Aisef Ahmed
Rotation 5 – Psychiatry rotation
H&P 3
06/18/2026

Location: Elmhurst Hospital
Religion: Protestant
Source of Information: patient
History obtained from: Patient, Chart review
Mode of transport: Brought in by EMS & NYPD
Race: African American
Marital status: separated
Patient hearing: is not hard of hearing, deaf, or mute.
Patient preferred to speak English for this assessment

Chief complaint: “I’m the savior of Far Rockaway, and I'm the superior being, but people are after me”

History of presenting illness: BB is a 53-year-old undomiciled female with a past psychiatric history of generalized anxiety disorder, schizoaffective disorder, Major depressive disorder, and a past medical history of opiate use disorder. Patient has multiple prior psychiatric admissions to an inpatient psychiatric unit, with her most recent hospitalization at Saint John's Episcopal Hospital from 12/22/2024 to 01/28/2025, with multiple prior CEPEP visits in the past. The patient self-activated 9-1-1 for hearing voices, homicidal ideation, and worsening anxiety. The patient was brought to the hospital by EMS and the NYPD from a friend's house, where she was temporarily staying. During the course of observation at CEPEP. The patient had presented with paranoid delusions and audible hallucinations, where patient would become illogical and irritable when spoken to. The patient was compliant with the prescribed medication of Seroquel. Patient had requested voluntary admission to the unit in order to escape from tormentors from Far Rockaway. No available collateral was listed on admission, and the patient refused for the unit to contact said collateral.

Patient was found in her bed, disheveled in hospital clothes, with poor dentition, and initially appeared calm and superficially cooperative to the writer. She reported being targeted by multiple notable figures, such as Donald Trump, Eric Adam, and associates from the World Resort Casino, such as “Allen Prickler,” who are after her because her mother is an FBI agent and they're trying to get to her mother through her to take her inheritance. Patient referred to herself as “Baby Girl,” asked the writer to refer her to the “superior being,” and said she has “superpowers.” Patient is aware of her previous diagnosis in 2016 for depression and has ever since felt she was being targeted since then. She reports she has cameras in her eyes that the alleged pursuers have implanted in her. Patient reported she was previously hospitalized in 2024 at Saint Episcopal Hospital for a similar episode. Patient described that dealing with these people harassing her has made her feel frustrated with others, she would often mention how “people pretend to not know what I'm talking about” and state “you've heard of me from the radio and television, I'm all over the media”. She expressed how these experiences have often made her feel depressed, for which she was previously prescribed Wellbutrin in the past. Patient was previously taking two dime bags (20 mg total) of heroin and using Xanax (unspecified quantity) every other day. Patient also reports

frequent nicotine and cannabis usage, reporting 1 pack a week since she was 18 years old, and she still currently smokes. Patient states she would socially consume alcohol, but was not able to quantify the amount of liquor regularly consumed weekly. Patient was previously in a methadone program 5 months ago prior to her current admission, stating she used to receive “70 mg” while incarcerated at Rikers Island. However, when she was released, she was unable to connect to the methadone clinic and had received her methadone from the streets, 10 mg. She currently denies any suicidal or homicidal ideations and denies any current auditory, visual, or tactile hallucinations. Patient denies chest pain, SOB, palpitations, anxiety, lightheadedness, weakness, dizziness, N/V/D. No Extra-pryramidal symptoms or akathisia noted or observed.

Past medical history

- Opiate Use Disorder

Past Psychiatric History

- Major depressive Disorder with psychotic features
- Schizoaffective disorder
- Generalized anxiety disorder

Current prescribed medications

- Klonopin (unable to specify dosage and regimen)
- Cogentin (unable to specify dosage and regimen)

Scheduled Medications

- Methadone 20 mg PO daily for opioid use disorder maintenance.
- Quetiapine 200 mg PO daily for psychosis and mood stabilization.
- Quetiapine 200 mg PO nightly for psychosis and mood stabilization.
- Sertraline 25 mg PO daily for depression and anxiety symptoms.
- Sennosides 17.2 mg PO nightly for constipation prophylaxis.

