3. SUPPORT SYSTEMS

Family contact/involvement (F1)
- Sister limits contact due to pattern of harassing her w/ delusions
- little contact z other sisters/mom, estranged. will be.

Support network

☐Family/significant other ☐Social/recreational ☒Community mental health resources
☐Educational/vocational ☐Spiritual ☐Peer
☐Other

Explain other: under commitment will be assigned CCM. - Patti Fields (651) 266-4389 resolved. Question re: which county, both say other should be CCM.

Comments and contact information including name, address, phone number

new to client. w/ hospice George Lopez, CCM Ramsey County Human Services 160 E. Kellogg Blvd. St. Paul, MN 55101 (651) 266-4039

Significant social relationships (past and present):
- Hx of rel. z therapist
- Father's siblings, sisters/mom → estranged
- Current friend Pat Morris (religious connection)

4. NEEDS/STRENGTHS/PLAN RELATED TO TREATMENT AND DISCHARGE

NEEDS	STRENGTHS
- stabilize MH, restore to capacity	- Takes medication
- Insight into MI (grandiose)	very communicative
- learn to identify appropriate boundaries/not harass others	- Has hx of seeing MD, participating in tx process
- address concerns re: apt in community z CCM, SW	- Has responded well to medication

History of physical, emotional or sexual abuse: My family was rejecting, shaming. Sister reports parent has hx of violence sexually inappropriate behaviors but chooses not to give details.

MI or CD issues in family ☐ Yes ☒ No Describe: unknown

Diversity issues affecting treatment

Describe:

- ☐ Age
- ☒ Spiritual
- ☐ Socioeconomic
- ☐ Learning potential
- ☐ Other
- ☐ Health
- ☐ Language barrier
- ☐ Sexual orientation
- ☐ Cultural/ethnic

I'm a secular religions "don't want to be persecuted.

Explain other:

Faith is a resource, fears persecution

Employment/occupation history: Pizza Hut, Post office, Acting, Tax preparation (New Orleans) writer- 2001 2 mo. 2001- 2 haunted houses.

Employment status: Alias from BHIS "lay religions"

Education history: Catholic elementary, HS → Washburn Reports history of attending several colleges, unclear if reliable info.

Highest grade completed: Alias from BHIS

St. John's U of M-B-?.. Education M.A. History Phd. - History

Military service: Alias from BHIS

no ROTC 1 year in college.

Legal history/issues impacting current treatment and discharge planning:

Hx of repeatedly calling, faxing letters to many people and institutions re: delusions of persecution. Threatens others at times, accusatory nature.

Legal status: Alias from BHIS Delusions of grandeur

Rule 20.01

felony terroristic threats

MH/psych and CD history past three years (life span if MSOP):

Dr. Hall - med monitoring last couple years - stable. (St addict to AMRTC

HCMC records indicate multiple admissions over the years to HCMC, AMRTC, and a prison unit in Georgia (1974) for "dining and dashing"

VULNERABILITIES

Talks non-stop when decomp. (may annoy others, provoke)
Accuses others & delusions (annoying others)
Poor insight into MI (calling others, harassing)

Needs financial management intervention ☐Yes ☒No Describe: unknown

Social work intervention plan, including high-risk therapeutic issues: (F1)

- Treat mental illness, restore to capacity per Rule
- assist w/ planning to maintain apt. or move
- assist w/ questions re: bill & AMRTC, MA status.

Discharge/aftercare planning recommendations including input from case manager, family& patient: (F1)

- Discharge to Ramsey County ADC when competent to proceed w/ legal charges.
- CCM to continue intervention in community.
- client would like to move out of state near family for a fresh start.

5. FORENSIC ONLY

Legal contacts:

Craig Boone - Public Defender

Commitment status:

MI, Rule 20

Legal basis for commitment:

Rule 20

Summary of dangerous behaviors:

Threatening behavior/Harassment to court clerks, w/d/m staff due to decompensation, delusions. Rule 20 for criminal charges.

Name of preparer: Tonia Willand Date: 9/16/02

Signature: [signature]

- wants to move out of state for fresh start - location keeps changing - unclear if realistic.
- Showed this SW proof of oblate status @ St. John's Abbey.
- Apt. in community. Rent auto-paid, RSDI deposited.
- 1976 to 1983 lived @ Build Hall

STATE OPERATED SERVICES
Bio-psycho-social assessment component

HISTORY AND PHYSICAL ASSESSMENT

1. CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

Patient name: _____ BHIS #: _____

Date of assessment: 9/10/02 Time of assessment: 1:15 P.M.

Gender ☒ M ☐ F Age: 33yr.

Staff present during exam: ☐ Y ☒ N

Chief complaint:

= "I have no real concern."
= Non-suicidal.

History of present illness:

2nd admission = age: 25 (1st Admit) → Frustrated = 1 month + cancelled bed = Schizophrenia / paranoid type. Compliant w/ meds.

Past medical history (General health, infectious disease, surgeries and injuries, previous hospitalizations, review of available old medical records/lab tests, specific procedures)

= Surgery: minor's ? = 5th finger (L).
Multiple tatts — 4 yrs. old.
= In fair health.
= Patient wt: 190 lb.

Family medical history:

= Parents are DO = healthy
= ① Bro Russ
② DC Mrs > healthy

Current medications

Risperadal 3 mg (1) daily
Ativan 1 mg daily
Haldol 1 mg q 8-12 pm.

Allergies

Medications: NKA

Environment:

Food:

2. REVIEW OF SYSTEMS

General: I am in fair health

Respiratory system:

Skin: Ulcer

Cardiovascular system:

Breast:

G.I system: sagging w/ hold

G.U system:

Date of last breast exam and mammogram:

Date of last pelvic exam and pap smear:

Hematopoiesis:

Menstrual history/LMP: NA

Endocrine system:

Pregnancy history:

HEENT:

Contraceptives:

Neck:

Nervous system:

Lymph nodes:

Musculoskeletal :

Comments:

Mental status:

Paranoid Schizophrenia
vs.
Bipolar

3. PERSONAL AND SOCIAL HISTORY

Education: HS / PHD. Writing

Occupation: Writer / Writing

Marital Status: Single

Socioeconomic (F1): Apt in St. Paul

Habits

Diet: Regular

Exercise: Need more exercise

Sleep: Poor.

Nicotine Use: Quit smoker.

Caffeine Use: 1 pot/day.

Alcohol Use : Social drinker.

Illicit Drugs Use (inc.IV drug use):

Additional information

4. PHYSICAL EXAM-SKIN, HEENT

VITALS

Temperature	97.6	**Blood Pressure** Systolic	104	Height	5'8½"
Pulse	99	Diastolic	69	Weight	188 lb.
Respiration	20				

Skin

☑ WNL ☐ Not done Describe skin:
☐ Abnormality/deviation

Head

☑ WNL ☐ Not done Describe head:
☐ Abnormality/deviation

Eyes: Pupils, Vision, Fundi

☑ WNL ☐ Not done ~~Describe eyes:~~ w/ glasses
☐ Abnormality/deviation

Conjunctiva

☑ WNL ☐ Not done Describe conjunctiva:
☐ Abnormality/deviation

Ears

☐ WNL ☐ Not done
☐ Abnormality/deviation

TMS

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe ear:

Nose

☑ WNL ☐ Not done
☐ Abnormality/deviation

Sinus

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe nose/sinus:

Teeth/gums

☑ WNL ☐ Not done
☐ Abnormality/deviation

Mouth

☑ WNL ☐ Not done
☐ Abnormality/deviation

Tongue

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe oral cavity:

Trachea

☑ WNL ☐ Not done
☐ Abnormality/deviation

Thyroid

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe neck:

Lymph nodes

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe lymph node exam:

5. PHYSICAL EXAM- CHEST, LUNGS, CARDIOVASCULAR

Chest

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe chest exam:

LUNGS

Expansion

☐ WNL ☐ Not done
☐ Abnormality/deviation

Percussion

☐ WNL ☐ Not done
☐ Abnormality/deviation

Auscultation

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe lung exam:

CARDIOVASCULAR

Blood pressure

☑ WNL ☐ Not done
☐ Abnormality/deviation

Bruits

☑ Not present
☐ Abnormality/deviation

Heart rate

☑ WNL ☐ Not done
☐ Abnormality/deviation

Heart sounds

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe Cardiovascular exam:

5. PHYSICAL EXAM-LUNGS, CARDIOVASCULAR continued

PULSE

Carotid

☐ WNL ☐ Not done
☐ Abnormality/deviation

Femoral

☐ WNL ☐ Not done
☐ Abnormality/deviation

Radial

☐ WNL ☐ Not done
☐ Abnormality/deviation

Edema

☐ Not present
☐ Abnormality/deviation

Posterior Tibial

☐ WNL ☐ Not done
☐ Abnormality/deviation

Varicosities

☐ Not present
☐ Abnormality/deviation

Describe pulse exam:

6. PHYSICAL EXAM-GI, GU, ENDOCRINE

BREASTS/AXILLAE

Breasts/axillae

☐ WNL ☐ Not done
☐ Abnormality/deviation

Self breast exam reviewed

☐ Yes ☐ No

Describe breast/axillae exam:

ABDOMEN

Inspection

☐ WNL ☐ Not done
☐ Abnormality/deviation

CVA tenderness

☐ Yes ☐ Not done
☐ No

Palpation

☐ WNL ☐ Not done
☐ Abnormality/deviation

Bowel sounds

☐ WNL ☐ Not done
☐ Abnormality/deviation

Liver, spleen, kidney

☐ WNL ☐ Not done
☐ Abnormality/deviation

Lymph Nodes

☐ WNL ☐ Not done
☐ Abnormality/deviation

Describe abdominal exam:

GENITOURINARY – MALE

Penis

☐ WNL ☐ Not done
☐ Abnormality/deviation

Prostate

☐ WNL ☐ Not done
☐ Abnormality/deviation

Hernia

☐ WNL ☐ Not done
☐ Abnormality/deviation

Rectum

☐ WNL ☐ Not done
☐ Abnormality/deviation

Self testicular exam reviewed

☐ WNL ☐ Not done
☐ Abnormality/deviation

Hemoccult

☐ Negative ☐ Positive

Testes/scrotum

☐ WNL ☐ Not done
☐ Abnormality/deviation

Describe male genitourinary exam:

