- Family denies a known history of schizophrenia, schizoaffective disorder, or completed suicide.
- The maternal cousin has a history of substance use disorder.
- Family medical history is significant for hypertension, type 2 diabetes mellitus, hyperlipidemia, and coronary artery disease
- Information was obtained from the collateral

Social History:

- Domiciled, living with family (parents and sister) in a private residence.
- Currently unemployed.
- Education: High school graduate; attended college briefly but did not complete a degree.
- Relationship history: Engaged and maintains regular contact with fiancée.
- Smokes cigarettes daily and uses cannabis products. Unable to quantify the number of cigarettes per day.
- Denies any alcohol use
- Denies current legal involvement.

Review of System:

Based on the history provided for TA, a ROS consistent with the interview would be: dermatology and psychiatry ROS +

ROS:

General – Denies fever, chills, weight loss, night sweats, fatigue, or malaise.

Head – Denies headache, dizziness, lightheadedness, or recent head trauma.

Neck – Denies neck pain, stiffness, or localized masses.

Pulmonary System – Denies shortness of breath, cough, wheezing, or hemoptysis.

Cardiovascular System – Denies chest pain, palpitations, syncope, leg swelling, or known heart disease.

Gastrointestinal System – Denies abdominal pain, nausea, vomiting, diarrhea, constipation, change in bowel habits, or blood in stool.

Genitourinary System – Denies dysuria, urinary frequency, urgency, hematuria, or incontinence.

Neurological System – Denies weakness, numbness, paresthesias, tremors, seizures, headaches, or loss of consciousness.

Musculoskeletal System – Denies muscle pain, joint pain, joint swelling, stiffness, or gait disturbances.

Dermatological System – Reports history of eczema and nodulocystic acne. Has visible nodular cystic acne along his face. Denies current rash, pruritus, or skin infections.

Psychiatric – Admits to elevated mood, decreased need for treatment, grandiose beliefs, and paranoid thoughts. Denies suicidal ideation, homicidal ideation, auditory hallucinations, visual hallucinations, and tactile hallucinations. Demonstrates poor insight into psychiatric illness.

Vital Signs: BP 123/70, Pulse 84, Temp 98 °F (Oral), Resp 18, Ht 1.803 m (5' 11"), SpO2 98%, BMI 27.14 kg/m², Wt 194lbs

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 extremities
Skin: no visible rash, multiple nodular cystic acne present along the face, remainder of skin intact,

Mental Status Exam:

General:

1. Appearance – TA is a 28-year-old male who appears to be of stated age, dressed appropriately in hospital attire. Well-nourished with fair grooming and hygiene.
2. Behavior and Psychomotor Activity – Patient appears restless, intrusive, and intermittently agitated throughout the interview and while observed on the unit. Frequently observed arguing with staff and making inappropriate comments. Increased psychomotor activity noted.
3. Attitude Toward Examiner – Initially calm, cooperative, and engaged with the interview. Readily shared personal history, beliefs, and future plans. Became argumentative when discussing medications and hospitalization.

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, though frequently redirected due to grandiose and paranoid thought content.
4. Capacity to Read and Write – Not assessed.
5. Thought Process – tangential with loose associations. Patient statements are illogical and overly detailed with grandiose themes. 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 formally assessed.

Mood and Affect

1. Mood – "Amazing."
2. Affect – Expansive and labile.
3. Appropriateness – Mood and affect were generally consistent with the topics discussed. The patient exhibited emotional lability with periods of irritability and agitation.

Motor

1. Speech – Loud, pressured, and hyperverbal.
2. Eye Contact – Intense and sustained.
3. Body Movements – Increased motor activity noted. No abnormal movements, tremors, EPS, or akathisia were observed during the interview.

Thought Content and Perception

1. Suicidality – Denies current suicidal ideation, plan, or intent.
2. Homicidality – Denies current homicidal ideation, plan, or intent. However, the patient has made verbal threats toward staff and peers while hospitalized.
3. Hallucinations – Denies current auditory, visual, or tactile hallucinations.
4. Delusions/Paranoia – Delusions elicited: Grandiose and paranoid. Patient states that he is God, a king, and the smartest being in the world. Reports that the staff is attempting to poison him with medications.
5. Internal Preoccupation – Patient denied internal preoccupation. No overt evidence of responding to internal stimuli was noted during the interview.

Reasoning and Control

1. Impulse Control – Poor.
2. Judgment – Impaired.
3. Insight – Poor. Patient demonstrates limited insight into his psychiatric illness and the need for treatment.

Assessment:

28-year-old domiciled Bengali male with a past psychiatric history of Bipolar I Disorder with psychotic features and Cannabis Use Disorder, multiple prior psychiatric hospitalizations, prior CPEP visits, and a history of medication nonadherence, presenting with acute psychiatric decompensation. Current presentation is characterized by prominent manic and psychotic symptoms, including grandiose and paranoid delusions, pressured and hyperverbal speech, tangential thought process with loose associations, expansive and labile affect, increased psychomotor activity, poor impulse control, and impaired insight and judgment. The patient endorses beliefs that he is God, a king, and the smartest being in the world, and expresses paranoid beliefs that hospital staff is attempting to poison him with medications. He denies suicidal ideation, homicidal ideation, and auditory or visual hallucinations, although he has demonstrated verbal aggression toward staff and peers and required emergency IM medications for agitation during this admission.