PRN Medications

- Acetaminophen 650 mg PO every 6 hours PRN for mild pain, headache, or fever.
- Aluminum hydroxide/magnesium hydroxide/simethicone 30 mL PO every 6 hours PRN for dyspepsia, heartburn, or indigestion.
- Haloperidol 5 mg PO every 6 hours PRN for severe agitation, psychosis,
- Lorazepam 2 mg PO every 6 hours PRN for anxiety, agitation, or insomnia.
- Nicotine polacrilex gum 2 mg PO every 2 hours PRN for nicotine cravings.
- Polyethylene glycol 17 g PO daily PRN for constipation.

Known allergies

- Denies any allergies

Social history

- 53-year-old separated African American female who is currently unincarcerated and intermittently stays with friends when housing is available. Prior to admission, she was residing temporarily at a friend's home in Far Rockaway. She reports limited social support and declined to provide collateral contacts during this hospitalization. The patient is currently unemployed and receives financial assistance through public benefits. She has a history of incarceration at Rikers Island, where she participated in a methadone maintenance program, receiving methadone 70 mg daily. Following her release, she experienced difficulty reconnecting with outpatient treatment services.

Review of Systems (ROS):

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

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

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

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

Cardiovascular System – Denies chest pain, palpitations, syncope, orthopnea, or lower extremity edema.

Gastrointestinal System – Denies abdominal pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia, or changes in bowel habits.

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

Neurological System – Denies weakness, numbness, paresthesias, tremors, seizures, headaches, or focal neurological deficits.

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

Dermatological System – Denies rashes, pruritus, skin lesions, bruising, or changes in skin, hair, or nails.

Endocrine System – Denies heat or cold intolerance, excessive thirst, excessive hunger, or polyuria.

Hematologic/Lymphatic System – Denies easy bruising, easy bleeding, or lymph node enlargement.

Psychiatric System – Endorses a history of depression, anxiety, auditory hallucinations, paranoid ideation, grandiose delusions, and prior homicidal ideation leading to hospitalization. Currently denies suicidal ideation, homicidal ideation, auditory hallucinations, visual hallucinations, and tactile hallucinations.

Continues to express fixed persecutory and grandiose delusional beliefs, including being targeted by prominent individuals and possessing special powers. Reports frustration and distress related to these beliefs. Insight and judgment remain impaired.

Physical examination

Vital Signs: BP 134/92 mmHg, Pulse 88 bpm, Temperature 98.9 F (oral), Respiratory rate 17 breaths/min Height 1.59 m (5 ft 2.6 in), Weight 75 kg (165 lb 4.8 oz), SpO2 97% on room air, BMI 29.66

General: Disheveled appearing female, intermittently agitated but in no acute medical distress.

HEENT: Moist mucous membranes, pupils equal, round, and reactive to light and accommodation pupils equal, round, and reactive to light, extraocular movements intact without nystagmus, hearing grossly intact, no facial droop, normal palatal and tongue movement, no dysarthria appreciated.

Neck: Full range of motion, no lymphadenopathy or masses appreciated.

Pulmonary: Breathing comfortably on room air

Abdomen: Soft, non-tender, non-distended, no guarding or rebound.

Extremities: Full range of motion in all joints, no deformities or edema noted.

Neurological: Alert and intermittently cooperative, oriented to person, place, and time, gait grossly intact, spontaneous movement of all extremities observed.

Skin: Intact, no rashes, lesions, or bruising noted.

Mental Status Examination:

General

1. Appearance: The patient is a 53-year-old African American female who appears disheveled and older than stated age. Grooming and hygiene are poor. No obvious scars or deformities noted.
2. Behavior and Psychomotor Activity: Behavior was generally within normal limits during the interview, with no overt agitation or psychomotor retardation observed. No abnormal movements or tics were noted.
3. Attitude Towards Examiner: The patient was cooperative with the examiner and able to engage in the interview appropriately, though responses were intermittently guarded when discussing delusional content.