GENITOURINARY – FEMALE

Uterus

☐ WNL ☐ Not done
☐ Abnormality/deviation

Rectum

☐ WNL ☐ Not done
☐ Abnormality/deviation

Ovaries

☐ WNL
☐ Abnormality/deviation
☐ Not done

Hemoccult

☐ Negative
☐ Positive

Cervix

☐ WNL
☐ Abnormality/deviation
☐ Not done

External genitalia - vagina

☐ WNL
☐ Abnormality/deviation
☐ Not done

Describe female genitourinary exam:

7. PHYSICAL EXAM-NEUROLOGIC

Coordination

☐ WNL
☐ Abnormality/deviation
☐ Not done

Gait

☐ WNL
☐ Abnormality/deviation
☐ Not done

Describe coordination and gait:

Romberg

☐ WNL
☐ Abnormality/deviation
☐ Not done

Describe Romberg

CRANIAL NERVES

II fields

☐ WNL
☐ Abnormality/deviation
☐ Not done

III, IV, VI, PERRLA

☐ WNL
☐ Abnormality/deviation
☐ Not done

Fundi

☐ WNL ☐ Not done
☐ Abnormality/deviation

EOMs

☐ WNL ☐ Not done
☐ Abnormality/deviation

Describe cranial nerves II, III, IV, VI

V sensation

☐ WNL ☐ Not done
☐ Abnormality/deviation

V Masseters

☐ WNL ☐ Not done
☐ Abnormality/deviation

VII symmetry

☐ WNL ☐ Not done
☐ Abnormality/deviation

VIII hearing

☐ WNL ☐ Not done
☐ Abnormality/deviation

Describe cranial nerves, V, VII, VIII

IX,X uvula rises

☐ WNL ☐ Not done
☐ Abnormality/deviation

XI Sternocleidomastoid and trapezius

☐ WNL ☐ Not done
☐ Abnormality/deviation

XII tongue midline

☐ WNL ☐ Not done
☐ Abnormality/deviation

Describe cranial nerves IX,X, XI, and XII

Reflexes/Babinski

☐ WNL ☐ Not done
☐ Abnormality/deviation

Sensation/vibration

☐ WNL ☐ Not done
☐ Abnormality/deviation

Strength

☑ WNL ☐ Not done
☐ Abnormality/deviation

Tremors/abnormal movements

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe other neurological findings

TBI SCREENING (Complete within 15 days of admission- refer to DHS policy 6230)

Patient has had a head injury, anoxic incident, coma or neurological procedure that required hospitalization
☐ Yes ☑ No ☐ Unknown

Patient has a present DX of organic mental disorder, which may be attributed to a previous cerebral event or process traumatic, vascular, anoxic, infectious or toxic
☐ Yes ☑ No ☐ Unknown

Patient has any neurological motor, sensory or autonomic symptoms present other than idiopathic seizures for which there is no documented etiology.
☐ Yes ☑ No ☐ Unknown

Patient has dysfunction of thinking, emotions, communication or behavior, which may be attributed to a previous cerebral event or process.
☐ Yes ☑ No ☐ Unknown

8. PHYSICAL EXAM-MUSCULOSKELETAL

Upper limbs

☑ WNL ☐ Not done
☐ Abnormality/deviation

Lower limbs

☑ WNL ☐ Not done
☐ Abnormality/deviation

Spine

☑ WNL ☐ Not done
☐ Abnormality/deviation

ROM

☑ WNL ☐ Not done
☐ Abnormality/deviation

Joints

☑ WNL ☐ Not done
☐ Abnormality/deviation

Describe musculoskeletal exam

9. PHYSICAL EXAM-REVIEW

LAB drug & HCWC –
- UA
- Basic panel
- Liver panel
- CBC panel

Hepatitis B –

10. DIAGNOSTIC ASSESSMENT

Axis I Paranoid Schizophrenia **Axis III** No active illness.
Past Hx: (inactive)
- tonsillectomy

Axis II deferred

Patient has increased risk for adverse medical consequences with seclusion or restraint
☐ Yes ☒ No

Patient has observable evidence of abuse or neglect
☐ Yes ☒ No

Patient appears free of communicable disease
☒ Yes ☐ No

Comments:

Therapeutic plan-including treatments, medications, labs, and x-ray

= Regular diet.
= Cough meds.
= Diet as tolerated.

Follow-up appointments/recommendations

- Seen as needed.

Signature _____ Date 9/9/02

Run Date: 09/10/2002

ANOKA METRO REGIONAL TREATMENT CENTER
3301 SEVENTH AVENUE NORTH
ANOKA, MN 55182

Nursing Initial Assessment

ÚÄÄ
³Client Name: ODOUGHERTY,PATRICK (39972) ³Admission Date: 09/10/2002 ³
³Episode #: 2 ³Discharge Date: ³
³Chart Number: 20042 ³Physician: DAM,HIEN ³
³Legal Status: MI COMMITMENT ³ ³
³Prepared on: 09/10/2002 At: 02:21 PM ³Prepared by: Doreen Dittbenner RN ³
ÀÄÄÄ

1. General

Date of assessment: 09/10/2002

Time of assessment: 02:06 PM

Gender: MALE

Date of birth: 12/11/1946

Primary language: ENGLISH

Speak / understand English: Yes

Read / write English: Yes

Orientation: Person, Place, Time

APPEARANCE

Eye color: green

Hair color : grey

Tattoos: none

Scars / birthmarks: scar between eyebrows

Neatly groomed: Yes

Appropriately dressed: Yes

VITALS

Temperature: 97.6

Pulse: 99

Respiration: 20

Blood pressure: 104/65

ALLERGIES

Allergies: Denies

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Describe allergies (include medications, food, environmental, latex, bee sting, other. Define type of reaction):
NKA

CURRENT MEDS / TREATMENTS

Prescription, dose, reason for use, date last taken:
Risperdal Elixir 3mg HS - clearer thinking, PRN'S ativan 1 mg q 4 hrs - anxiety and Haldol 5mg q 4 hrs - agitation. Has no neuroleptic court order. Has been medication compliant at HCMC.

OTC / herbal, dose, reason for use, date last taken:
MVI - daily for supplements

Current treatments - include reason, date of last treatment:
none

IMMUNIZATIONS / MANTOUX / CHEST X-RAY

Last tetanus / DPT: less than 10 yrs ago

Pneumovax: fall 2001

Influenza: fall 2001

Polio : childhood

Last mantoux date: 8/10/02

Mantoux results: Negative

Chest X-ray results and date: none

MMR / Measles: childhood

COMMUNICABLE AND INFECTIOUS DISEASES

Communicable and infectious diseases: Denies

HIV / AIDS: Denies

STD: Denies

Explain (other hepatitis): denies

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SEXUAL ACTIVITY / RISK FACTORS

Sexually active: Denies

Birth control : no

Safe sex practices: celebate

Given information about STD/ Safe Sex practices: Yes

Vision: Glasses / contacts with

Comments (vision) (F1) :
sees well with his glasses, no contacts

Hearing: Denies problem

2. Review of systems

Neurological: Denies problem

Cardiovascular: Denies problem

Respiratory: Denies problem

Comments (respiratory) (F1) :
is a non-smoker

GI / digestive: Denies problem

Bladder / urinary: Denies problem

Musculoskeletal: Denies problem

Skin: Denies problem

Sleep / rest problems: Denies problem

3. Behavior

Current psychiatric symptoms: Delusions, Other

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Comments (current psychiatric symptoms):
very delusional about his abilities to right the wrongs in the world. He believes that some Judges are involved in a conspiracy. He was arrested July 8 2002 and charged with one count of felony terroristic threats. He is hyperverbal and has loose associations. He is grandiose. Paranoia.

Present mood / affect: Pleasant, Other

Comments (present mood/affect) (F1) :
hyperverbal

Present behavior: Cooperative, Good eye contact

Comments(assaultiveness/aggression)(F1):
has been harrassing and threatening the history dept at the U of M since 1989. He gets upset with officials and makes false claims against them (ie: implicating a police officer in car theft, the kidnapping of Jacob Wetterling and cover ups of other murders) He threatened a Judge and has been charged with one count of felony terroristic threats. He denies that he gets physically aggressive.

4. Chemical use

ALCOHOL USE

Alcohol use: Yes

Type(s): beer

Date last used: 3 months ago

Frequency / amount /pattern : 2 drinks once a week

Age began using: 21 yrs old

TOBACCO USE

Current tobacco use: Denies problem, Denies problem

History of tobacco use: Denies problem

OTHER SUBSTANCE USE

Other substance use: Denies problem

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IV DRUG USE

IV drug use: Denies problem

Withdrawal : Denies problem

5. Screenings

VISION SCREENING (mandatory for adolescents)

Comments(vision screening) (F1):
2 yrs ago, no problems noted at that time

NUTRITIONAL SCREENING

Height: 5'8 1/2"

Weight (F1): 185

Body mass index (F1): 28

Recent weight change: Yes

Comments(recent weight change):
gained about 7 lbs in the last month due to inactivity

Teeth: Denies problem

Modified diet/schedule: No

Fluid restriction: No

Receiving nutritional supplements: No

Using stool softners: No

Appetite change: No

Nutrition related disorders: Difficulty swallowing, Denies problem

Comments (nutrition-related disorders) (F1) :
Haldol sometimes causes him to have a little difficulty swallowing "gags me a bit"

Diabetic management: No current management

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FUNCTIONAL STATUS SCREENING

Bathing independent: Yes

Dressing independent: Yes

Elimination independent: Yes

Grooming independent: Yes

Eating independent: Yes

Physical disability present: No

Currently receiving physical therapy: No

Mobility independent: Yes

Recent problem with falls, balance and coordination:
No

Pain: Denies problem

VOCATIONAL SCREENING

The patient has difficulty communicating his/her needs:
No

The patient has been employed within the last 6 months:
Yes

Comments (patient has been employed within last 6 mo):
worked for a phone book company "I also do taxes and investments"

The patient has difficulty maintaining a job: No

Comments (patient has difficulty maintaining a job):
"I have been independent most my life"

The patient expressed an interest in exploring employment opportunities after discharge: Yes

SUICIDE SCREENING

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Ever attempted suicide: Denies problem

Current / recent suicidal ideation: Denies problem

Suicide plan: Denies problem

Self harm: Denies problem

Identified triggers (F1):
"a lot of losses of friends due to death."

