STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM CLARENDON COUNTY
Court of Common Pleas

W.B. McCullough, Special Referee

Case Number: 2018-002199

Wilmington Savings Fund Society, FSB, D/B/A Christina Trust as Owner Trustee of the Residential Credit Opportunities Trust V ..... Respondent,

v.

Leroy Hooks, II and Ford Motor Credit Company, LLC .....
Defendants,

Of Whom Leroy Hooks, II is the Appellant,
And

Patrick A Wheeler and Maria D. Williams, ... Respondents.

RECORD ON APPEAL

VOLUME I

William Ceth Land, Esquire
Land Parker Welch LLC
Post Office Box 138
Manning, SC 29102
(803) 435-8894
Attorney for Appellant Hooks

Chad W. Burgess, Esquire
3800 Fernandina Road, Suite 110
Columbia, SC 29210
803-454-3540
Atty. for Respondent Wilmington Savings

Patrick R. Watts, Esquire
P.O. Box 2046
Summerville, SC 29484
843-851-7050
Atty. for Respondent Wheeler and Williams

INDEX

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	THIRD JUDICIAL CIRCUIT
COUNTY OF CLARENDON)	DOCKET NO. 2018-CP-14-00044

Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff,	
Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendants,	**ORDER DENYING MOTION**
Patricia A. Wheeler and Maria D. Williams, Intervenors.	

This matter comes before the undersigned Special Referee on the MOTION FOR A NEW TRIAL OR FOR RELIEF FROM ORDER filed by the defendant, Leroy Hooks, II, by and through his attorney. A hearing was held in my office at which time I was attended by William Ceth Land, Esquire, attorney for Leroy Hooks, II, (HOOKS); Caroline Glenn, Esquire, attorney for the Plaintiff; and, Patrick R. Watts, Esquire, attorney for the intervenors.

The motion is based upon the grounds that Hooks is an incompetent person. Rule 17(c) requires the Court/Special Referee to appoint a Guardian ad litem to protect the interest of an incompetent person before his property can be divested. It is also argued that in this action the Court lacked personal jurisdiction over Hooks, thereby rendering the Judgment of Foreclosure and Sale void.

The Intervenors, being the purchasers at the sale of the property subject of the said Order, are parties to this action, and should be allowed to intervene.

Delphine Howard alleges to be the sister of Hooks. At the hearing her affidavit, and attachments, were submitted to the Court by Mr. Land. The attachments are marked as follows:

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Exhibit 1: an unsigned form letter from the VA regional office stating Hooks was rated 100 percent, service-connected, permanent and totally disabled effective 5/19/1989. Also two unsigned form letters mailed to Hooks, at his request, confirming his VA disabilities.

Exhibit 2: an unsigned form letter dated 04/09/2018 from the Social Security office addressed to Kayia Davis of Tampa Florida, attaching her unsigned application to be representative payee for Hooks

Exhibit 3: unsigned medical records progress notes dated 09/12/2018. Hooks is noted as stating he had a cough that started a couple weeks ago and was on antibiotics, that he did not understand why the VA would not pull his tooth, and that his niece became his payee two months earlier. He appeared alert and oriented with moderately impaired insight and judgment. He appeared at interviews alone, and without assistance. He stated he wanted to handle his own money. His MENTAL STATUS EXAM reported him to be well groomed, with no abnormal behavior, normal speech, cooperative and attentive, normal affect, and with "linear, goal directed" thought process without auditory or visual hallucinations. Paranoia was noted that his family was taking his possessions. Concentration and attention fully intact. Short and long term memory also intact.

Exhibit 4: is an unsigned portion of a CHASE statement.

The Delphine Howard affidavit mainly recites cherry picked statements from the attached VA medical records and concludes the schizophrenia causes many problems and Hooks is unable to handle his own legal and financial needs.

A list of documents and an index were submitted at the hearing, a full copy of which may be filed by Mr. Land, if he so desires, and the Clerk of Court for Clarendon County permits such a filing.

2

Debra Williams, a Social Worker with the VA, appeared at the hearing, solely for the purpose of authenticating the VA medical records attached to the said affidavit were from the VA office.

No expert testimony was presented at the hearing relating to Hooks' mental incompetence.

There was no evidence that a general guardian had ever been appointed for Hooks since the diagnosis, or certification, made by the VA in 1989.

No motion or application for the appointment of a Guardian ad litem was made during the pendency of this action.

I therefore find that Mr. Hooks' motion should be, and it is therefore, DENIED.

W. B. McCollough
SPECIAL REFEREE

Kingstree, South Carolina
November 16, 2018

3

FORM 4

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON IN THE COMMON PLEAS COURT	JUDGMENT IN A CIVIL CASE CASE NO. 2018-CP-14-00044
Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V PLAINTIFF(S)	Leroy Hooks, II; Ford Motor Credit Company, LLC DEFENDANT(S)

Submitted by: Brock & Scott, PLLC Westpark Center 3800 Fernandina Road Suite 110 Columbia, SC 29210	Attorney for : ☒ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (*CHECK APPLICABLE BOX*): ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

2018 MAY 14 AM 8:56

IT IS ORDERED AND ADJUDGED: ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk :

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Agninst (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
		N/A

If applicable, describe the property, including tax map information and address, referenced in the order:
All that certain piece, parcel or lot of land situate lying and being in Clarendon County, State of South Carolina the same being more fully described as Lot No. 5 containing 2.14 acres on a plat surveyed for Sarah Watson Ragin by Edisto Surveyors, Inc., dated 07/02/1985, as recorded in Plat Book No. 36 Page 132 the same being bound and measuring as follows: East by Lot No. 5 on aforesaid plat and measuring thereon 330.20 feet; North by lands of South Carolina Public Service Authority and measuring thereon 276.33 feet; West by lands of S. C. Public Service Authority and measuring thereon 200 feet; West by Lot No. 4 on aforesaid plat and measuring thereon 430.34 feet; this being a portion of a tract of land designated on Track "F" containing 12.4 acres on a plat for Sarah W. Ragin dated July 12, 1971, by Baughman Land Surveyors, Inc., and the same being conveyed to Sarah W Ragin by Pansey H. Parnell et. al., by deed dated December 4, 1971, as recorded in Deed Book No. A-46 Page 190 in Office of the Clerk of Court for Clarendon County, State of South Carolina.

Together with an 30 foot easement and right of ingress and egress of the eastern side of Tract "F" beginning at Road S-14-419 then in a

Northern direction for 409.41 feet; then in a northeastern direction for 202.86 feet to the presises above described, the same being more fully shown on the aforementioned plat. This easement and right of way is to run with the land.

This being the same property conveyed to Leroy Hooks, II by Deed of Sarah W. Ragin dated July 17, 1985 and recorded July 19, 1985 in Book A131 at Page 69 in the Office of the Register of Deeds for Clarendon County, South Carolina.

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. **Note: Title abstractors and researchers should refer to the official court order for judgment details. E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.**

Adam McCulloch — 2084 — 5/02/2018

~~Circuit Court Judge~~ Special Referee — Judge Code — Date

For Clerk of Court Office Use Only

This judgment was entered on the ____ day of _____, 2018 and a copy mailed first class or placed in the appropriate attorney's box on this ____ day of _____, 2018 to attorneys of record or to parties (when appearing pro se) as follows:

Brock & Scott, PLLC
Westpark Center
3800 Fernandina Road Suite 110
Columbia, SC 29210
ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

CLERK OF COURT

Court Reporter:

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

STATE OF SOUTH CAROLINA
COUNTY OF CLARENDON

IN THE COURT OF COMMON PLEAS
CASE NO.: 2018-CP-14-00044

Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,

Plaintiff,

v.

Leroy Hooks, II; Ford Motor Credit Company, LLC,

Defendant(s)

SPECIAL REFEREE'S ORDER AND JUDGMENT OF FORECLOSURE AND SALE

DEFICIENCY WAIVED

Pursuant to Rule 53 of the South Carolina Rules of Civil Procedure (hereinafter "SCRCP"), the above-entitled matter was referred to the undersigned Special Referee to make appropriate findings of fact and conclusions of law, with authority to enter a final Judgment in the cause. Any appeal from the decision of the Special Referee shall be directly to the South Carolina Court of Appeals or Supreme Court.

Pursuant to the said reference, a hearing was held, a record was made, which is reported herewith, and from the testimony and evidence, I find and conclude as follows:

FINDINGS OF FACT:

1. The Lis Pendens was filed on February 5, 2018.

2. The Summons and Complaint were filed on February 5, 2018.

3. Service was made upon the Defendants named in this Report as is shown by the proofs of service filed herein.

4. The Defendant(s) are in default as shown by Affidavit filed herein.

5. According to an Affidavit filed herein, no Defendant in default is in the military service of the United States of America, as contemplated under the Servicemembers' Civil Relief Act fka Soldiers' and Sailors' Civil Relief Act of 1940, and any amendments thereto.

6. The Defendant(s) were notified of the time, date and place of hearing in this matter.

7. For value received, Leroy Hooks, II made, executed and delivered a note, dated December 18, 2008, promising thereby to pay to the order of Beach First National Bank the sum of $239,112.00 with interest at the rate of 6.5% per annum (hereinafter "Note"). Other terms and conditions are stated in the note, which is of record herein.

8. To better secure the payment of the Note described above, the said Leroy Hooks, II made, executed and delivered a mortgage to Mortgage Electronic Registration Systems, Inc. as nominee for Beach First National Bank, in writing, dated December 18, 2008, covering real property in Clarendon County, which is the same as that described in the Complaint. The Mortgage was recorded on December 29, 2008, and is of record in the Clarendon County Registry in Book 825 at page 160.

9. This mortgage constitutes a valid first lien on the subject property.

10. Thereafter, the Mortgage was assigned to GMAC Mortgage, LLC by assignment recorded on April 5, 2010 in Book 875 at Page 174. Thereafter, the Mortgage was assigned to Ocwen Loan Servicing, LLC by assignment recorded on May 3, 2013 in Book 981 at Page 283. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB DBA Christiana Trust as Trustee for HLSS Mortgage Master Trust for the benefit of the holders of the Series 2014-1 Certificates issued by HLSS Mortgage Master Trust by assignment recorded on February 10, 2017 in Book 1100 at Page 105. Thereafter, the Mortgage was

assigned to Secretary of Housing and Urban Development by assignment recorded on February 10, 2017 in Book 1100 at Page 106. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB d/b/a Christiana Trust, not in its individual capacity but solely in its capacity as Owner Trustee of Matawin Ventures Trust Series 2016-2 by assignment recorded on February 10, 2017 in Book 1100 at Page 107. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V by assignment recorded on January 10, 2018 in Book 1130 at Page 232.

11. Subsequently, Leroy Hooks, II did make, execute and deliver to GMAC Mortgage, LLC (servicer for the loan at the time of the modification), its successors and assigns, a certain Loan Modification Agreement, dated 10/01/2010, amending and supplementing the Note and Mortgage described above. By virtue of the Loan Modification Agreement, the unpaid principal balance was modified to $245,460.16, together with interest at the rate of 4.75% per annum on the unpaid balance.

12. As required by South Carolina Supreme Court Administrative Order 2009-05-22-01 (hereinafter, "the Administrative Order"), Plaintiff states that this loan is not owned or guaranteed by Fannie Mae, nor is it owned or guaranteed by Freddie Mac, nor has the Servicer signed an agreement to participate in the Home Affordable Modification Program (hereinafter, "the HAMP"); therefore, the loan is not eligible for modification under the HAMP.

13. Furthermore, Plaintiff complied with Administrative Order 2011-05-02-1 issued by the South Carolina Supreme Court.

14. The titleholder(s) of record of the Property as of the filing of the Lis Pendens in this action was/were Leroy Hooks.

15. Payment due on the Note has not been made as provided for therein, and the Plaintiff, as the holder thereof, has elected to accelerate payment of the entire indebtedness and has placed the Note and Mortgage in the hands of its attorney of record herein for collection.

16. Having considered the nature, extent and difficulty of the services rendered (the field of mortgage foreclosures being a specialized area of practice); the time involved in reviewing the various loan documents, performing the title search, preparing the pleadings and preparing for and attending hearings; the professional standing of the Plaintiff's attorney; the fee customarily charged in this jurisdiction for similar services; and the beneficial results obtained for the Plaintiff, I find that the sum of $2,280.00 is a reasonable attorney's fee for the Plaintiff's attorney for services performed and anticipated to be performed until final adjudication of the within action, under the terms of the note and mortgage. Services anticipated to be performed until final adjudication contemplates completion of this matter within a reasonable time and does not include exceptional, unanticipated circumstances delaying conclusion beyond the normal time. The amount due and owing on the Note and Mortgage, with interest at the rate provided in the Note, and other costs and expenses of collection, including attorney's fees, secured by the Note and Mortgage, is as follows:

Principal due as of today's date:	05/03/18			$224,544.82
Accrued interest from:	09/01/15	to:	05/03/18	$ 28,501.60
Accruing at:	4.75% per annum			
Advancements to Escrow				$ 1,907.63
Corporate Advances				$ 2,280.66
Late charges:				$ 1,587.82

Other charges:	$ 1,045.00
Costs of collection prior to hearing:	$ 1,261.08
Attorney's fees:	$ 2,280.00

Total Debt secured by Note and Mortgage, including interest to date is $263,408.61. Interest for the period from the date shown above through the date of this judgment, at above stated rate, to be added to the above stated "Total Debt" to comprise the amount of the Judgment debt entered herein, and interest after the date of Judgment at the rate of 4.75% per annum, the Note's current rate, pursuant to the terms of the Note and Mortgage on the judgment debt should be added to such judgment debt to comprise the amount of the Plaintiff's debt secured by the Mortgage through the date to which such interest is computed.

17. The Plaintiff is seeking foreclosure of its mortgage and has, in the Complaint or subsequently thereto in writing, expressly Waived the right to a personal or deficiency Judgment pursuant to Rule 71(b), SCRCP.

18. The Defendant(s), below listed, claim or may claim liens upon or interests in the subject property; and in the event there is a surplus from the sale of the subject property, the validity, priority and amount of any such lien claims will be determined at a hearing subsequent to the sale, in accordance with Rule 71(c), SCRCP. The said Defendants and such claims or liens are as follows:

> The Defendant, Ford Motor Credit Company, LLC, has or may claim to have some interest in the Property by virtue of a pending civil action against Andrew A. Hooks and Leroy A. Hooks, II a/k/a Leroy A. Hooks, which was filed in the Clarendon County Records on 09/05/2017, Civil Action No.: 2017-CP-14-00333. Any interest that this Defendant presently has or may acquire through the referenced pending civil action or by any other lien or civil proceeding up to the

time of any foreclosure sale herein would be junior to Plaintiff's mortgage and it is hereby ordered removed from the title to the Property.

CONCLUSIONS OF LAW: I, therefore, conclude as follows:

1. The Plaintiff should have judgment of foreclosure of its Mortgage; and the Property should be ordered sold at public auction after due advertisement.
2. That there is due to the Plaintiff on its Note and Mortgage the sum of $263,408.61, representing the Total Debt due to the Plaintiff as outlined above, together with interest thereon at the rate provided in the Note to the date hereof.
3. That the amount due in the preceding paragraph (the "Total Debt") and later accrued interest and costs shall constitute the total judgment debt due to the Plaintiff and shall bear interest hereafter at the rate of 4.75% per annum, the current interest rate of the Note.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED:

1. That the Defendant(s) liable for the aforesaid Mortgage debt shall, prior to the date and time of the sale of the Property, hereinafter described, pay to the Plaintiff, or the Plaintiff's attorney, the amount of the Plaintiff's debt as aforesaid, together with the costs and disbursements of this action.
2. That on default of payment prior to the date and time of the sale, the Property, hereinafter described, shall be sold by the undersigned Special Referee at public auction, at the Clarendon County Courthouse, City of Manning, County and State aforesaid, on some convenient sales day hereafter, on the following terms, that is to say:

   A. FOR CASH: The undersigned Special Referee shall require a deposit of 5% on the amount of the bid (in cash or equivalent) the same to be applied on the purchase

price only upon compliance with the bid, but in case of non-compliance within thirty (30) days the same to be forfeited and applied to the costs and then to the Plaintiff's debt.

B. Interest on the balance of the bid shall be paid to the day of compliance at the rate of 4.75% per annum, which is the Note's current interest rate.

C. The sale shall be subject to taxes and assessments, existing easements and restrictions of record, and any other senior encumbrances.

D. Purchaser to pay for the deed and the cost of recording the deed.

3. If the Plaintiff is the successful bidder at the said sale, for a sum not exceeding the amount of costs, expenses and the indebtedness of the Plaintiff in full, the Plaintiff may pay to the undersigned Special Referee only the amount of the costs and expenses, crediting the balance of the bid on the Plaintiffs indebtedness.

4. That a personal or deficiency Judgment being Waived, the bidding will not remain open for thirty (30) days and bidding will be final on the date of the sale, and compliance with the bid may be made immediately.

5. That the undersigned Special Referee will, by advertisement according to law, give notice of the time and place of sale and the terms thercof; and that he/she will execute to the purchaser, or purchasers, a deed to the Property sold. The Plaintiff, or any other party to this action, or any other person may become a purchaser at such sale. If such sale is made to anyone other than the Plaintiff or its assignee, should the successful bidder, or his/her assignee, fail to comply with the terms thereof within thirty (30) days after the date of sale, then the undersigned Special Referee may re-advertise the Property for sale on the next, or some other subsequent, sales day,

at the risk of the highest bidder, and so on from time to time thereafter until a full compliance shall be secured.

6. That the undersigned Special Referee shall apply the proceeds of the sale as follows:

FIRST: To the payment of the amount of the costs and expenses of this action, including any Guardian Ad Litem fee or fees of attorneys appointed under Order of Court; and

NEXT: To the payment of the amount to the Plaintiff, or the Plaintiffs Attorney, of the amount of the Plaintiff's debt and interest (including attorney fees) or so much thereof as the purchase money will pay on the same; and

NEXT: Any surplus will be held pending further Order of this Court pursuant to Rule 71(c), SCRCP.

7. That it is further ORDERED, ADJUDGED AND DECREED that each Defendant named herein, and all persons whomsoever claiming under him, them or it, be forever barred and foreclosed of all right, title, interest and equity of redemption in the said mortgaged premises so sold, or any part thereof.

8. That it is further ORDERED ADJUDGED AND DECREED that the deed of conveyance made pursuant to this judgment and said sale shall contain the names of only the Plaintiff, the first-named Defendant, who was the title holder of the mortgaged property at the time of the filing of the Lis Pendens, and the Grantee; and that the Clarendon County Register of Deeds is hereby authorized to omit from the indices pertaining to such conveyance the names of all parties not contained in said deed.

9. It is further ORDERED, ADJUDGED AND DECREED that in the event the successful bidder to whom the deed of conveyance has been issued subsequent to the sale is other

than the Defendants in possession herein, the Sheriff of Clarendon County may be ordered and directed to eject and remove from the premises the occupants of the property sold, together with all personal property located thereon, and put the successful bidder to whom the deed of conveyance has been issued or his assigns in full, quiet and peaceable possession of said premises without delay, and to keep said successful bidder or his assigns in such peaceable possession.

10. That it is further ORDERED ADJUDGED AND DECREED that after the Order Confirming Sale and Disbursements has been issued and filed, the undersigned Special Referee shall direct the Register of Deeds to release of record the lien(s) being foreclosed, which lien(s) are described in the Findings of Fact herein above.

11. That it is further ORDERED ADJUDGED AND DECREED that the following is a description of the Property herein ordered to be sold:

ALL THAT CERTAIN PIECE, PARCEL OR LOT OF LAND SITUATE LYING AND BEING IN CLARENDON COUNTY, STATE OF SOUTH CAROLINA THE SAME BEING MORE FULLY DESCRIBED AS LOT NO. 5 CONTAINING 2.14 ACRES ON A PLAT SURVEYED FOR SARAH WATSON RAGIN BY EDISTO SURVEYORS, INC., DATED 07/02/1985, AS RECORDED IN PLAT BOOK NO. 36 PAGE 132 THE SAME BEING BOUND AND MEASURING AS FOLLOWS: EAST BY LOT NO. 5 ON AFORESAID PLAT AND MEASURING THEREON 330.20 FEET; NORTH BY LANDS OF SOUTH CAROLINA PUBLIC SERVICE AUTHORITY AND MEASURING THEREON 276.33 FEET; WEST BY LANDS OF S. C. PUBLIC SERVICE AUTHORITY AND MEASURING THEREON 200 FEET; WEST BY LOT NO. 4 ON AFORESAID PLAT AND MEASURING THEREON 430.34 FEET; THIS BEING A PORTION OF A TRACT OF LAND DESIGNATED ON TRACK "F" CONTAINING 12.4 ACRES ON A PLAT FOR SARAH W. RAGIN DATED JULY 12, 1971, BY BAUGHMAN LAND SURVEYORS, INC., AND THE SAME BEING CONVEYED TO SARAH W RAGIN BY PANSEY H. PARNELL ET. AL., BY DEED DATED DECEMBER 4, 1971, AS RECORDED IN DEED BOOK NO. A-46 PAGE 190 IN

OFFICE OF THE CLERK OF COURT FOR CLARENDON COUNTY, STATE OF SOUTH CAROLINA.

TOGETHER WITH AN 30 FOOT EASEMENT AND RIGHT OF INGRESS AND EGRESS OF THE EASTERN SIDE OF TRACT "F" BEGINNING AT ROAD 5-14-419 THEN IN A NORTHERN DIRECTION FOR 409.41 FEET; THEN IN A NORTHEASTERN DIRECTION FOR 202.86 FEET TO THE PRESISES ABOVE DESCRIBED, THE SAME BEING MORE FULLY SHOWN ON THE AFOREMENTIONED PLAT. THIS EASEMENT AND RIGHT OF WAY IS TO RUN WITH THE LAND.

THIS BEING THE SAME PROPERTY CONVEYED TO LEROY HOOKS, II BY DEED OF SARAH W. RAGIN DATED JULY 17, 1985 AND RECORDED JULY 19, 1985 IN BOOK A131 AT PAGE 69 IN THE OFFICE OF THE REGISTER OF DEEDS FOR CLARENDON COUNTY, SOUTH CAROLINA.

CURRENT ADDRESS OF PROPERTY: 1992 Jacks Creek Road, Summerton, SC 29148

TMS: 038-00-02-016-00

AND IT IS SO ORDERED.

The Honorable W.B. McCollough
Special Referee for Clarendon County

Date: May 2 2018
Kingstree, South Carolina

File reference: 17-16410

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff, vs. Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendant(s).	IN THE COURT OF COMMON PLEAS C/A NO.: 2018-CP-14-00044 **ORDER OF REFERENCE** (Action for Foreclosure)

Upon motion of the undersigned attorney for Plaintiff, it appearing that this case is a foreclosure action; and it further appearing, pursuant to Rule 53(b) South Carolina Rules of Civil Procedure, that this is a proper matter to refer to The Honorable W.B. McCollough as Special Referee for Clarendon County.

Now therefore, IT IS ORDERED that the above entitled cause be, and the same is hereby, referred to The Honorable W.B. McCollough as Special Referee for Clarendon County for a final foreclosure hearing to be held, wherein the Special Referee will make appropriate findings of fact and conclusions of law with authority to dispose of any and all issues and enter a final judgment in the cause, without further order of court, to order a judicial sale on any day, not just a regular judicial sales day and to hear any issues and make any orders after sale or judgment, including but not limited to, issues involving surplus funds pursuant to Rule 71(c) SCRCP, Petitions or Motions relating to Writ of Assistance or any other actions as to possession, and/or removal of property, and issues pursuant to appraisal proceedings under S.C. Code Ann. Section 29-3-680, et seq. (1976 SC Code of Laws, as amended).

Any appeal from the final judgment in this cause shall be to the South Carolina Court of Appeals.

_____
Clerk of Court

Clarendon, South Carolina
Date: _____

WE SO MOVE:
s/ Mary R. Powers
SC Bar #: 16534
Attorney for Plaintiff
Brock & Scott, PLLC
3800 Fernandina Road, Suite 110
Columbia, SC 29210
Phone 803-454-3540
Date: 3/1/2018
Mary.Powers@brockandscott.com

Clarendon Common Pleas

Case Caption: Wilmington Savings Fund Society Fsb , plaintiff, et al VS Leroy Hooks II , defendant, et al

Case Number: 2018CP1400044

Type: Order/Referred to Master or Special Referee

So Ordered

s/Beulah G. Roberts, Clerk of Court

Electronically signed on 2018-03-12 09:49:48 page 2 of 2

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON	IN THE COURT OF COMMON PLEAS CASE NO. 2018-CP-14-00044
Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff, vs. Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendants.	**ORDER FOR SERVICE BY PUBLICATION**

WHEREAS the attorney for Plaintiff moves this court for an order authorizing service by publication upon Defendant(s) Leroy Hooks, II. This court reviewed the motion together with the affidavit(s) in support thereof and any other filings in this case as deemed advisable by the undersigned. Said review results in a determination: that a cause of action does exist and is pending against the aforementioned Defendant(s); that said Defendant(s) is/are proper party(ies) to the action by virtue of a lien or interest in real property in South Carolina to which the action is related; and that said Defendant(s) cannot, after due diligence, be found within the State of South Carolina.

NOW, THEREFORE, ON MOTION of the attorney for the Plaintiff,

IT IS ORDERED that the Summons in the above entitled action, together with the Notice of Filing the Complaint, be served upon Defendant(s) Leroy Hooks, II by publication of the same in a weekly newspaper of general circulation published in the County of Clarendon, South Carolina, once a week for three (3) consecutive weeks. I find the *The Manning Times* is the newspaper most likely to give notice to the Defendant(s) sufficiently,

IT IS FURTHER ORDERED that copies of the Summons be deposited in the U.S. Mail as provided in §15-9-740 of the *S.C. Code Ann.* (1976) to the last known address of Defendant(s) Leroy Hooks, II.

END OF DOCUMENT

ELECTRONIC SIGNATURE PAGE TO FOLLOW

Clarendon Common Pleas

Case Caption: Wilmington Savings Fund Society Fsb , plaintiff, et al VS Leroy Hooks II , defendant, et al

Case Number: 2018CP1400044

Type: Order/Publication

So Ordered

s/Beulah G. Roberts, Clerk of Court

Electronically signed on 2018-02-20 16:43:16 page 2 of 2

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF Clarendon) Third JUDICIAL CIRCUIT
)
) CASE NO.: 2018-CP-14-00044
)
Wilmington Savings Fund Society, et al.) **MOTION AND ORDER INFORMATION**
Plaintiff,) **FORM AND COVERSHEET**
vs.)
)
Leroy Hooks, II, et al)
Defendant.)

Plaintiff's Attorney:	Defendant's Attorney:
Mary R. Powers, Bar No. 16534 Address: 3800 Fernandina Rd. Ste 110, Columbia, SC 29210 Phone: 803-454-3540Fax 803-454-3541 E-mail: mary.powers@brockandscott.comOther: ____	William Ceth Land, Bar No. 13490 Address: PO Box 138 Manning, SC 29102 Phone: 803-435-8894 Fax803-435-8362 E-mail: ceth@lpwlawfirm.comOther: ____

☒ **MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)**
☐ **FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)**
☐ **PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)**

SECTION I: Hearing Information

Nature of Motion: Motion for New Trial or Relief From Order
Estimated Time Needed: 30 minutes Court Reporter Needed: ☒YES/☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☐ Plaintiff/☒ Defendant 7/19/18 Date submitted

SECTION III: Motion Fee

☐ PAID – AMOUNT: $ _____
☐ EXEMPT: (check reason)
☐ Rule to Show Cause in Child or Spousal Support
☐ Domestic Abuse or Abuse and Neglect
☐ Indigent Status ☐ State Agency v. Indigent Party
☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
☐ Motion for Stay in Bankruptcy
☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter: _____
☐ Other: _____

2018 JUL 19 AM 11:02

JUDGE'S SECTION	
☐ Motion Fee to be paid upon filing of the attached order. ☐ Other:	JUDGE CODE _____ Date: _____

CLERK'S VERIFICATION

Collected by:_____ Date Filed: _____
☐ MOTION FEE COLLECTED: $ _____
☐ CONTESTED – AMOUNT DUE: $ _____

STATE OF SOUTH CAROLINA)
) CASE NO: 2018-CP-14-00044
) IN THE COURT OF COMMON PLEAS
COUNTY OF CLARENDON)

2018 JUL 19 AM 11:02

Wilmington Savings Fund Society, FSC, d/b/a Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,

Plaintiff,

Vs.

Leroy Hooks, II and Ford Motor Credit Company, LLC,

Defendants.

MOTION FOR A NEW TRIAL OR FOR RELIEF FROM ORDER

TO: **THE PLAINTIFFS ABOVE NAMED AND THEIR ATTORNEYS, MARY R. POWERS, BROOK DELOACH DANGERFIELD AND CAROLINE RICHARDSON GLENN:**

That the Defendant, Leroy Hooks, II, by and through his undersigned attorney, moves pursuant to Rule 59 for a New Trial and Rule 60 for Relief from the "Judgment or Order related to the Judgment of Foreclosure and Sale", hereinafter "Order", issued by W.B. McCollough, Special Referee for Clarendon County, clocked in on May 14, 2018. The Motions are brought pursuant to the following:

1. The family of Defendant Hooks received notice of the Order on July 12, 2018; therefore, this Motion is timely pursuant to Rule 59(b) and 60(b).
2. That Defendant Hooks suffers from schizophrenia; therefore, is an incompetent person and pursuant to Rule 17(c) a Guardian *ad litem* should have been appointed on his behalf. The Court lacked personal jurisdiction over Defendant Hooks because he is an incompetent person and a Guardian *ad litem* was not appointed to protect his interests.

3. The attorneys for the Plaintiffs filed a "Certificate of Compliance" with South Carolina Supreme Court Administrative Order No. 2011-05-02-1 on April 26, 2018 indicating that the property "is not an owner-occupied dwelling". This filing with the Court was erroneous in that Defendant Hooks is the owner and occupant of the subject property located at 1992 Jacks Creek Road, Summerton, South Carolina.
4. Pursuant to Rule 59(a) a new trial should be held to allow additional testimony, new or amended findings of fact and conclusions of law and the entry of a new Order.
5. Pursuant to Rule 60(3) the Plaintiffs have committed fraud, misrepresentation, or other misconduct by failing to have a Guardian *ad litem* appointed for the incompetent Defendant Hooks and by filing the "Certificate of Compliance" stating that the property was not an "owner-occupied dwelling" when it in fact was owner-occupied.
6. Pursuant to Rule 60(4) the Order is void because the Court lacked personal jurisdiction over Defendant Hooks because he is an incompetent person and a Guardian *ad litem* had not been appointed pursuant to Rule 17(c).

Therefore, Defendant Hooks respectfully requests that the Court reconsider the Order and set aside the same to allow the appointing of a Guardian *ad litem* for Defendant Hooks, allow Defendant Hooks to file responsive pleadings, require the Plaintiffs to comply with Administrative Order No. 2011-05-02-1, hold a new trial to allow additional testimony, new or amended findings of fact and conclusions of law and the entry of a new Order.

PLEASE TAKE NOTICE that if you fail to appear Defendant Hooks will move before the Court in your absence for the relief requested.

Respectfully submitted.

LAND, PARKER & WELCH, P.A.

BY: _____

William Seth Land, Esquire
Post Office Box 138
29 South Mill Street
Manning, South Carolina 29102
803-435-8894

Manning, South Carolina

7/19, 2018

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON	IN THE COURT OF COMMON PLEAS CASE NO. 2018-CP-14-00044
Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff, vs. Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendants.	**MOTION FOR SERVICE BY PUBLICATION**

A cause of action exists in favor of the above named Plaintiff against the above named Defendant(s) relating to real property in the State of South Carolina, the same being shown by the Complaint filed herein. The Defendant Leroy Hooks, II, after due diligence, cannot be found within the State of South Carolina. Said named Defendant is proper party to the action, as more fully described in the pleadings of the Plaintiff filed herein. It appears that the said Defendant may have or claim a lien or interest in the subject real property. An affidavit in support of this motion is being filed herewith and is incorporated herein by reference.

The undersigned, Attorney for the Plaintiff, does hereby move for an order

that the Summons in the above entitled action, together with the Notice of Filing the Complaint, be served upon Defendant Leroy Hooks, II by publication of the same in a weekly newspaper of general circulation published in the County of Clarendon, South Carolina, once a week for three (3) consecutive weeks.

IT IS FURTHER ORDERED that in the event the Plaintiff amends its Complaint pursuant to Rule 15, South Carolina Rules of Civil Procedure, and the above-referenced Defendant has not made a formal appearance in this case at that time, then service of said amended pleading(s) shall be authorized pursuant to this order in the manner described above.

I SO MOVE

Date: 2/14/18

S/Bradford M. Stokes
SCBar# 78032
Brock & Scott, PLLC
3800 Fernandina Road, Suite 110
Columbia, SC 29210
Phone 844-856-6646 Fax 803-454-3451
Attorneys for Plaintiff
Brad.stokes@brockandscott.com

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff, vs. Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendant(s).	IN THE COURT OF COMMON PLEAS C/A NO.: _____ **SUMMONS AND NOTICES** (Non-Jury) FORECLOSURE OF REAL ESTATE MORTGAGE

TO THE DEFENDANT(S) ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to appear and defend by answering the Complaint in this action, a copy of which is hereby served upon you, and to serve a copy of your Answer on the subscribers at their offices at 3800 Fernandina Road, Suite 110, Columbia, SC 29210, within thirty (30) days after the service hereof, exclusive of the day of such service; except that the United States of America, if named, shall have sixty (60) days to answer after the service hereof, exclusive of the day of such service; and if you fail to do so, judgment by default will be rendered against you for the relief demanded in the Complaint.

TO MINOR(S) OVER FOURTEEN YEARS OF AGE, AND/OR TO MINOR(S) UNDER FOURTEEN YEARS OF AGE AND THE PERSON WITH WHOM THE MINOR(S) RESIDES, AND/OR TO PERSONS UNDER SOME LEGAL DISABILITY:

YOU ARE FURTHER SUMMONED AND NOTIFIED to apply for the appointment of a guardian *ad litem* within thirty (30) days after the service of this Summons and Notice upon you. If you fail to do so, application for such appointment will be made by Attorney for Plaintiff.

YOU WILL ALSO TAKE NOTICE that Plaintiff will move for an Order of Reference or the Court may issue a general Order of Reference of this action to a Master-in-Equity/Special Referee, pursuant to Rule 53 of the *South Carolina Rules of Civil Procedure*.