Sensorium and Cognition

1. Alertness and Consciousness: The patient was alert throughout the evaluation and maintained full consciousness during the interview.
2. Orientation: The patient was oriented to person, place, and time.

3. Concentration and Attention: Attention was grossly intact, and the patient responded appropriately to questions. However, thought content intermittently disrupted sustained focus due to grandiose and persecutory ideation.
4. Capacity to Read and Write: Not formally assessed during this encounter.
5. Abstract Thinking: Abstract reasoning was limited, with a tendency toward concrete, illogical interpretations of events, consistent with delusional thinking.
6. Memory: Recent and remote memory appeared grossly intact based on the interview, though not formally tested.
7. Fund of Information and Knowledge: Estimated average based on conversational interaction and responses.

Mood and Affect

1. Mood: The patient reports feeling anxious and irritable.
2. Affect: Affect is appropriate but mildly constricted and intermittently reactive to the content discussed.
3. Appropriateness: Mood and affect were generally congruent with the interview content, though emotional tone was influenced by underlying paranoid and grandiose thought processes.

Motor

1. Speech: Speech is pressured but coherent and generally goal-directed.
2. Eye Contact: Eye contact was appropriate and sustained throughout the interview.
3. Body Movements: No tremors, tics, or abnormal involuntary movements noted. Psychomotor activity was within normal limits.

Reasoning and Control

1. Impulse Control: Impulse control appears intact during the interview; no aggressive or self-injurious behaviors observed.
2. Judgment: Judgment is impaired in the context of ongoing psychotic symptoms and fixed delusional beliefs.
3. Insight: Insight is severely limited; the patient demonstrates poor understanding of her psychiatric condition and need for ongoing treatment.

Assessment

BB is a 53-year-old undomiciled African American female with a past psychiatric history significant for schizoaffective disorder, Major Depressive Disorder, and generalized anxiety disorder, as well as a history of opioid use disorder with an 11-pack-year history of nicotine, who presents to Elmhurst Hospital via EMS and NYPD after self-activating 911 due to worsening paranoia, auditory hallucinations, homicidal ideation, and escalating anxiety. On evaluation, the patient demonstrates a chronic, severe, and recurrent psychotic illness characterized by prominent persecutory and grandiose delusions, ideas of reference, and disorganized thought content, including fixed beliefs that she is being targeted by public figures and possesses special powers. Although she currently denies suicidal or homicidal ideation and denies active

hallucinations, her history and collateral hospital records indicate recurrent episodes of psychosis with similar symptomatology and prior psychiatric hospitalizations, most recently in 2024.

The patient's presentation is most consistent with an acute exacerbation of schizoaffective disorder, likely bipolar type, in the context of medication nonadherence and significant psychosocial stressors, including chronic homelessness, limited social support, unemployment, and substance use history. Her condition is further complicated by a history of opioid use disorder with prior heroin and benzodiazepine misuse, as well as intermittent cannabis and nicotine use, which may contribute to mood instability and impaired judgment. Current mental status examination reveals pressured speech, anxious and irritable mood, illogical thought processes, and severely impaired insight with poor judgment.

Given the severity of her psychotic symptoms, poor insight, and inability to reliably distinguish delusional content from reality, the patient remains at high risk for functional decompensation in the community. While no acute safety concerns are expressed at this time, her history of homicidal ideation, recurrent psychotic episodes, and impaired judgment necessitate continued inpatient psychiatric hospitalization for stabilization, medication optimization, monitoring of response to antipsychotic and mood-stabilizing treatment, and coordination of safe discharge planning with appropriate outpatient psychiatric and substance use follow-up services.