Collateral information from the patient's sister indicates a two-week period of worsening irritability, agitation, grandiosity, disorganized behavior, and psychotic symptoms preceding hospitalization. Symptoms developed despite ongoing outpatient psychiatric follow-up and occurred in the setting of recent medication changes, including the tapering of lithium and the transition to long-acting injectable paliperidone. Given his documented history of Bipolar I Disorder with psychotic features, prior psychiatric admissions, previous stabilization with mood stabilizers and antipsychotic treatment, and current presentation of mania with psychosis, the presentation is most consistent with an acute manic episode with psychotic features secondary to Bipolar I Disorder, likely precipitated by medication nonadherence and/or insufficient therapeutic response during the recent medication transition.

The patient currently demonstrates poor insight and limited capacity to make informed decisions regarding psychiatric treatment due to active grandiose and paranoid delusions, inability to appreciate the severity of his psychiatric illness, and refusal of recommended pharmacologic treatment. Continued inpatient psychiatric hospitalization remains necessary for stabilization, medication management, and reduction of risk to self and others.

Differential Diagnosis:

1. Bipolar I Disorder, current episode manic with psychotic features – Most likely
   Most consistent with the patient's established psychiatric history of Bipolar I Disorder with psychotic features and current presentation. He demonstrates classic manic symptoms including elevated mood, grandiosity, hyperverbal and pressured speech, increased psychomotor activity, irritability, poor judgment, and impaired insight. Psychotic symptoms are present in the form of grandiose and paranoid delusions. Collateral information describes a progressive two-week period of worsening mania and psychosis, consistent with an acute manic episode.

2. Schizoaffective Disorder, bipolar type
   Considered due to the presence of both mood symptoms and psychotic symptoms. The patient exhibits significant grandiose and paranoid delusions alongside manic features. However, there is insufficient evidence that psychotic symptoms occur independently of mood episodes. His documented psychiatric history and prior diagnoses support Bipolar I Disorder with psychotic features rather than a primary psychotic disorder.

3. Substance-Induced Bipolar and Related Disorder (Cannabis-Induced Psychosis/Mania)
   Considered given the patient's history of Cannabis Use Disorder. Cannabis use can precipitate or worsen manic and psychotic symptoms, particularly in individuals with underlying bipolar disorder. Although there is no evidence of acute intoxication during the interview and the patient did not report recent substance use, toxicology screening would be useful to evaluate for a substance-related contribution to the current presentation.

Plan:

Psychiatric Management

- Continue inpatient psychiatric admission for stabilization and medication management.
- Close monitoring of manic symptoms, psychosis, agitation, impulsivity, and behavioral dysregulation.
- Continue Lithium 600 mg PO BID for mood stabilization.
- Continue Olanzapine Zydis 5 mg PO daily and 10 mg PO nightly for management of psychosis and mania.
- Continue Lorazepam 2 mg PO q6h PRN for anxiety or agitation.
- Continue Haloperidol 5 mg PO q6h PRN for severe agitation, psychosis, or behavioral escalation.
- Provide structured psychoeducation regarding Bipolar I Disorder, psychosis, medication adherence, and consequences of untreated illness. Assess insight and capacity regarding treatment decisions as psychosis improves.
- Encourage participation in group therapy, individual therapy, and structured milieu activities.
- Obtain additional collateral information from the sister, family members, and outpatient psychiatry providers at Elmhurst Hospital Center.

Medical Management

- Monitor vital signs daily.
- Monitor hydration, nutritional intake, and sleep patterns.
- Continue benzoyl peroxide topical treatment for acne.
- Monitor eczema and dermatologic symptoms while receiving lithium therapy.
- Encourage smoking cessation and utilize nicotine gum as needed.

Labs and Diagnostics

- CBC, CMP
- Monitor for Lithium level.
- TSH.
- HbA1c.
- Fasting lipid panel.
- Urine toxicology screen to evaluate for recent cannabis or other substance use.
- Monitor renal function and thyroid function while receiving lithium therapy.
- Monitor weight and metabolic parameters while receiving antipsychotic medications.

Safety

- Q15-minute safety checks.
- Monitor for agitation, aggression, sexually inappropriate behavior, and escalation requiring PRN medications.
- Monitor for the emergence of suicidal ideation, homicidal ideation, or worsening psychosis.
- Utilize verbal de-escalation and behavioral interventions when possible prior to medication intervention.

Disposition

- Discharge when manic symptoms, grandiose delusions, paranoia, and behavioral dysregulation have significantly improved.
- Coordinate follow-up with Elmhurst Outpatient Psychiatry Clinic.
- Involve family in discharge planning and medication education.
- Given the history of relapse associated with medication nonadherence, continue evaluation of long-acting injectable antipsychotic treatment and adherence strategies following discharge.