YOU WILL ALSO TAKE NOTICE that under the provisions of S.C. Code Ann. § 29-3-100, effective June 16, 1993, any collateral assignment of rents contained in the referenced Mortgage is perfected and Attorney for Plaintiff hereby gives notice that all rents shall be payable directly to it by delivery to its undersigned attorneys from the date of default. In the alternative, Plaintiff will move before a judge of this Circuit on the 10th day after service hereof, or as soon thereafter as counsel may be heard, for an Order enforcing the assignment of rents, if any, and compelling payment of all rents covered by such assignment directly to the Plaintiff, which motion is to be based upon the original Note and Mortgage herein and the Complaint attached hereto.

s/Mary R. Powers
S.C. Bar No. 16534
Attorney for the Plaintiff
3800 Fernandina Road, Suite 110
Columbia, SC 29210
Phone: 803-454-3540 Fax: 803-454-3541
Mary.Powers@brockandscott.com

STATE OF SOUTH CAROLINA COUNTY OF CLARENDON	IN THE COURT OF COMMON PLEAS C/A NO.: _____
Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, Plaintiff, vs. Leroy Hooks, II; Ford Motor Credit Company, LLC, Defendant(s).	**COMPLAINT** (Non-Jury) FORECLOSURE OF REAL ESTATE MORTGAGE (Deficiency Judgment Demanded as to Defendant(s) Leroy Hooks, II)

The Plaintiff above-named, complaining of the Defendant(s) herein, alleges that:

1. Plaintiff, Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V, is a business entity duly authorized to conduct business in the State of South Carolina.

2. Upon information and belief, the Defendant(s), Leroy Hooks, II, and Ford Motor Credit Company, LLC, may claim some interest in the real estate, which is the subject of this action and this Court has proper jurisdiction over said Defendants.

3. The real property hereinafter described, that is the subject of this action, is situated and located in the County of Clarendon, State of South Carolina, and this Court has proper jurisdiction over the subject matter and the parties of this action.

4. Heretofore, Leroy Hooks, II (hereinafter, "Borrower(s)") made, executed, and delivered to Beach First National Bank (hereinafter, "Lender") a certain Fixed Rate Note dated December 18, 2008, in writing (hereinafter, "Note"), wherein and whereby Leroy

Hooks, II promised to pay to Beach First National Bank, the principal sum of $239,112.00, together with interest at the rate of 6.5% per annum on the unpaid balance; said principal and interest being payable in monthly installments thereafter until the said Note is fully paid.

5. In order to secure the payment of said Note, the said Leroy Hooks, II (hereinafter, "Mortgagor(s)"), did make, execute, and deliver to Mortgage Electronic Registration Systems, Inc. as nominee for Beach First National Bank, its successors and assigns, a certain mortgage dated December 18, 2008 (hereinafter, "Mortgage") securing the below described real property, including any and all improvements to the property, located in the County and State aforesaid (hereinafter, "Property"):

> All that certain piece, parcel or lot of land situate lying and being in Clarendon County, State of South Carolina the same being more fully described as Lot No. 5 containing 2.14 acres on a plat surveyed for Sarah Watson Ragin by Edisto Surveyors, Inc., dated 07/02/1985, as recorded in Plat Book No. 36 Page 132 the same being bound and measuring as follows: East by Lot No. 6 on aforesaid plat and measuring thereon 330.20 feet; North by lands of South Carolina Public Service Authority and measuring thereon 276.33 feet; West by lands of S. C. Public Service Authority and measuring thereon 200 feet; West by Lot No. 4 on aforesaid plat and measuring thereon 430.34 feet; this being a portion of a tract of land designated on Track "F" containing 12.4 acres on a plat for Sarah W. Ragin dated July 12, 1971, by Baughman Land Surveyors, Inc., and the same being conveyed to Sarah W Ragin by Pansey H. Parnell et. al., by deed dated December 4, 1971, as recorded in Deed Book No. A-46 Page 190 in Office of the Clerk of Court for Clarendon County, State of South Carolina.
>
> Together with an 30 foot easement and right of ingress and egress of the eastern side of Tract "F" beginning at Road 5-14-419 then in a Northern direction for 409.41 feet; then in a northeastern direction for 202.86 feet to the presises above described, the same being more fully shown on the aforementioned plat. This easement and right of way is to run with the land.

This being the same property conveyed to Leroy Hooks, II by Deed of Sarah W. Ragin dated July 17, 1985 and recorded July 19, 1985 in Book A131 at Page 69 in the Office of the Register of Deeds for Clarendon County, South Carolina.

Parcel Number: 038-00-02-016-00
Property Address: 1992 Jacks Creek Road, Summerton, SC 29148

6. Said Mortgage was recorded on December 29, 2008 in Book 825 at Page 160, in the Clarendon County Registry.

7. Thereafter, the Mortgage was assigned to GMAC Mortgage, LLC by assignment recorded on April 5, 2010 in Book 875 at Page 174. Thereafter, the Mortgage was assigned to Ocwen Loan Servicing, LLC by assignment recorded on May 3, 2013 in Book 981 at Page 283. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB DBA Christiana Trust as Trustee for HLSS Mortgage Master Trust for the benefit of the holders of the Series 2014-1 Certificates issued by HLSS Mortgage Master Trust by assignment recorded on February 10, 2017 in Book 1100 at Page 105. Thereafter, the Mortgage was assigned to Secretary of Housing and Urban Development by assignment recorded on February 10, 2017 in Book 1100 at Page 106. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB d/b/a Christiana Trust, not in its individual capacity but solely in its capacity as Owner Trustee of Matawin Ventures Trust Series 2016-2 by assignment recorded on February 10, 2017 in Book 1100 at Page 107. Thereafter, the Mortgage was assigned to Wilmington Savings Fund Society, FSB, D/B/A Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V by assignment recorded on January 10, 2018 in Book 1130 at Page 232.

8. The Mortgage evidences and secures the repayment of money advanced by the Lender to, or on behalf of, the Mortgagor(s) and constitutes a valid first lien on the Property.

9. Subsequently, Leroy Hooks, II did make, execute and deliver to GMAC Mortgage, LLC (servicer for the loan at the time of the modification), its successors and assigns, a certain Loan Modification Agreement, dated 10/01/2010, amending and supplementing the Note and Mortgage described above. By virtue of the Loan Modification Agreement, the unpaid principal balance was modified to $245,460.16, together with interest at the rate of 4.75% per annum on the unpaid balance.

10. As required by South Carolina Supreme Court Administrative Order 2009-05-22-01 (hereinafter, "the Administrative Order"), Plaintiff states that this loan is not owned or guaranteed by Fannie Mae, nor is it owned or guaranteed by Freddie Mac, nor has the Servicer signed an agreement to participate in the Home Affordable Modification Program (hereinafter, "the HAMP"); therefore, Plaintiff alleges upon information and belief, that the loan is not eligible for modification under the HAMP.

11. Any notice required by the terms of the Mortgage or by State or Federal law has been given to the applicable defendant(s) prior to the commencement of this action.

12. The Plaintiff herein is entitled to enforce said Note and has the right to foreclose by virtue of the Plaintiff's status as holder of the instrument, a nonholder in possession of the instrument who has the rights of a holder, or person not in possession of the instrument who is entitled to enforce the instrument pursuant to S.C. Code Ann. §§ 36-3-309 or 36-3-418(d) (2008).

13. In and by the terms of said Note and the Mortgage securing the same, it is provided, among other things, that on failure to pay any installment of either principal or interest or any portion thereof when due, or if any of the conditions and requirements in the Mortgage securing the same not be complied with, then the whole principal sum and accrued interest

shall at the option of the legal holder thereof become at once due and payable without notice, and collectible by foreclosure.

14. In and by the terms of the said Note it is further provided that the maker thereof shall pay all collection costs including reasonable attorneys' fees if the said Note be placed in the hands of an attorney for collection after default.

15. The Plaintiff demands a personal or deficiency judgment, and the Plaintiff has the right to seek a deficiency judgment against the maker(s) of its Note, Leroy Hooks, II. That in the event that the net amount realized by the Plaintiff upon the sale of the subject property is insufficient to pay in full the total indebtedness of the Plaintiff, including costs of collection, the Plaintiff demands a personal judgment against said Defendant(s) in the amount of such deficiency.

16. The installments of principal and interest falling due from and after October 1, 2015 have not been paid although demand for the payment thereof has been made. The Plaintiff, has and does hereby elect to declare the entire balance of said principal and interest due and payable at once; that there is now due and owing and unpaid upon the said Note and Mortgage the full and just principal sum of $224,544.82, together with interest at the rate of 4.75% per annum, the current/modified rate of interest, from the date of the last payment, together with reasonable attorneys' fees for the collection thereof and the costs of this action. Plaintiff may be forced to pay sums for taxes, insurance and costs for securing the property, which sums, according to the terms of the Mortgage, should be added to the amount of the debt.

17. Upon information and belief, said information having been obtained from the records of Clarendon County, South Carolina, the Defendant(s) below named has/have or

may claim to have some interest in or lien upon the Property by virtue of the matters and things herein below alleged, to-wit:

A. The Defendant, Ford Motor Credit Company, LLC, has or may claim to have some interest in the Property by virtue of a pending civil action against Andrew A. Hooks and Leroy A. Hooks, II a/k/a Leroy A. Hooks, which was filed in the Clarendon County Records on 09/05/2017, Civil Action No.: 2017-CP-14-00333. Any interest that this Defendant presently has or may acquire through the referenced pending civil action or by any other lien or civil proceeding up to the time of any foreclosure sale herein would be junior to Plaintiff's mortgage and should be removed from the title to the Property upon the completion of a properly held foreclosure sale.

WHEREFORE, Plaintiff prays judgment that:

A. The amount due upon the said Note and Mortgage held by the Plaintiff be ascertained and determined under the direction of this Court, together with attorney's fees and costs of this action.

B. Appoint a Receiver to collect the rents, issue, profits or designated sums from the mortgagor(s), and/or the grantee(s) of the mortgagor(s), and/or tenant(s) occupying or exercising control over the mortgaged premises and hold the same subject to the further order of this Court.

C. Plaintiff's Mortgage be declared a valid first lien and that Plaintiff have judgment of foreclosure for the amount so found to be due and owing thereon, together with any taxes or insurance premiums which may be due or which may be or have been paid by Plaintiff, together with attorney's fees and for the costs of this action.

D. The Property be sold according to law and the practice of this Court, the equity of redemption be barred and that the proceeds of sale be applied as follows:

First, to the costs and expenses of the within action and said sale;

Second, to the payment and discharge of the amount due on Plaintiff's Note and Mortgage, together with attorney's fees as aforesaid; and

Third, the surplus, if any, be distributed according to law.

Fourth, that the Plaintiff be awarded a deficiency judgment against the Defendant(s), Leroy Hooks, II, in the event that the proceeds of the sale of the Property are insufficient to pay in full the indebtedness, including costs of collection.

E. For such other and further relief as may be just and proper.

FURTHER, in the event the successful bidder (at the time of this foreclosure sale) is other than the Defendant(s) in possession herein, the Sheriff of Clarendon County will be ordered and directed to eject and remove from the premises the occupants of the property sold, together with all personal property located therein, and put the successful bidder or his assigns in full, quiet and peaceable possession of said Property without delay, and to keep the successful bidder or his assigns in such peaceable possession.

s/Mary R. Powers
S.C. Bar No. 16534
Attorney for the Plaintiff
3800 Fernandina Road, Suite 110
Columbia, SC 29210
Phone: 803-454-3540 Fax: 803-454-3541
Mary.Powers@brockandscott.com

STATE OF SOUTH CAROLINA)		CASE NO: 2018-CP-14-00044
)		IN THE COURT OF COMMON PLEAS
COUNTY OF CLARENDON)		
Wilmington Savings Fund Society, FSC, d/b/a Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,	)	
Plaintiff,	)	
Vs.	)	AFFIDAVIT OF DELPHINE HOWARD
Leroy Hooks, II and Ford Motor Credit Company, LLC,	)	
Defendants.	)	

PERSONALLY APPEARED BEFORE ME, Delphine Howard, who being duly sworn deposes and says:

My brother, Leroy A Hooks II, is the son of Leroy A. Hooks Sr., a World War II veteran, and Dorothy Ragin Hooks, an educator for the Board of Education. Leroy followed in his father's footsteps and enlisted in the Army in the 1970's. While in the military, he sustained injuries that resulted in a mental breakdown. He was later diagnosed with schizophrenia, paranoia, and depression. After his medical discharge, Leroy was classified as a 100% disabled veteran effective May 19, 1989. (Ex. 1). He was then released into the care of his father. In addition to be 100% disabled by the Department of Veteran Affairs my brother has also been deemed disabled by the Social Security Administration. Because Leroy did not handle his money well various family members have been his "Representative Payee," with Kaiya Davis, his niece, acting in this capacity since April of this year. (Ex. 2).

My brother was married, but after years together his marriage ended in divorce. Following his divorce, his physical and mental health declined. He was now faced with

another health diagnoses Perforated Diverticulosis, which resulted in a series of operations including a colostomy. His frustration with his life and health and now having a colostomy bag, further aggravated his depression. Everything in his life became so overwhelming that he distanced himself from his responsibilities, family, and friends.

I have attached my brother's medical records from the VA for his treatment over the past nine years. (Ex. 3). I will point out some of the statements in his records:

Page 1: 9/12/18 "Involuntarily admitted to Recovery East due to report of worsening psychosis."

Page 2: 9/12/18 "Diagnoses: Unspecified Depressive Disorder, Schizophrenia."

Page 4-5: 1/30/15 "Five-day inpatient stay. . . . Paranoia: Yes, Veteran is paranoid that his family is taking his belongings."

Page 7: 9/9/18 "Veteran yelled out while laying in bed 'He keeps following me' . . . 'I know, but I just keep hearing voices.'"

Page 9-11: 11/6/15 "January 2015 for paranoid thoughts, committed for 5 days. 2009 hospitalized; one-year hospitalization in Monroe, NY over 30 years ago and was diagnosed with schizophrenia at that time. . .Schizophrenia, paranoid type. . . <u>He has not managed his money before and given the history of head injury and memory problems would recommend to continue with a fiduciary for his disability</u>." (Emphasis Added).

Page 14: 9/8/18 "Psychotic (hallucinations)."

Page 22-23: 9/10/18 "His niece recently started helping him with payment of his bills. . . She may be willing to assist him in the management of his affairs. . . Provider spoke with sister of patient, Delphine Howard, who confirmed all of the above information.

She reports that he was having difficulty for some time and is thankful that he is in hospital setting."

Page 25: 9/8/18 "'I have been feeling depressed and I was hearing voices'. . . He states he has been hearing voices telling him to kill himself and he knew he needed help. . . auditory hallucinations. . . The patient has been diagnosed with schizophrenia and schizoaffective disorder, in the past and is 100% service connected for psychiatric illness. He estimates he has been psychiatrically hospitalized 'about 10 times'."

Page 27: 9/8/18 "Disheveled male appearing older than stated age. . . Schizophrenia, Paranoid Type."

Page 29: 9/7/18 "Depressive disorder has been involuntarily admitted to Recovery East on 9/7/18 . . . Said that he no longer wants to harm his brother."

Page 34: 9/8/18 "Suicidal thoughts and command auditory hallucinations telling him to kill himself."

Page 39: 11/19/15 "Schizophrenia . . . In January 2015 he was committed to psych hospital in Charleston, SC, because his brother made allegations he shot at him."

Page 44: 9/12/18 "Does this patient lack the cognitive ability to make relevant decisions? Yes."

Page 51: 9/7/18 "Exacerbation of his paranoid schizophrenia; patient is having hallucinations, some which are bizarre and reports threating VOICES telling him that he will die, and that he should go ahead and kill himself."

Page 58: 9/10/18 "Paranoid schizophrenia with (primarily) auditory hallucinations and suicidal ideation."

Page 65: 2/19/10 "Bipolar Disorder".

Page 67: 12/4/09 "He was impulsive and had racing thoughts. He was having auditory hallucinations that had faded away. . . He stated that he has been feeling well and the hallucinations and 'erratic' behavior had faded away."

Page 70-71: 10/28/09 "Mr. Hooks arrived agitated, confused and probably delusional/paranoid. His psychosis has cleared but pt. continues to have anxiety of the 'no contact' order that his former tenant has on him. . . . Bipolar disorder vs Schizophrenia vs Schizoaffective disorder."

Page 85: 10/26/09 "Patient seems to be rambling and tangential . . . Bipolar disorder vs Schizophrenia. . . Patient with pressured speech, tangentiality, grandiose presentation, racing thoughts, and describes resolving paranoia. Symptoms most consistent with bipolar disorder."

Page 86: 10/26/09 "Demon lady has been blowing marijuana on me while she locks me in the bathroom."

Page 89: 10/26/09 "Patient is a very poor historian. Tells stories that cannot be well correlated."

Page 95: 10/26/09 "Auditory / Visual Hallucinations / Delusions / Disorganized Behavior . . . PTSD."

Page 99: 10/24/09 "Schizophrenia."

Page 119: 10/23/09 "He is always talking about them coming to get him. . . sat in corner mumbling to himself throughout the assessment . . . hearing voices."

Page 121: 10/23/09 "100% SC for schizophrenia. . . Was a relatively poor historian and offers a vary disjointed story."

Page 123: 10/23/09 "I am hearing voice and I am afraid to go in my house."

As you can see from these medical records my brother's Schizophrenia causes him many problems and he is unable to handle his own legal and financial needs. My brother did not know his house was being foreclosed on because he never received notice or even if he did receive notice he doesn't have the capacity to know what to do about a foreclosure action. When we were contacted and informed that the house was sold at an auction this was an issue for the entire family because the house is located on inherited family property.

Our family is also confused by why this case was even brought. My brother's mortgage is paid automatically from this bank account as can be seen from the attached bank statements. (Ex. 4). Each month $1,227.67 was taken out of his account to pay what we believed to be the home mortgage.

I ask that on behalf of my brother that his case be reopened so that our family can hire an attorney to fight this foreclosure for our brother. It is unfair and un-American to have my brother's home taken away from him after he as fought and suffered for our country.

SWORN to before me this 15

Day of Oct., 2018.

Notary Public for S.C.

My Commission Expires: 10/5/28

Delphine Howard

Delphine Howard

5

STATE OF SOUTH CAROLINA)
)
COUNTY OF CLARENDON)

CASE NO: 2018-CP-14-00044
IN THE COURT OF COMMON PLEAS

Wilmington Savings Fund Society, FSC, d/b/a Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,

Plaintiff,

Vs.

Leroy Hooks, II and Ford Motor Credit Company, LLC,

Defendants.

EXHIBIT 1

Department Of Veterans Affairs
110 9th Avenue South
Nashville, TN 37203

July 20, 2018

In Reply Refer To: 320/NCC/AE
C XXXXX477
HOOKS L A

LEROY HOOKS
1992 JACKS CREEK RD
SUMMERTON SC 29148

Dear Leroy A Hooks,

This letter is a summary of benefits you currently receive from the Department of Veterans Affairs (VA). We are providing this letter to disabled Veterans to use in applying for benefits such as state or local property or vehicle tax relief, civil service preference, to obtain housing entitlements, free or reduced state park annual memberships, or any other program or entitlement in which verification of VA benefits is required. Please safeguard this important document. This letter is considered an official record of your VA entitlement.

Our records contain the following information:

Personal Claim Information

Your VA claim number is:XXXXXX477
You are the Veteran.

Military Information

The character(s) of discharge and service date(s) of the veteran include:
Honorable, Army, 08/25/1975-03/29/1977
(There may be additional periods of service not listed above)

VA Benefits Information

Service-connected disability: Yes
Your combined service-connected evaluation is: 100%
Your current monthly award amount is:
Are you entitled to a higher level of disability due to being unemployable: No
Are you considered to be totally and permanently disabled due to your service-connected disabilities: Yes
Are you service-connected for loss of or loss of use of a limb, or are you totally blind in or missing at least one eye: No
Have you received a Specially Adapted Housing (SAH) and/or Special Home Adaptation (SHA) grant: No

You should contact your state or local office of veterans' affairs for information on any tax, license, or fee-related benefits for which you may be eligible. State offices of veterans' affairs are available at http://www.va.gov/statedva.htm.

Department Of Veterans Affairs
110 9th Avenue South
Nashville, TN 37203

July 20, 2018

LEROY HOOKS
1992 JACKS CREEK RD
SUMMERTON SC 29148

In Reply Refer To: 320/NCC/AE
C XXXXX477
HOOKS L A

To Whom it May Concern:

The official records of the Department of Veterans Affairs verify that Leroy A Hooks was rated 100 percent, service-connected, permanent and totally disabled effective 5/19/1989.

Do You Have Questions or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	For Compensation, call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711. For Pension, call us at 1-877-294-6380.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov.
Write	Put your full name and VA file number on the letter. Please send all correspondence to the address below: Department of Veterans Affairs Intake Center PO Box 4444 Janesville, WI 53547-4444 Toll Free Fax: 1-844-531-7818 DID : 248-524-4260

With sincere regard for the Veteran's service,

RO Director
VA Regional Office

To email us visit https://iris.va.gov

For the Veteran's Use Only

Department Of Veterans Affairs
110 9th Avenue South
Nashville, TN 37203

July 20, 2018

In Reply Refer To: 320/NCC/AE
C XXXXX477
HOOKS L A

LEROY HOOKS
1992 JACKS CREEK RD
SUMMERTON SC 29148

Dear Leroy A Hooks,

This is in reply to your request for a statement verifying your service-connected disabilities.

Department of Veterans Affairs (VA) records show your service-connected disabilities are as follows:

Percentage	Disability	Diag Code
100	schizophrenia, chronic undifferentiated (previously evaluated as schizophrenia, paranoid under 9203)	9204
0	left knee sprain	5257
0	sensorineural hearing loss, left ear (previously evaluated under 6297)	6200
0	Scars, head, face or neck	7800
0	prostatitis	7527

100	**Combined Rating**

Do You Have Questions or Need Assistance?

If you have any questions, you may contact us by telephone, e-mail, or letter.

If you	Here is what to do.
Telephone	For Compensation, call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the number is 711. For Pension, call us at 1-877-294-6380.
Use the Internet	Send electronic inquiries through the Internet at https://iris.va.gov.
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STATE OF SOUTH CAROLINA	)	CASE NO: 2018-CP-14-00044
	)	IN THE COURT OF COMMON PLEAS
COUNTY OF CLARENDON	)	

Wilmington Savings Fund Society, FSC, d/b/a Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,	)
Plaintiff,	)
Vs.	)
Leroy Hooks, II and Ford Motor Credit Company, LLC,	)
Defendants.	)

EXHIBIT 2

Social Security Administration
Important Information

SOCIAL SECURITY
240 BULTMAN DR

SUMTER, SC, 29150

Date: 04/09/2018
Number: [redacted]

KAIYA DAVIS
PO BOX 272782
TAMPA FL 33688

595 - RP

We attached the application you submitted requesting to be representative payee for LEROY ALEXANDER HOOKS.

What You Need To Do

- If you disagree with any of your statements, you should contact us within 10 days.
- If any of the information changes, let us know as soon as possible.

Important Reminder - Penalty of Perjury.

You declared under penalty of perjury that you examined all the information on the application and it is true and correct to the best of your knowledge. You were told that you could be held liable under law for providing false statements.

Suspect Social Security Fraud?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

If You Have Questions

If you have any questions, you may call, write or visit any Social Security office. If you call or visit this office, please have this letter with you and ask for _____. The telephone number where I can be reached is 877-445-0840. We can answer most questions over the phone. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Manager

See Next Page

KWH

Request To Be Selected As Payee

[redacted]

I request that the Social Security Benefits for LEROY ALEXANDER HOOKS be paid to me as representative payee.

LEROY ALEXANDER HOOKS needs a payee because he has a mental impairment.

I would be the best payee for LEROY ALEXANDER HOOKS because I take care of him, there is no one else who is willing to be payee, and I am his relative.

I will know about LEROY ALEXANDER HOOKS' needs because The Applicant will Call Daily, Has a Family care plan, Plans to move back to the Summerton SC area..

Information About The Person For Whom You Are Applying

LEROY ALEXANDER HOOKS lives alone.

LEROY ALEXANDER HOOKS has no other relatives or close friends who live with or are interested in being his representative payee.

LEROY ALEXANDER HOOKS does not have a legal guardian.

Information About Payee Applicant

My name is KAIYA DAVIS. My social security number is [redacted] I was born on January 18, 1971.

I submitted Driver's License as my proof of identity.

I am the Niece of LEROY ALEXANDER HOOKS.

I have never been convicted of a felony.

I have never been imprisoned for more than one year.

I do not have an unsatisfied felony warrant.

I am employed by UNITED STATES POSTAL SERVICE, DADE CITY, FL. I have worked there since September 1999.

My mailing address is PO BOX 272782, TAMPA, FL, 33688.

My home address is 2509 MOBILAIRE DR, LUTZ, FL, 33559.

I have lived at this address since January 2014.

LEROY ALEXANDER HOOKS lives at 1992 JACKS CREEK RD, SUMMERTON, SC, 29148.

My telephone number is (813)735-3007.

Additional Remarks

The Applicant (AP) is the Niece of the Beneficiary (BN). The AP knows the needs of the Bn through Calls and visits. The AP has family local that can also assist with ensuring care. The AP plans to move back to the local area. The BN trusts the AP to be his Rep Payee...KWH595SR

I/my organization:

- Must use all payments made to me/my organization as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs.
- May be held liable for repayment if I/my organization misuses the payments or if I/my organization am/is at fault for any overpayment of benefits.
- May be punished under Federal law by fine, imprisonment or both if I/my organization am/is found guilty of misuse of Social Security or SSI benefits.

I/my organization will:

- Use the payments for the claimant's current needs and save any currently unneeded benefits for future use.
- File an accounting report on how the payments were used, and make all supporting records available for review if requested by the Social Security Administration.
- Reimburse the amount of any loss suffered by any claimant due to misuse of Social Security or SSI funds by me/my organization.
- Notify the Social Security Administration when the claimant dies, leaves my/my organization's custody or otherwise changes his/her living arrangements or he/she is no longer my/my organization's responsibility.
- Comply with the conditions for reporting certain events (listed on the attached sheet(s) which I/my organization will keep for my/my organization's records) and for returning checks the claimant is not due.
- File an annual report of earnings if required.
- Notify the Social Security Administration as soon as I/my organization can no longer act as representative payee or the claimant no longer needs a payee.

I know that anyone who makes or causes to be made a false statement or representation of material fact relating to a payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

Signature _____ _____

Date _____ _____

You Must Notify The Social Security Administration Promptly If Any Of The Following Events Occur And Promptly Return Any Payment To Which The Claimant Is Not Entitled:

- the claimant dies (Social Security entitlement ends the month before the month the claimant dies);
- the claimant marries, if the claimant is entitled to child's, widow's, mother's, father's, widower's, or parent's benefits, or to wife's or husband's benefits as a divorced wife/husband, or to special age 72 payments;
- the claimant's marriage ends in divorce or annulment, if the claimant is entitled to wife's, husband's or special age 72 payments;
- the claimant's school attendance changes, if the claimant is age 18 or over and entitled to child's benefits as a full time student;
- the claimant is entitled as a stepchild and the parents divorce (benefits terminate the month after the month the divorce becomes final);
- the claimant is under full retirement age (FRA) and works for more than the annual limit (as determined each year) or for more than the allowable time (for work outside the United States);
- the claimant receives a government pension or annuity or the amount of the annuity changes;
- the claimant leaves your custody or care or otherwise changes address;
- the claimant no longer has a child in care, if he/she is entitled to benefits because of caring for a child under age 16 or who is disabled;
- the claimant is confined to jail, prison, penal institution or correctional facility;
- the claimant is confined to a public institution by court order in connection with a crime.
- the claimant has an unsatisfied felony warrant (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for his/her arrest;
- the claimant is violating a condition of probation or parole under State or Federal law.

If The Claimant Is Receiving Disability Benefits, You Must Also Report If:

- the claimant's medical condition improves;
- the claimant starts working;
- the claimant applies for or receives worker's compensation benefits, Black Lung Benefits from the Department of Labor, or a public disability benefit;
- the claimant is discharged from the hospital (if now hospitalized).

If The Claimant Is Receiving Special Age 72 Payments, You Must Also Report If:

- the claimant or spouse becomes eligible for periodic governmental payments, whether from the U.S. Federal government or from any State or local government;
- the claimant or spouse receives supplemental security income or public assistance cash benefits;
- the claimant or spouse moves outside the United States (the 50 states, the District of Columbia and the Northern Mariana Islands).

In Addition To These Events About The Claimant, You Must Also Notify Us If:

- You change your address;
- You are convicted of a felony or any offense under State or Federal law which results in imprisonment for more than one year;
- You have an unsatisfied felony warrant (or in jurisdictions that do not define crimes as felonies, a crime punishable by death or imprisonment exceeding 1 year) issued for your arrest.

Benefits May Stop If Any Of The Above Events Occur. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

Remember:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to tell us as soon as you know you will no longer be able to act as representative payee or the claimant no longer needs a payee.

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

The Privacy And Paperwork Reduction Acts

We are required by section 205(j) and 205(a) of the Social Security Act to ask you to give us the information on this form. This information is needed to determine if you are qualified to serve as representative payee. Although responses to these questions are voluntary, you will not be named representative payee unless you give us the answers to these questions.

Sometimes the law requires us to give out the facts on this form without your consent. We must release this information to another person or government agency if Federal law requires that we do so or to do the research and audits needed to administer or improve our representative payee program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the Federal Register. If you want to learn more about this, contact any Social Security office.

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 855-433-5873. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
SUITE 100
4010 GUNN HIGHWAY
TAMPA FL 33618

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

SSA Office 949

STATE OF SOUTH CAROLINA)
)
COUNTY OF CLARENDON)

CASE NO: 2018-CP-14-00044
IN THE COURT OF COMMON PLEAS

Wilmington Savings Fund Society, FSC,
d/b/a Christiana Trust as Owner Trustee
of the Residential Credit Opportunities Trust V,

Plaintiff,

Vs.

Leroy Hooks, II and Ford Motor Credit
Company, LLC,

Defendants.

EXHIBIT 3

NOTE DATED: 09/12/2018 07:49
LOCAL TITLE: MH ASSESSMENT AND TREATMENT PLAN UPDATE
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN NOTE
VISIT: 09/12/2018 07:49 WJB MH INPT NP DAILY NOTE
MH ASSESSMENT AND TREATMENT PLAN UPDATE

LEROY A HOOKS is a 66 year old MALE seen on rounds today SEP 12, 2018. Chart reviewed and patient discussed with treatment team.

Admitted on SEP 7,2018 12:21, 66 YO AAM, 100% SC, that involuntarily admitted to Recovery East due to report of worsening psychosis.

Pertinent nursing staff report and observations:
09/11: A/O. Ambulating about unit without difficulty. Spends most of time in dayroom. C/O excessive gas and worries about roommate's reaction. Vet may benefit from simethacone. He says he has no control over the gas. Denies pain, constipation, or diarrhea. Appetite fair, sleep fair, med compliant. Denies AVH, denies SI/HI. Appears depressed. Affect resricted and pt appears guarded. No acute distress. Will continue close observation.

09/12: Patient appeared to be sleeping in bed upon safety rounds. No sign of pain or discomfort noted. He slept approximately 7 hours during this shift. Patient was awakened by staff at 0600hrs for vital signs and medication. Patient escorted to united treatment room and allowed laboratory personnel to draw his blood for scheduled labs. Patient escorted back to unit. Patient voiced no complaints of pain or discomfort and exhibited no sign of distress.

Procedures completed:
09/08: Dental consult
09/08: Dietetics consult: . Double portions have been ordered and he should be receiving them by now. Ensure Plus qmeal is already in place in his orders.
09/10: SATP Consult
09/11: Dental Imaging: #30 gross decay, PA reveals PAP # 30. No swelling/abcess present. Needs ext. VCP Ext #30. Rx inpatient meds Amox 500 mg, Motrin 400 mg.
09/11: COMMUNITY CARE-DENTAL SPECIALTY SERVICES: Oral/Maxillofacial Surgery Treatment plan for additional dental care to be developed by private provider and returned to VA for review and authorization.
09/11: Urology consult

Recent vital signs:

Temperature:	98.3 F [36.8 C] (09/12/2018 06:28)
Pulse:	78 (09/12/2018 06:28)
Respiration:	18 (09/12/2018 06:28)
Blood Pressure:	131/85 (09/12/2018 06:28)
Height:	67 in [170.2 cm] (09/10/2018 15:15)
Weight:	99.4 lb [45.2 kg] (09/07/2018 13:21)
Pain:	0 (09/12/2018 06:28)

SUBJECTIVE: Patient reports that he has a cough that started a "couple of weeks ago". He reports, "I have been on antibiotics". Chest Xray was completed. He

** THIS NOTE CONTINUED ON NEXT PAGE **

09/12/2018 07:49 ** CONTINUED FROM PREVIOUS PAGE **

reports smoking 1ppd for the last 5 yrs, smoked as teenager, but quit for 25 yrs. He seemed SOB ambulating to conference. When asked does this happen often? He reported that it occurs with exertion (walking, showering, ambulating to BR). He reports still with urinary frequency, therefore awakening every 2 - 3 hrs each night. Advised him that a consult was sent to Urology and some labs will need to be obtained. He verbalized understanding. He denies any SI/HI or AVH. He reports feeling "much better since being here". He talked about his dental consult and stated that he does not understand why he is not able to have tooth pulled here at the VA. Advised, will have check into this. He talked about currently where he lives and that his niece became his payee 2 months ago.

TTP: Will add Albuterol inhaler for SOB and Simethicone for excessive flatulance (per nrsg that occurred last night). Patient declines RCF placement.

OBJECTIVE: Mental Status Exam: Patient was ambulating down hallway and came to conference room for this interview. He is a short, thin small framed AA male dressed appropriately and has adequate hygiene. He appears his stated age. He is cooperative with the interview with good eye contact. He exhibits normal motor activity and speech. His mood is "good" with a constricted affect. Thought processes are more organized today. Thought content without suicidal or homicidal ideations. He does not appear to respond to internal stimuli, no overt paranoia. He is alert and oriented. He has moderately impaired insight and judgment.

Diagnoses:
Unspecified Depressive Disorder
Schizophrenia
Stimulant Use Disorder (Cocaine)
Alcohol Use Disorder

Plan:
1. Continue Olanzapine for management of mood disturbance.
2. Continue medications for management of medical problems: Guaifenesin for management of cough. CXR negative.
3. MVI/Thiamine/Folate for supplementation due to chronic alcohol use.
   Discontinue CIWA-A protocol due to absence of withdrawal symptoms.
   9/12, initiate Simethicone for excessive flatulence
   9/12, initiate Albuterol inhaler for SOB.
4. SATP referral for management of substance use disorder.
5. SW service to assist in review of housing situation.
6. Transfer to B status with participation in group activities to strengthen coping skills and stress management skills.
7. Patient with benefit from structure and support of therapeutic milieu.
8. Monitor patient progress for response of SI to treatment.
9. Discharge planning as clinically appropriate. Submit DE reports when appropriate.
10: Dental Imaging and Dental consult:
   9/11, Dental initiated Amoxicillin 500 mg, Motrin 400 mg for Periapical abscess.
11: Urology consult - PSA, UC, Labs: Hgbalc and Lipids.