Differential Diagnoses:

1. Bipolar I Disorder with Psychotic Features (Most Likely)
The patient presents with a history of bipolar I disorder and current symptoms consistent with a severe manic episode, including pressured speech, grandiosity ("superior being," "superpowers"), irritability, and disorganized/illogical thought processes. The presence of prominent psychotic features (persecutory and grandiose delusions, ideas of reference) occurring in the context of mood dysregulation strongly supports bipolar I disorder with psychotic features. Medication nonadherence and significant psychosocial stressors likely contributed to the current decompensation.

2. Schizophrenia Spectrum Disorder: Given the frequent intrusive thoughts of persecutory delusions, ideas of reference, and disorganized thought content across multiple hospitalizations, a primary schizophrenia spectrum disorder remains a key consideration. The persistence of psychotic symptoms, including delusional systematization and functional decline in the setting of homelessness and poor insight, may suggest an underlying primary psychotic disorder independent of mood episodes.

3. Substance-Induced Psychotic Disorder (Polysubstance: Opioids, Benzodiazepines, Cannabis): The patient has a significant history of polysubstance use, including heroin, benzodiazepines, cannabis, and inconsistent methadone adherence. Substance use or withdrawal states may exacerbate or contribute to psychotic symptoms, mood instability, and behavioral dysregulation. However, the chronicity of symptoms and prior psychiatric hospitalizations make a purely substance-induced etiology less likely, though still clinically relevant as a contributing factor.

Plan

#Scheduled Medications

- Methadone 10 mg PO daily for opioid use disorder maintenance and titrate based on repsonse and tolerance
- Quetiapine 50 mg PO every 12 hours for mood stabilization and psychotic symptoms
- Sertraline 25 mg PO daily for depressive and anxiety symptoms
- Lithium carbonate 300 mg PO BID for mood stabilization

#PRN Medications

- Haloperidol PRN for acute agitation or severe psychotic symptoms
- Lorazepam PRN for anxiety, agitation, or insomnia
- Nicotine replacement therapy PRN for nicotine cravings

#Monitoring / Safety

- Full code status
- Legal status: 9.39 involuntary psychiatric admission
- Vital signs per unit protocol
- Diet: General
- Observation level: Q15-minute checks for disorganized behavior and safety monitoring

#Substance Use Monitoring

- Monitor closely for opioid withdrawal symptoms despite methadone maintenance, including cravings, GI distress, myalgias, diaphoresis, rhinorrhea, and autonomic instability; adjust treatment as clinically indicated
- Monitor for benzodiazepine withdrawal symptoms given prior Klonopin use, including anxiety, agitation, tremor, insomnia, and perceptual disturbances; use PRN lorazepam cautiously as indicated
- Observe for polysubstance-related effects or withdrawal complications, including changes in mental status, vital sign instability, or worsening agitation
- Monitoring and assessing the severity of benzodiazepine and opiate withdrawal by using the CIWA-B score and COWs score

#Lithium Initiation & Monitoring

- Titrate lithium by 300 mg every 3–5 days as needed based on clinical response and serum levels
- Target therapeutic lithium level: 0.8–1.2 mEq/L (acute phase)
- Obtain 12-hour trough lithium level 5 days after initiation or dose change as needed

#Baseline Labs / Workup

- BMP (renal function, electrolytes, sodium)

- TSH with reflex T4
- CBC
- ECG weekly monitoring

#Treatment, Hospital Course & Disposition

- Continue inpatient psychiatric hospitalization for safety, stabilization, and medication optimization
- Optimize psychiatric medications based on clinical response and tolerability
- Monitor therapeutic response and adverse effects of lithium, quetiapine, sertraline, and methadone
- Provide ongoing psychoeducation regarding diagnosis, medication adherence, and risks/benefits; the patient demonstrates limited insight and requires reinforcement
- Obtain collateral information from family or prior treatment facilities to clarify baseline functioning and longitudinal psychiatric history
- Engage the patient in the therapeutic milieu to support structure, engagement, and behavioral stabilization
- Plan for safe discharge with outpatient psychiatric follow-up, lithium monitoring capability, and coordination with substance use treatment services when clinically appropriate