Identified coping mechanisms (F1):
lies down and reads, and calls friends.

6. Initial Nursing Treatment Plan

Strengths:
"socially outgoing, good conversationalist, I'm a teacher, and religious" Able to type, has been self employed. Graduated with a PHD in History, states he has published 10 books. Is able to maintain his own apt.

ACTION PLAN

Referral(s): No

Additional assessments

Nutritional : Yes

Falls : No

Hearing : No

Vision : No

Rehab and Community Living : No

Pain : No

Suicide Risks : No

Addiction : No

Comments(additional assessments):
primary health care provider - social security part A and B, no specific clinic

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or doctors.

Problems / needs / vulnerabilities:
potential for problems with bowel elimination, loose associations, paranoia,grandiose, delusional, hyperverbal, can be irritating due to his harrassments and false accusations. He is a rule 20.01 sub div 5. He was arrested on July 8 2002 and charged with one count of felony terroristic threats. (threatened a Henn Co Judge). Hx of Tardive Dyskinesia.

Action:
encourage healthy bowel habits. encourage active participation in tx and with medication compliance. Wkly med education and educate on sx of MI and management
of sx. redirect and reality base prn. May need to continue phone restrictions. Utilize prn meds and quiet time. on going Discus.

Draft/Final: Final

Signature/Title

Date Doreen Dittbenner RN
9-10-02

Patient Name: Patrick O'Dougherty Patient Number: 20042

Part VI: Initial Rehabilitation Functional Skills Screen Summary

Information obtained from: ✓Patient, __Previous Chart, ✓Pre-Admission Screening

Pre-Admission Screening has identified/recommended _____as a placement site.
✓Pre-Admission Screening did not recommend a placement site.
__ Rule 20.

I A. Patient has the following skills: (Check all that apply)

- ✓Able to get around in the community.
- ✓Able to use a phone directory/411
- ✓Knows how and when to use 911
- ✓Able to converse socially
- ✓Able to follow 2 & 3 step directions
- ✓Is oriented to time, place, and day
- ✓Able to obtain meals when living in the Community.
- ✓Has all necessary Personal Identification
- ✓Able to write checks
- ✓Able to identify situations that cause frustration./anger
- ✓Able to distinguish correct change
- ✓Able to plan a Leisure Activity.
- ✓Able to structure free time
- ✓Able to identify supportive resources (CSP)
- ✓Able to locate and utilize Leisure Resources
- ✓Willing to initiate social contacts with family/friends

I B. Current Functional Skill Strengths and Leisure/Social Resources related to discharge.

Patrick states he has lived independently for years & is able to cook & shop for self as well as handle his finances. He states he does have a drivers license but uses the bus to get around. Patrick states his leisure interests include visiting books, being on active & religion. PT states need to work on coping skills currently he states that he holds all his feelings inside.

II. Recommended OT and TR treatment interventions/modalities.

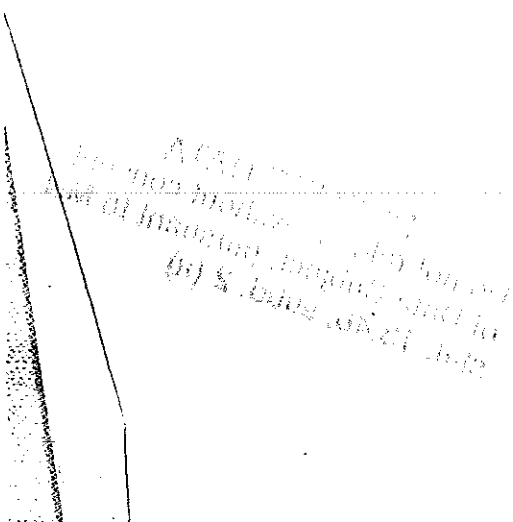
Modalities to address ↑ knowledge of coping skills & practice of these skills

III. Comments: (Include patient's appearance, communication style, attention span. Add any specific requests the patient has made, ie; ability to get to appointments/groups, how and when patient would like to be reminded/prompted and any diversity needs to consider.)

Patient noted to be talk non-stop. His statements appear to be grandiose. He felt need to show his therapist identifications he had with him & show the many organizations he is affiliated with

Laura Kelley COTA
Therapist Signature

9-11-02
Date



Occupational Therapy
Kitchen Evaluation
(Non-standardized)

The treatment team of Unit D requested an Independent Living Skills assessment for Patrick O'Dougherty. The kitchen evaluation administered on 12-31-02 was designed to assess Patrick's knowledge of nutritional needs, safety in the kitchen, and actual observation of his skills while preparing a package of Lipton flavored noodles. In addition, the therapist is able to assess the ability of the patient to read and follow written and verbal directions, organize and sequence the task and sub-tasks, time the cooking, judge when the noodles are cooked, and complete thorough clean up of utensils and area. Results follow:

Nutrition – Patrick was able to identify 6/6 food groups and identify a well-balanced meal. He prefers to make simple things like soups, cereals, and sandwiches.

Safety in the kitchen – Patrick washed his hands before and during the cooking task. He stirred frequently to prevent food from burning, turned off the burner, and cooked with the panhandles inward. He washed the dishes with cold soapy water and did not rinse the soap off before wiping. He was asked a series of questions related to the prevention and treatment of injuries while in the kitchen. Patrick stated he would use a hot pad to prevent burns and treat a minor burn with cold water. He would prevent falls by making sure the floor was dry and free from spills. When asked how do you prevent electric shock he reported that he would have the right fuse. He stated he would put out a grease fire with baking soda and if his clothes caught on fire he would stop, drop, & roll. He reported that he would keep tuna in the refrigerator for about a day. When asked why it is important to wash your hands and counter tops after handling raw meat, he replied to prevent the spread of bacteria.

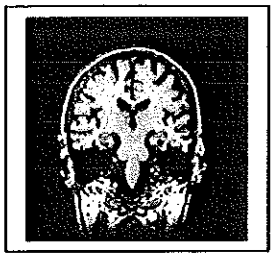
The actual cooking task – Patrick read and referred to the printed directions when questions arose. He was able to follow verbal directions given by the therapist also. He correctly gathered the supplies, sequenced the tasks, measure the ingredients, and timed the food. He also was able to engage in conversation while completing the task.

Recommendations – Patrick has the skills and abilities to be safe in the kitchen while preparing a meal. He did participate in a review of kitchen safety after the kitchen assessment to clarify how to prevent electric shock and how to wash dishes.

Respectfully,

Aimee House OTR/L

ODOUGHERTY, PATRICK M/
AMRTC BHIS #39978
#20042 ADM 9-10-02
DOB 12-11-46



ANOKA-METRO REGIONAL TREATMENT CENTER
Neuropsychology Department
Como Community Consultation (CCU)

NEUROPSYCHOLOGICAL EVALUATION

NAME:	O'DOUGHERTY, Patrick	**EDUCATION:**	16+graduate courses
AGE:	56	**BIRTH DATE:**	12-11-1946
GENDER:	Male	**PROGRAM:**	CCU
DATES OF EVALUATION:	3-5-03	**HAND DOMINANCE:**	Left

REFERRAL AND BACKGROUND INFORMATION: Mr. O'Dougherty is a 56-year-old male with an extensive psychiatric history, dating back to 1989, related to symptoms of Schizophrenia, Paranoid Type. The patient was committed as mentally ill through Hennepin County under Rule 20 conditions of criminal procedure due to a charge of terroristic threats. On 10-29-02, this examiner conducted a treat to competency evaluation and concluded that the patient was competent to proceed to trial; however, the Court concluded that the patient was not competent and likely never would achieve competency. The Court ordered another competency evaluation in six months time; therefore, this examiner completed neuropsychological testing to assist in determining the patient's intellectual and neurocognitive abilities, such as attention, memory, language, and executive functioning skills.

O'Dougherty has been psychiatrically hospitalized on numerous occasions at HCMC, Metropolitan Medical Center, AMRTC and in Georgia. The patient's symptoms include grandiose delusions, often revolving around left-wing political movements, disorganized thinking, evidenced by loosening of associations, and paranoia. When treated with antipsychotic medication, the patient can focus on the topic of conversation, understands his need for medication and ongoing treatment and actively participates in treatment groups. There is no evidence of a substance abuse history and the patient's medical history is similarly unremarkable. During the neuropsychological interview, he reported a history of tardive diskinesia, but a change in medication ameliorated that problem. When asked if he has noted any problems with attention, memory, thinking or concentration, he stated, "I'm at an age that I'm not as sharp as I once was."

Mr. O'Dougherty does not appear to have a family history of mental illness. His father was employed as an attorney and his mother was reportedly active in local politics. The patient has three sisters, all with graduate degrees and one brother who owns a business and has an engineering degree.

During the neuropsychological interview Mr. O'Dougherty stated that he completed a B.S. in education at St. John's University and went on to complete an MA and PhD in "intellectual history." While records indicate that he completed his undergraduate degree his graduate degrees are unsubstantiated. Mr. O'Dougherty reported that he always did well in school, excelling in history, and English but consistently struggled with math courses and the "hard sciences." The patient indicated that he began working at the age of eleven as a paperboy. In college, he was employed in the library and then managed his family's apartment building for many years. He described his involvement in various political organizations, but when doing so his statements became difficult to track and his speech became tangential and at times incoherent.

BEHAVIORAL OBSERVATIONS: Mr. O'Dougherty was amicable and cooperative throughout the testing procedures. He was casually dressed and adequately groomed, alert and oriented in all spheres. His speech was of normal rate, rhythm and volume, although its content was noteworthy for occasional grandiose themes and loosening of associations. Generally, Mr. O'Dougherty's mood was euthymic, although he stated he was distressed over his legal situation and expressed concern about the Court's decision. The patient indicated that he experienced a rare recurrence of suicidal ideation over the past weekend, but felt better after discussing his thoughts with staff.