** THIS NOTE CONTINUED ON NEXT PAGE **

09/12/2018 07:49 ** CONTINUED FROM PREVIOUS PAGE **

12. Will need to be assigned to a PCP Team on discharge.

Admission labs: Admission labs were WNL with the exception of creat 1.4H, T. Protein 8.4H, Mag 2.2H, UDS +cocaine >1000H.

Education:
Patient educated about the following:
1. Importance of medication adherence, side effects.
2. Depression/mood as it related to substance abuse.
3. Educated on the negative effective of substance use.

Outcome: Patient verbalized understanding.

Signed by: /es/ Henretta N Milton, NP
Nurse Practitioner
09/12/2018 11:32

LOCAL TITLE: MH 7-DAY POST D/C FOLLOW-UP NOTE
STANDARD TITLE: MENTAL HEALTH OUTPATIENT NOTE
DATE OF NOTE: JAN 30, 2015@13:48 ENTRY DATE: JAN 30, 2015@13:48:57
AUTHOR: SEJUIT,MATTHEW D EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH 7-DAY POST D/C FOLLOW-UP NOTE Has ADDENDA ***

7-DAY D/C FOLLOW-UP NOTE:

Veteran presents for his scheduled 7 day follow up. Veteran states that he had a five day inpatient stay after an argument with his family. He reports that his family members lied when they informed law enforcement officials that he threatened them with a weapon. Veteran reports that when he returned to his home this week items were missing from his home. He plans on filing a police report, as he suspects his family took his belongings. Veteran reports being angry over the situation because he was involuntarily held in a facility for five days. Veteran reports that he missed a scheduled GI appointment during that time. The veteran reports waiting a significant amount of time for the GI appointment. He has concerns over a colostomy bag that he uses. Veteran anticipates needing surgery for a GI condition. Veteran has rescheduled his GI appointment.

The veteran also reports concerns for his father's well-being. He feels that other family members may be taking advantage of him - taking all of his money. The veteran's father lives in Tampa, FL. Veteran was unable to provide any contact information for his father. Veteran was advised that if he is concerned he should contact Adult Protective Services in Tampa, FL. SW was unable to file a report without contact information for the veteran's father.

The veteran has two other concerns at this time. He would like to be able to manage his own money. Veteran reports that his ex-wife was managing his money but she no longer wishes to do so. Veteran also has complaints of impotence since having his colostomy bag placed. SW will alert the veteran's primary care provider of these concerns.

non-combat veteran seen in clinic today.
Patient was alone

PURPOSE OF VISIT:
Previous inpatient admission describe location/details Charleston for five days.

Social/Living situation: Changes are as follows: Family are no longer in his home. May have moved to Florida.

MEDICATIONS: Current profile reviewed. Document new medications.
No new medications.

Psychotropics:

Side effects: None

CHIEF COMPLAINTS/ CONCERNS OF PATIENT on this visit:
Post hospitalization follow up.

MENTAL STATUS EXAM:

Appearance:
well groomed

Behavior/psychomotor activity:
no abnormalities noted

Speech:
normal rate and tone

Attitude toward examiner:
cooperative, attentive

Mood:
euthymic

Affect:
normal ranged

Thought Process:
linear, goal directed

Hallucinations:
No
Visual:
No
Auditory:
No

Tactile: Describe:
Olfactory Describe:
Illusions: Describe:

Thought content:
Rational: Yes
Delusions: No Describe:
Preoccupations: No Describe:
Obsessions: No Describe:
Phobias: No Describe:
Suspiciousness: No
Paranoia: Yes Describe: Veteran is paranoid that his family is taking his belongings.

SUICIDAL/HOMICIDAL:
Suicidal Ideation: no
Suicidal Plan: no Describe:
Suicidal Intent: no Describe:
Suicidal Risk: no Describe:

Homicidal Ideation: no
Homicidal Plan: no Describe:

Cognitive Evaluation:
Concentration/attention: fully intact
Describe:
Alertness: normal

Memory:
Short Term Memory: intact
Memory: Remote: intact

Symptom review:
Sleep: restless, fragmented, daytime napping Colostomy keeps him away.
Total hours of sleep: 5-6

Appetite:
adequate, self-reported weight loss Not attempting to lose weight.

Energy:
adequate

Nightmares:
absent

Flashbacks:
absent

ETOH USE: present
Alcohol 1/29 - 2-3 drinks.

DRUG USE: Denies

Plan: Veteran will meet with Sumter Psychology on 2/13/15 at 1430.

Length of visit: 30-60 minutes

PATIENT EDUCATION:
Patient/family verbally educated about the following:
Plan of care, illness and condition:

Recipient of education: patient
Outcome: verbalizes understanding

****
Veteran has complaints of impotence and wanting to manage his own finances - please advise.
****

/es/ MATTHEW D SEJUIT
SOCIAL WORKER
Signed: 01/30/2015 14:55

Receipt Acknowledged By:
01/30/2015 15:00 /es/ BELINDA J KAIGLER
RN
for LISA ALLBRITTON
01/30/2015 16:12 /es/ LESLIE PAULEY
Psychologist
01/30/2015 16:06 /es/ RITA J ROBINSON
Internal Medicine

01/30/2015 ADDENDUM STATUS: COMPLETED
Booked veteran for f/u 2/13@1430 as previously discussed with SW.

/es/ LESLIE PAULEY
Psychologist
Signed: 01/30/2015 16:14

Receipt Acknowledged By:
02/02/2015 08:15 /es/ MATTHEW D SEJUIT
SOCIAL WORKER

LOCAL TITLE: MH INPATIENT NOTE
STANDARD TITLE: MENTAL HEALTH INPATIENT NOTE
DATE OF NOTE: SEP 09, 2018@06:54 ENTRY DATE: SEP 09, 2018@06:54:57
AUTHOR: WILSON,RODNEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH INPATIENT NOTE Has ADDENDA ***

0650hrs

Veteran yelled out while laying in bed. When this writer responded, patient stated, "He keeps following me!" referring to his roommate who was laying quietly in his own bed. This writer explained that his roommate had a right to be in the room. He responded with, "I know, but I just keep hearing voices." Veteran declined PRN Risperidone oral solution when offered. He stated, "I'm okay, I don't need anything!" He was encouraged to notify nursing staff if he changed his mind. Veteran verbalized understanding.

/es/ RODNEY WILSON
REGISTERED NURSE

Signed: 09/09/2018 07:04

Receipt Acknowledged By:

09/09/2018 10:15	/es/	ADDONCOLIA BENNETT REGISTERED NURSE
09/09/2018 07:55	/es/	KAREN KINARD REGISTERED NURSE
09/12/2018 00:23	/es/	SAJINI VARKEY REGISTERED NURSE
09/09/2018 09:10	/es/	SHARON C WANNAMAKER Registered Nurse
* AWAITING SIGNATURE *		WILSON,TYRONE NATHANIEL

09/09/2018 ADDENDUM STATUS: COMPLETED
0707hrs

This writer returned to veteran's room to reassessment his mood. Veteran laying quietly in bed and appeared to be sleeping. Veteran's roommate was awake in bed and stated that everything was "fine."

/es/ RODNEY WILSON
REGISTERED NURSE
Signed: 09/09/2018 07:10

LOCAL TITLE: MH MEDICATION MANAGEMENT NOTE TL
STANDARD TITLE: MENTAL HEALTH MEDICATION MGT NOTE
DATE OF NOTE: NOV 06, 2015@13:52 ENTRY DATE: NOV 06, 2015@13:52:59
AUTHOR: SMITH,KATHERINE S EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH MEDICATION MANAGEMENT NOTE TL Has ADDENDA ***

1:26pm- 1:51 pm, 25minutes

HISTORY OF PRESENT ILLNESS:
63yo single, male, Army, Vietnam Veteran, no deployments, 2.5 years, with SC 100% for Schizophrenia, referred for assessment after not showing up multiple times for his colostomy bag reversal that was placed two years ago and is non-compliant with the recommendation.

He reports that he is here to be assessed for how he will handle the colostomy bag reversal. He reports he is looking forward to getting this surgery completed. Asked why he missed so many appointments to have the colstomy bag reversal. He reports that he missed the prior appointments to reverse the colostomy bag bc he traveling taking care of his father in Tampa, Fl. He understands that the needs to get the surgery and he wants the surgery.

He denies hearing voices; he is not having suicidal thoughts. He is not depressed but he is "depressed" that his surgery is not done yet. He reports he

missed the last appointment due to his car was flooded from the storm. He no longer has a car. His friend or cousins will give him rides to all appointments and will make sure he is at the surgery.

While in the service, he was in a car accident in Germany and flipped in jeep around a corner, hit head, he was the passenger, he was hospitalized due to head injury, med-vac to Washington DC and then Marshall VA and then was discharged from service. After the accident he was hearing voices, couldn't think. He reports no voices nor medicines in "over 20 years".

REVIEW OF SYSTEMS:
Review of Systems is negative/non applicable unless otherwise indicated:
General:
Head/Neck:
Chest/Heart:
Abdomen:
Neuro:
Other:
PAST PSYCHIATRIC HISTORY:

Inpatient hospitalizations: significant for January 2015 for paranoid thoughts, committed for 5 days. 2009 hospitalized; one year hospitalization in Monroe, NY over 30 years ago and was dx with Schizophrenia at that time.

History of outpatient treatment: no consistent treatment.

History of suicide attempts: denies

History of violence: significant for committed in hospital for reported threats of harm to others. Patient reports family lied.

Previous psychiatric medication trials: risperidone, VPA in 2009,sertraline: 1999; cyproheptadine. Seroquel.

PAST MEDICAL HISTORY: Diverticulitis; needs colostomy bag reversal; Urethral stricture

---

FAMILY HISTORY: denies

SOCIAL HISTORY:

Living situation, marital status, # of children: single, divorced. one son.

Education level/Occupation: disabled

Alcohol use, past & current: beer, 1-2 once a week.

Tobacco use: positive

Other substances: denies any current use; h/o cannabis abuse in VISTA.

Guns in the home: no

Legal history: denies

DevHx; Pertinent childhood history: significant for raised by parents; no abuse, trauma nor neglect as a child.
Risk Factors: poor medical health

MENTAL STATUS EXAM:

Appearance, Grooming, and Hygiene: neat, clean, casual

Behavior: cooperative
Psychomotor Activity: none
Speech: normal rate and tone
Mood: euthymic
Affect: appropriate, full
Thought Content (including SI/HI): no delusions, no AVH, no suicidal nor homicidal thoughts, no obsessions, no preoccupation with violence.
Hallucinations and/or Delusions: denies
Thought Processes: appropriate rate of thoughts appropriate, logical, able to reason abstractly
Associations: intact
Memory/Orientation: limitations
Concentration: distracted at times
Fund of knowledge/Estimate of Intelligence: average
Language: able to name objects/repeat phases
Judgment:fair
Insight: fair

ASSESSMENT AND TREATMENT PLAN GOALS:

Diagnosis & Assessment:
Schizophrenia, paranoid type; Diverticulitis; needs colostomy bag reversal; Urethral stricture

PLAN AND PROGRESS TOWARDS TREATMENT PLAN GOALS:

1. Medication recommendations: pt declines any symptoms that would be treatable with medications. Reviewing the information in the chart he probably has some baseline paranoia that cycles in intensity but he appears to understand the importance of getting the surgery at this point in time and is committed to following thru. Symptoms of Schizophrenia can go in remission at times without medications. Unsure why he did not follow thru in the past. He does appear to

have significant issues with memory from car accident. There is no indication for medications nor would the patient consent to it. There is no acute safety issues. There is no reason for commitment. Pt asked about being his own fiduciary bc his son is not interested in doing it anymore but recommended that he find another relative as he has not managed his money before and given the history of head injury and memory problems would recommend to continue with a fiduciary for his disability.

If there is any concern with a return of symptoms after his reversal, an inpatient psych consult could be placed or if signs of paranoa return then the patient could be given a low dose of anti-psychotic such as haldol. Paranoia can present as hostile, irrational agruing, agitation, irritablity, or delusional thoughts. At this time there is no evidence to suggest that this would happen but if it did it could be easily treated.

2. Psychotherapeutic recommendations: none
3. RTC: not necessary at this time.
4. Labs: n/a
5. Other recommendations: Interviewed patient on the extensive details of the surgery what is to happen and expectations. Pt verbalizes understanding.
6. Duration of treatment: n/a

*Recipient of education: [x]patient
*Outcome: [x]verbalizes understanding [ ]needs reinforcement [ ]discounts or refuses treatment/medical recommendations

Patient/family verbally educated about the following:
[x]Plan of care:
[x]Medications: possible side effects, dosing schedules
[x]Diagnosis
[x]therapeutic recommendations
[ ]impact of substance use on treatment/symptoms
[x]Veteran received a handout with this provider's contact number, crisis line, and opportunity to write down all medication and therapy recommendations.
[x] importance of sleep hygiene, sleep handout available in Telehealth room.
*********The Diagnoses utilized are based on the DSM-V criteria*********
**THE VETERAN HAD TO TRAVEL TO DORN FOR THIS SERVICE AS THIS SERVICE IS NOT AVAILABLE AT THE SUMTER CLINIC DUE TO NO EXTRA ROOM/SPACE FOR TANDBERG IN SUMTER CLINIC.
Verbal Informed Consent has been obtained. The patient has been provided with a full explanation of risks and benefits of telemedicine. After educating the patient about the differences between Telehealth and In-Person care, the provider and patient are amenable to using Telehealth for this consultation. The patient understands that he/she has the right to decline the use of Telehealth technology and be seen in person without adversely impacting their continued access to health care services. Further, the patient understands that the consultant will make the final determination as to whether Telehealth technology is appropriate for this visit.

Chart Reviewed
PATIENT IDENTIFIED BY:
[x] Patient full name

PURPOSE OF VISIT:
[x]Medication management

[ ] Patient home address
[ ] Complete date of birth
[x] Social Security Number
[ ] Facial recognition
[x]Supportive counseling
[ ]Walk-in/crisis triage
[x]Medication evaluation
[ ]Other

Allergies/ADR: Patient has answered NKA
Outpatient: Medication Reconciliation

Active Outpatient Medications (excluding Supplies):

Active Outpatient Medications	Status / Refills	Issue Date / Last Fill / Expiration
1) BISACODYL 10MG RTL SUPP Qty: 1 for 14 days Sig: INSERT 1 SUPPOSITORY(IES) IN RECTUM ONE TIME UNWRAP AND INSERT 1 SUPPOSITORY RECTALLY THE DAY OF THE PROCEDURE AT LEAST 2 HOURS BEFORE THE EXAMINATION.	ACTIVE Refills: 0	Issu:10-21-15 Last:10-24-15 Expr:11-20-15
2) BISACODYL 5MG EC TAB Qty: 4 for 1 days Sig: TAKE FOUR TABLETS BY MOUTH ONE TIME ON THE NIGHT BEFORE THE PROCEDURE AT 7:30PM WITH A FULL 8 OUNCE GLASS OF WATER	ACTIVE Refills: 0	Issu:10-21-15 Last:10-26-15 Expr:11-20-15
3) MAGNESIUM CITRATE LIQUID Qty: 2 for 2 days Sig: TAKE THE CONTENTS OF ONE BOTTLE BY MOUTH AT 5:30PM THE NIGHT BEFORE AND ONE-HALF BOTTLE ON THE MORNING OF THE PROCEDURE AT 8:00AM	ACTIVE Refills: 0	Issu:10-21-15 Last:10-26-15 Expr:11-20-15

********** Medication Reconciliation:**********

No changes needed. Active and Non-VA Medications listed is accurate and should continue.

NO DISCREPANCIES FOUND - The patient's medication list/medication history was compared with CPRS and reviewed with the patient/caregiver and reconciled for any discrepancies. A copy of the updated medication list was provided to the patient/caregiver.

* All changes in medications, including all non-VA/Herbals/OTC medications were entered into CPRS, and documented in this note.

* If there were any medications the patient should no longer take, they were discontinued. The discontinued medications are documented in this note.

* The patient/cargiver was instructed to update this list,discard old lists, and take this list to their next appointment, whether with a

VA or non-VA provider.

Medication list was updated and reviewed with and provided to patient.

CLINICAL REMINDER ACTIVITY
Depression Screening:
PHQ-9
A PHQ-9 screen was performed. The score was 0 which is suggestive of no depression.

1. Little interest or pleasure in doing things
Not at all

2. Feeling down, depressed, or hopeless
Not at all

3. Trouble falling or staying asleep, or sleeping too much
Not at all

4. Feeling tired or having little energy
Not at all

5. Poor appetite or overeating
Not at all

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
Not at all

7. Trouble concentrating on things, such as reading the newspaper or watching television
Not at all

8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual
Not at all

9. Thoughts that you would be better off dead or of hurting yourself in some way
Not at all

10. If you checked off any problems, how DIFFICULT have these problems made it for you to do your work, take care of things at home or get along with other people?
Not difficult at all

/es/ Katherine S. Smith, DO

Charleston Tele Mental Health Psychiatry
Signed: 11/06/2015 14:06

11/06/2015 ADDENDUM STATUS: COMPLETED
pre-op work up might include a UDS to ensure no cannabis in his system given the history of use and avoidance about discussion of this.. Cannabis can cause paranoid thoughts to increase.

/es/ Katherine S. Smith, DO
Charleston Tele Mental Health Psychiatry
Signed: 11/06/2015 14:09

LOCAL TITLE: MH NURSING REASSESSMENT-TL
STANDARD TITLE: MENTAL HEALTH NURSING NOTE
DATE OF NOTE: SEP 08, 2018@00:28 ENTRY DATE: SEP 08, 2018@00:29:01
AUTHOR: VARKEY,SAJINI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH NURSING REASSESSMENT-TL Has ADDENDA ***

Admission Date: SEP 7,2018 12:21 Current Ward/Room Number: B220-A
Brief review of problems/needs identified on treatment plan and patient's progress in meeting goals and objectives:
SPN - Selected Prog Notes
09/07/2018 18:40 Local Title: MH GOALS -INPATIENT
Standard Title: MENTAL HEALTH INPATIENT NOTE

ASSESSMENT (Nursing Problems/diagnosis):
Depression
Alcohol abuse.
Drug abuse
Psychotic (hallucinations)
GOALS/OUTCOMES
Stabilize mood
Sobriety
Absence of hallucinations
Will not injure self or others
OBJECTIVES: The patient will:
Agree to safety contract with staff
Not cause injury to self or others because of suicidal, homicidal, aggressive, or assaultive behavior.
Become sober and remain sober while hospitalized.
Not respond to internal stimuli
Verbalize reality based thoughts; realistic assessment of situation
Interact and socializes appropriately with others
Attends and participate in assigned groups
Verbalize two appropriate skills for coping with the problem(s) identified
Use caution when ambulating on unit and getting in and out of bed

INTERVENTIONS:
Orient to unit milieu, patient rights and responsibilities
Close observation of behavior
Provide calm, non-threatening environment
Provide supportive interaction encouraging verbalization of feelings, concerns, solutions
Give medications as prescribed to manage symptoms/observe for side effects, adverse reactions
Set limits on inappropriate behavior and provide re-direction
Reality orientation
Provide schedule of group activities and encourage participation

MENTAL/NEURO STATUS:
Oriented to: name vet appeared sleeping
Level of Consciousness: Other vet appeared sleeping
Mood/Affect: other: vet appeared sleeping
Behavior: other vet appeared sleeping
Speech: Other: vet appeared sleeping
Thoughts: other: vet appeared sleeping
Hallucinations: No vet appeared sleeping
Thought Content:
Rational: Yes
Delusions: No vet appeared sleeping
Preoccupations: No vet appeared sleeping
Obsessions: No vet appeared sleeping
Phobias: No vet appeared sleeping
Suspiciousness: No vet appeared sleeping
Paranoia: No vet appeared sleeping
AM: Patient stated Goals: n/a
Describe the patient's behavior on the unit, including symptoms related to the reason for admission: vet appeared to be sleeping upon safety rounds, no distress noted
Are there any new problems/symptoms/needs?
No
Are there any medical complaints or findings?
No
FALL RISK ASSESSMENT:
Morse Fall Scale:
The Morse Fall scale was performed and score was 15. This is indicative of low risk of falls.

History of falling in past 3 months?
No

Secondary diagnosis:
No

Ambulatory aid:
None/bedrest/nurse assist

Intravenous therapy/Heparin lock:
No

Gait/Transferring:
Normal/bed rest/immobile

Mental Status:
Overestimates/forgets limitations
Morse Fall Score is 0-24. Patient is at low risk for falls.
Previous Fall Risk Score:
SHF - Health Factor Select
REMINDER FACTORS
FALL LOW RISK PT 09/07/2018

PAIN ASSESSMENT:
No Pain
Patient appears to have no pain.
INTRAVENOUS ACCESS
Does Patient have Intravascular Access?
NO- None at this time.
GENITOURINARY:
Does patient have Foley Catheter (via the urethra)?
No- None at this time.
Normal urination habits without any identified problems
ELOPEMENT REASSESSMENT:
RISK REASSESSMENT FOR ESCAPE OR ELOPEMENT:
Is this patient considered to be a danger to self or others?
No,
Does this patient lack the cognitive ability to make relevant decisions?
No
Does this patient have a history of escape or elopement?
No
Does this patient have physical or mental impairments that increase the risk of harm to self or others?
Yes
Total Points/Risk:At Risk = 1 or more risk factors selected
Elopment Risk Interventions Initiated:MH Ward - Controlled Environment
Does the patient require continued stay in the hospital?
Patient needs continued stay.
Explain: Vet needs mood stabilization and meds adjustments
NURSING SUMMARY/PLAN: Vet will be observed for safety and behavior and administer meds as ordered.

/es/ SAJINI VARKEY
REGISTERED NURSE
Signed: 09/08/2018 00:32

09/08/2018 ADDENDUM STATUS: COMPLETED
Vet appeared sleeping through night, no distress noted/ no concerns voiced.

/es/ SAJINI VARKEY
REGISTERED NURSE
Signed: 09/08/2018 05:27

LOCAL TITLE: MENTAL HEALTH INPATIENT GROUP EDUCATION
STANDARD TITLE: MENTAL HEALTH EDUCATION NOTE
DATE OF NOTE: SEP 11, 2018@20:28 ENTRY DATE: SEP 11, 2018@20:28:59
AUTHOR: BUFORD,CRAIG EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient's level of understanding: good
Vet expressed his goals for today and says that he successfully met them.

/es/ CRAIG BUFORD
NURSING ASSISTANT
Signed: 09/11/2018 20:30

Receipt Acknowledged By:
* AWAITING SIGNATURE * JENKINS,KATHY

LOCAL TITLE: MH ASSESSMENT AND TREATMENT PLAN UPDATE
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN NOTE
DATE OF NOTE: SEP 12, 2018@07:49 ENTRY DATE: SEP 12, 2018@07:49:10
AUTHOR: MILTON,HENRETTA N EXP COSIGNER:
URGENCY: STATUS: COMPLETED

MH ASSESSMENT AND TREATMENT PLAN UPDATE

LEROY A HOOKS is a 66 year old MALE seen on rounds today
SEP 12, 2018. Chart reviewed and patient discussed with treatment team.

Admitted on SEP 7,2018 12:21, 66 YO AAM, 100% SC, that involuntarily admitted to Recovery East due to report of worsening psychosis.

Pertinent nursing staff report and observations:
09/11: A/O. Ambulating about unit without difficulty.
Spends most of time in dayroom. C/O excessive gas and worries about roommate's reaction. Vet may benefit from simethacone. He says he has no control over the gas. Denies pain, constipation, or diarrhea. Appetite fair, sleep fair, med compliant. Denies AVH, denies SI/HI. Appears depressed. Affect resricted and pt appears guarded. No acute distress. Will continue close observation.

09/12: Patient appeared to be sleeping in bed upon safety rounds. No sign of pain or discomfort noted. He slept approximately 7 hours during this shift. Patient was awakened by staff at 0600hrs for vital signs

and medication. Patient escorted to united treatment room and allowed laboratory personnel to draw his blood for scheduled labs. Patient escorted back to unit. Patient voiced no complaints of pain or discomfort and exhibited no sign of distress.

Procedures completed:
09/08: Dental consult
09/08: Dietetics consult: . Double portions have been ordered and he should be receiving them by now. Ensure Plus qmeal is already in place in his orders.
09/10: SATP Consult
09/11: Dental Imaging: #30 gross decay, PA reveals PAP # 30. No swelling/abcess present. Needs ext. VCP Ext #30. Rx inpatient meds Amox 500 mg, Motrin 400 mg.
09/11: COMMUNITY CARE-DENTAL SPECIALTY SERVICES: Oral/Maxillofacial Surgery Treatment plan for additional dental care to be developed by private provider and returned to VA for review and authorization.
09/11: Urology consult

Recent vital signs:

Temperature:	98.3 F [36.8 C] (09/12/2018 06:28)
Pulse:	78 (09/12/2018 06:28)
Respiration:	18 (09/12/2018 06:28)
Blood Pressure:	131/85 (09/12/2018 06:28)
Height:	67 in [170.2 cm] (09/10/2018 15:15)
Weight:	99.4 lb [45.2 kg] (09/07/2018 13:21)
Pain:	0 (09/12/2018 06:28)

SUBJECTIVE: Patient reports that he has a cough that started a "couple of weeks ago". He reports, "I have been on antibiotics". Chest Xray was completed. He reports smoking 1ppd for the last 5 yrs, smoked as teenager, but quit for 25 yrs. He seemed SOB ambulating to conference. When asked does this happen often? He reported that it occurs with exertion (walking, showering, ambulating to BR). He reports still with urinary frequency, therefore awakening every 2 - 3 hrs each night. Advised him that a consult was sent to Urology and some labs will need to be obtained. He verbalized understanding. He denies any SI/HI or AVH. He reports feeling "much better since being here". He talked about his dental consult and stated that he does not understand why he is not able to have tooth pulled here at the VA. Advised, will have check into this. He talked about currently where he lives and that his niece became his payee 2 months ago.

TTP: Will add Albuterol inhaler for SOB and Simethicone for excessive flatulance (per nrsg that occurred last night). Patient declines RCF placement.

OBJECTIVE: Mental Status Exam: Patient was ambulating down hallway and came to conference room for this interview. He is a short, thin small framed AA male dressed appropriately and has adequate hygiene. He appears his stated age. He is cooperative with the interview with good eye contact. He exhibits normal motor activity and speech. His mood is "good" with a constricted affect. Thought processes are more organized today. Thought content without suicidal or

homicidal ideations. He does not appear to respond to internal stimuli, no overt paranoia. He is alert and oriented. He has moderately impaired insight and judgment.

Diagnoses:
Unspecified Depressive Disorder
Schizophrenia
Stimulant Use Disorder (Cocaine)
Alcohol Use Disorder

Plan:
1. Continue Olanzapine for management of mood disturbance.
2. Continue medications for management of medical problems: Guaifenesin for management of cough. CXR negative.
3. MVI/Thiamine/Folate for supplementation due to chronic alcohol use.
   Discontinue CIWA-A protocol due to absence of withdrawal symptoms.
   9/12, initiate Simethicone for excessive flatulence
   9/12, initiate Albuterol inhaler for SOB.
4. SATP referral for management of substance use disorder.
5. SW service to assist in review of housing situation.
6. Transfer to B status with participation in group activities to strengthen coping skills and stress management skills.
7. Patient with benefit from structure and support of therapeutic milieu.
8. Monitor patient progress for response of SI to treatment.
9. Discharge planning as clinically appropriate. Submit DE reports when appropriate.
10: Dental Imaging and Dental consult:
   9/11, Dental initiated Amoxicillin 500 mg, Motrin 400 mg for Periapical abscess.
11: Urology consult - PSA, UC, Labs: Hgbalc and Lipids.
12. Will need to be assigned to a PCP Team on discharge.

Admission labs: Admission labs were WNL with the exception of creat 1.4H, T. Protein 8.4H, Mag 2.2H, UDS +cocaine >1000H.

Education:
Patient educated about the following:
1. Importance of medication adherence, side effects.
2. Depression/mood as it related to substance abuse.
3. Educated on the negative effective of substance use.

Outcome: Patient verbalized understanding.

/es/ Henretta N Milton, NP
Nurse Practitioner
Signed: 09/12/2018 11:32

LOCAL TITLE: MH ASSESSMENT AND TREATMENT PLAN UPDATE
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN NOTE

Progress Notes

DATE OF NOTE: SEP 11, 2018@08:27 ENTRY DATE: SEP 11, 2018@08:27:31
AUTHOR: MILTON,HENRETTA N EXP COSIGNER:
URGENCY: STATUS: COMPLETED

MH ASSESSMENT AND TREATMENT PLAN UPDATE

LEROY A HOOKS is a 66 year old MALE seen on rounds today SEP 11, 2018. Chart reviewed and patient discussed with treatment team.

Admitted on SEP 7,2018 12:21, 66 YO AAM, 100% SC, that involuntarily admitted to Recovery East due to report of worsening psychosis.

Pertinent nursing staff report and observations:
09/10: Patient was seen by Dietetics for an established diet. He is underweight and has Hx of colostomy and reversal. Food and Nutrition Related History: The pt is known to Nutr. Double portions have been ordered and he should be receiving them by now. Ensure Plus qmeal is already in place in his orders. He attended a group on the unit. CIWA scoring was zero.

09/11: Upon safety rounds vet observed resting quietly in bed with eyes closed. Respiration regular and unlabored with no signs of pain or discomfort noted. will continue to monitor. Vet appears to have slept for approximately 6-7 hours on this shift.

Procedures completed:
09/08: Dental consult
09/08: Dietetics consult: . Double portions have been ordered and he should be receiving them by now. Ensure Plus qmeal is already in place in his orders.
09/10: SATP Consult
09/11: Dental Imaging: #30 gross decay, PA reveals PAP # 30. No swelling/abcess present. Needs ext. VCP Ext #30. Rx inpatient meds Amox 500 mg, Motrin 400 mg.
09/11: COMMUNITY CARE-DENTAL SPECIALTY SERVICES: Oral/Maxillofacial Surgery Treatment plan for additional dental care to be developed by private provider and returned to VA for review and authorization.
09/11: Urology consult

Recent vital signs:

Temperature:	98.2 F [36.8 C] (09/11/2018 06:00)
Pulse:	67 (09/11/2018 06:00)
Respiration:	18 (09/11/2018 06:00)
Blood Pressure:	140/83 (09/11/2018 06:00)
Height:	67 in [170.2 cm] (09/10/2018 15:15)
Weight:	99.4 lb [45.2 kg] (09/07/2018 13:21)
Pain:	0 (09/11/2018 06:00)

SUBJECTIVE: Patient reports that he slept "ok" during the night, had to attend BR "every 2 hrs". He denies any SI/HI. He denies any AVH currently. Stated that "I used to hear the TV coming at me and this would make me depressed". He

describes his mood as "7/10". He reports, "I am suppose to have a gynecology and dental appt this morning. He reports that his teeth hurt "sometimes" on the lower gum. Advised him that it is probably a Urology consult and will check for the dental consult. Appetite good.

TTP: Patient will attend the walk-in dental clinic today. A consult to be placed with Urology. His Attending to speak with his sister today.

OBJECTIVE: Mental Status Exam: Patient was lying in bed. He sat up to talk. He is a short, thin AA male dressed appropriately in hospital pajamas and adequate hygiene. He appears his stated age. He is cooperative with the interview with fair eye contact. He exhibits normal motor activity and speech. His mood is 7/10 with a constricted affect. Thought processes are little more organized today. Thought content without suicidal or homicidal ideations. He does not appear to respond to internal stimuli, no overt paranoia. He is alert and oriented. He has moderately impaired insight and judgment.

Diagnoses:
Unspecified Depressive Disorder
Schizophrenia
Stimulant Use Disorder (Cocaine)
Alcohol Use Disorder

Plan:
1. Continue Olanzapine for management of mood disturbance.
2. Continue medications for management of medical problems: Guaifenesin for management of cough. CXR negative.
3. MVI/Thiamine/Folate for supplementation due to chronic alcohol use. Discontinue CIWA-A protocol due to absence of withdrawal symptoms.
4. SATP referral for management of substance use disorder.
5. SW service to assist in review of housing situation.
6. Transfer to B status with participation in group activities to strengthen coping skills and stress management skills.
7. Patient with benefit from structure and support of therapeutic milieu.
8. Monitor patient progress for response of SI to treatment.
9. Discharge planning as clinically appropriate. Submit DE reports when appropriate.
10: Dental Imaging and Dental consult:
9/11, Rx inpatient meds Amox 500 mg, Motrin 400 mg.
11: Labs: Hgbalc and Lipids.

Admission labs: Admission labs were WNL with the exception of creat 1.4H, T. Protein 8.4H, Mag 2.2H, UDS +cocaine >1000H.

Education:
Patient educated about the following:
1. Importance of medication adherence, side effects.
2. Depression/mood as it related to substance abuse.
3. Educated on the negative effective of substance use.

Outcome: Patient verbalized understanding.

/es/ Henretta N Milton, NP
Nurse Practitioner
Signed: 09/11/2018 12:43

LOCAL TITLE: MH ATTENDING NOTE
STANDARD TITLE: MENTAL HEALTH ATTENDING NOTE
DATE OF NOTE: SEP 10, 2018@10:27 ENTRY DATE: SEP 10, 2018@10:27:48
AUTHOR: JACOBS,VERNETTA H EXP COSIGNER:
URGENCY: STATUS: COMPLETED

66 YO AAM, 100% SC, that involuntarily admitted to Recovery East due to report of worsening psychosis.

Per nursing 09/09: Calm. In bed during assessment. Sleeping most of the day. "The medicine makes me sleeply." Denies SI, HI, A/V hallucinations or pain at this time. Reports reduced coughing. Encouraged to drink fluids as well as get up out of bed. Watched TV in the dayroom briefly and quickly returned to bed. Denies needs at this time. Will continue to monitor.

Per nursing 09/10: Patient appeared to be sleeping in bed upon safety rounds. No sign of pain or discomfort noted. He slept approximately 7 hours during this shift. Patient was awakened by staff at 0600hrs for vital signs and medication.

CIWA-A scores - 0 (over past 24 hrs)

On interview, patient reports that he is not doing well on today. He discusses with provider numerous stressors which contributed to need for hospitalization. He reports that he visited his father in Tampa, Florida recently. Upon return, nearly all of his possessions were removed from his home (refrigerator, stove, TV, air conditioner, checks, Visa card, etc). He states that he filed a police report. He reports that he began to feel depressed by his situation. He states he has a pending court hearing this week regarding loss of his house and land. When asked more about this, he states that he was told that he has not been paying the mortgage. When asked if this was true, he reports that his niece recently started helping him with payment of his bills. He complains of health problems (chronic cough, tooth pain, "no sperm"). He reports that he recently spoke to his sister who lives in Florida and she may be willing to assist him in the management of his affairs. He began drinking and drugging in response to stressors. He tells provider that he has been drinking and drugging 2-3 times a week. Patient discusses multiple topics in a short period of time. Provider is uncertain if patient is a reliable historian.

Patient describes his mood as depressed. He slept well on last evening. His appetite is good and he desires double portions of meals. He denies thoughts to harm himself or others. He reports tolerating medications with no significant side effects. He denies experiencing auditory hallucinations with addition of

current medication. He denies problems on Recovery East.

Patient gives provider permission to contact his sister. Provider spoke with sister of patient, Delphine Howard, who confirmed all of the above information. She reports that he has been having difficulty for some time and is thankful that he is in the hospital setting. She plans to travel from Florida to SC for court hearing scheduled for Thursday. She desires to have a family meeting on tomorrow to discuss care of the patient.

VS: BP 139/87 P 66

MSE: Patient is a short, thin AA male dressed appropriately in hospital pajamas. He has fair hygiene and appears stated age. He is cooperative with the interview with fair eye contact. He exhibits normal motor activity and speech. His mood is depressed with a constricted affect. Thought processes are disorganized. Thought content without suicidal or homicidal ideations. He does not appear to respond to internal stimuli, no overt paranoia. He is alert and oriented. He has moderately impaired insight and judgment.

Diagnoses:
Unspecified Depressive Disorder
Schizophrenia
Stimulant Use Disorder (Cocaine)
Alcohol Use Disorder

Plan:
1. Continue Olanzapine for management of mood disturbance.
2. Continue medications for management of medical problems: Guaifenesin for management of cough. CXR negative.
3. MVI/Thiamine/Folate for supplementation due to chronic alcohol use. Discontinue CIWA-A protocol due to absence of withdrawal symptoms.
4. SATP referral for management of substance use disorder.
5. SW service to assist in review of housing situation.
6. Maintain C status with participation in group activities to strengthen coping skills and stress management skills.
7. Patient with benefit from structure and support of therapeutic milieu.
8. Monitor patient progress for response of SI to treatment.
9. Discharge planning as clinically appropriate. Submit DE reports when appropriate.

/es/ VERNETTA H JACOBS
PSYCHIATRIST
Signed: 09/10/2018 13:17

LOCAL TITLE: MH ATTENDING NOTE
STANDARD TITLE: MENTAL HEALTH ATTENDING NOTE
DATE OF NOTE: SEP 09, 2018@12:15 ENTRY DATE: SEP 09, 2018@12:15:09
AUTHOR: CRAWFORD,PAMELA M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

S: The patient was seen on rounds. He said he had difficulty sleeping last night, in part due to not feeling comfortable with his roommate. He said his roommate appeared to follow him and kept him up at night. He said he felt better now that he had been moved to his own room. He said that when he was having difficulty with the roommate he was hearing voices but he is not hearing them at this time. He says his mood is still depressed. He does not like that the Zyprexa is making him feel sleepy but is willing to continue. He asked about being started on an antidepressant and I told him I would mention this to his treating psychiatrist. He denies any thoughts of harming himself or others. No delusional beliefs discussed.

MSE: The patient is a thin, disheveled male appearing older than stated age. He is alert and fully oriented. His speech is normal in rate and tone. He has no abnormal movements. He maintains appropriate eye contact with the examiner. His mood is "depressed." His affect is constricted. His thoughts are organized. He has no suicidal or homicidal thoughts or plans. He reports occasional auditory hallucinations and has no delusional beliefs. He does not appear to be responding to internal stimuli. His recent and remote memory are intact. His intelligence appears to be within the average range. His insight and judgment are impaired.

DIAGNOSIS/ASSESSMENT:

Psychiatric Diagnosis:
Unspecified Depressive Disorder
Schizophrenia, Paranoid Type
Stimulant Use Disorder, Cocaine, severe
Alcohol Use Disorder

1. Continue C status.
2. CIWAs q 4 hours while awake.
3. Continue Zyprexa 10 mg po qhs. Discussed r/b/se of this medication with patient.
4. Consider beginning antidepressant medication.
5. SAPT Consult
6. Dietary Consult (patient is underweight). Double portions to be ordered.
7. Dental Consult
8. Ask SW to explore patient's housing circumstances and possibility of homelessness.
9. Discharge when clinically stable.

/es/ PAMELA M CRAWFORD
MD
Signed: 09/09/2018 12:18

LOCAL TITLE: MH ATTENDING NOTE
STANDARD TITLE: MENTAL HEALTH ATTENDING NOTE
DATE OF NOTE: SEP 08, 2018@11:15 ENTRY DATE: SEP 08, 2018@11:15:45

AUTHOR: CRAWFORD,PAMELA M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Initial Psychiatric Assessment

CC: "I have been feeling depressed and I was hearing voices."

HPI: The patient is a divorced 66 year old male who presented to the Dorn VA with complaints of feeling depressed and suicidal. He stated he had been hearing voices telling him to kill himself and he knew he needed help. He said he felt sick and wanted to die but did not want to kill himself because of his son.

During the initial psychiatric assessment, the patient said that he had been feeling depressed for "about 2 weeks." He said his house had been broken into approximately 2 months ago and he had many items stolen, including his air conditioner. He said he began drinking alcohol more heavily (fifth of wine per day) and became more depressed. He began having auditory hallucinations and had thoughts about wanting to die. He said he has not been on his antipsychotic medications for "over a year" and felt he needed help and "maybe to get back on my medicine." The patient denied abuse of drugs, but his urine drug screen was positive for cocaine. The patient currently denies suicidal thoughts and reports the voices are "once in a while." He denies command hallucinations to kill himself.

The patient had been seen in mid-August by mental health, as a walk in. The notes indicate that the patient was known to have a diagnosis of schizophrenia and was on no medication, but appeared to be stable and not in need of acute treatment.

Psychiatric History: The patient has been diagnosed with schizophrenia and schizoaffective disorder, in the past and is 100% service connected for psychiatric illness. He estimates he has been psychiatrically hospitalized "about 10 times." A review of his records from JLV indicates that the patient has had only occasional contact with VA mental health over the last decade. The records indicate that when prescribed psychotropic medications, the patient only takes them for a short period of time and does not follow up. When asked about this, the patient said he does not follow up with mental health because, "I don't want to get locked in a place like this." The patient reports a history of being treated with trilifon, stelazine, mellaril and Risperdal.

Social History: The patient was born in Orangeburg, SC. He was raised by both parents. He has one brother and one sister. He graduated from high school and has two years of college. He is divorced and has 3 children with whom he has occasional contact. He is 100% service connected for schizophrenia. He says he has not worked on a continual basis "for about 30 years." He lives in Summerton, SC. He lives in a house he owns, but believes he may be losing his house and that he may be homeless.

Alcohol and Substance Abuse History: The patient reports he drinks "about a fifth of wine" per day. He denies any drug use but says he smoked marijuana, "a

long time ago." He denies use of cocaine, however, his UDS is positive for cocaine. He denies a history of substance abuse treatment.

Family Psychiatric History: None.

Legal History: Patient denies a history of arrests.

MILITARY HISTORY:
BRANCH OF SERVICE: ARMY
MAR 1975 - NOV 1978
VIETNAM ERA
SERVICE DISCHARGE TYPE: HONORABLE
Combat Veteran Status: None Indicated
Eligibility: SERVICE CONNECTED 50% to 100% VERIFIED
Total S/C %: 100
PSYCHOSIS, SCHIZ UNDIFF 100% S/C
PROSTATE GLAND CONDITION 0% S/C
EAR INFECTION 0% S/C
KNEE CONDITION 0% S/C
FACIAL SCARS 0% S/C
NO

PAST MEDICAL HISTORY:
Diverticulitis of colon. S/p colostomy and colostomy reversal

DRUG SENSITIVITIES & ALLERGIC REACTIONS: Patient has answered NKA

Active Inpatient Medications (including Supplies):

	Inpatient Medications	Status
1)	ACETAMINOPHEN TAB 650MG PO Q4H PRN C/O PAIN	ACTIVE
2)	ALOH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL 30ML PO Q6H PRN C/O INDIGESTION	ACTIVE
3)	HALOPERIDOL INJ,SOLN 5MG/1ML IM Q4H PRN Instructions too long. See order details for full text.	ACTIVE
4)	Hydroxyzine HCL TAB 50MG PO Q6H PRN anxiety or sleep disturbance	ACTIVE
5)	Lorazepam INJ 2MG/1ML IM Q4H PRN Instructions too long. See order details for full text.	ACTIVE
6)	Lorazepam TAB 2MG PO Q4H PRN Instructions too long. See order details for full text.	ACTIVE
7)	MAGNESIUM HYDROXIDE SUSP,ORAL 30 MLS OF PO DAILY PRN FOR CONSTIPATION	ACTIVE
8)	RISPERIDONE SOLN,ORAL 2MG/2ML PO BID PRN Instructions too long. See order details for full text.	ACTIVE
9)	TUBERCULIN, PPD READ INJ PPD READ MISC ONCE Pharmacy -SCHEDULE READING FOR 1 TIME ONLY 48 HOURS AFTER ADMINISTRATION. Nursing - ENTER READING AS COMMENT	ACTIVE

AND ENTER THE PPD READ PROGRESS NOTE.
10) TUBERCULIN,PURIFIED PROTEIN DERIVATIVE 5UNT/1TEST ID ACTIVE
ONCE

Current Vitals:
T: 98.2 F [36.8 C] (09/08/2018 10:03)
P: 80 (09/08/2018 10:03)
R: 18 (09/08/2018 10:03)
BP: 127/80 (09/08/2018 10:03)
Pain: 0 (09/07/2018 13:21)

MSE: The patient is a thin, disheveled male appearing older than stated age. He is alert and fully oriented. His speech is normal in rate and tone. He has no abnormal movements. He maintains appropriate eye contact with the examiner. His mood is "depressed." His affect is constricted. His thoughts are organized. He has no suicidal or homicidal thoughts or plans. He reports occasional auditory hallucinations and has no delusional beliefs. He does not appear to be responding to internal stimuli. His recent and remote memory are intact. His intelligence appears to be within the average range. His insight and judgment are impaired.

DIAGNOSIS/ASSESSMENT:

Psychiatric Diagnosis:
Unspecified Depressive Disorder
Schizophrenia, Paranoid Type
Stimulant Use Disorder, Cocaine, severe
Alcohol Use Disorder

1. Continue C status.
2. CIWAs q 4 hours while awake.
3. Will begin Zyprexa 10 mg po qhs. Discussed r/b/se of this medication with patient.
4. SAPT Consult
5. Dietary Consult (patient is underweight). Double portions to be ordered.
6. Dental Consult
7. Ask SW to explore patient's housing circumstances and possibility of homelessness.
8. Discharge when clinically stable.

/es/ PAMELA M CRAWFORD
MD
Signed: 09/08/2018 12:04

LOCAL TITLE: MH COMPREHENSIVE RECOVERY PLAN
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN NOTE
DATE OF NOTE: SEP 07, 2018@14:57 ENTRY DATE: SEP 07, 2018@15:12:14
AUTHOR: COX,SAMUEL EXP COSIGNER: HAMILTON,VENUS C

URGENCY: STATUS: COMPLETED

DATE/TIME PATIENT ENTERED TREATMENT: 9/7/2018 2:59:32 PM
MH COMPREHENSIVE RECOVERY PLAN - 7 Sep, 2018 @ 02:57 PM 7 Sep, 2018 @ 14:57 -
WJB MH INPT PEER SPT IND

TREATMENT PLAN TYPE: Comprehensive

PRIMARY CLINIC OR PROGRAM: Inpatient Unit

CLINICS OR PROGRAMS:
Inpatient Unit

MHTC not assigned

TEAM MEMBERS:
COX,SAMUEL: PEER SUPPORT SPECIALIST
JACOBS,VERNETTA H: PSYCHIATRIST
ROGERS,MARY R: SOCIAL WORKER
GETER-HERNDON,APRIL: SOCIAL WORKER
SCHUYLER,ERIN: PSYCHOLOGY INTERN
HOUSER,JENNIFER N: CLINICAL PHARMACIST
CARN-HOLMES,EARLINE: REGISTERED NURSE
COVINGTON,KAREN R: NURSE PRACTITIONER - STAFF
BELLIN,ROBERT JR: CHAPLAIN
MUSICK,JEFFREY: PSYCHOLOGIST
DOWNIE,NOAH C: PSYCHIATRIST
JENKINS,KATHY: REGISTERED NURSE/PERMANENT EMPLOYEE
WANNAMAKER,SHARON C: NURSE - RN

RISK ASSESSMENT (DANGER TO SELF AND OTHERS):
Substance Abuse/Dependence Relapse
Suicidal Ideation

PATIENT'S PERCEPTION OF NEEDS AND PREFERENCES:
sobriety
improved social skills
skills and tools to help with anxiety reduction

PATIENT'S RESTRICTIONS:
Locked Ward

PATIENT'S PRIVILEGES:
Street Clothes

PATIENT'S STRENGTHS/ABILITIES:
Provider Identified:
Insightful - aware of illness
Expressed desire/motivation for change
Sobriety

PATIENT'S BARRIERS TO CARE:
Chronic psychiatric symptoms, without remission
Substance abuse/dependence

INTERDISCIPLINARY INTEGRATED SUMMARY:
Interpretive Summary::
Psychiatry Attending Inpatient Admission Note

CC: "just some family issues gone wrong"

HPI: 55 y/o AAM w/ a h/o etoh use disorder and unspecified depressive d/o has
been involuntarily admitted to Recovery East on 9/7/18 for HI toward his brother
without a plan.
Pt. said that his brother, who lives in Columbia, has been saying insulting
things about his mother and sister, and pt. became angry and wanted to kill him.
Pt. said that he called and told a SW at Dorn about this, and EMS was called to
bring pt. to Dorn ED for admission to Recovery East.
Pt. endorses being "a litle depressed," but denies SI/HI and contracts for
safety. Said that he no longer wants to harm his brother. He is just angry
with him for insulting his mother and sister for no apparent reason. Denies
feeling hopeless/helpless/worthless, denies anhedonia. Sleep is good, with pt.
reportedly getting 8 hours or more/night on average, energy, appetite and
concentration are all good. Pt. said that he has some anxiety, denies panic
attacks.
Denies sx/episodes of mania/hypomania. Denies all psychotic sx, including AVH
and paranoia. Pt. denies h/o traumas.
Pt. reports drinking etoh 3-4 x/wk on average, 1 pint of liquor on average at a
time. Reports smoking marijuana 3-4x/wk, said that he "may have done cocaine,
but doesn't remember," denies other illicit drugs. He does not think drugs or
etoh are a problem for him. Denies h/o w/d seizures or DTs. Reports current
w/d sx of anxiety. Reports 1 DUI in the 1980s.
Pt. currently is taking no psych meds, said he last took them about 1 week ago,

and he is willing to restart. Doesn't need help with housing.

Past Psychiatric History:
SA: denies
INPT: x 1 in 1990s on RE
OUTPT: Weyant MD
past treatment/rehab for etoh/illicit drugs: x 1 in the 1990s at Dorn
past psych meds: mirtazapine, fluoxetine, gabapentin, acamprosate, amitriptyline, bupropion, abilify, melatonin

Family Psychiatric History:
denies

PMH:
htn
hld

Social History:
Lives in Columbia with his nephew in a house
Married x 1, widowed
Has 3 grown children
Unemployed, disabled
Some college
Denies legal problems
Served in the Army x 12 years, d/c honorably as E6

MSE:
Pt. is an AAM of average build, who appears to be his stated age, hygiene
appropriate for the current condition, wearing hospital pjs. He is appropriate
and cooperative, and maintains good eye contact. No pma/pmr/tremor/tics noted.
Mood is "restless," affect is anxious. TC is devoid of SI/HI/AVH/delusions and
he does not appear to be responding to internal stimuli. TP are linear, coherent, goal directed and organized. A&O x 4. Cognition appears to be
intact, but is not formally tested. Insight and judgement are poor.

Assessment/Plan: 55 y/o AAM w/ a h/o etoh use disorder and unspecified depressive d/o has been involuntarily admitted to Recovery East on 9/7/18 for HI
toward his brother without a plan. Pt. currently denies SI/HI and contracts for
safety.

Diagnoses: etoh use disorder, unspecified depressive d/o (r/o SIMD, r/o MDD),
h/o panic d/o, cannabis use disorder

ANTICIPATED DISCHARGE DATE: 09/14/2018

DISCHARGE PLANNING/CRITERIA:
Medication Adherence
Appropriately uses/access to community resources
Clinically Stable
Not abusing addictive substances
Plans for follow-up care
Utilizes effective coping skills
Safe to self and others

PATIENT PARTICIPATION IN TREATMENT PLANNING:
MET WITH TEAM.
MET WITH PROVIDER.
VETERAN AGREED TO PLAN (draft) DISCUSSED.
VETERAN INPUT:
Met with Veteran in order to discuss the recovery process and assess strengths, needs, preference and abilities (SNAP), recovery goals and begin post dis-charged planning. Provided basic information about Recovery East such as the structure of clinical team and this author's role (e.g. recovery/discharge planning, assessment, therapy referrals, etc.). Informed Veteran about the Recovery East group/class schedule and encourage him/her to attend these groups in order to learn more about the recovery process, coping skills, safety planning, medication etc. Also, oriented Veteran to the 10 components of recovery, according to SAMHSA, including hope, strengths-based, and respect. Provide information about local recovery resources (e.g., NAMI), and encouraged Veteran to select any desired brochures and handbooks from the Recovery Resource Library.

FAMILY PARTICIPATION IN TREATMENT PLANNING:
VETERAN'S FAMILY NOT AVAILABLE.
FAMILY INPUT:
No family mentioned

MENTAL HEALTH DIAGNOSES AND RELEVANT MEDICAL CONDITIONS:
Alcohol Use Disorder

Cannabis Use Disorder

Depressive Disorder

TREATMENT PLAN PROBLEMS/NEEDS LISTED BY PRIORITY:
Veteran reports continued use of substance(s) despite interference in function
Clinic or Program: Inpatient Unit

Exacerbation of symptoms, Substnce Induced , associated with the diagnosis of Depression
Clinic or Program: Inpatient Unit

Safety of self or others while on the unit
Clinic or Program: Inpatient Unit

TREATMENT PLAN:

Problem: Veteran reports continued use of substance(s) despite interference in function
Goal: Veteran will withdraw from substance alcohol/cannabis abuse/dependence with minimal discomfort
Goal: Veteran will make aftercare plans
Objective: To instruct in the process of setting realistic aftercare plans and goals. To be accomplished by: 14 Sept,2018
Intervention: Review resources, appointments, and phone numbers using preferred style of learning Provider: Psychiatrist One time(s) per Day for 5 day/days

Problem: Exacerbation of symptoms, Substnce Induced , associated with the diagnosis of Depression
Goal: Veteran will demonstrate/verbalize decreased symptoms associated with depression prior to discharge
Goal: Veteran will verbalize effectiveness of medication regime prior to discharge
Objective: To return to a more regular/baseline sleep pattern. To be accomplished by: 14 Sept,2018
Intervention: Identify ways to reduce environmental stimulation Provider: Psychiatrist One time(s) per Day for 5 day/days

Problem: Safety of self or others while on the unit
Goal: Veteran will not commit any acts of self-harm or harm to others while on the unit
Objective: To ensure a safe environment while hospitalized. To be accomplished by: 14 Sept,2018.
Intervention: Medications evaluated and adjusted daily
Provider: Psychiatrist One time(s) per Day for 5 day/days

/es/ SAMUEL COX
PEER SUPPORT SPECIALIST
Signed: 09/07/2018 15:12

/es/ Venus C Hamilton,LISW-CP
Social Worker
Cosigned: 09/10/2018 17:28

Receipt Acknowledged By:
09/10/2018 13:45 /es/ VERNETTA H JACOBS

		PSYCHIATRIST
09/10/2018 08:25	/es/	MARY R ROGERS
		Social Worker
09/11/2018 10:35	/es/	APRIL GETER-HERNDON, LMSW
		SOCIAL WORKER
* AWAITING SIGNATURE *		SCHUYLER,ERIN
09/07/2018 15:22	/es/	JENNIFER HOUSER, PHARM.D, BCPP, BCGP
		Clinical Pharmacy Specialist, Mental Health
09/10/2018 14:19	/es/	KATHY JENKINS
		REGISTERED NURSE
	for	EARLINE CARN-HOLMES
* AWAITING SIGNATURE *		COVINGTON,KAREN R
09/11/2018 09:43	/es/	ROBERT BELLIN JR
		MDiv, ThM, Certified Clinical Chaplain
09/07/2018 15:12	/es/	JEFFREY MUSICK
		PSYCHOLOGIST
09/10/2018 07:50	/es/	NOAH C DOWNIE
		MD
09/10/2018 14:19	/es/	KATHY JENKINS
		REGISTERED NURSE
09/09/2018 17:26	/es/	SHARON C WANNAMAKER
		Registered Nurse

LOCAL TITLE: MH GOALS -INPATIENT
STANDARD TITLE: MENTAL HEALTH INPATIENT NOTE
DATE OF NOTE: SEP 07, 2018@18:40 ENTRY DATE: SEP 07, 2018@18:41
AUTHOR: HOVEYDA,MARTA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ASSESSMENT (Nursing Problems/diagnosis):
Depression
Alcohol abuse
Drug abuse
Psychotic (hallucinations)
GOALS/OUTCOMES
Stabilize mood
Sobriety
Absence of hallucinations
Will not injure self or others
OBJECTIVES: The patient will:
Agree to safety contract with staff
Not cause injury to self or others because of suicidal, homicidal, aggressive, or assaultive behavior.
Become sober and remain sober while hospitalized.
Not respond to internal stimuli
Verbalize reality based thoughts; realistic assessment of situation
Interact and socializes appropriately with others

Attends and participate in assigned groups
Verbalize two appropriate skills for coping with the problem(s) identified
Use caution when ambulating on unit and getting in and out of bed

INTERVENTIONS:
Orient to unit milieu, patient rights and responsibilities
Close observation of behavior
Provide calm, non-threatening environment
Provide supportive interaction encouraging verbalization of feelings, concerns, solutions
Give medications as prescribed to manage symptoms/observe for side effects, adverse reactions
Set limits on inappropriate behavior and provide re-direction
Reality orientation
Provide schedule of group activities and encourage participation

/es/ Marta C Hoveyda,BSN,RN
STAFF NURSE
Signed: 09/07/2018 18:42

LOCAL TITLE: MH HISTORY & PHYSICAL (FY07) - TL
STANDARD TITLE: MENTAL HEALTH H & P NOTE
DATE OF NOTE: SEP 08, 2018@10:31 ENTRY DATE: SEP 08, 2018@10:31:30
AUTHOR: CLANCY,CHARLENE C EXP COSIGNER: DOWNIE,NOAH C
URGENCY: STATUS: COMPLETED

MENTAL HEALTH ADMISSION HISTORY AND PHYSICAL

Veteran admitted Involuntarily to Psych East, yesterday afternoon, from the Dorn VAMC emergency room. Veteran presented to the emergency room with c/o suicidal thoughts and command auditory hallucinations telling him to kill himself.

See MH Attending Note this date for complete history and MSE.

MILITARY HISTORY:
BRANCH OF SERVICE: ARMY
MAR 1975 - NOV 1978
VIETNAM ERA
SERVICE DISCHARGE TYPE: HONORABLE
Combat Veteran Status: None Indicated
Eligibility: SERVICE CONNECTED 50% to 100% VERIFIED
Total S/C %: 100
PSYCHOSIS, SCHIZ UNDIFF 100% S/C
PROSTATE GLAND CONDITION 0% S/C
EAR INFECTION 0% S/C
KNEE CONDITION 0% S/C
FACIAL SCARS 0% S/C
NO

PAST MEDICAL HISTORY:
Diverticulitis of colon

DRUG SENSITIVITIES & ALLERGIC REACTIONS: Patient has answered NKA

Active Inpatient Medications (including Supplies):

	Inpatient Medications	Status
1)	ACETAMINOPHEN TAB 650MG PO Q4H PRN C/O PAIN	ACTIVE
2)	ALOH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL 30ML PO Q6H PRN C/O INDIGESTION	ACTIVE
3)	HALOPERIDOL INJ,SOLN 5MG/1ML IM Q4H PRN Instructions too long. See order details for full text.	ACTIVE
4)	Hydroxyzine HCL TAB 50MG PO Q6H PRN anxiety or sleep disturbance	ACTIVE
5)	Lorazepam INJ 2MG/1ML IM Q4H PRN Instructions too long. See order details for full text.	ACTIVE
6)	Lorazepam TAB 2MG PO Q4H PRN Instructions too long. See order details for full text.	ACTIVE
7)	MAGNESIUM HYDROXIDE SUSP,ORAL 30 MLS OF PO DAILY PRN FOR CONSTIPATION	ACTIVE
8)	RISPERIDONE SOLN,ORAL 2MG/2ML PO BID PRN Instructions too long. See order details for full text.	ACTIVE
9)	TUBERCULIN, PPD READ INJ PPD READ MISC ONCE Pharmacy -SCHEDULE READING FOR 1 TIME ONLY 48 HOURS AFTER ADMINISTRATION. Nursing - ENTER READING AS COMMENT AND ENTER THE PPD READ PROGRESS NOTE.	ACTIVE
10)	TUBERCULIN,PURIFIED PROTEIN DERIVATIVE 5UNT/1TEST ID ONCE	ACTIVE

Current Vitals:
T: 98.2 F [36.8 C] (09/08/2018 10:03)
P: 80 (09/08/2018 10:03)
R: 18 (09/08/2018 10:03)
BP: 127/80 (09/08/2018 10:03)
Pain: 0 (09/07/2018 13:21)
Pulse Ox: No PULSE OXIMETRY Vitals taken in the last 1 Year.

REVIEW OF SYSTEMS:
HEENT -- No history of head trauma, seizure disorder, headache, dizziness, vertigo, diplopia, epistaxis, dysphagia.
* RESPIRATORY -- No hemoptysis.
C/O cough and wheezing, "for a while" unable to elaborate
CARDIOVASCULAR -- No chest pain, palpitations, cyanosis, claudication, peripheral edema.

GASTROINTESTINAL -- No nausea, vomiting, diarrhea, hematemesis, melena, hematochezia, jaundice, recent change in bowel habits.
GENITO-URINARY -- No dysuria, hematuria, urgency, incontinence.
LYMPHATIC -- No lymphadenopathy.
HEMOPOIETIC -- No bruising, bleeding.
SKIN -- No bruising, pruritus, icterus.
EXTREMITIES -- No edema, clubbing, cyanosis.
NEUROLOGIC -- No history of neurologic disease, no numbness or parasthesias.
PSYCHIATRIC -- See HPI and psychiatric history

PHYSICAL EXAM:
GENERAL -- Well developed, well nourished, in no acute distress.
HEAD -- Normocephalic, atraumatic.
* EYES -- Pupils equal and reactive, extraocular movements intact, conjunctivae moderately injected without discharge.
* EARS -- Hearing grossly normal, canals patent, tympanic membranes occluded by dark amber cerumen.
NOSE -- No septal deviation, no lesions.
MOUTH - Mucosa pink and moist.
THROAT -- No erythema or exudate, normal gag reflex.
* TEETH -- Poor hygiene, poor repair - no upper teeth; no dentures
NECK -- Supple, no lymphadenopathy, no thyromegaly, no bruits, trachea midline.
CHEST -- Good expansion, no increase in AP diameter.
* LUNGS -- + wheezing in upper lobes bilaterally.
+ diminished sounds in bases bilaterally.
No egophony; no whispered pectoriloquy
CARDIOVASCULAR -- Regular rate and rhythm, PMI non-displaced, no rubs murmurs or gallops, pulses 2+ and symmetric throughout.
ABDOMEN -- Soft, non-tender, no masses or organomegaly, bowel sounds present.
GENITAL / RECTAL EXAM -- Deferred to Patient's Primary Care Provider.
BACK -- No kyphosis or spondylosis, no CVA tenderness.
* EXTREMITIES -- No cyanosis or edema.
+ mild clubbing of nailbeds bilaterally.
NEUROLOGICAL -- CN II-XII grossly intact, motor 5/5 all four extremities, DTRS 2+ and equal throughout, sensation intact, cerebellar function intact, toes downgoing.
SKIN -- Cool, dry, anicteric, no rashes or bruises.
LYMPHATICS -- No lymphadenopathy.

MENTAL STATUS EXAM: See MH Attending Note this date

DIAGNOSIS/ASSESSMENT:

Psychiatric Diagnosis:
Schizophrenia, Paranoid Type

Stimulant Use Disorder, Cocaine, severe

Relevant Medical Diagnosis:
None noted

Contributing Factors:
Lives Alone
Non-compliance

PLAN:

Assessment of Suicide Risk following admission:
[x] Low
[ ] Moderate
[ ] High

Patient will be placed on q 15 min checks per unit protocol unless otherwise specified in ORDERS for:
[ ] Close observation (visual monitoring of patient at all times)
[ ] 1:1 observation (within arms reach of patient at all times)
[ ] Locked Door Order for safety

Interventions:
[x] Adjust medications as appropriate
[ ] Admission benzodiazepines:
[ ] "quick set" prn orders
[ ] routine orders
[x] Group therapy
[x] Activities
[x] Individual therapy
[x] SATP
[ ] Assistance with ADLs
[ ] VR consult
[ ] Other

Safety observation for:
[x] Self injury / suicide
[x] Aggressive / threatening behavior
[ ] Falls

* Medical problems:
Goal -- Patient will be medically stable at the time of discharge.
Interventions --
[x] Medications as indicated - Guaifenesin 400 mg po tid
[x] Routine admission labs
[x] Tests / procedures: CXR
[ ] Consults as appropriate
[ ] Other

Patient participation:
[x] Patient participated in the treatment planning process.
[ ] Patient unable to participate due to:
[x] Patient expresses understanding.
[ ] Patient partially understands due to:
[x] Patient agreed with the plan.
[ ] Patient disagreed with the plan.

EDUCATION: Patient and/or family / caregiver is/are educated about following --
[x] Condition
[x] Plan of care
[x] Medications
[ ] Pain Management
[ ] Tests / procedures
[ ] Basic health practices (smoking, exercise, alcohol use, diet, immunizations)
[ ] Other:
[ ] Patient unable to participate due to:

Recipient of education:
[x] Patient
[ ] Family / caregiver
[ ] Other

Teaching method:
[x] Verbal
[ ] Printed material
[ ] Demonstration
[ ] Audiovisual

Outcome:
[x] Verbalizes understanding
[ ] Able to demonstrate
[ ] Needs reinforcement

CLINICAL REMINDER ACTIVITY
AIMS Exam:
AIMS (Mental Health Instrument)
The patient was evaluated for symptoms of tardive dyskinesia using the AIMS.
Total score for items 1-7: 0

Follow-up Pos Alcohol :
Concern expressed to patient about their alcohol use.
Patient to be followed up with at next ambulatory visit.

Feedback regarding relationship of alcohol to the patient's specific health issues and risks were reviewed with patient.
Specifically the following were reviewed:
High blood pressure, heart disease, liver disease, seizures, injury, medication interactions, depression and anxiety, insomnia, bleeding from the stomach, stroke, dementia, cancers
Advised patient to abstain from drinking alcohol due to contraindications.
Patient should abstain due to:
Medication interaction, Medical condition
The patient declines referral for alcohol use assessment or treatment at this time. Plan: rescreen annually.

/es/ CHARLENE C CLANCY
Physician Assistant
Signed: 09/08/2018 10:58

/es/ NOAH C DOWNIE
MD
Cosigned: 09/10/2018 09:27

LOCAL TITLE: MH INPATIENT CONSULT
STANDARD TITLE: MENTAL HEALTH INPATIENT CONSULT
DATE OF NOTE: NOV 19, 2015@14:23 ENTRY DATE: NOV 19, 2015@14:23:20
AUTHOR: HASTIE,CASHENA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

INPATIENT PSYCHIATRIC CONSULTATION

Psychiatric Intake Note:

Chief Complaint:" I am waiting to have surgery "

History of Present Illness:
Vet is a 63 yo AAM with a past psych hx sig for Schizophrenia.
Vet seen today for psychiatric assessment and medication management.

Pt reported he was admitted for colostomy bag reversal surgery. He explained that "I was diagnosed with diverticulitis and a part of my colon was removed and I have been using a bag...inorder for me to use the bathroom like normal people without the bag need to have the colostomy bag reversal surgery". He stated that he has missed so many appointments in regards to this proceedure because he was either traveling to Florida to visit family ot the Phillipine to visit his fiance. He understood benefits and risks of the proceedure. He stated risks included :"infection or bleeding or even death" and stated benefits included "being able to use the bathroom without a bag".

He stated that he lives in the Phillipines for part of the year. He explained in Jan 2015 he was comitted to a psych hospital in Charleston, SC because he brother made up an allegation that he shot at him. He denies this being true.

He reported he was dicharged because he was able to prove with a witness that he was safe. He reported his brother made up this allegation inorder to get him out of the house so the brother could steal his items. He also stated the brother made up these allegations because he was trying to get the brother evicted since he had been living in the home rent free for several years. As per records from Charleston VA in vista web dated 1/27/15 records indicated that pt was able to obatain confirmation from a friend named Frank that he had infact been trying to evict the brother from the home and that he has homes abroad.

DEPRESSION: mood- good, appetite- good, sleep- disturbed due to having to empty the colostomy bag every 2 hrs., concentration- good, denied SI and HI. Pt reported he would sleep "just fine" but for this colostomy bag.

ANXIETY:denied
PTSD: denied
MANIA:denied

PSYCHOSIS:denied VH and AH. Reported it has been over 20 years since he has last had AH or VH. Records indicated he was last recieved antipsychotics in May 2010

SUBSTANCE:denied current use. In review of the chart pt has a hx of alcohol use and cannabis use.

Denies any other illicit substances.

Past Psychiatric History:
Inpt-Inpatient hospitalizations: significant for January 2015 for paranoid thoughts, committed for 5 days (Pt reported this hospitalization was based on a false alligation made by his brother). 2009 hospitalized; one year hospitalization in
Monroe, NY over 30 years ago and was dx with Schizophrenia at that time.