The patient stated that he enjoys tests, but as the session wore on, he appeared fatigued. Near the latter portion of the testing session, he appeared to take a more careless approach to the tasks, which might have lowered his performance, in particular, on a biletter cancellation task. Nevertheless, Mr. O'Dougherty appeared to persevere through much of the testing and seemed vested in performing optimally. Generally, his results likely an accurate reflection of his current level of cognitive functioning.

TESTS ADMINISTERED:

Wechsler Abbreviated Scale of Intelligence (WASI)
Wide Range Achievement Test-3 Reading (WRAT-3)
Repeated Battery for the Assessment of Neuropsychological Status (RBANS)
Letter Cancellation
Porteus Mazes
Color Trails
Finger Tapping

TEST RESULTS:

WECHSLER ABBREVIATED SCALES OF INTELLIGENCE (WASI)

Ability Level	Verbal IQ	Performance IQ	Full Scale IQ
Above Average	131		120
Average		109	
Low Average			
Much below average			

ACADEMIC ACHIEVEMENT

Academic Area	Standard Score	Grade Equivalent	Percentile
Reading	117	Post High School	87th percentile
Spelling			
Arithmetic			

NEUROCOGNITIVE DEFICITS:

Area	None	Low Avg.	Mild	Moderate	Severe
Attention		X			[illegible] Cancellation
Immediate Memory	X				
Visual /Constructional			X		
Delayed Memory		X			
Language		X			
Executive Functioning	Mazes				Trails B
Motor Speed	Finger Tapping (both hands)				

SUMMARY: Mr. O'Dougherty is a 56-year-old male with a history of Schizophrenia, Paranoid Type who was committed under Rule 20 conditions through Hennepin County. He was seen for neuropsychological assessment to assist in determining his intellectual and neurocognitive abilities.

Administration of the Wechsler Abbreviated Scales of Intelligence (WASI) revealed intellectual functioning in the Superior range with a wide discrepancy between his verbal abilities, in the Very Superior range and visuospatial abilities, in the Average range. This difference is in the direction one would expect however, given his history of difficulties with math and science. Mr. O'Dougherty's reading ability, as measured by achievement testing, revealed that he is reading at the post high school level.

Mr. O'Dougherty's neurocognitive results indicate variable performance, from no impairment to severe impairment on two subtests. Areas of severe impairment were noted for the scanning and tracking aspects of attention, and alternating attention between two competing stimuli. These results however may in part reflect the patient's fatigue, as these tests were administered later in the session and to his eyesight difficulties. Mild impairment was noted for visuospatial abilities, which corroborates the wide discrepancy between his verbal and performance scores on psychomoteric intellectual measures.

There was no impairment in functioning in most areas. Below average performance was demonstrated for general attention tasks, a straightforward vigilance task, delayed memory and language abilities. His language performance was lowered by a task requiring verbal initiation. Above average performance was noted for immediate memory functioning as well as for motor speed with both hands.

IMPRESSIONS AND RECOMMENDATIONS:

Overall Degree of Impairment:

Cognitive Abilities:	Mild
Adaptive Functioning:	Mild

Localization of Impairment: Right hemisphere with frontal lobe involvement

Neuropsychological Diagnosis:

Axis I: Cognitive Disorder Not Otherwise Specified

Neuropathological Implications: Results of the current evaluation reflect right hemisphere, frontal lobe involvement. Whether Mr. O'Dougherty's performance is a decline from his previous functioning is unknown given the absence of baseline data against which to compare, although based on psychometric intellectual functioning, one would expect higher neurocognitive scores. The etiology of the patient's cerebral functioning status is likely attributable to the effects of chronic Schizophrenia. His results reflect attention difficulties for tasks requiring scanning and shifting cognitive sets, and spontaneous verbal production indicative of hypofrontality. Developmental factors are likely underlying lower scores for tasks involving the right hemisphere. A subsequent decline in general cerebral functioning secondary to chronic Schizophrenia, results in visuospatial skills in the mildly impaired range, while tasks relying on verbal skills fall within the range of no impairment, due to exceptional premorbid verbal abilities.

Mr. O'Dougherty appears to be at psychiatric baseline; therefore, one would not expect significant improvement in cerebral functioning. However, if further psychiatric stabilization

occurs, improvement in some aspects of attention may be observed. Furthermore, the patient's memory functioning may be benefited by instruction in prospective memory strategies (remembering to remember).

Behavioral Implications: The current test results do not indicate behavior problems in themselves. He has the ability to anticipate consequences and perform problem-solving tasks.

Therapeutic Implications: Based on the available information it is anticipated that Mr. O'Dougherty will have minimal difficulty participating in most therapeutic approaches, provided there is adequate structure and expectations are made clear. Verbal methods to convey information will maximize his attention ability thus aid in memory functioning. Mr. O'Dougherty's memory benefits from cuing, and he demonstrates above average memory performance when information is organized in to a meaningful context, rather than presented as unrelated data. His attention might be improved by offering him support through psychotherapy or daily, brief one-to-one sessions, as stress appears to increase cognitive disorganization.

Implications for Daily Living: These results suggest that this individual may have the ability to return to essentially independent living provided there is community support in the form of medication monitoring. This recommendation is based solely on his neurocognitive abilities and does not take into account other factors, such as psychiatric issues. In terms of competency to stand trial: while Mr. O'Dougherty demonstrates deficits in some aspects of attention and shifting cognitive sets, his general attention, memory, language and problem solving skills are not impaired and indicate that cognitively, he has the capacity to understand information and make reasonable decisions. While he exhibits disorganized speech and his statements are incomprehensible at times, he completed over three hours of fatiguing tests, during which, he stayed focused on the task to the degree that his performance was unimpaired in most areas.

Please direct further questions to me at (763) 712-4228.

Kristen Ryan, Psy.D.
Clinical Psychologist
3-7-03

Erwin Concepcion, Ph.D., LP
Director of Behavioral Health Services
3-7-03

ANOKA METRO REGIONAL TREATMENT CENTER
3301 SEVENTH AVENUE NORTH
ANOKA, MN 55182

Nutritional Assessment

ÚÄÄ
³Client Name: ODOUGHERTY,PATRICK (39972) ³Admission Date: 09/10/2002 ³
³Episode #: 2 ³Discharge Date: ³
³Chart Number: 20042 ³Physician: DAM,HIEN ³
³Legal Status: MI COMMITMENT ³ ³
³Prepared on: 09/17/2002 At: 05:50 PM ³Prepared by: Liz Friday Dietitian ³
ÀÄÄ

1.Nutritional Assessment

Date of assessment: 09/17/2002

Time of assessment: 05:40 PM

Gender: MALE

Date of birth: 12/11/1946

Diagnosis: paranoid schizophrenia

Prescribed diet: regular

Food related cultural/religious practices: No

Food allergies: No

HEIGHT AND WEIGHT HISTORY

Height: 5'8.5'

Admission weight: 185#

Current weight: 185#

Body mass index (F1): 28

Desirable body weight (F1): 157#+/-10%

Recent weight change (F1): No

Comments (weight assessment -see action plan for details) (F1):
Overweight

Explain (other weight assessment):
wt at 107% of upper end of RBWR. BMI indicates low risk for health problems r/t weight. Wt is relatively stable per pt.

Activity level (F1): Aerobic

ESTIMATED NEEDS FOR ENERGY AND PROTEIN

Basal energy expenditures (F1): 1714 kcal

Patient Name: Patrick O'Dougherty **BHIS:** 39972

STATE OPERATED SERVICES
PSYCHIATRIC ASSESSMENT

IDENTIFICATION DATA

Assessment Date: 9-10-02 Assessment Time: 3:15 pm

Gender: Male Age: 55

City:
State:

Marital Status: Single Race: Caucasian
Education: PhD in history Religion: Roman Catholic

Occupation: He was once a Professor at the University of Minnesota.

Referral Source: HCMC and court papers, patient himself who was unreliable throughout most of the interview. He does have a advance directive status informal living well, and his court authorized medications status is no. His legal status is DC/MI 8-21-02 expires 2-21-03.

I. COMPLAINT/PRESENT ILLNESS

Chief complaint: "Some people said that I harassed them so the court sent me here."

History of Present Illness: A coherent medical history was difficult to obtain because the defendant was often guarded, tangential and non seneschal in his responses. He is currently here on a Rule 20.01 Subdivision 5 commitment. Records indicate that the patient has allegedly been harassing and threatening the History Department at the University of Minnesota since 1989. The Officer investigating his current harassment was sent a fax from Mr. O'Dougherty saying that he had a felony and that the police feel that Mr. O'Dougherty was going to get him fired. The defendant stated he had gotten a large number of people hired and fired within the University of Minnesota. In December 2001 the officer investigated another complaint of harassment against the defendant and in January 2, 2002 the patient left a message on the officers voice mail threatening to have him court marshaled and implicated in a cover up in the murder of Jacob Wetterling and other youths in the St. Cloud area. He was charged on March 15, 2002 with a gross misdemeanor count for harassment for this. On July 2, 2002 Mr. O'Dougherty made threats to a judge of Hennepin County Court. On July 2, 2002 he spoke to a receptionist and made threats to this judge. On July 5, he was in the Hennepin County Courthouse and demanded financial information on three judges. On July 8, he was back making another disturbance at the Government Center. He stated that certain judges are responsible for the routing of Highway 55 and deporting a Port Rican female. He was arrested on July 8 and charged with one count of felony terroristic threats. He was transferred to HCMC on August 8, 2002. Records from HCMC in Minneapolis indicate that the patient has created a diagnosis of schizophrenia, paranoid type for many years and has had multiple prior psychiatric hospitalizations at HCMC Metropolitan Medical Center, Anoka Metro Regional Treatment Center and at a Prison Medical Unit in Georgia. He has a prior admission at Hennepin County Medical Center from June 5 to June 23 1989 predicated by his threats to the University of Minnesota History Department staff and agitated behavior on campus. Another admission from April 10 to April 21st, 1989 was reciprocated by the patients threats to professors at the University and a decision to drive to visit Senators in Washington while evidence in grandiose delusional threatening ideas. Records indicate that the patient was also brought to Hennepin County Medical Center Crisis Intervention Center on May 2, 1996 following concerns regarding his decompensation and alleged threatening letters and phone call to staff at the Neuman Center at the University of Minnesota as well as the priest. The patient was then transferred to Adult Psychiatry and evaluated by Dr. Bruggemeyer on May 6, 1996. She noted that the patient appeared vicarious, very difficult to interrupt, rambling and tangential and over inclusive. He was religiously pre-occupied and spoke about militaristic directions in the human center. During the course of this hospitalization the patient was noted to have a full scale IQ of 101 and test results revealed minor impairments in his non-verbal abilities, the media and delayed recall and working memory. At that time he also

demonstrated perseverative tendencies. The test results were consistent with organic cerebral dysfunction and was eventually discharged on May 29, 1996 with a diagnosis of schizophrenia paranoid type with continuous and mild tardive dyskinesia. Medical records subsequent to 1996 were not available as other patients prior treatment history, although it is noted in records that the patient has tried anti psychotics including Prolixin, Mellaril and Haldol as well as Risperdal, Thorazine and Cogentin. Pre-admission assessment shows that the patient is currently on Risperdal Elixir 2 mg.