Outpt-denied

Previous Med Trials:
denied being on medication since 2010

Family Psychiatric History:
denied

Past Medical History:
Dicerticulitis
Visicocolic Fistula
Lumbago

Social History/Developmental History:

Marital Status: Divorced and currently enganged, 2 adult childrem and one son who is 17yo

Substance Use History (alcohol, tobacco, illicit drugs, prescription medications): Hx of Cannabis and Alcohol Use. Pt denied current use

Military History: Army x 2.5 years, Vietnam War

History of Violence: denied

Allergies:denied

Vitals:
Current Vitals:
T: 97.7 F [36.5 C] (11/19/2015 09:25)
P: 48 (11/19/2015 09:25)
R: 24 (11/19/2015 09:25)
BP: 151/82 (11/19/2015 09:25)
Pain: 0 (10/21/2015 11:14)
Pulse Ox: 11/19/15 100%

LABS; reviewed

MSE:
APPEARANCE/BEHAVIOR: casually dressed in hospital attire, cooperative with evaluation and good eye contact
PSYCHOMOTOR (gait/tremor/abnormal movement): no tremor movment appreciated, psychomotor wnl
SPEECH: normal rate, tone, volume; fluent
COGNITION: grossly intact but not formally assessed
ORIENTATION: A & O X 4
MOOD: "good"
AFFECT: congruent with mood
THOUGHT PROCESS: goal directed
THOUGHT CONTENT (hallucinations/delusions): denies auditory and visual hallucinations, no delusional ideation voiced, denies paranoia
SUICIDAL IDEATION: denies
HOMICIDAL IDEATION: denies
INSIGHT: fair
JUDGEMENT: fair

MSE Score: 29/30 (memory was 2/3 after five minutes)

Risk Factors: (legal, relationship, financial, medical)
Hx of Schizophrenia

Strengths: Understands the need for the proceedure

DIAGNOSTIC IMPRESSION (DSM 5): (Include possible rule outs)

PROBLEM 1: Schizophrenia by hx

Medications: pt not acutely psychotic at this time and denies AH and VH currenlty. Would not reccomend treatment for psychosis at this time. Even during last hospitalization in Jan 2015 in Charleston VA Medical Center it does not appear as though pt was treated for symptoms of psychosis. As per chart pt was last treated with antipsychotic 5/2010.

If pt become psychotic can consider an antipsychotic such as low dose Risperal at that time
Therapy:

PROBLEM 2: Pt not meet criteria for substance us dx at this time

- would consider a UDS given pt hx of Cannabis and Alcohol Use.

Will sign off on this pt at this time. Thank you for the opportunity for working with the vet.

/es/ CASHENA HASTIE
MD
Signed: 11/19/2015 14:58

LOCAL TITLE: MH NURSING REASSESSMENT-TL
STANDARD TITLE: MENTAL HEALTH NURSING NOTE
DATE OF NOTE: SEP 12, 2018@00:24 ENTRY DATE: SEP 12, 2018@00:24:26
AUTHOR: WILSON,RODNEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Admission Date: SEP 7,2018 12:21 Current Ward/Room Number: E217-C
Brief review of problems/needs identified on treatment plan and patient's progress in meeting goals and objectives:
SPN - Selected Prog Notes
09/07/2018 18:40 Local Title: MH GOALS -INPATIENT
Standard Title: MENTAL HEALTH INPATIENT NOTE

ASSESSMENT (Nursing Problems/diagnosis):
Depression
Alcohol abuse
Drug abuse
Psychotic (hallucinations)
GOALS/OUTCOMES
Stabilize mood
Sobriety
Absence of hallucinations
Will not injure self or others
OBJECTIVES: The patient will:
Agree to safety contract with staff
Not cause injury to self or others because of suicidal, homicidal, aggressive, or assaultive behavior.

Become sober and remain sober while hospitalized.
Not respond to internal stimuli
Verbalize reality based thoughts; realistic assessment of situation
Interact and socializes appropriately with others
Attends and participate in assigned groups
Verbalize two appropriate skills for coping with the problem(s) identified
Use caution when ambulating on unit and getting in and out of bed

INTERVENTIONS:
Orient to unit milieu, patient rights and responsibilities
Close observation of behavior
Provide calm, non-threatening environment
Provide supportive interaction encouraging verbalization of feelings, concerns, solutions
Give medications as prescribed to manage symptoms/observe for side effects, adverse reactions
Set limits on inappropriate behavior and provide re-direction
Reality orientation
Provide schedule of group activities and encourage participation

NIGHT SHIFT

MENTAL/NEURO STATUS:
Oriented to: Name SLEEPING
Level of Consciousness: Other SLEEPING
Mood/Affect: other: SLEEPING
Behavior: other SLEEPING
Speech: Other: SLEEPING
Thoughts: other: SLEEPING
Hallucinations: No; SLEEPING
Thought Content: SLEEPING
Rational: SLEEPING
Delusions: No SLEEPING
Preoccupations: No; SLEEPING
Obsessions: No; SLEEPING
Phobias: No; SLEEPING
Suspiciousness: No; SLEEPING
Paranoia: No; SLEEPING

AM: Patient stated Goals: N/A

Describe the patient's behavior on the unit, including symptoms related to the reason for admission: Patient appeared to be sleeping in bed upon safety rounds. No sign of pain or discomfort noted. He slept approximately 7 hours during this shift. Patient was awakened by staff at 0600hrs for vital signs and medication. Patient escorted to united treatment room and allowed laboratory personnel to draw his blood for scheduled labs. Patient escorted back to unit. Patient voiced no complaints of pain or discomfort and exhibited no sign of distress.

Are there any new problems/symptoms/needs?
No
Are there any medical complaints or findings?
No
FALL RISK ASSESSMENT:
Morse Fall Scale:
The Morse Fall scale was performed and score was 0. This is indicative of low risk of falls.

History of falling in past 3 months?
No

Secondary diagnosis:
No

Ambulatory aid:
None/bedrest/nurse assist

Intravenous therapy/Heparin lock:
No

Gait/Transferring:
Normal/bed rest/immobile

Mental Status:
Oriented to own ability/knows own limitations
Morse Fall Score is 0-24. Patient is at low risk for falls.
Previous Fall Risk Score:
SHF - Health Factor Select
REMINDER FACTORS
FALL LOW RISK PT 09/11/2018

PAIN ASSESSMENT:
No Pain
Patient appears to have no pain.
INTRAVENOUS ACCESS
Does Patient have Intravascular Access?
NO- None at this time.
GENITOURINARY:
Does patient have Foley Catheter (via the urethra)?
No- None at this time.
Normal urination habits without any identified problems
ELOPEMENT REASSESSMENT:
RISK REASSESSMENT FOR ESCAPE OR ELOPEMENT:
Is this patient considered to be a danger to self or others?
No
Does this patient lack the cognitive ability to make relevant decisions?
Yes

Does this patient have a history of escape or elopement?
No
Does this patient have physical or mental impairments that increase the risk of harm to self or others?
No
Total Points/Risk:At Risk = 1 or more risk factors selected
Elopment Risk Interventions Initiated:MH Ward - Controlled Environment
Does the patient require continued stay in the hospital?
Patient needs continued stay.
Explain: stabilize mood, regulate medication

NURSING SUMMARY/PLAN: Provide a safe/non-threatening environment, assist as needed, dispense scheduled medications, offer PRN medications when appropriate; monitor for effectiveness.

/es/ RODNEY WILSON
REGISTERED NURSE
Signed: 09/12/2018 06:51

LOCAL TITLE: MH NURSING REASSESSMENT-TL
STANDARD TITLE: MENTAL HEALTH NURSING NOTE
DATE OF NOTE: SEP 11, 2018@00:48 ENTRY DATE: SEP 11, 2018@00:48:05
AUTHOR: LAWAL,AHMED EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Admission Date: SEP 7,2018 12:21 Current Ward/Room Number: B220-A
Brief review of problems/needs identified on treatment plan and patient's progress in meeting goals and objectives:
SPN - Selected Prog Notes
09/07/2018 18:40 Local Title: MH GOALS -INPATIENT
Standard Title: MENTAL HEALTH INPATIENT NOTE

ASSESSMENT (Nursing Problems/diagnosis):
Depression
Alcohol abuse
Drug abuse
Psychotic (hallucinations)
GOALS/OUTCOMES
Stabilize mood
Sobriety
Absence of hallucinations
Will not injure self or others
OBJECTIVES: The patient will:
Agree to safety contract with staff
Not cause injury to self or others because of suicidal, homicidal, aggressive, or assaultive behavior.
Become sober and remain sober while hospitalized.
Not respond to internal stimuli
Verbalize reality based thoughts; realistic assessment of situation

Interact and socializes appropriately with others
Attends and participate in assigned groups
Verbalize two appropriate skills for coping with the problem(s) identified
Use caution when ambulating on unit and getting in and out of bed
INTERVENTIONS:
Orient to unit milieu, patient rights and responsibilities
Close observation of behavior
Provide calm, non-threatening environment
Provide supportive interaction encouraging verbalization of feelings, concerns, solutions
Give medications as prescribed to manage symptoms/observe for side effects, adverse reactions
Set limits on inappropriate behavior and provide re-direction
Reality orientation
Provide schedule of group activities and encourage participation

MENTAL/NEURO STATUS:
Oriented to: name Appears sleeping
Level of Consciousness: Other Appears sleeping
Mood/Affect: other: Appears sleeping
Behavior: other Appears sleeping
Speech: Other: Appears sleeping
Thoughts: other: Appears sleeping
Hallucinations: No Appears sleeping
Thought Content:
Rational: Yes
Delusions: No
Preoccupations: No
Obsessions: No
Phobias: No
Suspiciousness: No
Paranoia: No

AM: Patient stated Goals: NA
Describe the patient's behavior on the unit, including symptoms related to the reason for admission: Upon safety rounds vet observed resting quietly in bed with eyes closed. Respiration regular and unlabored with no signs of pain or discomfort noted. will continue to monitor. Vet appears to have slept for approximately 6-7 hours on this shift.
Are there any new problems/symptoms/needs?
No
Are there any medical complaints or findings?
No
FALL RISK ASSESSMENT:
Morse Fall Scale:
The Morse Fall scale was performed and score was 0. This is indicative of low risk of falls.

History of falling in past 3 months?

No

Secondary diagnosis:
No

Ambulatory aid:
None/bedrest/nurse assist

Intravenous therapy/Heparin lock:
No

Gait/Transferring:
Normal/bed rest/immobile

Mental Status:
Oriented to own ability/knows own limitations
Morse Fall Score is 0-24. Patient is at low risk for falls.

PAIN ASSESSMENT:
No Pain
Patient appears to have no pain.
SKIN:
Braden Scale - For Predicting Pressure Sore Risk
Sensory Perception: 4 = No Impairment
Moisture: 4 = Rarely Moist
Activity: 4 = Walks Frequently
Mobility: 4 = No Limitation
Nutrition: 3 = Adequate
Friction: 3 = No Apparent Problem
19-23 No Risk
Score: 22

CURRENT SKIN ASSESSMENT
Skin Color:
Color: Normal for ethnic group
Skin Temperature
Temp: Warm
Skin Moisture
Moisture: Dry
Skin Turgor
Turgor: Within normal limits

SKIN PROBLEMS

No wounds, pressure ulcers or other skin problems.
INTERVENTIONS
No data available

INTERVENTIONS
The pressure ulcer prevention protocol was not needed - patient is not at risk.
INTRAVENOUS ACCESS
Does Patient have Intravascular Access?
NO- None at this time.
GENITOURINARY:
Does patient have Foley Catheter (via the urethra)?
No- None at this time.
Normal urination habits without any identified problems
ELOPEMENT REASSESSMENT:
RISK REASSESSMENT FOR ESCAPE OR ELOPEMENT:
Is this patient considered to be a danger to self or others?
No
Does this patient lack the cognitive ability to make relevant decisions?
Yes
Does this patient have a history of escape or elopement?
No
Does this patient have physical or mental impairments that increase the risk of harm to self or others?
No
Total Points/Risk:At Risk = 1 or more risk factors selected
Elopment Risk Interventions Initiated:MH Ward - Controlled Environment
Does the patient require continued stay in the hospital?
Patient needs continued stay.
Explain: To stabilize mood
NURSING SUMMARY/PLAN: Provide therapeutic environment and to administer medication as prescribed while monitoring for any side effects or adverse reactions.

/es/ AHMED LAWAL
REGISTERED NURSE
Signed: 09/11/2018 07:11

LOCAL TITLE: MH WALK-IN NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: SEP 07, 2018@10:29 ENTRY DATE: SEP 07, 2018@10:29:22
AUTHOR: KING,ERIC EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Mental Health Diagnosis: PSYCHOSIS
Length of Session: 60 mins
Mental Status Exam:
Appearance/Grooming: Poor hygiene, Unkept
Attitude/Behavior: Cooperative, Restless
Mood: Negative, Irritable, Anxious
Affect: Flat
Sensorium: Confused/Disoriented
Perceptual Distortions: Auditory Hallucinations, Visual Hallucinations

by report, Command Hallucinations, Tactile Hallucinations
Thought Processes: Illogical, Disorganized/Incoherent
Insight: Poor
Judgement: Poor

Has the Veteran been seen in outpatient mental health in the past two years?
No

Veteran's description of presenting problem: "feel sick, want to die, going crazy" Veteran reported hearing command voices instructing him to die. Veteran reports wanting to kill himself but didn't want to upset his son. Veteran was visually upset and receiving commands from a voice telling him to commit suicide. Veteran would look at wall and yell "why do I have to kill myself" and explain that a voice was telling him to commit suicide. Veteran was agreeable to inpatient care; however, IPV part one was completed by Social Worker due to the risk associated with psychosis with leaving care after voluntary admittance.

The following concerns were addressed during today's session:
Suicidal/Homicidal Ideations observed/verbalized?
Yes- indicate interventions:
Assessment and Hospitalization

Medication Refills/Renewals/Adjustments

Plan for follow-up and intervention:
Urgency of follow-up services:
No follow-up necessary:
Reason:
Other: Inpatient care
Coordinated evaluation for admission in the ED for SI/HI

Provided information:
-The Veteran is made aware of how to process and deal with any imminently dangerous thoughts, knows to contact the number for the Veteran's Crisis Line (1-800-273-8255), and/or to report to the clinic or local emergency room, or to dial 911 for imminent thoughts of intended harm toward self or others.
-Call Center/Telephone Advice Line (TAP)
-MyhealtheVet
-MH Team Support

Patient Education:
Recipient of education: Patient
Outcome: verbalizes understanding

/es/ ERIC KING, LMSW
SOCIAL WORKER
Signed: 09/07/2018 10:39

LOCAL TITLE: MH WALK-IN NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: MAY 11, 2015@13:12 ENTRY DATE: MAY 11, 2015@13:12:43
AUTHOR: PUNTER,DEBORAH J EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Time spent: GREATER THAN 120 MINS
Vet came in office alone

identifiers: SSN, ADDRESS, PHONE NUMBER

chief complaint:

Vet came into ER to request for services in GI to have Colostomy be removed. Vet does not have transportation. vet was diag with Schizophrenia in 1977. Vet reports having to take medication as needed since 2005 by VA in Atlanta.

Vet is requesting to get home from Dorn VA. Mr. Alan Jones, to see if an arrangement can be made for transportation to home.

Vet requested:
4. I need some to talk to: No SW available at walk in time
5.I am currently homeless. Vet has home in Summerton, but have recently been sleeping in rented vehicle that was returned this morning.
6. Vet is requesting case management services to assist in medical concerns.

Vet seen 3 three times by RN CM PUNTER to address issues. Vet will wait for Mr. Alan for assistance in getting home and will address other issues via telephone tomorrow.

/es/ DEBORAH J PUNTER
RN
Signed: 05/11/2015 13:23

Receipt Acknowledged By:
05/11/2015 14:48 /es/ MICHELLE R ANTHONY-RICHARDSON
RN
05/11/2015 14:45 /es/ ALAN E JONES
LISW-CP

LOCAL TITLE: EMERGENCY DEPT PHYSICIAN NOTE TL
STANDARD TITLE: PHYSICIAN EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: SEP 07, 2018@11:21 ENTRY DATE: SEP 07, 2018@11:21:16
AUTHOR: BOYTER,CHARLES W JR EXP COSIGNER:
URGENCY: STATUS: COMPLETED

LEROY A HOOKS is a 66 year old BLACK OR AFRICAN AMERICAN MALE who presents to Emergency Dept with c/o:
"Veteran came in from bldg 106 with c/o SI and

psychosis."
Patient is in the ER for medical clearance. He needs to be admitted for exacerbation of his paranoid schizophrenia ; patient is having hallucinations, some which are bizarre and reports threatening VOICES telling him that he will die, and that he should go ahead and kill himself. Patient denies homicidal ideation and plans.
Patient is a SMOKER and WINE DRINKER per his report.
He DENIES any use of illicit drugs.
With respect to the patient's medical status, he denies chest pains, dyspnea, palpitations, abdominal pain, vomiting, diarrhea, GI bleeding, and urinary symptoms.
Patient states that he has NO HISTORY of DIABETES, HYPERTENSION, HEART DISEASE, peptic ulcer disease, ASTHMA/COPD, RENAL INSUFFICIENCY, or SEIZURES.

ROS: otherwise negative

PMH: PROBLEMS..... REVIEWED..... includes paranoid schizophrenia, nicotine dependence, others,.....

FH:

ALLERGIES: Patient has answered NKA

MEDICATIONS:Computer is the source for the following medication list:

DM 10/GUAIFENESN 100MG/5ML (ALC-F/SF)SYR Sig: TAKE 1 TABLESPOONFUL OF BY MOUTH EVERY 4 HOURS AS NEEDED
DOXYCYCLINE MONOHYDRATE 100MG CAP/TAB Sig: TAKE ONE CAPSULE/TABLET BY MOUTH TWICE A DAY

OTC/Non-VA Medications:

PERSONAL/SOCIAL HISTORY: Smoker, drinker

PHYSICAL EXAM:

VITALS:
BP: 152/98 (09/07/2018 10:44)
Temp: 97.8 F [36.6 C] (09/07/2018 10:44)
Pulse: 70 (09/07/2018 10:44)
Resp: 16 (09/07/2018 10:44)
Pulse Ox:No PULSE OXIMETRY Vitals taken in the last 1 Year.
Pain: 0 (09/07/2018 10:44)

GENERAL: WDWN (EXCPT SOMEWHAT CACHECTIC) in NAD,NONTOXIC.

HEENT: PERRL, EOMI bilateral. NOSE CLEAR. Oropharynx clear, no erythema or

exudate,
SL. DRY mucous membranes. Head WNL, ATRAUMATIC.

NECK: Mobile and supple. No lymphadenopathy. NO THYROMEGALY. NO MENINGISMUS.

CVS: RRR without murmurs. RADIAL PULSES INTACT.

LUNGS: Clear to auscultation BILAT.

ABD: Soft, non-distended with NL bowel sounds; nontender; NO MASSES OR ORGANOMEGALY.

MUSCULOSKELETAL: Extremities warm, without edema. NO CALF TENDERNESS OR CORDS. NECK AND BACK ARE NONTENDER.

NEURO: AAO x 3. CN II-XII are INTACT. Sensorimotor within normal limits. NO FOCAL DEFICTS.

PSYCHIATRIC: FLAT AFFECT AND DEPRESSED MOOD; +SI.

SKIN: warm and dry; NO rashes noted.

ED COURSE: INTERVIEW; EXAM; NEEDS PSYCH ADMIT.....DR. DOWNIE WILL ADMIT TO RECOVERY EAST.

PERTINENT LABS & X-RAYS:

AMPHETAMINES INTERPRETATION: Negative
BARBITURATES INTERPRETATION: Negative
BENZODIAZEPINES INTERPRETATION: Negative
CANNABINOIDS INTERPRETATION: Negative
COCAINE (ARCHITECT): >1000.0 H
COCAINE INTERPRETATION: Positive
METHADONE INTERPRETATION: Negative
OPIATES INTERPRETATION: Negative
CREAT-CU: >37.00
AMPHETAMINES CONFIRMATION: N
BENZODIAZEPINES CONFIRMATION: N
OPIATES CONFIRMATION: N

APPEARANCE: CLEAR
UR COLOR: Yellow

SPECIFIC GRAVITY: 1.010
UROBILINOGEN: <2.0
UR BLOOD: NEGATIVE
UR BILIRUBIN: NEGATIVE
UR KETONES: NEGATIVE
UR GLUCOSE: NEGATIVE
UR PROTEIN: NEGATIVE
UR PH: 5.0
NITRITE, URINE: NEGATIVE
LEUKOCYTE ESTERASE, URINE: NEGATIVE

TSH-DXI 800: 2.00
FT4-DXI 800: 1.10

TOTAL BILIRUBIN: 0.5
ASAT: 30
ALKALINE PHOSPHATASE: 65
TOTAL PROTEIN: 8.4 H
ALBUMIN: 4.0
SODIUM: 139
POTASSIUM: 4.4
CHLORIDE: 105
CO2: 27
ANION GAP (CALCULATED): 7
GLUCOSE: 97
CREATININE: 1.4 H
CALCIUM: 9.6
MAGNESIUM: 2.2 H
ALT: 23
EGFR: 61
BILIRUBIN, DIRECT (ARCH): 0.2
ETHANOL (ARCH): <10.0
UREA, BUN: 13

WBC: 4.7
RBC: 4.32
HGB: 13.0
HCT: 40.1
MCV: 92.6
MCH: 30.1
MCHC: 32.5
RDW: 13.0
PLT: 180
MPV: 8.4
EOSINO, ABSOLUTE: 0.1
BASO, ABSOLUTE: 0.0
GRAN % (SS): 51.8
LYMPH % (SS): 34.2
MONO % (SS): 11.8
EOS% (SS): 1.7

BASO% (SS): 0.5
GRAN# (SS): 2.4
LYMPH# (SS): 1.6
MONO# (SS): 0.6

ASSESSMENT:
1. PARANOID SCHIZOPHRENIA
2. HALLUCINATIONS
3. TOBACCO USE DISORDER
4.

CONDITION ON DISCHARGE: FAIR; STABLE;
PATIENT is MEDICALLY CLEARED for PSYCHIATRIC ADMISSION.

PLAN/INSTRUCTIONS:
ADMIT TO RECOVERY EAST; ACCEPTED BY DR. DOWNIE.

Patient educated about the following:
[x] Plan of Care/illness & condition
[] Medications (Including drug-food interactions that apply: Ciprofloxacin, Levofloxacin, and Gatifloxacin)
[] Pain Management
[] Tests/procedures
[] Basic health practices (smoking, alcohol use, diet, immunizations, etc.)
[] Other (specify):

Education Summary & Comments:

Recipient of education: [x]Patient []Family/caregiver []Other

Teaching method: []Verbal []Demonstration/doing []Printed material
[]Audiovisual

Outcome: []Verbalizes understanding []Needs reinforcement
[]Able to demonstrate

/es/ CHARLES W. JR. BOYTER
PHYSICIAN, MD
Signed: 09/10/2018 00:23

LOCAL TITLE: EMERGENCY DEPT PHYSICIAN NOTE TL
STANDARD TITLE: PHYSICIAN EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: AUG 15, 2018@11:45 ENTRY DATE: AUG 15, 2018@11:45:51
AUTHOR: RASUL,MUHAMMAD F EXP COSIGNER:
URGENCY: STATUS: COMPLETED

LEROY A HOOKS is a 66 year old BLACK OR AFRICAN AMERICAN MALE who presents to the Emergency Dept." c/o sob x 1 week along wiht productive cough and also hearing voices, Pt denies SI/HI thoughts". Patient complaining of cold and cough going on for a week. Started with a head cold and sore throat now coughing with a phlegm. No chest pain or dyspnea. No nausea vomiting as well. Also having hearing voices, further evaluation the ED by the psych/social work associate.

ROS:
GENERAL: no fever, chills, sweats, change in appetite or weight, malaise,fatigue
EYES: no redness, pain, change in vision
EARS/NOSE/THROAT: no decreased hearing, nasal congestion or drainage,sore throat
CARDIOVASCULAR: no chest pain, palpitations, orthopnea, peripheral edema
RESPIRATORY: no dyspnea, cough, excessive sputum
GASTROINTESTINAL: no nausea, vomiting, frequent indigestion or reflux symptoms, abdominal pain, diarrhea, constipation, melena
GENITOURINARY: no dysuria, urgency, frequency, hematuria, incontinence
MUSCULOSKELETAL: no joint pain, swelling, stiffness
NEUROLOGIC: no headache, dizziness, paresthesias, muscle weakness
PSYCHIATRIC: no depression, anxiety

PMH: Reviewed.

ALLERGIES: Patient has answered NKA

MEDICATIONS:

Computer is the source for the following medication list:

OTC/Non-VA Medications:
SURGERIES:
INFECTIOUS DISEASE:
SMOKE/ETOH:
PERSONAL/SOCIAL HISTORY:

PHYSICAL EXAM:

VITALS:

HEIGHT: 67 in [170.2 cm] (09/18/2013 18:06)inches
WEIGHT: 121 lb [55.0 kg] (11/24/2015 17:29)lbs
BLOOD PRESSURE: 172/84 (08/15/2018 11:35) mm/hg
PULSE: 92 (08/15/2018 11:35)
RESPIRATION: 18 (08/15/2018 11:35)
TEMPERATURE: 97.9 F [36.6 C] (08/15/2018 11:35) degrees F

PAIN LEVEL: 0 (08/15/2018 11:35)

GENERAL: AOx3; No distress or diaphoresis.

HEENT: PERRL, EOMI bilateral. Oropharynx clear,

NECK: Supple with full ROM. No JVD. Trachea midline.

CVS: RRR without M/G/R.

LUNGS: CTA bilaterally without wheezes, rales or rhonchi.

CHEST: Nontender, atraumatic with symmetrical chest excursion.

ABD: Soft, non-distended with good bowel sounds. There is no tenderness or masses appreciated. There is no voluntary guarding or rebound noted.

CONDITION: Stable

PERTINENT LABS & X-RAYS:
AMPHETAMINES INTERPRETATION: Negative
BARBITURATES INTERPRETATION: Negative
BENZODIAZEPINES INTERPRETATION: Negative
CANNABINOIDS INTERPRETATION: Negative
COCAINE INTERPRETATION: Negative
METHADONE INTERPRETATION: Negative
OPIATES INTERPRETATION: Negative
CREAT-CU: >37.00
AMPHETAMINES CONFIRMATION: N
BENZODIAZEPINES CONFIRMATION: N
OPIATES CONFIRMATION: N
ETHANOL (ARCH): <10.0
TOTAL BILIRUBIN: 0.4
ASAT: 31
ALKALINE PHOSPHATASE: 65
TOTAL PROTEIN: 7.7
ALBUMIN: 3.6
SODIUM: 139
POTASSIUM: 4.1
CHLORIDE: 105
CO2: 28
ANION GAP (CALCULATED): 6
GLUCOSE: 88
CREATININE: 1.2
CALCIUM: 9.4
ALT: 24
EGFR: 73
UREA, BUN: 14
WBC: 4.3
RBC: 4.11 L

HGB: 12.4 L
HCT: 37.6 L
MCV: 91.5
MCH: 30.2
MCHC: 33.0
RDW: 12.8
PLT: 155 L
MPV: 8.6
EOSINO, ABSOLUTE: 0.0
BASO, ABSOLUTE: 0.0
GRAN % (SS): 53.9
LYMPH % (SS): 31.5
MONO % (SS): 12.3
EOS% (SS): 1.1
BASO% (SS): 1.2 H
GRAN# (SS): 2.3
LYMPH# (SS): 1.4
MONO# (SS): 0.5

Chest X-ray:NAD,

MDM noteURI/early bronchitis, medication prescribed, patient advised follow-up with the PCP for further care.

ASSESSMENT: URI/early bronchitis, see above.

CONDITION ON DISCHARGE: Stable.

PLAN/INSTRUCTIONS:

PAIN MANAGEMENT/EDUCATION:

Patient educated about the following:
[] Plan of Care/illness & condition
[] Medications (Including drug-food interactions that apply: Ciprofloxacin, Levofloxacin, and Gatifloxacin)
[] Pain Management
[] Tests/procedures
[] Basic health practices (smoking, excercise, alcohol use, diet, immunizations, etc.)
[] Other (specify):

Education Summary & Comments:

Recipient of education: []Patient []Family/caregiver []Other

Teaching method: []Verbal []Demonstration/doing []Printed material
[]Audiovisual

Outcome: []Verbalizes understanding []Needs reinforcement
[]Able to demonstrate

/es/ MUHAMMAD F RASUL
PHYSICIAN, MD
Signed: 08/15/2018 14:54

LOCAL TITLE: EMERGENCY DEPT PHYSICIAN NOTE TL
STANDARD TITLE: PHYSICIAN EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: NOV 19, 2015@02:14 ENTRY DATE: NOV 19, 2015@02:14:40
AUTHOR: ILSLEY,JEFFREY E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

LEROY A HOOKS is a 63 year old BLACK OR AFRICAN AMERICAN MALE who presents to the Emergency Dept. pt here to see surgeon about surgery scheduled for today. Missed previous anest. appt. Told to follow up with surgery in am to reschedule surgery. No see by ER MD. No medical complaints.

/es/ JEFFREY E ILSLEY
PHYSICIAN, MD
Signed: 11/19/2015 02:16

LOCAL TITLE: EMERGENCY DEPT PHYSICIAN ADMISSION DISPOSITION NOTE
STANDARD TITLE: EMERGENCY DEPT DISCHARGE NOTE
DATE OF NOTE: SEP 10, 2018@00:25 ENTRY DATE: SEP 10, 2018@00:25:39
AUTHOR: BOYTER,CHARLES W JR EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*****THIS NOTE APPLIES TO PT'S SEPT 7th ADMISSION TO RECOVERY EAST*****

Admission Diagnosis: PARANOID SCHIZOPHRENIA with (primarily) AUDITORY HALLUCINATIONS and SUICIDAL IDEATION

Accepting Physician: DR. DOWNIE

Admitting Location: Psy-East

/es/ CHARLES W. JR. BOYTER
PHYSICIAN, MD
Signed: 09/10/2018 00:28

LOCAL TITLE: EMERGENCY DEPT NURSING NOTE

STANDARD TITLE: NURSING EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: NOV 19, 2015@01:37 ENTRY DATE: NOV 19, 2015@01:37:38
AUTHOR: HERLONG,DAVID P EXP COSIGNER:
URGENCY: STATUS: COMPLETED

pt arrived to ED, states he was suppossed to arrive at Dorn the night prior to be admitted to have his ostomy reversed on 11/19. However, pt instructed to f/u with his surgeon at 7 am this morning per order from Dr Ilsley. pt has followed bowel prep as pre op order. pt has no complaints currently.

/es/ DAVID P HERLONG
RN
Signed: 11/19/2015 01:43

LOCAL TITLE: EMERGENCY DEPT NURSING DISCHARGE NOTE TL
STANDARD TITLE: NURSING EMERGENCY DEPARTMENT DISCHARGE NOTE
DATE OF NOTE: AUG 15, 2018@15:11 ENTRY DATE: AUG 15, 2018@15:11:12
AUTHOR: SANDERS,BILLY M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Condition on discharge: Stable

Age: 66 Sex: MALE
Vital Signs:
Pulse:
88
Respirations:
18
BP:
155/80
Oxygen Saturation:
99 Room Air
PAIN ASSESSMENT:
Pain Level:
0
Location of pain:
none
Description of pain:
none
Frequency/Duration:
none
Discharge to: Home
Has patient received narcotics, sedatives, sedating antihistamines, and/or other medications that may affect mental status in the Emergency Department?
No

Does the patient have any special requests or needs based upon his/her cultural or religious preferences or living/financial situation?

No

Does the patient have difficulty reading or understanding written instructions? No

Barriers to Learning:

Assessment of learning needs/barriers included a review of the following areas: Vision or hearing ability;understanding medical advice; remembering or understanding medical advice;physical limits that interfere with learning; financial problems to prevent following the medical provider's advice;cultural/religious beliefs that might affect the way we care for him/her; and emotional trouble that will interfere with his/her learning.

The Patient indicated NO problems in these areas.

Patient prefers to learn by using: Written material with verbal explanation

Patient Education:
Patient instructed in: Medications (reviewed by MD)[Including drug-food interactions that apply: Ciprofloxacin, Levofloxacin, and Gatifloxacin), Follow up care
Patient verbalized understanding of these instructions. Yes

Patient Aligned Care Team (PACT) will be notified of visit via: N/A, patient unassigned

Toll free Telenurse number (1-888-651-2683) was provided to patient for additional questions or concerns.

/es/ BILLY M SANDERS
REGISTERED NURSE
Signed: 08/15/2018 15:12

LOCAL TITLE: EMERGENCY DEPT PHYSICIAN NOTE TL
STANDARD TITLE: PHYSICIAN EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: AUG 27, 2014@08:25 ENTRY DATE: AUG 27, 2014@08:26:19
AUTHOR: WHITE,EMMA EXP COSIGNER: KINNEY,KRISTY L
URGENCY: STATUS: COMPLETED

*** EMERGENCY DEPT PHYSICIAN NOTE TL Has ADDENDA ***

LEROY A HOOKS is a 62 year old BLACK OR AFRICAN AMERICAN MALE who presents to the Emergency Dept.reporting irritated skin surrounding his colostomy bag. Mr. Hooks had an appointment in the surgery clinic today (8/27) but it was cancelled due to clinic downsizing. He states he needs the appointment because of his irritation and pruritis. Pt stated he was using clorox, alcohol, and dishwasher detergent to clean the area and to "get rid of the smell." Pt was educated that those substances will irritate and break down the skin, and was instructed to just use soap and water daily to clean the area.

ROS: Otherwise negative

PMH: Diverticulosis, schizophrenia

ALLERGIES: Patient has answered NKA

MEDICATIONS:

Computer is the source for the following medication list:

PASTE,STOMAHESIVE C#1839-10 Sig: APPLY INCH(ES) TO AS DIRECTED AS DIRECTED COLOSTOMY CARE.
POUCH,DRAINABLE,SUR-FIT C#4015-03 Sig: POUCH AS DIRECTED AS DIRECTED COLOSTOMY CARE.
SKIN PREP WIPE Sig: USE ONE WIPE AFFECTED AREA AS DIRECTED COLOSTOMY CARE
WAFER,STOMAHESIVE W/FLANGE C#4015-76 Sig: ONE WAFER AS DIRECTED COLOSTOMY CARE.
BACITRACIN 500/POLYMYXIN 10000/GM OINT Sig: APPLY LIBERAL AMOUNT TO AFFECTED AREA TWICE A DAY FOR MEATAL CARE
CIPROFLOXACIN 500MG TAB Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY FOR INFECTION *TAKE ON AN EMPTY STOMACH*
ACETAMINOPHEN 325MG TAB Sig: TAKE TWO TABLETS BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN/FEVER *MAX 4000MG ACETAMINOPHEN PER DAY

SURGERIES: partial sigmoidectomy with temporary ostomy in 2013
SMOKE/ETOH: denies
PERSONAL/SOCIAL HISTORY: caretaker of his 94 yo father

PHYSICAL EXAM:

VITALS:

HEIGHT: 67 in [170.2 cm] (09/18/2013 18:06)inches
WEIGHT: 118 lb [53.6 kg] (07/18/2014 15:04)lbs
BLOOD PRESSURE: 124/87 (08/27/2014 08:04) mm/hg
PULSE: 74 (08/27/2014 08:04)
RESPIRATION: 16 (08/27/2014 08:04)
TEMPERATURE: 96.9 F [36.1 C] (08/27/2014 08:04) degrees F

PAIN LEVEL: 0 (08/27/2014 08:04)

GENERAL: AOx3; No distress or diaphoresis.