2. HARM POTENTIAL/ALCOHOL/DRUGS

Harm Potential

Ever thought about suicide: Denies.

Circumstances:

When was the last time: Denies.

History of suicide attempts:

When and how:

Current self harm potential: Denies.

Current harm to others potential: Denies.

ALCOHOL/SUBSTANCE USE

Average number of drinks per day: Denies.

Has patient ever felt or been told that he/she is drinking too much? Denies.

History of Blackouts, Delirium Tremens, Seizures: Denies.

Ever used drugs of abuse? Denies.

Last time patient took drugs: Denies.

Drugs of abuse: Denies all drugs of abuse.

3. PSYCHIATRIC/FAMILY HISTORY

Past psychiatric history: Per court records the patient's sister reported that the patient has suffered from schizophrenia for greater than 30 years and had decompensated in the last year. Records from HCMC indicate that the patient has an extensive psychiatric treatment history with multiple hospitalizations for the treatment of schizophrenia paranoid type. During prior psychiatric hospitalizations the patient evidence psychotic symptoms inclusive of the following: Grandiose and paranoid thinking, disorganized thinking, rambling, tangential and over inclusive speech as well as religious preoccupation. Per the patient he had been diagnosis once in 1996 with bipolar schizophrenia and hypo[illegible] and defensive personality.

Childhood developmental/psychiatric problems: He denies.

History of physical, emotional or sexual abuse: He denies.

Patient Name: Patrick O'Dougherty **BHIS:** 39972

Family structure: He states his mother's age is 82 and his mother's occupation is Social Worker, retired. He did not know his father's age but he stated that his father was deceased. His parent's marital status. His parents were married, widowed and mother remarried. Sibling #1, his name is Mike. He is 54 years old. He is a biological brother. Sibling #2 is Margaret, age 52, biological sister. Sibling #3 is Marianne, she is 49 years old, biological sister, Sibling #4 Maureen is a biological sister, age 48.

Family history of psychiatric problems, suicide attempts, drug abuse/alcoholism, psychiatric medications: Patient indicates that he has a paternal aunt with mental retardation.

Legal history: History of repeated harassments towards departments at the University of Minnesota beginning in 1989.

Military history: ROTC in college.

Social history: Per patient, the patient has no children and was never married. He lived in a 3 bedroom apartment in St.Paul with two other student roommates.

4. MEDICAL HISTORY

Sleep difficulties: Includes snores heavily. As he claims to have a little sleep apnea.

Smokes: Denies, although he states that he smoked several years ago as a teen. **Packs per day:**
Other uses of tobacco: Denies.

Number of cups of coffee, tea or cola per day: 3 to 4 cups of coffee and one cola.

Allergies: He states the Haldol causes gagging and Prolixin causes tardive dyskinesia as does Cogentin.

Health problems (including surgeries and traumatic brain injuries): He states that he had a tonsillectomy as a child as well as pneumonia as a child.

Sexual history including any sexual problems: The patient indicates that he is heterosexual and celibate at this time.

Current medications: Risperdal, 3 mg. as well as Ativan prn.

Medication history: Risperdal, Thorazine, Ativan, Prolixin, Haldol and Cogentin. Again he states that Haldol causes him gagging and Prolixin and Cogentin causes him tardive dyskinesia.

5. MENTAL STATUS EXAM

General appearance: Includes normal weight and age appropriate.

Attitude during interview: Was traumatic.

Dress and personal habits: Appeared appropriately groomed.

Motor behavior: Normal.

Speech: Excessive verbalization.

Comments: Excessive rambling and incoherent speech.

Facial expression: Anxious and stares into space.

Affective states: Include Euthymic.

Mood: Was elevated.

Thought processes: Included preservations, tangentially, blocking, halluce associations and flight of ideas.

Disorders of perception: Denies.

Thought content: Includes paranoid ideation.

Delusions: Persecutory grandiose.

Suicidal ideation: Denies.
Homicidal ideation: Denies.

Physiological parameters of psychological significance: Includes hypo _____. Comments: History of hypo _____ per patient.

Somatic complaints: Weight gain. Comments: Include 6 to 7 pound weight gain since June.

Alertness and level of consciousness (*alternative for cognitive exam is to use MMSE): Alert.

Orientation: Oriented to time, place, person and situation.

Memory: Within normal limits for all concentration.

Concentration: Serial sevens.

Abstract thinking: Able to abstract similarities.

Fund of information and intelligence: Is above average.

Comment on how intelligence was estimated: Was by quizzing him on historical events and simple mathematic calculations.

Judgment: Social judgment.

Insight: None.

Comments: Patient states that he is unusual but not delusional.

6. MINI MENTAL STATUS EXAM

ORIENTATION
What is the (year-1) (season-1) (date-1) (day-1) (month-1)? (Maximum 5 points) 5

Where are we (state-1) (county-1) (city-1) (hospital/clinic-1) (floor-1)? (5 points) 5

Patient Name: Patrick O'Dougherty **BHIS:** 39972

REGISTRATION

Have patient repeat three words after you have said them. Examiner says, Tony, purple, 128 (1 second to say each). Give 1 point for each word repeated correctly. (3 points) 3

Then repeat the words until patient learns all three. Count trials and record. ___

ATTENTION AND CALCULATION

Serial 7s (begin at 100 and subtract backwards by 7). Stop after 5 answers. One point for each Correct (5 points) 3

Alternatively, spell "earth" backwards. The score is the number of letters in correct order. ___

RECALL

Ask for the 3 objects repeated above. Give 1 point for each correct. (3 points) 3

LANGUAGE

Name a pencil and a watch. (2 points) 2

Repeat "No, ifs, ands, or buts." (1 point) 1

Follow a 3-stage command: "Take a paper in your right hand, fold it in half using both hands, And put it on the floor". (3 points) 3

Read and obey the following: "Close your eyes." (1 point) 1

Write a sentence. (1 point) 1

Copy design (1 point) 1

Total: 28

LEVEL OF CONSCIOUSNESS

Comments: Alert.

BIOPSYCHOSOCIAL FORMULATION

Biopsychosocial formulation: This is a 55 year old, Caucasian male, here under Rule 20.01 charged with one count of felony terroristic threats. The patient has a long standing history of paranoid schizophrenia with several past psychiatric hospitalizations. It unclear when his last hospitalization occurred. The patient has been off his medication since August 1 and was re-started again on August 19. He apparently decompensated at that time and has succumbed to a series of psychotic delusions. It can best be describec as paranoid. It is unclear at this time whether the patient has suffered any type of traumatic brain injury. He denies alcohol abuse or illicit drug usage at this time.

DIFFERENTIAL IMPRESSION

Axis I. Schizophrenia paranoid type.

Axis II. Deferred

Axis III. None

Axis IV. Legal problems
Lack of social support, and housing is a problem after discharge.

Patient Name: Patrick O'Dougherty **BHIS:** 39972

Axis V. Current GAF -- 30
Past Year GAF –

STRENGTHS
1. Highly educated.
2. Gentlemen with good communication skills.
3. Positive attitude about self-improvement and takes medications.
4. Good physical health.

WEAKNESS
1. Legal problems.
2. Poor insight into the delusional thoughts.

TREATMENT AND MANAGEMENT PLAN
1. Psychological assessment for appropriate group therapy referral.
2. Continue psychotropic medication treatment and adjustment.
3. Assessment of chemical dependency potential.
4. Follow up on legal problems.

Richard P. Tuhy, MS3
Medical Student

9/16/02
Date

Hien Dam, MD

9-16-02
Date

Hien Dam, M.D.
Staff Psychiatrist /dkc

Date Dictated: 09/12/2002
Date Received: 09/16/2002
Date Typed: 09/16/2002
Date Printed: 09/16/2002

Patient name:_____ BHIS #_____

Elimination

☒ Independent and Continent
☐ Elimination with Assistance
☐ Independent and Incontinent

Explain:

Patient Education

☐ Understands why has fallen
☐ Can state preventative measures
☐ Practices preventive measures
☐ No understanding of why has fallen

Explain:
denies history of falling

Action Plan:

Signature Sandra Kroell RN Date 9-1-02

Patient name:_____BHIS #_____

☒ None Explain:

Patient able to:

☐ Stand in one place for 30 sec/both feet w/o holding
☐ Walk straight forward.
☐ Walk through doorway
☐ Walk making a turn.