HEENT: PERRL, EOMI bilateral. Oropharynx clear, no erythema or exudate, moist mucous membranes.

NECK: Supple with full ROM. No JVD. Trachea midline. No significant lymphadenopathy.

CVS: RRR without M/G/R.

LUNGS: CTA bilaterally without wheezes, rales or rhonchi.

CHEST: Nontender, atraumatic with symmetrical chest excursion.

ABD: Colostomy bag in place in LLQ, no erythema, no edema, no noted skin breakdown, no drainage.
Soft, non-distended with good bowel sounds. There is no tenderness or masses appreciated. There is no voluntary guarding or rebound noted.

BACK: Nontender with no CVA tenderness.

GU: Deferred

RECTAL: Deferred

EXT: Warm, without edema and good peripheral pulses.

NEURO: AAO x 3.

PSYCHIATRIC: Denies suicidal ideation

SKIN: There is no evidence of any rashes.

CONDITION: Stable

ASSESSMENT: 62 yo male presenting with irritated colostomy/stoma site

CONDITION ON DISCHARGE: Stable.

PLAN/INSTRUCTIONS:
1. Colostomy irritation
   -copy NP Kristy to note, see if she can get him into surgery clinic sooner than 9/27.
   -Ordered Petrolatum white ointment for relief of irritation
   -Educated pt to only use soap and water to clean the area (not clorox/alcohol)
   -Instructed pt to return to ER if he develops fever/chills, or redness, swelling, or drainage appear around surgical area.

/es/ EMMA WHITE
Medical Student
Signed: 08/27/2014 09:03

/es/ KRISTY L KINNEY
Nurse Practitioner
Cosigned: 08/27/2014 09:50

Receipt Acknowledged By:
08/27/2014 10:58 /es/ DAVID E KOON SR
STAFF PHYSICIAN

08/27/2014 ADDENDUM STATUS: COMPLETED
Called Ms WHite and explained that her attending needs to be her cosigner. Also gave her the name of our colostomy nurse, Lane Gunter, RN at ext 7259, for pt to call with colostomy questions/issues untill we can see him in clinic.

/es/ KRISTY L KINNEY
Nurse Practitioner
Signed: 08/27/2014 09:56

LOCAL TITLE: EMERGENCY DEPT NURSING NOTE
STANDARD TITLE: NURSING EMERGENCY DEPARTMENT NOTE
DATE OF NOTE: AUG 15, 2018@12:31 ENTRY DATE: AUG 15, 2018@12:31:08
AUTHOR: SANDERS,BILLY M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** EMERGENCY DEPT NURSING NOTE Has ADDENDA ***

Skin
Skin color Within normal limits for ethnic group
Temperate Warm
Moisture:Dry
Turgor Good
Skin intact: YES
Neurological
Level of consciousness
Awake, Alert, Oriented:
Other Symptoms:
Elevated blood pressure

/es/ BILLY M SANDERS
REGISTERED NURSE
Signed: 08/15/2018 12:36

08/15/2018 ADDENDUM STATUS: COMPLETED
1230: #22 LFA, labwork sent, pt on monitor

1350: provider @ bedside
1405: labs resulted
1500: pt d/c

/es/ BILLY M SANDERS
REGISTERED NURSE
Signed: 08/15/2018 15:11

Facility Date/Time Type of Note Author

ATLANTA VA 02/19/2010 15:26 MH PSYCHIATR CLAUDIA ANN
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: FEB 19, 2010@15:26 ENTRY DATE: FEB 19, 2010@15:26:39
AUTHOR: TAYLOR,CLAUDIA A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

THERAPIST NOTE/SCHEUDLED APPOINTMENT

S/O: "I am doing ok today."

Pt seen today for follow up with therapist, this is my initial visit with this pt, pt was released from the 4th floor in December and has been referred to MHC for follow up. Pt has not had medications refilled since December 6, 2009 and states he is not taking them every day. I discussed with pt the importance of taking medication as ordered, he agreed to began doing this. Pt states he has felt stable since his discharge and things have been going ok. He is working on legal issues and will report on that at next visit.

Pt has not been med compliant but agrees to become so, he is motivated to return for follow up visit.

Pt is Ox3, denies s/hi, no evidence of psychosis or paranoia, mood is subdued, affect constricted, sleep is good, appetite fair, memory and concentration fair, judgment adequate at this time, pt denies using any substances.

A: Bipolar disorder.

P: Con't to see pt for supportive therapy and case management, pt is in agreement with this plan.

/es/ Claudia Ann Taylor, RN, M.Ed., NCC
REGISTERED NURSE
Signed: 02/19/2010 15:43

ATLANTA VA 01/19/2010 14:12 MH PSYCHIATR JOSE R RIEFK
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE

STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: JAN 19, 2010@14:12 ENTRY DATE: JAN 19, 2010@14:12:59
AUTHOR: RIEFKOHL,JOSE R EXP COSIGNER:
URGENCY: STATUS: COMPLETED

30 Min (SC)

S: "I am doing fine".

O: Pt explains that he has been doing well.
He described his mood as stable. He denied any mania, depression, anxieties or psychosis.
No drugs or alcohol.
He lives part time in his farm house in South Carolina and other times here in Atlanta. He has a good friend here he likes to visit.
No SI/HI or psychosis.
He denied adverse effects from the medications.

A: Bipolar disorder
AIMS=0 on 4 DEC 09

P: Cont. Risperidone 2 mg q pm
Cont Divalproex 1000 mg q pm
Cont. Case Management with Ms Taylor
RTC 3 months

GAF 70

CLINICAL REMINDER ACTIVITY/PLAN OF CARE
Medication Reconciliation:
Reconciled patient medication list:

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status
1)	DIVALPROEX 500MG 24HR (ER) SA TAB TAKE TWO TABLETS BY MOUTH EVERY EVENING	ACTIVE

000066

2) RISPERIDONE 4MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY EVENING FOR MENTAL HEALTH ACTIVE
This Medication list was reviewed by the provider with the patient/family member, reconciled.

/es/ JOSE R RIEFKOHL MD
STAFF PHYSICIAN
Signed: 01/19/2010 14:19

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ATLANTA VA 12/04/2009 14:46 MH PSYCHIATR JOSE R RIEFK
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: DEC 04, 2009@14:46 ENTRY DATE: DEC 04, 2009@14:46:28
AUTHOR: RIEFKOHL,JOSE R EXP COSIGNER:
URGENCY: STATUS: COMPLETED

60 Min (SC)

S: "I am doing alright".

O: 57 y/o male patient who comes to the MHC due to get his medications. He explains that he has problems with his mood.
He was not treated for 25 years and got sick in June 2009. He explains that he
was feeling depression. He also had problems with concentration. There were times that he had difficulties sleeping and had high energy. He was impulsive and had racing thoughts.
He was having auditory hallucinations that had faded away.
He lost the property he owned. He was behind in his mortgage and lost it.
At this time he denied SI/HI or psychosis. He stated that he has been feeling well and the hallucinations and "erratic" behavior had faded away.
No drugs or alcohol.
He is planning into moving to his farm house in South Carolina.
He denied adverse effects from the medications.

A: Bipolar disorder
AIMS=0 on 4 DEC 09

P: Decrease Risperidone to 2 mg q pm
D/C Benztropine
Cont Divalproex 1000 mg q pm

Cont. Case Management with Ms Taylor
RTC 2 months

GAF 70

CLINICAL REMINDER ACTIVITY/PLAN OF CARE
Medication Reconciliation:
Reconciled patient medication list:

Active Outpatient Medications (including Supplies):

	Pending Outpatient Medications	Status
1)	DIVALPROEX 500MG 24HR (ER) SA TAB TAKE TWO TABLETS BY MOUTH EVERY EVENING	PENDING
2)	RISPERIDONE 4MG TAB TAKE ONE-HALF TABLET BY MOUTH EVERY EVENING	PENDING
3)	TABLET CUTTER USE CUTTER AS INSTRUCTED EVERY DAY WHEN NEEDED TO SPLIT TABLETS	PENDING

This Medication list was reviewed by the provider with the patient/family member, reconciled.

AIMS:
AIMS (Mental Health Instrument)
The patient was evaluated for symptoms of tardive dyskinesia using the AIMS.
Total score for items 1-7: 0

/es/ JOSE R RIEFKOHL MD
STAFF PHYSICIAN
Signed: 12/04/2009 15:19

ATLANTA VA 10/28/2009 13:04 MH PSYCHIATR MARIE A. DEW
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: OCT 28, 2009@13:04 ENTRY DATE: OCT 28, 2009@13:04:26

AUTHOR: DEWITT,MARIE A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

S: Patient eager to be discharged to deal with legal matters. Tolerating medications well and without side effects. Feels mind is thinking more clearly and able to focus/concentrate. Forward thinking. Understands importance of taking medications as prescribed and refraining from substance use.

O:
Vitals: BP= 94/67 (10/28/2009 11:09), PULSE= 64 (10/28/2009 11:09), TEMP= 97.8 F [36.6 C] (10/28/2009 11:09), RESP= 16 (10/28/2009 11:09)
Pain: 0 (10/28/2009 11:09)

MSE:
orientation - alert, fully oriented
appearance - casual attire, fairly groomed
behavior - calm, pleasant, cooperative
speech - increased rate but not pressured
mood - "better"
affect - euthymic
TP - tangential at times
TC - denies SI/HI, delusions and paranoia resolved
Perceptions - no evidence of AVH
Insight - limited
Judgment - limited
Impulse Control - fair
Cognition - intact

Active Inpatient Medications (including Supplies):

	Active Inpatient Medications	Status
1)	BENZTROPINE TAB 0.5MG PO QHS	ACTIVE
2)	CYANOCOBALAMIN TAB 1000MCG PO DAILY x 7 days	ACTIVE
3)	DIVALPROEX TAB,SA,24HR (EXTENDED 1000MG PO QPM	ACTIVE
4)	RISPERIDONE TAB 3MG PO QHS	ACTIVE
5)	TERBINAFINE 1% CREAM,TOP SMALL AMOUNT TOP BID PRN APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATLETE'S FOOT	ACTIVE

VPA serum level: 65

IMPRESSION:
Axis I:
Bipolar Disorder, Type I, current episode manic
Cannabis Abuse
Axis II: deferred
Axis III: none known
Axis IV: severe - recent legal problems, relationship problems, unstable housing
Axis V: 30

PLAN:
Patient denies suicidal ideation, homicidal ideation, and there is no evidence of active psychosis. Patient is forward thinking with nearly resolved manic symptoms. Tolerating medications well. Will discharge today as patient signed AMA and no grounds/need to hold patient against his will. Recommend further increases in VPA (as tolerated/needed) in outpatient follow-up.

/es/ MARIE A. DEWITT, M.D.
STAFF PHYSICIAN
Signed: 12/30/2009 23:40

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ATLANTA VA 10/28/2009 10:16 MH INTERDISC ROBERT E. SW
Note Text
LOCAL TITLE: MH INTERDISCIPLINARY TREATMENT PLAN NOTE
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN INTERDISCIPLINARY N
DATE OF NOTE: OCT 28, 2009@10:16 ENTRY DATE: OCT 28, 2009@10:16:54
AUTHOR: SWAY,ROBERT E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

MH INTERDISCIPLINARY FINAL/DISCHARGE TX PLAN

Mr. Hooks arrived agitated, confused and probably delusional/paranoid. His psychosis has cleared but pt. continues to have anxiety of the "no contact" order that his former tenant has on him. Pt. admitted that there is some family/friendship connection which makes it difficult. The charges against him were dropped by the courts while he was in the hospital. This was confirmed by Mr. Clinton Miles at 404-613-2196.

TEAM MEMBERS:

STOUT,STEVEN C: STAFF PHYSICIAN

GUPTA, RUBY: RESIDENT PHYSICIAN

SWAY,ROBERT E: SOCIAL WORKER

RAMISHA: NURSE - RN

HANKIN,DAVID J: CLINICAL PHARMACIST

Treatment Plan:

Axis I: r/o Bipolar d/o vs Schizophrenia vs Schizoaffective disorder
Cannabis Abuse

Axis II: deferred

Axis III: none known

Axis IV: severe - recent legal problems, relationship problems, unstable housing

Axis V: 30

PLAN:
Pt had signed an AMA yesterday.

1. Bipolar d/o vs Schizophrenia, bipolar type
- Will ct Depakote 1000mg po qhs for suspected bipolarity.
- will ct risperdal 3 mg po QHS paranoia and delusions.
- cogentin 0.5 mg QHS to prevent EPS

- Pt. is going back to his apartment. Transportation was arranged by SW.
FU appt. with Dr. Riefkohl on Nov. 16, 2009 at 08:30hrs.

/es/ ROBERT E. SWAY, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/28/2009 10:27

Receipt Acknowledged By:
10/28/2009 12:26 /es/ SHARI THOMAS
MEDICAL RESIDENT, PGY 1
10/30/2009 13:26 /es/ MARIE A. DEWITT, M.D.
STAFF PHYSICIAN
* AWAITING SIGNATURE * GUPTA,RUBY

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ATLANTA VA 10/27/2009 17:30 MH PSYCHIATR JOSEPH W BIS
Note Text
LOCAL TITLE: MH PSYCHIATRY CONSULT
STANDARD TITLE: MENTAL HEALTH CONSULT
DATE OF NOTE: OCT 27, 2009@17:30 ENTRY DATE: OCT 27, 2009@17:31:03
AUTHOR: BISHOP,JOSEPH WILLI EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ASSIGNED BY INPATIENT PSYCHIATRY STAFF TO DR RIEFKOHL AND F/U APPT MADE.
WILL NEED F/U WITH THERAPIST- MS TAYLOR AND F/U APPT MADE AS WELL.

/es/ JOSEPH W BISHOP MD
STAFF PHYSICIAN
Signed: 10/27/2009 17:31

Receipt Acknowledged By:
10/29/2009 11:15 /es/ JOSE R RIEFKOHL MD
STAFF PHYSICIAN
10/28/2009 17:39 /es/ Claudia Ann Taylor, RN, M.Ed., NCC
REGISTERED NURSE

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ATLANTA VA 10/27/2009 14:39 NURSING REAS RAMISHA A. D
Note Text
LOCAL TITLE: NURSING REASSESSMENT
STANDARD TITLE: NURSING E & M NOTE
DATE OF NOTE: OCT 27, 2009@14:39 ENTRY DATE: OCT 27, 2009@14:40:09
AUTHOR: DAVIS,RAMISHA A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Nursing Reassessment
Interim Reassessment:
Neurological Assessment:
Alert; oriented to person, place, time & situation; follows commands; speech clear. Pupils equal. Moves all extremities.
Wandering Risk Assessment:

Does the patient have a court appointed legal guardian?
no
Is this patient considered to be a danger to him/herself or others?
no
Has this patient been legally committed?
no
Does this patient lack the cognitive abilty to make decisions?
no
Does this patient have a history of escape or elopement?
no
Does this patient have physical or mental impairments that increase their risk of harm to self or others?
yes
Is this patient capable of mobility?
yes

EENT Assessment:
Normal; denies any vision/auditory deficits; denies nasal/throat abnormalities.

Cardiovascular Assessment:
Radial/pedal pulses palpable and equal; heart rhythm regular. No peripheral edema.

Respiratory Assessment:
Airway patent; respirations spontaneous, unlabored, symmetrical, with regular rate, rhythm, and depth.

Gastro-intestinal Assessment:
Tolerating diet. Abdomen soft/non-tender/non-distended; Bowel sounds active X4 quadrants.

Genito-urinary Assessment:
Clear, yellow to amber urine. No burning/frequency/urgency reported.

VANOD Skin Reassessment
BRADEN SKIN RISK ASSESSMENT

Sensory Perception:	4	= No Impairment
Moisture:	4	= Rarely Moist
Activity:	4	= Walks Frequently
Mobility:	4	= No Limitation
Nutrition:	4	= Excellent
Friction:	3	= No Apparent Problem

19-23 No Risk
Score: 23

CURRENT SKIN ASSESSMENT
Skin Color:
Color: Normal for ethnic group
Skin Temperature
Temp: Warm
Skin Moisture
Moisture: Dry
Skin Turgor
Turgor: Within normal limits

SKIN PROBLEMS

No wounds, pressure ulcers or other skin problems.

INTERVENTIONS
The pressure ulcer prevention protocol was not needed - patient is not at risk.

Musculo-Skeletal/Functional Assessment:
Moves all joints; ambulatory. No gross deformities/contractions/ muscle weakness. Absence of swelling & tenderness; no evidence of inflammation. Performs ADLs independently.

Venous Thromboembolism (VTE) Prophylaxis
Not indicated

FALL RISK ASSESSMENT

MORSE FALL SCALE
The Morse Fall scale was performed and score was 15. This is indicative of low risk of falls.

History of falling in past 3 months?
No

Secondary diagnosis:
Yes

Ambulatory aid:
None/bedrest/nurse assist

Intravenous therapy/Heparin lock:
No

Gait/Transferring:
Normal/bed rest/immobile

Mental Status:
Oriented to own ability/knows own limitations

OTHER RISK FACTORS
Secondary Diagnosis
The patient/resident is on multiple medications to manage co-morbidities.
Medications that may increase risk of falls or of injury from falls:
Psychotropics

FALL PREVENTION INTERVENTIONS
Institute Universal Fall Precautions on All Patients/Residents
Patient/Resident Education:
Orient to surroundings
Purpose and use of call light
Use of non-skid slippers or gripper socks
Request assistance for daily activities (such as getting out of bed, toileting, transfers)
Purpose and use of assistive devices and mobility aids if needed
Environment of Care
Place patient/resident articles within easy reach
Call light (if applicable) in easy reach and answered promptly
Place bed in low position when in bed
Lock bed wheels
Lock wheelchair wheels if applicable
Provide proper lighting (night lights)
Keep floor free of clutter
Clean up spills immediately
Modify environment for safe transfers

For secondary diagnoses:
Reinforce MD instructions for preventions of complications related to medical diagnoses/problems
Review medications with patient/resident and family/support person and take into account risks specific to the patient/resident
Instruct patient/resident in medication time/dose, side effects and interactions with food or other medications and supplements

Complete surveillance rounds
Every 15 minutes
Endocrine Assessment:
No past or present symptoms noted.
Pain Assessment:
PAIN ASSESSMENT Choose this if patient has NO pain.

Patient reports having no pain (0/10 on a scale of 0-10) at time of this
interview. On a scale of 0-10 (0 = no pain; 10 = worst pain), if patient experiences pain, his/her acceptable pain level would be:
Comment: 3/10 or less
Psychological/Mental Health Assessment:
Abnormal
Behavior/Thoughts/Perceptions observed/reported:
Denies Depression
Mood is:
Anxious
Are there religious practices or spiritual concerns that you want the chaplain, your physician, and other health care team members to immediately know about?
Verbalizes spiritual resources in place & meeting his/her needs. Denies any religious beliefs/issues such as dietary restrictions/rituals that require adjustment in hospital environment or plan of care. Denies use of alternative medicine modalities.

####Focus: Altered Mental Status #####

G: Goal: A statement of the expected outcome related to the FOCUS.Oct 27,2009
Pt will have minimal or no AH with no desire to harm self or others
by 11/07/09

D: Oct 27,2009@13:25
Visible on the unit. At nurses station with multiple request. Went to Dental Clinic today, wants to go to DAV. AMA remains active. Concerned about possible discharge sometime this week.
A: Oct 27,2009@13:27
Administer psychotropic drugs and monitor for effectiveness. Encourage patient to focus on the reality of external world vs. patient's distorted fantasy. Explore feelings surrounding stressors that triggered psychotic episodes. Assist

patient in reducing threat in the enviroment.
R: Oct 27,2009@13:30
Denies feeling depressed at this time. Denies current S/I and H/I.

ADL Notes

Patient checked at:
Oct 27,2009@13:57- - -
- call light within reach.
Up ad lib.
Had no BM this shift.
Voided this shift using bathroom toilet.
Patient required no assistance with bath.
Ate 80% of breakfast with no assistance.
Ate 85% of lunch with no assistance.

/es/ RAMISHA A. DAVIS, BSN, RN
REGISTERED NURSE
Signed: 10/27/2009 15:05

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ATLANTA VA 10/27/2009 03:08 + MH PSYCHIA RUBY GUPTA
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: OCT 27, 2009@03:08 ENTRY DATE: OCT 27, 2009@03:08:47
AUTHOR: GUPTA,RUBY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH PSYCHIATRY GENERAL PROGRESS NOTE Has ADDENDA ***

S:Pt was sen near the medication window. Reported that he wanted to leave as he wanted to go and see his son and daughter. He also wanted to fix the pending legal issues. Ptdenies any SI/HI. Denies any AVH.

O:
Vitals: BP= 101/66 (10/26/2009 16:49), PULSE= 86 (10/26/2009 16:49), TEMP= 98.7 F [37.1 C] (10/26/2009 16:49), RESP= 18 (10/26/2009 16:49)
Pain: 0 (10/26/2009 16:49)

MSE:
orientation - alert, fully oriented
appearance - in VA pajamas with fair grooming/hygiene, long fingernails
behavior - calm, cooperative, no PMA/PMR
speech - pressured, rambling
mood - "I want to leave"
affect - restricted
TP - tangential
TC - +delusions, +paranoia ,denies SI/HI, denies A/VH
Insight - poor
Judgment - poor
Impulse Control - poor
Cognition - intact

Active Inpatient Medications (including Supplies):

	Active Inpatient Medications	Status
1)	BENZTROPINE TAB 0.5MG PO QHS	ACTIVE
2)	CYANOCOBALAMIN TAB 1000MCG PO DAILY x 7 days	ACTIVE
3)	DIVALPROEX TAB,SA,24HR (EXTENDED 1000MG PO QPM	ACTIVE
4)	HALOPERIDOL INJ,SOLN 2.5MG/0.5ML IM Q6H PRN FOR AGITATION/DB	ACTIVE
5)	HALOPERIDOL TAB 2MG PO Q6H PRN FOR AGITATION/DB	ACTIVE
6)	RISPERIDONE TAB 3MG PO QHS	ACTIVE
7)	TERBINAFINE 1% CREAM,TOP SMALL AMOUNT TOP BID PRN APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATLETE'S FOOT	ACTIVE

ASSESSMENT:
Axis I: r/o Bipolar d/o vs Schizophrenia vs Schizoaffective disorder
Cannabis Abuse

Axis II: deferred

Axis III: none known

Axis IV: severe - recent legal problems, relationship problems, unstable housing

Axis V: 30

PLAN:
Pt had signed an AMA yesterday.

1. Bipolar d/o vs Schizophrenia, bipolar type
- Will ct Depakote 1000mg po qhs for suspected bipolarity.
- will ct risperdal 3 mg po QHS paranoia and delusions.
- cogentin 0.5 mg QHS to prevent EPS

Paged Dr. Adam Pruett, pic#11771, to get more information about pt's last admission at Grady Memorial hospital, but did not hear back from her. Will try again.

Pt was discussed with Dr. Dewitt, who agrees with the above assesment and plan.

/es/ RUBY GUPTA
PSYCHIATRY RESIDENT, PGY 1
Signed: 10/27/2009 08:52

10/27/2009 ADDENDUM STATUS: COMPLETED
Patient seen and examined. Assessment and plan discussed with resident. Patient signed AMA yesterday. Today with significantly decreased pressured speech and tangentiality, although mildly present. Paranoia has resolved. No evidence of and patient denies AVH. Denies SI and HI. Forward thinking with desire to pursue legal counsel with regards to real estate matters. Discussed need to take medication regularly as prescribed as opposed to "when he feels like he needs it." Informed him that recommendation is to continue treatment as inpatient at this time to further stabilize medication. Patient feels he is "thinking clearly...that medication really does work...I don't feel so angry and agitated, I feel calm and my thinking is good." Tolerating medications. He feels that remaining as an inpatient is keeping him from attending to personal and legal matters. Attempts to contact cousin (Amy Brunson: h 803-478-2300, c 803-225-9988) and Grady Hospital for collateral information have been unsuccessful. Continue risperidone 3mg nightly. Continue Depakote ER 1000mg nightly. Change to level 2; dental clinic and DAV.

/es/ MARIE A. DEWITT, M.D.
STAFF PHYSICIAN

Signed: 10/27/2009 17:10

11/23/2009 ADDENDUM
DISCHARGE SUMMARY

STATUS: COMPLETED

ADMISSION DATE: 10/23/2009
DATE OF DISCHARGE: 10/28/2009

ATTENDING PHYSICIAN: Dr. Marie DeWitt

FINAL DIAGNOSIS(ES) or Axiles I-V:
Axis I:
Bipolar Disorder, type I, current episode manic with psychoses, resolving
Cannibis abuse
Axis II: Deferred
Axis III: Vitamin B12 Deficienct
Axis IV: Moderate (legal, primary support)
Axis V: 51 at discharge (30 on admission)

COMPLICATIONS: none

CONSULTATIONS: DENTAL

OPERATIONS/PROCEDURES PERFORMED: NONE

HISTORY OF PRESENT ILLNESS:
Pt is a 57 yrs old AAM, who was brought to the ER by his cousin, Amy as she believed that pt has not been taking care of his himself and not taking his medications. Pt reports that he was here because he was scared to go back to his apartment. "I was behind in my mortgage because I was ill, but now my owner tells me that I should not come back to my apartment. He is sending me nasty e-mails. I have given 50% of the mortgage. I have been sneaking into my house like a thief. I have been staying like an animal. I need to get the lawyer." Pt also mentions about a tenant lady who was staying in this house and trying to do bad to him by blowing marijuana, complained to the police that he had broken a window of the house to get into the house "I did break

the window but then I fixed it." Reports that this lady has been evicted by the owners. Pt was locked in jail for 3 weeks and came out just 2 weeks ago. He has to report to the court on Monday. He also reports that while in jail he was given some medicines (which he does not remember)which caused him to overdose and get sick, so he went to Grady and they gave him different medications. He notes he has had no medications x 1 week. Pt denies any AVH. He does say that he feels that people are against him "My tenants are fighting against me, my property manager, my wife, my owner, my daughter, everyone is fighting against me." He does say that he feels safe here in the ward. Pt denies any SI/HI currently. Pt denies any mood symptoms. Denies any symptoms of mania. Denies any trauma to the head.

PERTINENT PAST MEDICAL HISTORY:
Pt says that he was admitted in hospital at Montrose, NY , 25 yrs back. He was diagnosed with Schizophrenia, PT , at that time. Reports that he was admitted for a period of 1 year at that time. Pt does not rememeber anything about his medications. CPRS shows that pt has been tried with Sertraline upto 200mg po daily in the past. Pt does not remember taking this medication. He was also on Resperidone 2mg po daily and cogentin 0.5mg po hs.

MEDICATION ON ADMISSION: NONE

ALLERGIES: NO KNOWN ALLERGIES

PERTINENT REVIEW OF SYSTEM: ROS unremarkable for significant abnormalities

PERTINENT LAB AND RADIOLOGY: LIPID PROFILE WAS ABNORMAL

PERTINENT FINDING OF THE PHYSICAL EXAM, PARTICULARY ABNORMALITIES: P/E WNL

HOSPITAL COURSE: Pt came in with the c/o hearing voices. Reported that he had stopped taking his meds for the past several years. He was re-started on meds he was taking in the past. Pt was started on Resperidone 2mg daily and cogentin 0.5mg po od. Risperidone was increased to 3mg po daily. Pt was also started on Depakote 100o mg po QHS for stabilization of mood symptoms. Pt started feeling

better and wanted to go out to fix his pending issues. He was discharged on 28th Oct, 2009.

CONDITION OF PATIENT AT TIME OF DISCHARGE:
Pt was sen near the medication window. Reported that he wanted to leave as he wanted to go and see his son and daughter. He also wanted to fix the pending legal issues. Ptdenies any SI/HI. Denies any AVH.

MSE:
orientation - alert, fully oriented
appearance - in VA pajamas with fair grooming/hygiene, long fingernails
behavior - calm, cooperative, no PMA/PMR
speech - pressured, rambling
mood - "I want to leave"
affect - restricted
TP - tangential
TC - +delusions, +paranoia ,denies SI/HI, denies A/VH
Insight - poor
Judgment - poor
Impulse Control - poor
Cognition - intact

ACTIVITY AND/OR LIMITATIONS: AS TOLERATED

PLACE OF DISPOSITION:HOME

PLAN FOR FOLLOW-UP:
DR RIEFKOHL for psychiatry
MS TAYLOR for therapy

DISCHARGE MEDICATIONS:
BENZTROPINE MESYLATE 0.5MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME TO BE TAKEN WITH RISPERIDONE ACTIVE
Refills: 0 Quantity: 30
Issue Date: Oct 28, 2009 Provider: DEWITT,MARIE A

CYANOCOBALAMIN 1000MCG TAB TAKE ONE TABLET BY MOUTH EVERY DAY FOR B-12 SUPPLEMENT. ACTIVE
 # Refills: 0 Quantity: 30
Issue Date: Oct 28, 2009 Provider: DEWITT,MARIE A

DIVALPROEX 500MG 24HR (ER) SA TAB TAKE TWO TABLETS BY MOUTH EVERY EVENING ACTIVE
 # Refills: 0 Quantity: 60
Issue Date: Oct 28, 2009 Provider: DEWITT,MARIE A

RISPERIDONE 3MG TAB TAKE ONE TABLET BY MOUTH AT BEDTIME ACTIVE
 # Refills: 0 Quantity: 30
Issue Date: Oct 28, 2009 Provider: DEWITT,MARIE A

TERBINAFINE HCL 1% CREAM APPLY SMALL AMOUNT TO SKIN TWICE A DAY AS NEEDED FOR SKIN INFECTION. ACTIVE
APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATHLETE'S FOOT.
 # Refills: 0 Quantity: 24
Issue Date: Oct 28, 2009 Provider: DEWITT,MARIE A

DISCHARGE DIET: REGULAR

/es/ RUBY GUPTA
PSYCHIATRY RESIDENT, PGY 1
Signed: 11/27/2009 16:49

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ATLANTA VA 10/26/2009 16:38 + MH PSYCHIA RUBY GUPTA
Note Text
 LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: OCT 26, 2009@16:38 ENTRY DATE: OCT 26, 2009@16:39
 AUTHOR: GUPTA,RUBY EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

*** MH PSYCHIATRY GENERAL PROGRESS NOTE Has ADDENDA ***

S:Pt was seen near the dayroom. Reported that he cts to feel scared about going back to his residence at buckhead. Pt wished to get out of the unit as soon as possible, so that he could fix his pending housing problems. Pt denies any AVH. Deneis any SI/HI.

O:
Vitals: BP= 117/79 (10/26/2009 05:48), PULSE= 58 (10/26/2009 05:48), TEMP= 97.9 F [36.6 C] (10/26/2009 05:48), RESP= 18 (10/26/2009 05:48)
Pain: 0 (10/26/2009 05:48)

MSE:
orientation - alert, fully oriented
appearance - in VA pajamas with fair grooming/hygiene, long fingernails
behavior - calm, cooperative, no PMA/PMR
speech - pressured, rambling
mood - "I want to go out so that I can fix the problems"
affect - restricted
TP - tangential
TC - +delusions, +paranoia ,denies SI/HI, denies A/VH
Insight - poor
Judgment - poor
Impulse Control - poor
Cognition - intact

Active Inpatient Medications (including Supplies):

	Active Inpatient Medications	Status
1)	BENZTROPINE TAB 0.5MG PO QHS	ACTIVE
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3)	DIVALPROEX TAB,SA,24HR (EXTENDED 1000MG PO QPM	ACTIVE
4)	HALOPERIDOL INJ,SOLN 2.5MG/0.5ML IM Q6H PRN FOR AGITATION/DB	ACTIVE
5)	HALOPERIDOL TAB 2MG PO Q6H PRN FOR AGITATION/DB	ACTIVE
6)	RISPERIDONE TAB 3MG PO QHS	ACTIVE
7)	TERBINAFINE 1% CREAM,TOP SMALL AMOUNT TOP BID PRN APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATLETE'S FOOT	ACTIVE

ASSESSMENT:
Axis I: r/o Bipolar d/o vs Schizophrenia vs Schizoaffective disorder
Cannabis Abuse

Axis II: deferred

Axis III: none known

Axis IV: severe - recent legal problems, relationship problems, unstable housing

Axis V: 30

PLAN:
Pt seems to be rambling and tangential. He also has pressured speech which pt attributes to being "raised up in NY". He cts to talk about his property and how he is being wronged by his property manager and the house owner.

1. Bipolar d/o vs Schizophrenia, bipolar type
- Will add Depakote 1000mg po qhs for suspected bipolarity.
- will ct risperdal 3 mg po QHS paranoia and delusions.
- cogentin 0.5 mg QHS to prevent EPS

Mr. Sway talked to Mr. Clinton Miles, Fulton County Court Diversion Program, who confirmed that the pt owns this building in Buckhead. He also reported that pt has been tried on Seroquel and Risperidone. Will try to contact Ms. Wilene James, the property manager, at 678-725-2251 to tease out and have a clearer picture of what's going on. Pt had a pending date in the court today that he missed.

Pt was seen and discussed with Dr. Dewitt, who agrees with the above assesment and plan.

/es/ RUBY GUPTA
PSYCHIATRY RESIDENT, PGY 1
Signed: 10/26/2009 16:57

10/27/2009 ADDENDUM STATUS: COMPLETED
Patient seen and examined. Assessment and plan discussed with resident and pharmacy. Patient with pressured speech, tangentiality, grandiose presentation, racing thoughts, and describes resolving paranoia. Symptoms most consistent with bipolar disorder. Continue risperidone 3mg nightly. Start Depakote ER 1000mg nightly. Attempt to contact cousin (Amy Brunson: h 803-478-2300, c 803-225-9988) and Grady Hospital for collateral information.

/es/ MARIE A. DEWITT, M.D.
STAFF PHYSICIAN
Signed: 10/27/2009 17:03

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ATLANTA VA 10/26/2009 15:23 MH INPT PSYC ROBERT E. SW
Note Text
LOCAL TITLE: MH INPT PSYCHOSOCIAL ASSESSMENT NOTE
STANDARD TITLE: MENTAL HEALTH E & M NOTE
DATE OF NOTE: OCT 26, 2009@15:23 ENTRY DATE: OCT 26, 2009@15:23:04
AUTHOR: SWAY,ROBERT E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient was briefed on their multidisciplinary treatment team and average length of stay. Patient verbalized an understanding of this and is in agreement with current plan.

Patient Complaints/Presenting Problem(s):
"I had a mortgage for five years and I put down 50% of my life savings and then I got ill and had to go to the hospital and now they are trying to put me out of my house I have been paying for-I was behind and tried to catch it up but he would not take my money. I am scared to go to the house because they have ganged up on me and that demon lady has been blowing marijuana in me while she locks me in the bathroom."