Explain:

Falls Within Last Six Months

☒ No history of falling
☐ Has fallen 1 or 2 times.
☐ Has fallen 3 or more times
☐ Injury with previous falls

Explain:

Mobility

☒ No problems
☐ Confined to chair
☐ Uses walker
☐ Uses cane
☐ Prosthesis
☐ Needs assistance with transferring
☐ Recent decline in functional status

Explain:

Visual

☒ No visual impairment
☐ Limited vision
☐ Blind

Explain:

Hearing

☒ No hearing impairment
☐ Partial Hearing impairment
☐ Deaf

Explain:

Patient name:_____BHIS #_____

List other medications :

Change in meds and/or dosage in past 5days ☐ Yes ☒ No Explain:

Experiencing side effects from medications ☐ Yes ☒ No Explain:

Alcohol Consumption

☒ No alcohol consumption Explain: no ofes

☐ Recent history of alcohol consumption Explain:

Gait and Balance

☐ Demonstrates a wide base of support Explain:

☐ Demonstrates a loss of balance while standing Explain:

☐ Demonstrates balance problems when walking Explain:

☐ Demonstrates decreased muscular coordination Explain:

☐ Demonstrates lurching, swaying gait Explain:

☐ Demonstrates an instability when making turns Explain:

☐ Other Explain:

STATE OPERATED SERVICES

FALLS SCREENING

Patient name Patrick O'Dougherty BHIS# 39972

Date of assessment 9-11-02 Time of assessment 9AM

Gender ☐ M ☐ F Age 54

Mental Status Assessment

☒ Oriented at all times
☐ Intermittent confusion
☐ Confused at all times
☐ Anxiety, fear related to falling

Explain:

Medical History

☐ Osteoarthritis
☐ Dementia
☐ Neurological disorder
☐ Obesity
☐ Vertigo
☐ Post CVA
☐ Recent hypotension
☒ None

☐ Parkinson's
☐ Seizure disorder
☐ Cardiac disease
☐ Recent hypertension
☐ Loss of limbs
☐ Fractures
☐ TBI
☐ Other

Explain:

Medications

☐ Antihistamine
☐ Hypoglycemics
☐ Narcotics
☐ Over the counter meds

☐ Diuretic
☐ Laxatives
☐ Sedatives/hypnotics
☐ Other

☐ Antihypertensives
☐ Benzodiazepines
☒ Psychotropics
☐ None

Department of Human Services

Traumatic Brain Injury (TBI) Screen for Patients in State Operated Services

Complete within 15 days of admission (refer to DHS Policy 6230)

Yes ☐ No ☑ Unknown ☐ 1) Has the patient ever had a head injury, anoxic incident, coma or neurological procedure that required hospitalization?

Yes ☐ No ☑ Unknown ☐ 2) Is there a present diagnosis of organic mental disorder which may be attributed to a previous acute cerebral event or process either traumatic, vascular, anoxic, infectious or toxic (other than substance use related)?

Yes ☐ No ☑ Unknown ☐ 3) Are any neurologic motor, sensory or autonomic symptoms present other than idiopathic seizures for which there is no documented etiology?

Yes ☐ No ☑ Unknown ☐ 4) Does the patient have any dysfunction of thinking, emotions, communication or behavior which may be attributed to a previous acute cerebral event or process?

9-10-02 Date

Helen Dam, MD Signature

Upon completion of this document, if the team believes there is sufficient evidence that an acquired brain injury may exist, complete State Operated Services Referral.

Traumatic Brain Injury Program
State Operated Services Referral Form

Complete if questions in Traumatic Brain Injury Screen are answered "yes" and refer to the Minnesota Neurorehabilitation Hospital (MNH) TBI Screening Team per Policy 6230

MA/GAMC #:	Admission Date:
Repeat Referral Yes ☐ No ☐	State Operated Services Contact Person/Phone:

If you ask, we will give you this information in another form, such as Braille, large print or audiotape.

Facility Name:

Patient Name: O'LOUGHEATY, PATRICK /M
MREC #: MRTC BHIS #39972
Birthdate: 20042 ADM 9-
Sex:
Program/Unit: 08 12-1

ORIGINAL: Medical Record
COPY: MNH

DHS-3212 (9-98)

TRAUMATIC BRAIN INJURY SCREEN/REFERRAL FORM

SPIRITUALITY ASSESSMENT

completed by D. Nelson for Patricia

SECTION A: (To be completed by Patient) Date: 9/12/02

1. Religious/Faith Group preference: Catholic

2. Would you describe yourself as: ✓ religious ___ non-religious ___ atheist
___ spiritual ___ agnostic ___ believer ___ having a personal belief system

3. How much is your faith, God/Higher Power a source of strength and comfort to you now? ___ none ___ some ✓ much

4. My religious/spiritual background could be described as:
___ conservative ___ strict ___ liberal ___ positive ___ negative
✓ nurturing ___ fear inducing ___ legalistic ___ punishing
___ little/no background

5. I have had a special spiritual experience ✓ yes ___ no. If so, can you explain briefly?
I'm having one now -

6. Currently, or in the past, have you attended: (circle appropriate ones):
(Bible/religious studies) AA NA OEA EA AcoA CA
Dual Recovery Alanon Other:

7. Have you ever had a negative experience with religion or religious professionals? If so, can you explain briefly? NO

8. Recent or significant loss: generational - aunt, other family members

9. What spiritual/religious practices are meaningful or helpful for you?
sacraments; Bible reading & discussion

10. What brings you comfort or peace?
journalling

11. Other information you would like to share:

SECTION B: (To be completed by Chaplain)

Personal Interview Date: 9/12/02

Personal Data single; schizophrenic - paranoid, has made threats to court officials & a judge appears alone.

Community Spiritual Center: Cathedral of St. Paul

Name: _____ Phone: _____

Contacted: _____ Remarks: _____

Interview Summary:
appears pleasant
"everybody above me dies)" -

Recommendations for Treatment at AMRTC:
Father Gene will see.
Participate in Loss/Grief, Men's Group and Music Assimulation)

Aftercare Considerations:

Duane D. Olson
Chaplain

9/12/02
Date

IX. Recent es or Changes in F ionships. A. No es. B. Argument or displeasure with peer, staff, or significant other. C. One major loss, (i.e. loss of home, marriage, job, death of spouse). D. Several major losses. (List) __________ __________	C aunt died recently				
X. New Diagnosis or Recent Change in Health A. No change in physical or mental health B. Mild change, i.e. temporary illness C. Major changes – trauma, rape, new diagnosis	A				
XI. Warning Signs (check if present) ☐ A. Putting affairs in order ☐ B. Giving away prized possessions ☐ C. Covert suicide messages and death wishes ☐ D. Obvious suicide messages such as "I'd be better off dead" ☐ E. Suicide Note ☐ F. Returned early from a recent pass ☐ G. Has taken precautions against discovery ☐ H. Farewells to friends and family	☐ A. ☐ B. ☐ C. ☐ D. ☐ E. ☐ F. ☐ G. ☐ H.	☐ A. ☐ B. ☐ C. ☐ D. ☐ E. ☐ F. ☐ G. ☐ H.	☐ A. ☐ B. ☐ C. ☐ D. ☐ E. ☐ F. ☐ G. ☐ H.	☐ A. ☐ B. ☐ C. ☐ D. ☐ E. ☐ F. ☐ G. ☐ H.	☐ A. ☐ B. ☐ C. ☐ D. ☐ E. ☐ F. ☐ G. ☐ H.
Notified Attending or On Call Physician					
Nurse Initials	DD				

Signature	Initials	Signature	Initials
Doreen Dittleenne RN	DD		

ANOKA METRO REGIONAL TREATMENT CENTER
SUICIDE RISK ASSESSMENT

Directions: RN will complete at admission and whenever clinically indicated. In the column under each date the assessment is performed, indicate the letter of the item which best fits the patient's current functioning for each risk factor. Notify physician of results.

Date	9-10-08				
I. Suicidal Ideation, plan and intent to act on plan A. No thoughts and no plan or intent to harm self B. Has thoughts but no plan or intent to act on plan C. Has thoughts, active plan, but feels ambivalent about acting on plan. D. Has plan and intent to act on plan	A Length of time present:	Length of time present:	Length of time present:	Length of time present:	Length of time present:
II. Impulsivity A. No history and is not presently impulsive B. History of impulsivity, assaultive or self-destructive behavior C. Currently threatening to act out D. Currently unable to contract not to hurt self	B Length of time present:	Length of time present:	Length of time present:	Length of time present:	Length of time present:
III. Isolation A. Not isolating at all B. Readily responding to 1:1's or to participate C. Reluctant to socialize or participate D. Refusing to socialize, spending all time alone	A Length of time present:	Length of time present:	Length of time present:	Length of time present:	Length of time present:
IV. Reality Testing A. Oriented and lucid B. History of delusional, disoriented, confused thinking C. Currently hallucinating D. Command hallucinations to harm self	B Length of time present:	Length of time present:	Length of time present:	Length of time present:	Length of time present:
V. History of Suicide Attempts A. No history of attempts by self, family, or friends B. One attempt and/or family history of suicide C. Patient has more than one attempt but denies intent was to die. D. More than one attempt with intent to die, but none of the attempts required hospitalization. E. More than one attempt with intent to die, and patient required hospitalization after one of the attempts.	A				
VI. Level of Depression and or Anxiety A. No trouble eating or sleeping B. Minor trouble eating or sleeping F. Moderate trouble eating, sleeping, or concentrating. G. Major trouble eating or sleeping; feels helpless or hopeless; frequent crying without provocation; frequent panic attacks	A Length of time present:	Length of time present:	Length of time present:	Length of time present:	Length of time present:
VII. Currently level of hopelessness A. Patient believes they can get better B. Ambivalent about getting better C. Believes they cannot get better	A				
VIII. Chemical Use A. No history B. History of treatment, but sober now C. Multiple treatments, unable to remain sober D. Current alcohol or drug intoxication is endorsed or suspected; or patient is in withdrawal.	A				

PZ-82331 -01 (8-00)

ANOKA METRO REGIONAL TREATMENT CENTER
3301 SEVENTH AVENUE NORTH
ANOKA, MN 55182

Nutritional Assessment

ÚÄÄÄ
³Client Name: ODOUGHERTY,PATRICK (39972) ³Admission Date: 09/10/2002 ³
³Episode #: 2 ³Discharge Date: ³
³Chart Number: 20042 ³Physician: DAM,HIEN ³
³Legal Status: MI COMMITMENT ³ ³
³Prepared on: 09/17/2002 At: 05:50 PM ³Prepared by: Liz Friday Dietitian ³
ÀÄÄÄ

Basal energy expenditures x activity level (F1):
2228 kcal

Protein needs (F1): 67 gms

FLUID NEEDS/CONSUMPTION (See action plan for details)

Estimated fluid needs (F1): 2.3-3.0L

Water amount: 6-8

Coffee/tea amount: 3-4

Pop amount: occas

Alcohol amount: denies

Fluid consumption adequate: Yes

Fluid consumption inadequate: No

FOOD INTAKE/NUMBER OF SERVINGS PER DAY

Meat/protein amount (F1): 1-3

Milk/dairy amount (F1): 3-4

Fruit/vegetable amount (F1): 4-5

Bread/cereal amount (F1): 6-8

Food intake- (see action plan for details) (F1):
Food consumption adequate, Food preferences have been obtained

Meds that may have a significant food/drug interaction:
none

Lab values significant to nutritional status:
8/9/02: hemoglobin 15, hematocrit 43.8, mcv 91.2, potassium 3.8, albumin 4.2, sodium 139, BUN 15.