Financial:

-Employment Status: self employed
-Potential Employability: good
-Usual Occupation: retired
-Assets: yes
-Insurance Coverage:none
-Pension Amount: $36,984
-Social Security Amount: no
-Salary(ies) Amount: no
-Dividends/Interest: no
-Payee: No If Yes, name:

Highest Educational Level Achieved: 12 + 3 yrs college

Special Educational Training/Skills: Business,acting

Military:

-Branch of Service:Army
-Years of Service: 1975-1977
-Period of Service: Vietnam
-Prisoner of War:no
-Combat: no
-Witnessed Trauma: yes
-Wounded: no
-Service Connected Disabilities: yes
-Comments:

Social/Family:

-Marital Status: Married/separated
-Spousal/Significant Other Relationship: Good
-Names/Ages of Children: 3 ages 11, 15, 17.
-Relationship with Children: Good
-Current Living Arrangements:Living at Home
-Current Social Support System: family

Childhood History:

-Who raised you? parents
-Which best describe your family growing up?
good

-Growing up, your relationship with your parents was:
Mother: good
Father: good
-Your parents relationship with each other was:

-Do you have any brothers and sisters?
Number of brothers: 1
Number of sisters: 1
-Do you have a good relationship with your brothers and sisters now?
Explain/Describe:
-Did your family matters affect your use of alcohol/drugs?

Social/Peer Support Groups:

-Are you involved in any social/peer groups?
If yes, please list: none
-What community resources are currently used by the patient?

Sexual:

-Orientation: Hetersexual.
-Comments:

Abuse:

-Has Patient Ever been the Subject of Abuse while in the Military? no

-Was Treatment Requested:
-Was Treatment Received:
-Has Patient Ever been the Subject of Physical Abuse? no

-Has Patient Ever been the Subject of Sexual Abuse? no

-Has Patient Ever been the Subject of Emotional Abuse: no

Substance Abuse:

-Comments: uses be doesn't admit it is a problem.

Spirituality: Christian

Cultural/Ethnic:

-Are there any cultural or ethnic issues that need to be addressed while you are in hospital? no
If yes, please explain:

Leisure Skills:

-What are your leisure activities and interests? fishing and hunting
---
Legal:

-Cognitive Resources: fair-good
-Guardian/Fiduciary:no
-Does Patient Have any Current/Past Legal Problems: no
-List Name and Phone Number:
-Are there Pending Court Appearances? no
-Has Patient Ever been Arrested/Charged with Committing Physical, Sexual, or Emotional Abuse or being a sexual predator:no

-Comments:

Psychosocial Summary:

Pt is a very poor historian. Tells stories that cannot be well correlated. He was unable to provide names of medications but per remote data , was last prescribed cogentin and risperidone in New York in June 2009. There is poor compliance per record and he has no other MH treatment in VA system since that time. Tried to call pt's cousin Amy (803-478-2300) but she was not available on phone. According to SW notes "Mr. Miles called back from Diversion court in Fulton county and stated he had been charged with a misdemeanor then the judge determined it may have been due to mental health issues. Veteran needs to show proof he is receiving mental health services and medications and in 6 months from 9/10/09 he will be released. Mr. Miles also shared that much of the information he shared about many rental properties in Buckhead is true and that he lives in one of the units on the property. His wife does reside in Germany. Mr. Miles stated he became involved with someone who has been trying to cause problems for him when in fact he was paying all her bills. She pressed charges and in fact called the police again when he tried to retrieve belongings from his apartment-it was explained to her she could not have him thrown off his own property."
This individual apparently filed a charges and a restraining order was issued. Pt. missed his hearing date today. Provided SW name and phone number for Mr. Miles at Fulton County Court Diversion Program. SW spoke with Mr. Miles who contacted the Magistrate Court and was advised the warrants were dismissed.

His former proper manager, Wilene James, can be reached at 678-725-2251. It is unclear if he currently owns the bldg. or not.

/es/ ROBERT E. SWAY, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/26/2009 15:35

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ATLANTA VA 10/26/2009 08:20 + MH INTERDI ROBERT E. SW
Note Text
LOCAL TITLE: MH INTERDISCIPLINARY TREATMENT PLAN NOTE
STANDARD TITLE: MENTAL HEALTH TREATMENT PLAN INTERDISCIPLINARY N
DATE OF NOTE: OCT 26, 2009@08:20 ENTRY DATE: OCT 26, 2009@08:20:12
AUTHOR: SWAY,ROBERT E EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH INTERDISCIPLINARY TREATMENT PLAN NOTE Has ADDENDA ***

MH INTERDISCIPLINARY INITIAL TX PLAN
DATE/TIME PATIENT ENTERED TREATMENT: 10/26/2009 15:37 PM

MH INTERDISCIPLINARY TX PLAN NOTE 10/26/2009

TREATMENT PLAN TYPE: Initial

LEVEL OF CARE: Acute Inpatient Care

TEAM MEMBERS:

STOUT,STEVEN C: STAFF PHYSICIAN

GUPTA, RUBY: RESIDENT PHYSICIAN

SWAY,ROBERT E: SOCIAL WORKER

RAMISHA: NURSE - RN

HANKIN,DAVID J: CLINICAL PHARMACIST

RISK ASSESSMENT (DANGER TO SELF AND OTHERS):

Patient posed potential risk to self on admission due to SI

Patient meets criteria for high risk based on recent suicidal gesture prior to admission

Patient posed potential risk to others on admission due to HI

Pt does not appear acutely dangerous to himself or others. Pt however does harbor chronic risk factors that elevate the risk of harm (to self or otherwise) above that of the general population. Pt should continue to address medical as well as psychiatric/substance abuse issues to minimize this risk and improve prognosis.

PATIENT'S PERCEPTION OF NEEDS AND PREFERENCES:

Patient is lucid and aware of his situation

Patient perception is unrealistic

Patients perceptions are badly flawed

PATIENT'S RESTRICTIONS:

Patient is currently restricted to 4PSY safety

PATIENT'S PRIVILEGES:

Patient can participate in grps/activities as permitted on 4PSY

PATIENT'S STRENGTHS

Insightful - aware of illness

Expressed desire/motivation for change

Made good use of treatment in the past

Employed or has income/benefits

Has supportive family and/or friends

Has available spiritual support

PATIENT'S LIMITATIONS

Chronic psychiatric sxs

Discontinues use of medication

Need for frequent hospitalization

Substance abuse/dependence

Legal problems

INTERDISCIPLINARY INTEGRATED SUMMARY:

Reason patient entered care:
"I had a mortgage for five years and I put down 50% of my life savings and then I got ill and had to go to the hospital and now they are trying to put me out of my house I have been paying for-I was behind and tried to catch it up but he

would not take my money. I am scared to go to the house because they have ganged up on me and that demon lady has been blowing marijuana in me while she locks me in the bathroom."
(Per admission note)

EDUCATIONAL BARRIERS:
No educational barriers identified

ANTICIPATED DISCHARGE DATE: Within 3 to7 days of admission

DISCHARGE PLANNING/CRITERIA:

Clinically Stable

Medication Compliance

Capable of maintaining themselves in a community living situation

Independently participating in necessary treatments

Utilizes effective coping skills

Plans for follow-up care

PATIENT PARTICIPATION IN TREATMENT PLANNING:

*MET WITH TEAM.

*MET WITH PROVIDER.

*VETERAN AGREED TO PLAN (draft) DISCUSSED.

VETERAN INPUT/PROVIDER COMMENTS:

Case was discussed in treatment team meeting this AM. Pt is reportedly calm & cooperative and in agreement with current treatment plan. Pt is currently homeless. He will be given resource booklets for housing and community SA tx programs and encouraged to begin formulating a housing plan. to be consulted. Pt's identified problems to be assessed and treated/referred as noted in section of this document entitled 'TREATMENT PLAN'. No specified date scheduled for discharge presently.

FAMILY PARTICIPATION IN TREATMENT PLANNING:

*VETERAN'S FAMILY NOT AVAILABLE.

*VETERAN'S FAMILY AGREES TO PLAN.

FAMILY INPUT:

COLLABORATION WITH OTHERS:

Other VA Services: NONE

Legal Guardian: NONE

Family/Significant Other: NONE

Parole/Probation Officer: NONE

---INITIAL DSM-IV DIAGNOSIS:----------

Axis I: schizophrenia, PT
Axis II: deferred
Axis III: none
Axis IV: severe - recent legal problems, relationship problems
Axis V: 30

Entered by: Robert E. Sway, LCSW on 10/26/09.

TREATMENT PLAN PROBLEMS LISTED BY PRIORITY:

-Auditory/Visual Hallucinations/Delusions/Disorganized Behavior

-PTSD

-Anxiety

-Substance Abuse/Dependence

TREATMENT PLAN:

Problem #1 : Auditory/Visual Hallucinations/Delusions/Disorganized Behavior
Goal: Patient will be able to control or eliminate DELUSIONAL CONTENT.
Objective: Veteran will report an elimination or decrease in delusions. within 7-10 days.
Intervention: Educate on delusions/Assess need for psychotropic medication and order as necessary
Provider: Treatment Team.

Problem #2 : PTSD
Goal: Patient will be compliant with medications to help decrease PTSD signs and symptoms
Objective: Patient will report a decrease or elimination in following signs and

symptoms, as appropriate: nightmares, flashbacks, intrusive thoughts, insomnia, anger, hyper vigilance, and startle response within 7 days
Intervention: Monitor and evaluate medication compliance and effectiveness
Provider: Treatment Team

Problem #3 : Anxiety
Objective: Patient will decrease level of anxiety by formulating a plan for dealing with feelings of anxiety
Intervention: Administer and monitor medications for compliance and effectiveness. Provide assistance to patient in developing coping strategies of anxiety
Provider: Treatment Team: PRN

Problem #4 : Substance Abuse/Dependence
Goal: Patient will abstain from use of illicit mood-altering substances
Objective: Patient will be able to identify ways & behavior patterns that will need to change to maintain sobriety
Intervention: Assess for level of change: substance abuse assessment by substance abuse case manager if warranted.
Provider: Treatment Team.

Robert Sway, LCSW
Clinical Social Worker
Inpatient Psy
Atlanta VAMC
Ext:3541

/es/ ROBERT E. SWAY, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/26/2009 10:55

Receipt Acknowledged By:

10/26/2009 18:13	/es/	RAMISHA A. DAVIS, BSN, RN REGISTERED NURSE
10/27/2009 16:29	/es/	MARIE A. DEWITT, M.D. STAFF PHYSICIAN
* AWAITING SIGNATURE *		GUPTA,RUBY

10/27/2009 10:28 /es/ DAVID J HANKIN, Pharm D
Clinical Pharmacist, Mental Health
10/30/2009 15:02 /es/ MICHAEL J SORNA
PSYCHIATRY RESIDENT, PGY 4
10/26/2009 15:22 /es/ STEVEN C. STOUT, MD
STAFF PHYSICIAN

10/26/2009 ADDENDUM STATUS: COMPLETED
With Mr.Hook's permission this social worker called Mr. Clinton Miles Jr. at the Fulton County Court Diversion Program. His cell # is 770-369-4515. Mr. Miles will contact the Fulton county Magistrate Court and advise that Mr. Hooks is currently in the VAMC and is recieving treatment for his MH/SA issues.

Mr. Miles confirmed the story of the tenant with whom he was involved turning on him after he evicted her. Mr. Miles confirms there has been a no contact order issued to prevent any further interaction between the two.

Mr.Miles stated the pt. owns this 10 unit apartment building in Buckhead. The pt. states he paid $500,000 to purchase it but still owes about $500,000. This writer understood pt. to say that he is behind on the payments and the the man is talking about taking the property back. Apparently he did owner financing on the balance. Mr. Miles states he has no knowledge on this.

Mr. Miles suggested we talk to pt's property manager, Ms. Wilene James, at 678-725-2251.

/es/ ROBERT E. SWAY, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/26/2009 14:13

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ATLANTA VA 10/25/2009 16:51 + MH PSYCHIA LEAH M HABIB
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: OCT 25, 2009@16:51 ENTRY DATE: OCT 25, 2009@16:51:47
AUTHOR: HABIB,LEAH M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH PSYCHIATRY GENERAL PROGRESS NOTE Has ADDENDA ***

Patient seen and discussed with the attending psychiatrist, Dr. Khan, who agrees with the assessment and plan.

SUBJ:
Mr. Hooks seen in the hallway outside the dayroom. Per nursing he has been isolative but focused on a court date he has tomorrow. He denied A/VH as well as SI/HI during the interview today. However he also expressed several paranoid and disorganized thoughts about his place of residence and pending legal charges and foreclosure. In the Grady records, there is one visit to the PES in 4/09, but no admission.

MEDS:
Active Inpatient Medications (including Supplies):

	Active Inpatient Medications	Status
1)	BENZTROPINE TAB 0.5MG PO QHS	ACTIVE
2)	CYANOCOBALAMIN TAB 1000MCG PO DAILY x 7 days	ACTIVE
3)	HALOPERIDOL INJ,SOLN 2.5MG/0.5ML IM Q6H PRN FOR AGITATION/DB	ACTIVE
4)	HALOPERIDOL TAB 2MG PO Q6H PRN FOR AGITATION/DB	ACTIVE
5)	RISPERIDONE TAB 3MG PO DAILY	ACTIVE
6)	TERBINAFINE 1% CREAM,TOP SMALL AMOUNT TOP BID PRN APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATLETE'S FOOT	ACTIVE

VITALS:
Vitals: BP= 106/61 (10/25/2009 16:51), PULSE= 57 (10/25/2009 16:51), TEMP= 98 F [36.7 C] (10/25/2009 16:51), RESP= 18 (10/25/2009 16:51)

MSE:
orientation - alert, fully oriented
appearance - in VA pajamas with fair grooming/hygiene, long fingernails
behavior - calm, cooperative, no PMA/PMR
speech - regular rate and volume
mood - "ok"
affect - restricted
TP - disorganized, perseverative
TC - denied A/VH, not RIS, denied SI/HI, +paranoid delusions regarding house
Insight - poor

Judgment - poor
Impulse Control - poor
Cognition - intact

LABS:
CBC WNL except mild anemia 13.3/40.5, MCV 89
UA trace LE
TSH 1.91
B12 low at 174
UDS positive for THC
CMP WNL
EtOH <5

---- LIPID PROFILE ----

PLASMA	10/24 2009 03:45	Units	Reference Ranges
CHOL	162	mg/dL	100 - 200
TRIGLYC	86	mg/dL	0 - 199
DIR HDL	37 L	mg/dL	Ref: >=39
LDL-CHO	107.8	mg/dL	65 - 160
VLDL CH	17.2	mg/dL	5 - 50
LDL/HDL	2.9 H	ratio	0 - 2.5

ASSESSMENT:
Axis I: Schizophrenia, PT
Cannabis Abuse

Axis II: deferred

Axis III: none known

Axis IV: severe - recent legal problems, relationship problems, unstable housing

Axis V: 30

PLAN:
1. Schizophrenia, PT
- pt still disorganized and expressing paranoid delusions on interview today, psychosis and paranoia could also have some contribution from cannabis use

- acuity level 4 and with Q15 min. checks for disorganized behavior, can likely be level 2 tomorrow
- will increase risperdal to 3 mg daily tomorrow, consider moving to QHS dosing, may need further titration
- cogentin 0.5 mg QHS to prevent EPS

2. Dispo
- pt has unclear housing situation and may need referral to shelter/HWH
- pt will likely request discharge early in the week for court date

/es/ LEAH M HABIB
MEDICINE RESIDENT PGY 2
Signed: 10/25/2009 17:43

10/25/2009 ADDENDUM STATUS: COMPLETED
Started vit B12 replacement given mildly low level at 174, folate, A1c, HIV, RPR also pending.

/es/ LEAH M HABIB
MEDICINE RESIDENT PGY 2
Signed: 10/25/2009 17:43

==========

ATLANTA VA 10/24/2009 11:34 MH PSYCHIATR ROBERT B LLO
Note Text
LOCAL TITLE: MH PSYCHIATRY GENERAL PROGRESS NOTE
STANDARD TITLE: MENTAL HEALTH NOTE
DATE OF NOTE: OCT 24, 2009@11:34 ENTRY DATE: OCT 24, 2009@11:34:29
AUTHOR: LLOYD,ROBERT B EXP COSIGNER:
URGENCY: STATUS: COMPLETED

S: Per Mr. hooks, he staes that he was worried about his house being foreclosed before his admission. He was also having some AH before he came in but denies any currently. Denies paranoia, IOR, fear of poisoning or being controlled. He states he feels safe on the unit with no SI. He feels his depression is currently improving and he has a good appetite. Slept 7-8 hours last night.

O:
Vitals: BP= 127/77 (10/24/2009 06:19), PULSE= 54 (10/24/2009 06:19), TEMP= 97.6 F [36.4 C] (10/24/2009 06:19), RESP= 18 (10/24/2009 06:19)
Pain: 0 (10/24/2009 06:19)

MSE:
appearance - older AAM, in scrubs, disheveled uncombed hair
attitude - resting in bed under covers, fair eye contact
speech - regular rate and rhythm
psychomotor - +PMR
mood - "ok"
affect - restricted
thought process - linear but logical
thought content - no clear delusions, SI or HI, denies AH and VH
insight - poor
judgment - poor

Active Inpatient Medications (including Supplies):

	Active Inpatient Medications	Status
1)	BENZTROPINE TAB 0.5MG PO QHS	ACTIVE
2)	HALOPERIDOL INJ,SOLN 2.5MG/0.5ML IM Q6H PRN FOR AGITATION/DB	ACTIVE
3)	HALOPERIDOL TAB 2MG PO Q6H PRN FOR AGITATION/DB	ACTIVE
4)	RISPERIDONE TAB 2MG PO DAILY	ACTIVE
5)	TERBINAFINE 1% CREAM,TOP SMALL AMOUNT TOP BID PRN APPLY BETWEEN THE TOES AND OTHER AREAS OF FEET FOR ATLETE'S FOOT	ACTIVE
6)	TUBERCULIN,PURIFIED PROTEIN DERIVATIVE 5UNT/0.1ML ID NOW	ACTIVE

Axis I: schizophrenia, PT
Axis II: deferred
Axis III: none
Axis IV: severe - recent legal problems, relationship problems
Axis V: 30

1. schizophrenia - PT
- continue on risperdal currently
- there is no record of previous admission at Grady
- symptoms appear controlled

- will d/c accuchecks since no h/o DM

Both Dr. Khan and I saw and examined patient together. Discussed case and plan

and she agrees with above.

/es/ ROBERT B LLOYD
RESIDENT PHYSICIAN, PSYCHIATRY
Signed: 10/24/2009 11:41

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ATLANTA VA 10/23/2009 14:38 MH REC THERA JAN SAMSON L
Note Text
LOCAL TITLE: MH REC THERAPY COMPREHENSIVE ASSESSMENT NOTE
STANDARD TITLE: RECREATIONAL THERAPY INITIAL EVALUATION NOTE
DATE OF NOTE: OCT 23, 2009@14:38 ENTRY DATE: OCT 23, 2009@14:38:53
AUTHOR: SAMSON LLOYD,JAN EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Type of visit: INITIAL INPATIENT CONSULT, 0-20 MINUTES (99251)
Martial Status: Separated
Age: 57
Employment Status: Disabled
Highest grade attained: Attended college.

DIAGNOSIS:
Axis I schizophrenia, paranoid type; per CPRS polysubstance and alcohol dependence

Axis II deferred

Axis III none reported

Axis IV limited supports; poor coping skills, noncompliance

Axis V 30

BARRIERS:
The client demonstrated proper orientation to time, place, and person.
The client preferred to spend time with: Self/Alone
Client assessed socialization level: Moderate
The client was able to provide personal information.
The client feels comfortable with groups of people.
The client could not identify 3 leisure resources in the community.
The client was oriented to recreational activities and time schedule.
The client did not express interest in RT programs.

PAST INTERESTS:
Music
Dancing
Movies
T.V./Radio
Fishing
Religious Activities
Outdoor Activities

CURRENT INTERESTS:
Music
Movies
Computer Activities
Fishing
Religious Activities
T.V./Radio

--Problems identified/to be addressed by RT:
Pt. indicated the following problems as contributing to *his/her need for hospitalziation:
Loneliness:No Anger:No Fear:No
Tired:No Isolation:No Difficulty sleeping:No
Depressed:Yes Boredom:No Drug/alcohol use:No
Anxiety/worry:Yes
Other:

--RT Treatment Plan:

Statement to charge nurse:
Pt. will be encouraged to attend the following weekly RT/Pt. Education Groups to address these problems: Coping Skills x 2, Gym/Exercise x 5, Group Games and Music on unit x 3, Bingo x 1

RT will meet with pt. 1:1 for the following: RT Assessment Interview, d/c planning, ongoing individual RT needs. Additional Gymnasium and other events such as Bingo are available with staff supervision when RT is not on duty. Supplies within unit policy requirements will be made available in common areas for pt. use.

--RT Discharge Plan:

Pt. will be encouraged to continue positive leisure time activities and practice coping skills learned after discharge to reduce symptoms of Schizophrenia, paranoid type; per CPRS polysubstance and Alcohol Dependence, promote independence, healthy living, a more balanced lifestyle, and reduce the need for future inpatient hospitalization.

/es/ JAN E SAMSON
CTRS
Signed: 10/26/2009 15:23

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ATLANTA VA 10/23/2009 14:00 + MH HISTORY RUBY GUPTA
Note Text
LOCAL TITLE: MH HISTORY AND PHYSICAL
STANDARD TITLE: MENTAL HEALTH H & P NOTE
DATE OF NOTE: OCT 23, 2009@14:00 ENTRY DATE: OCT 23, 2009@14:00:47
AUTHOR: GUPTA,RUBY EXP COSIGNER: STOUT,STEVEN CHARLES
URGENCY: STATUS: COMPLETED

*** MH HISTORY AND PHYSICAL Has ADDENDA ***

---IDENTIFYING INFORMATION:----------

Age: 57 YRS
Race: AA
Gender: MALE
Marital Status:
Lives With: alone

---CHIEF COMPLAINT:----------

"I am nervous about going back to my house as the person I was giving mortgage to, wants the house back"

---HISTORY OF PRESENT ILLNESS:----------

Pt is a 57 yrs old AAM, who was brought to the ER by his cousin, Amy as she believed that pt has not been taking care of his himself and not taking his medications. Pt reports that he was here because he was scared to go back to his apartment. "I was behind in my mortgage because I was ill, but now my owner tells me that I should not come back to my apartment. He is sending me nasty e-mails. I have given 50% of the mortgage. I have been sneaking into my house like a thief. I have been staying like an animal. I need to get the lawyer." Pt also mentions about a tenant lady who was staying in this house

and trying to do bad to him by blowing marijuana, complained to the police that he had broken a window of the house to get into the house "I did break the window but then I fixed it." Reports that this lady has been evicted by the owners. Pt was locked in jail for 3 weeks and came out just 2 weeks ago. He has to report to the court on Monday. He also reports that while in jail he was given some medicines (which he does not remember)which caused him to overdose and get sick, so he went to Grady and they gave him different medications. He notes he has had no medications x 1 week. Pt denies any AVH. He does say that he feels that people are against him "My tenants are fighting against me, my property manager, my wife, my owner, my daughter, everyone is fighting against me." He does say that he feels safe here in the ward. Pt denies any SI/HI currently. Pt denies any mood symptoms. Denies any symptoms of mania. Denies any trauma to the head.

Describe any current maladaptive or problem behaviors.
Hx of previous suicide attempts? none
Hx of suicide attempt w/in 2 weeks prior to admission? none
Hx of violence? none

Does veteran feel safe in their living environment?
During the interview today with veteran, I observed the following:
[ ] No symptoms of abuse or neglect.
[ ] Suspicious injury, bruises, lacerations, burns or sprains.
[ ] Depressed, agressive, distraught, defensive, withdrawn.
[ ] Malnourished, poor hygiene, malodorous.
[ ] Sexual assault-verbal report or suspicious for.
[ ] Seemingly afraid of caregiver/family/friend/other.
[ ] Financial exploitation.
[ ] Neglect.
[ ] Other: (specify medical or physical findings as described):

---PAST PSYCHIATRIC HOSPITALIZATIONS:----------
Pt says that he was admitted in hospital at Montrose, NY , 25 yrs back. He was
diagnosed with Schizophrenia, PT , at that time. Reports that he was admitted for a period of 1 year at that time. Pt does not rememeber anything about his medications.

---PAST PSYCHIATRIC HISTORY:----------
CPRS shows that pt has been tried with Sertraline upto 200mg po daily in the

past. Pt does not remember taking this medication. He was also on Resperidone 2mg po daily and cogentin 0.5mg po hs.

---MEDICATIONS:

Active Inpatient Medications (including Supplies):

No Medications Found

-OTC & HERBAL MEDICATIONS: None

---MEDICATION RECONCILIATION:----------
This Medication list was reviewed by the provider with the patient/family member, reconciled, and provided to the patient/family member.

---SUBSTANCE USE:----------
ETOH: Drinks 1-2 glasses of beer once in a month or 2 months.
Last use: 1 month ago
Amount:
DWI:
Blackouts:

-AUDIT C:
1. How often do you have a drink containing alcohol?

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

3. How often do you have six or more drinks on one occasion?

-OTHER SUBSTANCE ABUSE:
Denies: Use of any other illicit drugs

HIV Status: Date of last test: "I don't know"
PPD Status: Date of last test: "I don't know"

Tobacco:
In the past twelve months, have you smoked tobacco [YES]
In the past twelve months, have you chewed tobacco [no]

1 PPD x 3 months

Counseling:
Patient was informed about the dangers of smoking and strongly encouraged to quit. Patient was also informed of the availability of the Smoking Cessation Treatment Program.

Tobacco Cessation Class:

---FAMILY HISTORY:----------

Pt denies any h/o mental illness in the family. He also denies any h/o suicides in the family. Pt has a wife, who stays in Germany. Pt does not have a passport to visit her anymore "She is no more my wife, she did not come to rescue me from the jail." Pt has 3 children.

---MEDICAL HISTORY:----------

athlete's foot, teeth problem

ALLERGIES:
Patient has answered NKA

---SOCIAL HISTORY:----------

Education (highest completed): 3 years of college
Legal: I have to go to the court on Monday
Occupation: retired
Spiritual Orientation: Christian
Military:
Branch: Army
Job in service: Communication
Dates of service:
Year Began: 1975
Year Ended: 1977
Era:
Combat exposure: no
Wounded: no
POW:
Witnessed trauma: yes

Sexual Orientation: heterosexual

---MENTAL STATUS EXAM:----------

ORIENTATION AND CONSCIOUSNESS: AOx3, dressed in VA scrubs
APPEARANCE AND BEHAVIOR: slightly disheveled, has artificial nails on all fingers and toes and a colourful paint on one of them
SPEECH:nl rate/rhythm/volume
LANGUAGE:appropriate
MOOD: "Scared"
AFFECT: euthymic
PERCEPTUAL DISTURBANCE (hallucinations, illusions):no AVH
THOUGHT PROCESS AND ASSOCIATION: disjointed
THOUGHT CONTENT (delusions, obsessions etc.): somewhat delusional, +paranoia
SUICIDAL OR VIOLENT IDEATION:no SI/HI
INSIGHT: poor
JUDGEMENT: poor
MEMORY: poor
FUND OF KNOWLEDGE: fair

---REVIEW OF SYSTEMS:----------

GENERAL...
Patient reports generally good health.
Patient health is stable.

SKIN...
No history of skin disorders.

CARDIAC...
No history of cardiac disease. Specifically, no history of chest pain, palpitation, PND, orthopnea, or pedal edema.
No history of rheumatic fever, valvular disease or syncope.

PULMONARY...
No history of respiratory problems. History is negative for: dyspnea on exertion or at rest, asthmatic attacks, TB, COPD, or hemoptysis.

LYMPH...

No history of lymphatic disorders.

HEENT...
No history of diseases of the head, eyes, ears, nose or throat.

GI...
No history of gastrointestinal problems. History is negative for: abdominal pain, constipation, diarrhea, or vomiting. No history of jaundice, hematemesis, melena, acolic stools or BRBPR.

GU...
No history of GU disease. Specifically, no recent history of: hematuria, dysuria, nocturia, nephrolithiasis, recurrent urinary tract infections, sexually transmitted diseases or flank pain.

EXT./MS...
No history of arthitis, arthralgias, muscle weakness or pain. No history of pedal edema.

NEUROLOGIC...
No history of chronic or recurrent headache, blurred vision, memory loss, paresthesias, or weakness.

---PHYSICAL EXAM:----------

BP= 123/76 (10/23/2009 12:18), PULSE= 56 (10/23/2009 12:18), TEMP= 97.3 F [36.3
C] (10/23/2009 12:18), RESP= 18 (10/23/2009 12:18)

GENERAL:
Well developed, well nourished patient in no acute distress.

ABDOMEN:
The abdomen was soft, bowel sounds normal, no hepatosple nomegaly noted. There was no guarding, tenderness, rebound, rigidity, masses or bruits.

BREAST:
No abnormal masses, nipple discharge or skin retraction.

CARDIAC:
The cardiac exam was within normal limits; PMI not displaced;

no gallops, murmurs or rubs.

CHEST:
The chest is clear to percussion and auscultation.

EXT/MS:
No clubbing cyanosis or pedal edema. Joint exam WNL.

GU:
The gentiourinary exam is within normal limits; no abnormal masses or hernia.

HEENT:
Normocephalic; PERRLA; sclera anicteric; conjunctivae normal. Ear, nose and throat exam with normal limits. Oral exam within normal limits.

LYMPH:
No adenopathy.

NECK:
The neck is supple, no adenopathy or thyroid enlargement noted; trachea in midline.

NEURO:
Neurologic exam intact.

RECTAL:
Rectal exam not performed.

SKIN:
Anicteric, no rashes, no bruises.

---RISK ASSESSMENT FOR SECLUSION AND RESTRAINT----------
The following preesixting conditions, disabilities, and limitations have been identified that would place the patient at greater risk during a seclusion or restraint event:

Physical:
[ ] None

History of:
[ ] Fractures
[ ] Arthritic conditions
[ ] Osteoporosis
[ ] Respiratory illness
[ ] Other _____
Comments:

Psychological:
[ ] None

History of:
[ ] Sexual abuse
[ ] Physical abuse
[ ] Patient has been a POW
[ ] Prior history of restraint/seclusion usage
[ ] Other _____
Comments:

Positive responses to the above are incorporated into the interdisciplinary treatment planning process.

---LABS & STUDIES:----------

---- CBC PROFILE ----

BLOOD	10/23 2009 10:43	Units	Reference Ranges
WBC	6.1	K/cmm	4 - 11
RBC	4.6 L	M/cmm	4.7 - 6.1
HGB	13.3 L	g/dL	14 - 18
HCT	40.5	%	40 - 52
MCV	89.0	fL	80 - 100
MCH	29.2 L	pg	31 - 34
MCHC	32.8	g/dL	32 - 37
RDW	14.4	%	11.6 - 16.5
PLT	184	K/cmm	150 - 400
MPV	9.8	fL	9.4 - 12.4
SEGS %	52.9	%	37.5 - 75.5

LYMPH %	33.4	%	20 - 55.5
MONO %	10.9	%	2.5 - 12
EOSIN %	2.5	%	0 - 6
BASO %	0.3	%	0 - 2.5
SEGS		%	40 - 75
BANDS		%	0 - 5
LYMPHS		%	15 - 41
MONOS		%	2 - 10
EOSINO		%	0 - 4
BASO		%	0 - 3
META		%	
MYELO		%	
ATY LYM		%	
BLASTS		%	
PROS		%	0 - 0
PLT EST			Ref: Adq
NORMOCY			
NORMOCH			
OVALOCY			
TEARDP			
ACANTHO			
ANISO		0-4+	
POIKILO		0-4+	
BASOPHI			
SCHIST			
MICROCY			
MACRO			
POLYCHR			
HYPO			
TARGET			
TOXIC G			
NRBC		/100WBC	
OTHER			
NEUTRO#	3.2	K/cmm	1.4 - 6.5

Comments: a

a. Evaluation for RBC:
Reference Ranges:
Male: 4.7 - 6.1 M/cmm
Female: 4.2 - 5.4 M/cmm
Evaluation for HGB:
Reference Ranges:

Male: 14.0 - 18.0 g/dl
Female: 12.0 - 16.0 g/dl
Evaluation for HCT:
Reference Ranges:
Male: 40.0 - 52.0%
Female: 37.0 - 47.0%
Evaluation for BASO %:
The above 5 parameters (SEGS %, LYMPH % MONO % EOSIN and BASO %) are part of an automated WBC differential.

---- CHEMISTRY PROFILE ----

PLASMA	10/23 2009 10:43		Units	Reference Ranges
NA	137		mmol/L	136 - 145
K	3.6		mmol/L	3.6 - 5.1
CL	105		mmol/L	99 - 111
CO2	26.0		mmol/L	22 - 32
GLUCOSE	111	H	mg/dL	70 - 110
CA	9.1		mg/dL	8.6 - 10.2
BUN	7	L	mg/dL	8 - 23
CREAT	1.1		mg/dL	.5 - 1.2
BUN/CR	6.4	L	Ratio	12 - 20
ALBUMIN	3.5		g/dL	3.4 - 4.8
T. BIL	0.8		mg/dL	.3 - 1.2
ALK PHO	71		IU/L	32 - 103
PROTEIN	7.3		g/dL	6.1 - 7.9
ALT	15		IU/L	0 - 44
AST	25		IU/L	8 - 40
GLOB	3.8		g/dL	2.6 - 4
A/G	0.9	L	Ratio	.95 - 1.59
MAG			mg/dL	1.6 - 2.6
NH3			umol/L	9 - 35
AMYLASE			U/L	25 - 125
D BILI			mg/dL	0 - .2
ETOH	<5		mg/dL	0 - 10
G-GTP			IU/L	7 - 50

HS-CRP	mg/L	0 - 7.5
LACTATE	mg/dL	.5 - 2.2
LDH	U/L	100 - 200
OSMOLAR		
PO4	mg/dL	2.4 - 4.5
URIC AC	mg/dL	2.3 - 7.6

Comments: a
a. Evaluation for ALT:
FEMALE REFERENCE RANGE: <34 IU/L
Evaluation for ETOH:
NORMAL RANGE: NONE DETECTED

---INITIAL DSM-IV DIAGNOSIS:----------

Axis I: schizophrenia, PT
Axis II: deferred
Axis III: none
Axis IV: severe - recent legal problems, relationship problems
Axis V: 30

---SUMMARY AND FORMULATION:----------

Pt is a very poor historian. Tells stories that cannot be well correlated. He was unable to provide names of medications but per remote data , was last prescribed cogentin and risperidone in New York in June 2009. There is poor compliance per record and he has no other MH treatment in VA system since that time. Tried to call pt's cousin Amy (803-478-2300) but she was not available on phone. According to SW notes "Mr. Miles called back from Diversion court in Fulton county and stated he had been charged with a misdemeanor then the judge determined it may have been due to mental health issues. Veteran needs to show proof he is receiving mental health services and medications and in 6 months from 9/10/09 he will be released. Mr. Miles also shared that much of the information he shared about many rental properties in Buckhead is true and that he lives in one of the units on the property. His wife does reside in Germany. Mr. Miles stated he became involved with someone who has been trying to cause problems for him when in fact he was paying all her bills. She pressed charges and in fact called the police again when he tried to retrieve belongings from his apartment-it was explained to her she could not have him thrown off his own property."