Observed or reported functional and behavioral problems (F1):
none.

Nutrition education - Diet compliance : N/A patient on regular diet

ANOKA METRO REGIONAL TREATMENT CENTER
3301 SEVENTH AVENUE NORTH
ANOKA, MN 55182

Nutritional Assessment

ÚÄÄÄ
³Client Name: ODOUGHERTY,PATRICK (39972) ³Admission Date: 09/10/2002 ³
³Episode #: 2 ³Discharge Date: ³
³Chart Number: 20042 ³Physician: DAM,HIEN ³
³Legal Status: MI COMMITMENT ³ ³
³Prepared on: 09/17/2002 At: 05:50 PM ³Prepared by: Liz Friday Dietitian ³
ÀÄÄÄ

Action Plan: Current nutritional status adequate

Comments (action plan):
Patrick appears to be adequately nourished per normal serum albumin, wt at 107% of upper end of RBWR, stable weight as well as self-reported good appetite and po intake. Regular diet appears appropriate. Pt excludes no major food groups and eats a relatively varied diet. Fluid intake is adequate. No difficulties chewing or swallowing. No bowel/elmination problems noted. Meds reviewed- no sig
fd-med interaction potential. Pt does take risperdal and haldol which can promote wt gain- he is aware of this. Briefly discussed ideas to prevent wt gain. Labs reviewed- no nutritional concerns here. Expect pt will continue to meet his nutritional needs while here at AMRTC. Appropriate nutritional goal would be no sig changes in weight. No scheduled RD f/u, but will be available per pt or staff request. RD will also follow monthly weights and intervene if significant change occurs.

Draft/Final: Final

Signature/Title Liz Friday RD 9/17/02

Date

INITIAL	FULL SIGNATURE	STATUS
CP	Cheryl Palinkas	RN

I	ISSUED MEDICATION
S	SELF MEDICATION
A	AWAY FROM TREATMENT CENTER

INITIAL	FULL SIGNATURE	STATU
DE		
CKB	Cindy Kasper BSN	LPN

STAT –ONE TIME – SINGLE ORDERS

MEDICAITON \ROUTE	DATE	HR	IN.

INJECTION SITE CODE

1. Right Arm
2. Left Arm
3. UDQ Right Buttock
4. UDQ Left Buttock
5. Right Leg
6. Left Leg

PATRICK ODOUGHERTY

Jarvis Exp. 2.19.04

OR Date / Inits,	Ep.date / Time	Medication – Dosage Frequency – Rt. of Adm.	DOSES GIVEN	
9/10/02 MJ	8/12	TYLENOL 650 MG PO Q 4 HR PRN MINOR PAIN	DATE	9/10
			TIME	10A
			INIT.	ME
9/10/02 MJ	8/12	MAALOX 15 CC PO Q 4 HR PRN G I UPSET	DATE	
			TIME	
			INIT.	
9/10/02 MJ	8/12	M. O. M. 30 CC PO Q HS PRN CONSTIPATION	DATE	
			TIME	
			INIT.	
4/1/03	9/6	NIZORAL SHAMPOO 1 % TOPICAL PRN	DATE	
			TIME	
			INIT.	
4/16/03 RS	7/16	SUNSCREEN TOPICALLY PRN	DATE	
			TIME	
			INIT	
			DATE	
			TIME	
			INIT.	
			DATE	
			TIME	
			INIT.	

PZ-81084-01B ODOUGHERTY, PATRICK /M

AMRTC BHIS #29972

Odougherty, Patrick #20042 ADM 9-10-05

Medication Administration Record

14 Day

Enter in Pencil # of forms in use. 1

ODOUGHERTY, PATRICK

AMRTC BHIS #39972

#20042 ADM 9-10-02

4/15 Level II mes

Janis Expires 2.19.04

Diagnoses: I. SCHIZOPHRENIA-- PARANOID-TYPE, R/O SCHIZO AFECTIVE D/O, R/O BIPOLAR DISORDER, MANIC WITH PSYCHOTIC FEATURES III. NO DX.

Allergies: NKA

Diet: REGULAR / MAY SELF MONITOR

Scheduled Medications - 44

DOB 12-1-

03 June DATE GIVEN

Date Init	Exp date	Medication – Dosage – Frequency – Rt. of Adm.	Hr	6/2	6/3	6/4	6/5	6/6	6/7	6/8	6/9	6/10	6/11	6/12	6/13	6/14	6/15
9/3/02 MJ	8/12	MVI 1 PO TAB QD	9A	A	A	S	S	S	S	S	S	S	S	S			
10/1/02 GT	8/12	RISPERIDOL 4 MG PO Q HS	9P	A	S	S	S	S	S	S	S	S	S	S			
1/7/03 SK	9/6	LITHOBID 600 MG PO	9A	A	A	S	S	S	S	S	S	S	S	S			
		BID	9P	A	S	S	S	S	S	S	S	S	S	S			
2/67/03 RS	M/O	FILL MEDI-MINDER Q WED	5P		BOP							S/A					
4/23/03 RS	8/12	LOPID 600 MG PO	9A	A	S	S	S	S	S	S	S	S	S	S			
		BID	9P	A	S	S	S	S	S	S	S	S	S	S			

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1-800-444-2123 (Industrial Client Service)

D. DAX TAYLOR, M.D.
DELBERT A. FISHER, M.D.

CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT				FINAL REPORT [X]	ACCOUNT NO.	ROUTE/STOP
ODOUGHERTY, PATRICK				PARTIAL REPORT [ ]	318162 ANOKA-METRO RTC LAB 3301 7TH AVE NO ANOKA, MN 55303	420000
SEX: M	AGE: 56	PATIENT ID	DRAWN DATE AND TIME: 05/20/2003 8:55			
SPECIMEN NO.: 615124575	HOSPITAL: Como 39972	DOCTOR: LUCAS	RECEIVED DATE: 05/20/2003			
COMMENTS					REPORT DATE AND TIME: 05/21/03 829A	

TEST NAME	RESULTS: WITHIN REFERENCE RANGE	RESULTS: OUTSIDE REFERENCE RANGE	UNIT OF MEASURE	REFERENCE RANGE
LIPID PANEL				
TRIGLYCERIDE/CHOLESTEROL				
TRIGLYCERIDES		207 H	MG/DL	<150
CHOLESTEROL, TOTAL		205 H	MG/DL	<200
CHOLESTEROL PERCENTILE	34		PERCENTILE	
HIGH DENSITY LIPOPROTEIN				
HDL CHOLESTEROL		38 L	MG/DL	>39
LDL CHOLESTEROL, CALCULATED				
LDL CHOLESTEROL, CALCULATED	126		MG/DL	<130
See note 1				
CHOLESTEROL/HDL RATIO		5.4 H		<5.0

Lipids
600 mg
Rid - cut - 1 wpth
5/21/03

Call 07

CONTINUED REPORT

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CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT				FINAL REPORT [X]	ACCOUNT NO.	ROUTE/STOP
ODOUGHERTY, PATRICK				PARTIAL REPORT [ ]	318162	420000
SEX	AGE	PATIENT ID	DRAWN DATE AND TIME		ANOKA-METRO RTC LAB	
M	50		05/20/2003 8:55		3301 7TH AVE NO	
SPECIMEN NO.		DOCTOR	RECEIVED DATE		ANOKA, MN 55303	
615124575	cano 39972	LUCAS	05/20/2003			

COMMENTS

REPORT DATE AND TIME: 05/21/03 829A

TEST NAME	RESULTS (WITHIN REFERENCE RANGE)	RESULTS (OUTSIDE REFERENCE RANGE)	UNIT OF MEASURE	REFERENCE RANGE
Note(s):	Text of Message			
1	LDL CHOLESTEROL (MG/DL) GOALS AND CUTPOINTS FOR THERAPEUTIC LIFESTYLE CHANGES (TLC) AND DRUG THERAPY IN DIFFERENT RISK CATEGORIES (AFTER EXCLUSION OR, IF APPROPRIATE, TREATMENT OF SECONDARY CAUSES OF LDL ELEVATION). FROM NCEP ATP-III REPORT, MAY 2001.			
RISK CATEGORY	LDL GOAL	LDL TO INITIATE TLC	LDL TO CONSIDER DRUG THERAPY	
CHD OR CHD EQUIVALENTS: 10 YR RISK >20%	<100	>99	>129 (100-129: DRUG OPTIONAL)	
2+ RISK FACTORS: 10 YR RISK 10-20%	<130	>129	>129	
2+ RISK FACTORS: 10 YR RISK <10%	<130	>129	>159	
0-1 RISK FACTORS:	<160	>159	>189 (160-189: DRUG OPTIONAL)	

5/21/03

6/7/03

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D. DAX TAYLOR, M.D.

DELBERT A. FISHER, M.D.

CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT: DOUGHERTY, PATRICK

SEX: M | AGE: 39 | PATIENT ID: [illegible] | DRAWN DATE AND TIME: [illegible]

SPECIMEN NO.: 30527917 | HOSP. NO.: 39972 | DOCTOR: ZNAMIEROWSKI

FINAL REPORT ☒

PARTIAL REPORT ☐

RECEIVED DATE: [illegible]

ACCOUNT NO.: [illegible] | ROUTE/STOP: [illegible]

[illegible]
[illegible]
3331 7th AVE NO
[illegible]

COMMENTS

REPORT DATE AND TIME: 03/18/03 10:09

TEST NAME	RESULTS (WITHIN REFERENCE RANGE)	RESULTS (OUTSIDE REFERENCE RANGE)	UNIT OF MEASURE	REFERENCE RANGE
LITHIUM, SERUM	0.8		MMOL/L	0.6-1.5
RISPERIDONE & 9-HYDROXYRISPER				
9-HYDROXYRISPERIDONE	27		NG/ML	
RISPERIDONE	5		NG/ML	
COMBINED TOTAL	32		NG/ML	
REFERENCE RANGE:				
4-6 MG/DAY: 36-54				
8-16 MG/DAY: 70-110				

THIS TEST WAS PERFORMED AT:

QUEST DIAGNOSTICS, NICHOLS INSTITUTE
33608 ORTEGA HWY.
SAN JUAN CAPISTRANO, CA 92690

3/17/03

3/21/03

DOUGHERTY, PATRICK

[illegible]

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D. DAX TAYLOR, M.D. — DELBERT A. FISHER, M.D.

CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT	SEX	AGE	PATIENT ID	DRAWN DATE AND TIME
ODOUGHERTY, PATRICK	M	5		04/15/2003 9:34

FINAL REPORT [X]
PARTIAL REPORT [ ]

ACCOUNT NO.	ROUTE/STOP
318162	420000

ANOKA-METRO RTC
LAB
3301 7TH AVE NO
ANOKA, MN 55303

SPECIMEN NO.	HOSP. NO.	DOCTOR	RECEIVED DATE
610164042	39972	BAUMER	04/15/2003

COMMENTS: como

REPORT DATE AND TIME: 04/21/03 520A

TEST NAME	RESULTS (WITHIN REFERENCE RANGE)	RESULTS (OUTSIDE REFERENCE RANGE)	UNIT OF MEASURE	REFERENCE RANGE
LITHIUM, SERUM	0.9		MMOL/L	0.6-1.5
RISPERIDONE & 9-HYDROXYRISPER				
9-HYDROXYRISPERIDONE	33		NG/ML	
RISPERIDONE	0		NG/ML	
COMBINED TOTAL	33		NG/ML	

REFERENCE RANGE:
4-6 MG/DAY: 36-54
8-16 MG/DAY: 70-110

THIS TEST WAS PERFORMED AT:

QUEST DIAGNOSTICS, NICHOLS INSTITUTE
33608 ORTEGA HWY.
SAN JUAN CAPISTRANO, CA 92690

4/25/03

4/21/03

610164042

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C. DAX TAYLOR, M.D. — DELBERT A. FISHER, M.D.

CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT	ODOUGHERTY, PATRICK
SEX	M
AGE	50
PATIENT ID	
DRAWN DATE AND TIME	04/22/2003 9:35
SPECIMEN NO.	611110161
HOSP. NO.	39972
DOCTOR	UUUMER
RECEIVED DATE	04/22/2003
COMMENTS	

FINAL REPORT [X]
PARTIAL REPORT [ ]

ACCOUNT NO.	318162
ROUTE/STOP	420000
	ANOKA-METRO RTC
	LAB
	3301 7TH AVE NO
	ANOKA, MN 55303

REPORT DATE AND TIME: 04/23/03 712A

TEST NAME	RESULTS (WITHIN REFERENCE RANGE)	RESULTS (OUTSIDE REFERENCE RANGE)	UNIT OF MEASURE	REFERENCE RANGE
LIPID PANEL				
TRIGLYCERIDE/CHOLESTEROL				
TRIGLYCERIDES	124		MG/DL	<150
CHOLESTEROL, TOTAL		221 H	MG/DL	<200
CHOLESTEROL PERCENTILE	51		PERCENTILE	
HIGH DENSITY LIPOPROTEIN				
HDL CHOLESTEROL	44		MG/DL	>39
LDL CHOLESTEROL, CALCULATED				
LDL CHOLESTEROL, CALCULATED		152 H	MG/DL	<130
See note 1				
CHOLESTEROL/HDL RATIO		5.0 H		<5.0

Re: Lipid 1 yr
Start Lipitor 10mg
Recheck chol.

4/25/03
LB

4/23/03

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CLIA REGISTRATION: 14D0417052
MEDICARE CERTIFICATE: 57-0920

PATIENT				FINAL REPORT [X]	ACCOUNT NO.	ROUTE/STOP
ODOUGHERTY, PATRICK				PARTIAL REPORT [ ]	318162	420000
SEX M	AGE 50	PATIENT ID	DRAWN DATE AND TIME 04/22/2003 9:35		ANOKA-METRO RTC LAB 3301 7TH AVE NO ANOKA, MN 55303	
SPECIMEN NO. 611110161	HOSP. NO. 39978	DOCTOR BUUMER	RECEIVED DATE 04/22/2003			
COMMENTS					REPORT DATE AND TIME 04/23/03 712A	

TEST NAME	RESULTS (WITHIN REFERENCE RANGE / OUTSIDE REFERENCE RANGE)	UNIT OF MEASURE	REFERENCE RANGE
Note(s): Text of Message			

1 LDL CHOLESTEROL (MG/DL) GOALS AND CUTPOINTS FOR THERAPEUTIC LIFESTYLE CHANGES (TLC) AND DRUG THERAPY IN DIFFERENT RISK CATEGORIES (AFTER EXCLUSION OR, IF APPROPRIATE, TREATMENT OF SECONDARY CAUSES OF LDL ELEVATION). FROM NCEP ATP-III REPORT, MAY 2001.

RISK CATEGORY	LDL GOAL	LDL TO INITIATE TLC	LDL TO CONSIDER DRUG THERAPY
CHD OR CHD EQUIVALENTS: 10 YR RISK >20%	<100	>99	>129 (100-129: DRUG OPTIONAL)
2+ RISK FACTORS: 10 YR RISK 10-20%	<130	>129	>129
2+ RISK FACTORS: 10 YR RISK <10%	<130	>129	>159
0-1 RISK FACTORS:	<160	>159	>189 (160-189: DRUG OPTIONAL)

4/23/03

4/23/03

ODOUGHERTY, PATRICK

611110161

Date	9-10-02	9-11-02	9-12-02	9-13-02	9-14-02	9-15-02	9-16-02
Time	8A	8A	8A 8P	8	8		
Pulse* / Temp.							
Respirations	20	20	18 20	16	16	16	
Blood Pressure	104/65	108/68	110/60 120/64	108/78	112/74	127/78	
Oral Intake							
Total Oral Intake							
Urine						9815	
F						100	
WT						191	
Total Output							
Stools							

Pulse 106° 105° 104° 103° 102° 101° 100° 99° 98° 97° 96° 95° 94° 93° 92°

Pulse 88 Pulse 68

(Chart Pulse in red ink)

DHS-1135 (8-91)

Facility Name:
Patient Name: (LOUGHERTY, PATRICK /M
MREC #:
Birthdate: MAR [illegible] A39472
Sex:
Program/Unit: [illegible]

GRAPHIC CHART

Date	9/17/02	9-19-02	weekly 9-22-02	weekly 10-5-02	weekly 10-12-02	weekly 10-20-02	11-2-02
Time	8A	8A					
Respirations	16	16	18	20	16	1	
Blood Pressure		114/76	110/80	98/64	124/82	120/0.8	118/74
Oral Intake	104						
Total Oral Intake	70						
Urine							
weight			190	193	192	192	194
Total Output							
Stools							

Pulse* / Temp.: 190 — 106° · 180 — 105° · 170 — 104° · 160 — 103° · 150 — 102° · 140 — 101° · 130 — 100° · 120 — 99° · 110 — 98° · 100 — 97° · 90 — 96° · 80 — 95° · 70 — 94° · 60 — 93° · 50 — 92°

T 98.6 · P 104 · T 99 · P 96 · T 97.9 · P 72

(Chart Pulse in red ink)

DHS-1135 (8-91)

Facility Name:

Patient Name:
MREC #:
Birthdate:
Sex:
Program/Unit:

GRAPHIC CHART

DOUGHERTY, PATRICK M

ANRTC UNIT # 39972

20042 ADM 9-10-02

DOB 12-11-45

MONTHLY NURSING ASSESSMENT RECORD

ar	Jan.	Feb.	March	April	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
WEIGHT												
2	~									191	194	198
3	208	211	208	219	215	219						
BLOOD PRESSURE										T. 994		
2	~									115/80	118/74	114/66
3	122/64	130/62	138/76	118/58	102/64	120/60						
PULSE										R. 14		
2	~									64	72	74
3	88	100	90	97	90	95						
FEET												
2	~									OK	OK	OK
3	O.K.	OK	OK	OK	OK	OK						
SKIN												
2	~									OK	OK	OK
3	O.K.	OK	OK	OK	OK	OK						
SCALP												
2	~									OK	OK	dry
3	O.K.	DRY	OK	OK	OK	OK						

1999-02 (8/95)

	Type of Vaccine	Date Given (Mo/Day/Yr)	Manufacturer	Lot #	Name and Title of Person Administering Vaccine
Diphtheria Tetanus Pertussis Type: DTP DT-Pediatric Td-Adult					
Polio Type: OPV IPV					
Measles Mumps Rubella					
Influenza	Trivalent Type A&B	10/23/02	Wyeth Lederle	4020033	[signature]
Hepatitis B					
Pneumococcal					
Other:					

Facility Name:

Patient Name:
MREC #:
Birthdate:
Sex:
Program/Unit:

DHS-1145A (8-97)
SIDE 1

IMMUNIZATION RECORD

MANTOUX TESTING

Date Given (Mo./Day/Yr)	Manufacturer and Lot #	Given By: Name/Title	Read By: Name/Title	Results Date/m.m.
9-10-02	Negative Mantoux at NMC on 8/10/02 (See enclosed form)		Moeller 9-10-02	
6/25/03	Berkedale # 001462P	Cindy Kasper Bean, LPN	T Todd	6/27/03 - 0.0mm

HEPATITIS B TESTING	Date	Results	Date	Results	Date	Results
Surface Antibody						
Core Antibody						
Surface Antigen						

OTHER DIAGNOSTIC TESTS	Date	Result
HIV		

DHS-1145A (8-97)
SIDE 2

Facility Name:

Patient Name: DOUGHERTY, PATRICK J.
MREC #:
Birthdate: DOB 12-11-46
Sex:
Program/Unit: ANRTC BHIS #39972
#20042 ADM 9-10-02

IMMUNIZATION RECORD