- At this point, it is really difficult to say whether what pt has told is true
or he is delusional. Will need to throw light into the matter.

- Will try to retrieve records from Grady Memorial hospital.

- Will admit in 4PSY, ACUITY LEVEL 4, Q15min checks for DB

- Will start the pt on Risperidone 2mg po daily for psychosis. Will also re-start him on Cogentin 0.5mg qhs.

- Have ordered other labs like serum B12, serum TSH, Lipid profile.

Note: Your electronic signature indicates agreement with the History & Physical content. Exceptions and additions should be noted with an addendum.

/es/ RUBY GUPTA
PSYCHIATRY RESIDENT, PGY 1
Signed: 10/23/2009 16:27

/es/ STEVEN C. STOUT, MD
STAFF PHYSICIAN
Cosigned: 10/23/2009 18:34

10/23/2009 ADDENDUM STATUS: COMPLETED
Pt. seen individually. Discussed case with resident. Pt. relates a convoluted story, involving throwing a rock at his own property because he thought he heard someone shooting at him, coming back to fix the window but being arrested and jailed for 3 weeks, and conflict with the tenant/friend at that house who he says may be in cohoots with the property manager (he had to fire his previous property manager) and the mortgage lender. Pt. states he has put half a million dollars into the house, along with his wife who has subsequently left for Europe. Pt. states that all this stress has him hearing voices and he needs to get stabilized back on medications which helped him in the past, and to get legal counsel.

Denies current SI/HI/VI. Denies recent substance use.

Denies medical problems. Of note, pt. has had 2 separate ER visits in the past year, both for insect bites.

MSE c/w resident note.

=> Schiz PT, homeless

- pt's story of real estate troubles appears most likely to be at least in part delusional; as stated, will attempt to gather collateral hx.
- concur with restarting risperdal and cogentin
- milieu treatment
- acuity level 4

/es/ STEVEN C. STOUT, MD
STAFF PHYSICIAN
Signed: 10/23/2009 19:00

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ATLANTA VA 10/23/2009 11:20 MH SUICIDE R MARLENE K. L
Note Text
LOCAL TITLE: MH SUICIDE RISK ASSESSMENT NOTE
STANDARD TITLE: SUICIDE PREVENTION RISK ASSESSMENT SCREENING NOT
DATE OF NOTE: OCT 23, 2009@11:20 ENTRY DATE: OCT 23, 2009@11:20:34
AUTHOR: LEVINE,MARLENE K EXP COSIGNER:
URGENCY: STATUS: COMPLETED

IDEATION
Patient presently has no suicidal ideation.
Previous attempts:
Patient has never made a suicide attempt.

IMPULSIVITY PREDICTORS
Indications:
History of impulsive behaviors such as substance consumption

ILLNESS
Substance Abuse
Alcohol Abuse
Psychosis

ACUTE FACTORS
Patient DOES complain of severe emotional distress.
Patient DOES NOT endorse severe anxiety.
Patient DOES NOT describe panic symptoms.
Patient DOES express hopelessness and/or demoralization.
Patient DOES NOT complain of insomnia.
Patient DOES NOT evidence obsessionality.
Patient DOES NOT have recent intoxications.
Patient DOES endorse hallucinations.
Patient DOES NOT complain of physical pain.

SOCIAL RISKS

Poor Social Support, Acute Life Stressors
recent involvement with court system and possible foreclosure

MEDICATION HISTORY
Poor Adherence

FIREARMS
Firearms ARE NOT available.

CONSIDERATION OF OTHER MEANS TO COMMIT SUICIDE
Patient has not considered other means.

MITIGATING CIRCUMSTANCES
Hopes and plans for future
Beliefs for continued living
Explicit reasons for living
Dependent others
Regular contacts with supports

CATEGORY OF RISK
CURRENT ACUTE RISK FACTORS
There is no indication of current acute risk factors.
BASELINE RISKS

It is this clinician's opinion that the pt presents limited baseline risk factors.

INTERVENTIONS AND PLAN:

CONTAINMENT: PLANS FOR MODIFICATION OF ENVIRONMENT

Admit to inpatient care

ARRANGE CONTINUING CARE:

Make sure patient has outpatient follow up scheduled.

TREATMENT OF RISK FACTORS: stabilize symptoms

ACUTE FACTORS ADDRESSED:

Symptoms

Medication Factors

TREATMENT OF UNDERLYING PSYCHIATRIC DISORDERS:

Medication Change or Adjustment

CONTACT MADE WITH FAMILY/SOCIAL SUPPORT: spoke with cousin who brought him in today

PATIENT RESPONSE TO CHANGES:

Positive

/es/ MARLENE K. LEVINE, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/23/2009 11:27

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ATLANTA VA 10/23/2009 11:00 + MH EMERGEN MARLENE K. L
Note Text
LOCAL TITLE: MH EMERGENCY ROOM NOTE
STANDARD TITLE: MENTAL HEALTH EMERGENCY DEPT NOTE
DATE OF NOTE: OCT 23, 2009@11:00 ENTRY DATE: OCT 23, 2009@11:00:46
AUTHOR: LEVINE,MARLENE K EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** MH EMERGENCY ROOM NOTE Has ADDENDA ***

Subjective:
"I had a mortgage for five years and I put down 50% of my life savings and then I got ill and had to go to the hospital and now they are trying to put me out of my house I have been paying for-I was behind and tried to catch it up but he would not take my money. I am scared to go to the house because they have ganged up on me and that demon lady has been blowing marijuana in me while she locks me in the bathroom."

Objective:
Mr. Leroy Hooks is a 57 year old 100%SC Vietnam Era Veteran. He was brought in to day by his cousin with whom he has been staying for the last week in South Carolina. She brought him here today because he has not been taking care of himself and not taking his medications. She stated he is always talking about them coming to get him. He states he owns an apartment complex here in Atlanta that they are trying to take away from him. He notes 3 weeks ago he was locked up in jail x 3 weeks when he threw a rock through a window to protect himself then the medicine they gave him caused him to overdose and get sick so he went to Grady and they gave him different medications. He notes he has had no medications x 1 week. He was unable to provide names of medications but per remote data has was last prescribed cogentin and risperidone in New York in June 2009. It notes poor compliance per record and he has no other MH treatment in VA system since that time. He states he has not been in a psychiatric hospital for over 20 years when he spent a long time at Montrose. He is currently married for the last 20 years but he and his wife do not live together. She currently lives in Germany with their 2 youngest children ages 11 and 15-she teaches school on the base there-his 17 year old lives in Florida with a friend of the family. Unclear about legal issues but has a social worker assigned to him through MH Diversion court-call has been placed to Mr. Miles 404-613-2196. Unclear if he manages his own money or if he has some assistance. His cousin stated she thought his check had been stopped but he talked about lots of money he has in the bank. In addition he states he had been visiting his wife and family regularly in Germany but now they took away his passport.

Assessment:
SW interviewed veteran in exam room. He was dressed in hospital issued pajamas and sat in the corner mumbling to himself throughout the assessment. He endorses poor appetite, hearing voices talking about him when he is around his apartment, paranoia and denies SI/HI. He denied alcohol/drug use but then stated the demon lady blows marijuana in him.

** MENTAL STATUS EXAM **:

- APPEARANCE/DRESS: Thin

- ATTENTION/CONCENTRATION: Poor concentration

- MEMORY: Patient reports: Intact

- ORIENTATION: Person, Place

- BEHAVIOR: Poor eye contact

- SPEECH: Soft, Hesitant

- MOOD: Labile

- AFFECT: Blunted

- NEUROVEGETATIVE SIGNS OF DEPRESSION: Decreased appetite, Agitation

- THOUGHT PROCESSES: Disorganized, Rambling

- THOUGHT CONTENT: Paranoid, Delusional, Auditory Hallucinations

- JUDGEMENT: Impaired

- INSIGHT: Poor/limited

Axis I	schizophrenia, paranoid type; per CPRS polysubstance and alcohol dependence
Axis II	deferred
Axis III	none reported
Axis IV	limited supports; poor coping skills, noncompliance
Axis V	30

Plan:
Contacted POD and case to be discussed. he will evaluate and make recommendations concerning final disposition.

/es/ MARLENE K. LEVINE, LCSW

CLINICAL SOCIAL WORKER
Signed: 10/23/2009 11:20

10/23/2009 ADDENDUM STATUS: COMPLETED
Mr. Miles called back from Diversion court in Fulton county and stated he had been charged with a misdemeanor then the judge determined it may have been due to mental health issues. Veteran needs to show proof he is receiving mental health services and medications and in 6 months from 9/10/09 he will be released. Mr. Miles also shared that much of the information he shared about many rental properties in Buckhead is true and that he lives in one of the units on the property. His wife does reside in Germany. Mr. Miles stated he became involved with someone who has been trying to cause problems for him when in fact he was paying all her bills. She pressed charges and in fact called the police again when he tried to retrieve belongings from his apartment-it was explained to her she could not have him thrown off his own property. Mr. Miles can be contacted in the future if needed. No further intervention indicated at this time.

/es/ MARLENE K. LEVINE, LCSW
CLINICAL SOCIAL WORKER
Signed: 10/23/2009 12:10

10/23/2009 ADDENDUM STATUS: COMPLETED
Pt seen and exmained by me, case reviewed and discussed with Ms. Levine.

This is a 57yo AAM 100% SC for schizophrenia who presented to the ED with his cousin for a MH assessment. The pt was a relatively poor historian and offers a very disjointed story. He stated he has been having trouble with legal issues and a woman living in his apartment complex. The pt stated that the bank has been trying to foreclose on his property and that he is scared to return because he might be arrested. He talked about a recent arrest, treatment at Grady, and feeling as though he was overdosed in the jail. He also talked about a witch placing spells on him by burning his mead, blowing smoke into him and placing fingernails on him. Pt thinks this may be causing some of his current problems. He reports AH but denies SI and HI.

Vitals: BP= 123/76 (10/23/2009 12:18), PULSE= 56 (10/23/2009 12:18), TEMP= 97.3 F [36.3 C] (10/23/2009 12:18), RESP= 18 (10/23/2009 12:18)
Pain: 0 (10/23/2009 12:18)

Collection DT	Spec	WBC	RBC	HGB	HCT	MCV	MCH	MCHC
10/23/2009 10:43	BLOOD	6.1	4.55 L	13.3 L	40.5	89.0	29.2 L	32.8

Collection DT	Spec	PLT	MPV	RDW
10/23/2009 10:43	BLOOD	184	9.8	14.4

Collection DT	Spec	CREAT	BUN	GLUCOSE	NA	K	CL	CO2
10/23/2009 10:43	PLASM	1.1	7 L	111 H	137	3.6	105	26.0

Collection DT	Spec	CA	PROTEIN	ALBUMIN	T. BIL	ALK PHO	AST	ALT
10/23/2009 10:43	PLASM	9.1	7.3	3.5	0.8	71	25	15

Collection DT	Spec	GLOB	A/G	BUN/CR
10/23/2009 10:43	PLASM	3.8	0.9 L	6.4 L

EtOH Lvl < 5

UA, UDS are pending

CLINICAL REMINDER ACTIVITY/PLAN OF CARE
Medication Reconciliation:
Reconciled patient medication list:

From NY VAMC
Risperdal 1mg po daily
Cogentin 0.5 mg po daily

Pt provided meds from Grady but does not know what he was given

This Medication list was reviewed by the provider with the patient/family member, reconciled, and provided to the patient/family member at discharge.

MSE: Pt was dressed in VA PJs. He had false fingernails on all fingers with 1 of them painted in bright colors, cooperative with interview, speech WNL, mood anxious, affect angry when talking about losing his apt bldg, TP disjointed at times, TC +paranoia and delusions, +AH. Denied SI and HI. A&O x iv, I&J poor

Assessment:

Axis I: schizophrenia, PT
Axis II: deferred
Axis III: none
Axis IV: severe - recent legal problems, relationship problems
Axis V: 30

Plan:

1. Pt will be admitted to the acute inpatient psychiatry unit. Place on q15 min checks for disorganized behavior

2. psychotherapeutics per primary treatment team.

/es/ DAVID C PURSELLE, MD
STAFF PHYSICIAN
Signed: 10/23/2009 15:01

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ATLANTA VA 10/23/2009 10:53 MH EMERGENCY MARY ALICE T
Note Text
LOCAL TITLE: MH EMERGENCY ROOM NURSING ASSESSMENT
STANDARD TITLE: NURSING EMERGENCY DEPT E & M NOTE
DATE OF NOTE: OCT 23, 2009@10:53 ENTRY DATE: OCT 23, 2009@10:53:44
AUTHOR: THOMAS,MARY AA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

MH EMERGENCY ROOM NURSING ASSESSMENT

CHIEF COMPLAINT: I am hearing voices and I am afraid to go in my house. I was given an
OD at Grady Hospital and they are trying to foreclose on my home. My wife, sister and daughter wants me to go to the hospital. I just spent 3 weeks in jail and the police. I just need my medication. I haven't smoked for 15 years and I started back and have been smoking for 6 months. Denies drinking and taking illicit drugs. Wife, sister and daughter all want me to be in the hospital. My wife is in Germany and my daughter is in Fla. I have been staying with my cousin for the last week.

VITALS: BP= 120/75 (10/23/2009 10:41), PULSE= 75 (10/23/2009 10:41), TEMP= 98.6 F [37.0 C] (10/23/2009 10:41), RESP= 18 (10/23/2009 10:41)

HT: 65 in [165.1 cm] (08/13/2009 09:40)
WT: 135 lb [61.4 kg] (08/13/2009 09:40)
AGE: 57

Patient's mode of arrival is ambulatory
Patient arrived from triage at Oct 23,2009@11:14
PHYSICAL ASSESSMENT:

Respiratory:

Normal Effort

CIRCULATORY:
Cardiovascular:

No complaints
---INTEGUMENTARY ASSESSMENT:
Skin color normal; warm, dry, intact.

NUTRITIONAL STATUS:
Regular diet

PSYCHOLOGICAL STATUS:
Suicidal

The SAD PERSONS Scale For Accessing The Risk of Suicide.

Sex	1
Age	0
Depression	0
Previous attempt	0
Ethanol abuse	0
Rational thinking loss	2
Social supports lacking	1
Organizational plan	0
No spouse	0
Sickness	0
Total	4

Action Taken: Brought to immediate attention of the Physician, and following actions taken based on orders., 1:1 suicide precaution

Hallucinations:
Auditory
Affect:
Appropriate
Are you in a relationship in which you have been physically hurt or threatened by your partner? no
Do you feel safe in your current environment? yes

Notify supervisor if question one is yes and question two is no

MUSCULOSKELETAL:
No complaint
Fall Risk Assessment:
Morse Fall Risk Assessment
History of falling; immediate or within 3 months: No = 0
Secondary diagnosis: Yes = 15
Ambulatory aid: None, bedrest, W/C, nurse = 0
IV/Heparin lock: No = 0
Gait/Transferring: Normal, bedrest, immobile = 0
Mental status: Oriented to own ability = 0
TOTAL SCORE: 15 A SCORE > 50 IS AT HIGH RISK FOR FALLS.
Fall Risk: No

NEUROLOGICAL:
Status:
Alert
Oriented:
Person
Place
Time
Event
PLAN:
Monitor vital signs q 2h.
Protect patient from injury.
Monitor level of consciousness.
Monitor and reassess mental status.
Provide calm, quite environment.

Educate patient about current condition/treatment plan.

/es/ MARY AA THOMAS
REGISTERED NURSE
Signed: 10/23/2009 11:22

==========

TAMPA FL V 12/13/2013 12:33 PACT PRE-PLA CINDY A KELL
Note Text
LOCAL TITLE: PACT PRE-PLANNING TELEPHONE NOTE
STANDARD TITLE: NURSING TELEPHONE ENCOUNTER NOTE
DATE OF NOTE: DEC 13, 2013@12:33 ENTRY DATE: DEC 13, 2013@12:33:53
AUTHOR: KELLY,CINDY A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

PACT Pre-Planning Telephone Note

Reason for visit: new patient eval, hospital discharge f/u

PATIENT PHONE - 813-732-3462
Patient was called in preparation for upcoming PCP appointment:
Dec 20,2013@10:30
Spoke to significant other or caregiver: Spoke with daughter, address of record and telephone number belong to her, not her father, the patient.

Pt was visiting from hi home is South Carolina and is followed by the Columbia SC VAMC. Last visit 12/9/13 with his PCP in SC Per Vista Web.

Daughter requests to have patient information updated to reflect pt's actual address and phone nuber of:

1992 Jacks Creek Road
Summerton, SC 29148
(803) 566-3567

Has Staff notified to change address as requested and cancel appointment

/es/ CINDY A KELLY, LPN
LICENSED PRACTICAL NURSE
Signed: 12/13/2013 12:38

Receipt Acknowledged By:
12/24/2013 10:40 /es/ DONNA M FISHER
PSA
12/16/2013 14:19 /es/ BRIAN B. ZILKA, M.D.
STAFF PHYSICIAN, AMBULATORY CARE

==========

TAMPA FL V 12/04/2013 08:11 PATIENT DISC NANCY PANAMB
Note Text
LOCAL TITLE: PATIENT DISCHARGE INSTRUCTIONS - MEDICATIONS
STANDARD TITLE: EDUCATION DISCHARGE NOTE
DATE OF NOTE: DEC 04, 2013@08:11 ENTRY DATE: DEC 04, 2013@08:11:17
AUTHOR: PANAMBO,NANCY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

HOOKS,LEROY ALEXANDER JUN 9,1952

DISCHARGE MEDICATION LIST

Patient discharge to home, ALF, med foster home, or home with hospice

PATIENT MEDICATION LIST DEC 04, 2013 08:11

****

THIS LIST REPLACES ANY PRIOR LIST OF MEDICATIONS received for your discharge home. This is a list of the medications you should be taking at home following this hospitalization. Please call your Primary Care Provider for questions related to these medications.

****

Active Outpatient Medications (including Supplies):

	Active Outpatient Medications	Status Refills	Issue Date Last Fill Expiration
1)	DOCUSATE NA 100MG CAP Qty: 60 for 30	ACTIVE	Issu:11-12-13

000127

	days Sig: TAKE ONE CAPSULE BY MOUTH TWICE A DAY (STOOL SOFTENER)	Refills: 0	Last:12-03-13 Expr:12-12-13
2)	GLOVE VINYL MEDIUM PWDR-FREE NONSTERILE Qty: 100 for 30 days Sig: USE VINYL MED ON HAND(S) AS NEEDED	ACTIVE Refills: 5	Issu:11-18-13 Last:11-20-13 Expr:11-19-14
3)	PASTE,STOMAHESIVE C#1839-10 Qty: 60 for 30 days Sig: APPLY SMALL AMOLUNG TO SKIN AS NEEDED FOR OSTOMY CARE	ACTIVE Refills: 5	Issu:11-18-13 Last:11-20-13 Expr:11-19-14
4)	PETROLATUM HYDROPHILIC 120GM CR Qty: 120 for 30 days Sig: APPLY TO AFFECTED AREA ON SKIN 3 TIMES A DAY AS NEEDED APPLY TO AREAS OF DRY SKIN ON FEET AND LEGS	ACTIVE Refills: 0	Issu:12-03-13 Last:12-03-13 Expr:01-02-14
5)	POUCH,DRAINABLE,SUR-FIT C#4015-03 Qty: 20 for 30 days Sig: APPLY 57MM (2-1/4IN) FLANGE TO SKIN AS NEEDED FOR OSTOMY CARE [SUPPLY ITEM]	ACTIVE Refills: 5	Issu:11-18-13 Last:11-20-13 Expr:11-19-14
6)	SKIN BARRIER WIPE C#2041 Qty: 54 for 30 days Sig: USE PAD ON SKIN AS NEEDED	ACTIVE Refills: 5	Issu:11-18-13 Last:11-20-13 Expr:11-19-14
7)	TRAMADOL HCL 50MG TAB Qty: 30 for 8 days Sig: TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE Refills: 0	Issu:12-03-13 Last:12-03-13 Expr:01-02-14
8)	WAFER,STOMAHESIVE W/FLANGE C#4015-76 Qty: 20 for 30 days Sig: APPLY 2-1/4 IN TO SKIN AS NEEDED	ACTIVE Refills: 5	Issu:11-18-13 Last:11-20-13 Expr:11-19-14

** This list doesn't include medications from other VA facilities. **

****
If you have a pending medication, it means that the medication has been ordered but the pharmacy has not completed processing the order at the time the medication list was printed.
****

PATIENT EDUCATION:
Reviewed content with patient and/or caregiver.

Patient instructed to:
* Provide updated medication list to primary care provider.

* Notify primary care provider of medication changes, when medications are discontinued, doses change or new medications are added.

* Carry medication information at all times, including prescribed and over the counter.

* Read the information packet provided with each new medication.

* Keep the old pill containers until receiving the next refill so drug name, dosage and instructions can be compared. Notify the prescriber if you do not understand why something changed.

Patient and/or care giver verbalized understanding and copy given to patient.

DISCHARGE MEDICATIONS: Medication delivered to bedside.

_____Signature of Patient

Reviewed By: _____

Attending Physician while hospitalized: STANDLEY,JOSEPH W

Primary Care Physician/Provider:

James A. Haley Veterans Hospital
13000 Bruce B. Downs Blvd.
Tampa, FL 33612

000129

STATE OF SOUTH CAROLINA)
)
COUNTY OF CLARENDON)

CASE NO: 2018-CP-14-00044
IN THE COURT OF COMMON PLEAS

Wilmington Savings Fund Society, FSC, d/b/a Christiana Trust as Owner Trustee of the Residential Credit Opportunities Trust V,

Plaintiff,

Vs.

Leroy Hooks, II and Ford Motor Credit Company, LLC,

Defendants.

EXHIBIT 4

CHASE

March 21, 2018 through April 19, 2018
Account Number: 000000866802028

ATM & DEBIT CARD WITHDRAWALS *(continued)*

DATE	DESCRIPTION	AMOUNT
04/17	Non-Chase ATM Withdraw 04/18 Abc Hotel Tarlac City Card 8412 Ph Peso 2000.00 X 0.01922667 (Exchg Rte)	43.26
04/17	Foreign Exch Rt ADJ Fee 04/18 Abc Hotel Tarlac City Card 8412	1.30
04/18	Card Purchase 04/18 Speedpay:Duke-Energy 866-316-3360 NC Card 8412	321.50
04/18	Card Purchase 04/18 Google *King G.CO/Helppay# CA Card 8412	9.99
04/18	Card Purchase 04/17 Securus Inmate Call-Vi 800-8446591 TX Card 8412	53.00
04/18	Card Purchase 04/17 Securus Inmate Call-Vi 800-8446591 TX Card 8412	53.00
04/18	Card Purchase 04/17 Securus Inmate Call-Vi 800-8446591 TX Card 8412	53.00
04/18	Non-Chase ATM Withdraw 04/18 Prime Asia Hotel Offsit Angeles B4 Card 8412 Ph Peso 10000.00 X 0.01918927 (Exchg Rte)	196.69
04/18	Foreign Exch Rt ADJ Fee 04/18 Prime Asia Hotel Offsit Angeles B4 Card 8412	5.90
04/18	Non-Chase ATM Withdraw 04/18 Prime Asia Hotel Offsit Angeles B4 Card 8412 Ph Peso 10000.00 X 0.01918927 (Exchg Rte)	196.69
04/18	Foreign Exch Rt ADJ Fee 04/18 Prime Asia Hotel Offsit Angeles B4 Card 8412	5.90
04/19	Card Purchase 04/16 Footlocker 800-9916815 WI Card 8412	111.18
Total ATM & Debit Card Withdrawals		**$7,708.02**

ELECTRONIC WITHDRAWALS

DATE	DESCRIPTION	AMOUNT
03/30	03/30 Online Payment 6925403826 To Ocwen Loan Servicing	$1,227.67
03/30	03/30 Cbp Transfer From Checking 2028	800.00
04/16	04/14 Cbp Transfer From Checking 2028	900.00
Total Electronic Withdrawals		**$2,927.67**

FEES

DATE	DESCRIPTION	AMOUNT
04/03	Non-Chase ATM Fee-With	$2.50
04/03	Non-Chase ATM Fee-With	2.50
04/03	Non-Chase ATM Fee-Inq	2.50
04/06	Non-Chase ATM Fee-With	2.50
04/06	Non-Chase ATM Fee-Inq	2.50
04/09	Non-Chase ATM Fee-With	2.50
04/09	Non-Chase ATM Fee-Inq	2.50
04/09	Non-Chase ATM Fee-Inq	2.50
04/11	Non-Chase ATM Fee-Inq	2.50
04/11	Non-Chase ATM Fee-Inq	2.50
04/12	Non-Chase ATM Fee-Inq	2.50
04/12	Non-Chase ATM Fee-Inq	2.50
04/13	Non-Chase ATM Fee-With	5.00
04/13	Non-Chase ATM Fee-With	5.00
04/13	Non-Chase ATM Fee-Inq	2.50
04/13	Non-Chase ATM Fee-Inq	2.50
04/13	Non-Chase ATM Fee-Inq	2.50
04/16	Non-Chase ATM Fee-With	5.00
04/16	Non-Chase ATM Fee-With	5.00
04/16	Non-Chase ATM Fee-With	5.00
04/16	Non-Chase ATM Fee-With	5.00

CHASE

March 21, 2018 through April 19, 2018
Account Number: 000000866802028

DEPOSITS AND ADDITIONS

DATE	DESCRIPTION	AMOUNT
03/30	Vacp Treas 310 Xxva Benef PPD ID: 9111036002	$3,139.67
03/30	Cbp Transfer To Checking 2028	650.00
03/30	Cbp Transfer To Checking 2028	150.00
04/03	Reversal: Wu Chrysler Capital 855-563-5635 TX 04/01 Claimid: 524386880910001 04/02/2018	203.75
04/04	Credit Return: Online Payment 6697523422 To Ocwen Loan Servicing	1,227.67
04/13	Deposit 1770563225	5,020.00
04/13	Deposit 1770563224	312.70
Total Deposits and Additions		$10,703.79

ATM & DEBIT CARD WITHDRAWALS

DATE	DESCRIPTION	AMOUNT
03/30	Card Purchase With Pin 03/30 Short Trip #4 Summerton SC Card 6655	$17.34
03/30	Non-Chase ATM Withdraw 03/30 133 Main St Summerton SC Card 6655	503.00
03/30	Card Purchase W/Cash 03/30 Wm Superc Wal-Mart Sup Manning SC Card 6655 Purchase $8.45 Cash Back $100.00	108.45
03/30	Card Purchase W/Cash 03/30 Wal-Mart Super Center Manning SC Card 6655 Purchase $10.08 Cash Back $100.00	110.08
03/30	Card Purchase With Pin 03/30 Short Trip #6 Summerton SC Card 6655	15.27
04/02	Card Purchase 03/30 Bojangles 837 01008374 Manning SC Card 6655	6.31
04/02	Card Purchase 04/01 Wu Chrysler Capital 855-563-5635 TX Card 6655	203.75
04/02	Card Purchase 04/01 Vzwrlss*Prepaid Pymnt 888-294-6804 FL Card 6655	44.38
04/03	Card Purchase 03/30 Air Canada 01421925 Aircanada.Com GA Card 6655	893.13
04/03	Non-Chase ATM Withdraw 04/03 8440 St Paul Rd Summerton SC Card 8412	62.75
04/03	Non-Chase ATM Withdraw 04/03 610 S. Guiginard DR. Sumter SC Card 8412	62.00
04/03	Card Purchase W/Cash 04/03 Dollar-General # 30 S Summerton SC Card 8412 Purchase $5.75 Cash Back $10.00	15.75
04/04	Card Purchase 04/03 Jack's Creek Marina And Summerton SC Card 8412	20.00
04/04	Card Purchase 04/03 Ez Shop 24 * Summerton SC Card 8412	25.00
04/05	Card Purchase 04/03 Bojangles 836 01008366 Sumter SC Card 8412	23.19
04/06	Card Purchase With Pin 04/06 Short Trip #6 Summerton SC Card 8412	27.42
04/06	Non-Chase ATM Withdraw 04/06 133 Main St Summerton SC Card 8412	463.00
04/06	Card Purchase W/Cash 04/06 Wal-Mart Super Center Sumter SC Card 8412 Purchase $86.05 Cash Back $40.00	126.05
04/06	Card Purchase With Pin 04/06 Short Trip #4 Summerton SC Card 8412	4.02
04/06	Card Purchase W/Cash 04/06 Wm Superc Wal-Mart Sup Manning SC Card 8412 Purchase $8.08 Cash Back $100.00	108.08
04/06	Card Purchase W/Cash 04/06 Dollar-General # 30 S Summerton SC Card 8412 Purchase $9.49 Cash Back $40.00	49.49
04/09	Card Purchase 04/06 Jack's Creek Marina And Summerton SC Card 8412	13.53
04/09	Non-Chase ATM Withdraw 04/07 24 S. Church St Summerton SC Card 8412	82.24
04/09	Card Purchase With Pin 04/07 Short Trip #4 Summerton SC Card 8412	6.26
04/09	Card Purchase W/Cash 04/07 Dollar-General # 30 S Summerton SC Card 8412 Purchase $22.12 Cash Back $30.00	52.12
04/09	Card Purchase W/Cash 04/09 Dollartre 497 W Boyce Manning SC Card 8412 Purchase $21.64 Cash Back $40.00	61.64
04/09	Card Purchase W/Cash 04/09 Wal-Mart Super Center Manning SC Card 8412 Purchase $32.66 Cash Back $40.00	72.66
04/09	Card Purchase W/Cash 04/09 Cvs/Pharmacy #03 03597 Manning SC Card 8412 Purchase $66.17 Cash Back $20.00	86.17
04/10	Card Purchase 04/09 Huddle House #127 Santee SC Card 8412	15.17
04/11	Card Purchase 04/09 Ez Shop 24 * Summerton SC Card 8412	25.00

THIS PAGE IS PART OF A STATEMENT REQUEST
GROUP ID G11Jun18-2267

CHASE

April 20, 2018 through May 18, 2018
Account Number: 000000866802028

ATM & DEBIT CARD WITHDRAWALS

DATE	DESCRIPTION	AMOUNT
05/01	Non-Chase ATM Withdraw 05/01 Bancnet Bank 010 Philippines Card 8412 Ph Peso 10000.00 X 0.01936293 (Exchg Rte)	$198.47
05/01	Foreign Exch Rt ADJ Fee 05/01 Bancnet Bank 010 Philippines Card 8412	5.95
05/01	Non-Chase ATM Withdraw 05/01 Bancnet Bank 010 Philippines Card 8412 Ph Peso 10000.00 X 0.01936293 (Exchg Rte)	198.47
05/01	Foreign Exch Rt ADJ Fee 05/01 Bancnet Bank 010 Philippines Card 8412	5.95
05/01	Non-Chase ATM Withdraw 05/01 Mrjj Supermarket Angeles B4 Card 8412 Ph Peso 3000.00 X 0.01936308 (Exchg Rte)	62.93
05/01	Foreign Exch Rt ADJ Fee 05/01 Mrjj Supermarket Angeles B4 Card 8412	1.89
05/01	Non-Chase ATM Withdraw 05/01 Prime Asia Hotel Offsit Angeles B4 Card 8412 Ph Peso 2000.00 X 0.01936444 (Exchg Rte)	43.57
05/01	Foreign Exch Rt ADJ Fee 05/01 Prime Asia Hotel Offsit Angeles B4 Card 8412	1.31
05/02	Non-Chase ATM Withdraw 05/02 Abc Hotel Tarlac City Card 8412 Ph Peso 10000.00 X 0.01930341 (Exchg Rte)	197.86
05/02	Foreign Exch Rt ADJ Fee 05/02 Abc Hotel Tarlac City Card 8412	5.94
05/02	Non-Chase ATM Withdraw 05/02 Abc Hotel Tarlac City Card 8412 Ph Peso 10000.00 X 0.01930341 (Exchg Rte)	197.86
05/02	Foreign Exch Rt ADJ Fee 05/02 Abc Hotel Tarlac City Card 8412	5.94
05/02	Non-Chase ATM Withdraw 05/02 Bancnet Bank 010 Philippines Card 8412 Ph Peso 5000.00 X 0.01930286 (Exchg Rte)	101.34
05/02	Foreign Exch Rt ADJ Fee 05/02 Bancnet Bank 010 Philippines Card 8412	3.04
05/03	Non-Chase ATM Withdraw 05/03 Prime Asia Hotel Offsit Angeles B4 Card 8412 Ph Peso 4000.00 X 0.01926824 (Exchg Rte)	81.89
05/03	Foreign Exch Rt ADJ Fee 05/03 Prime Asia Hotel Offsit Angeles B4 Card 8412	2.46
05/04	Card Purchase 05/02 Euroasia International Pampanga Card 8412 Ph Peso 1770.00 X 0.01932203 (Exchg Rte)	34.20
05/04	Foreign Exch Rt ADJ Fee 05/02 Euroasia International Pampanga Card 8412	1.02
Total ATM & Debit Card Withdrawals		**$1,150.09**

ELECTRONIC WITHDRAWALS

DATE	DESCRIPTION	AMOUNT
05/01	05/01 Online Payment 7014819085 To Ocwen Loan Servicing	$1,227.67
05/02	05/02 Cbp Transfer From Checking 2028	700.00
Total Electronic Withdrawals		**$1,927.67**

FEES

DATE	DESCRIPTION	AMOUNT
05/01	Non-Chase ATM Fee-Inq	$2.50
05/01	Non-Chase ATM Fee-Inq	2.50
05/02	Non-Chase ATM Fee-With	5.00
05/02	Non-Chase ATM Fee-With	5.00
05/02	Non-Chase ATM Fee-With	5.00
05/03	Non-Chase ATM Fee-With	5.00

CHASE

Printed from Chase Personal Online

PREMIER PLUS CKG (...2028)

−$135.00 Available balance	+$4,339.67 Deposits this month	-$4,377.85 Withdrawals this month
−$135.00 Present balance	Off Debit card coverage	Off Overdraft protection

SHOWING All transactions

Date	Description	Type	Amount	Balance
Oct 9, 2018	VET CANTEEN 544 VENDING COLUMBIA SC 10/05 (...0186)	Card	−$1.80	−$135.00
	VETERANS CANTEEN #544 COLUMBIA SC 10/05 (...0186)	Card	−$2.69	−$133.20
	JACK'S CREEK MARINA AND SUMMERTON SC 10/01 (...0186)	Card	−$50.00	−$130.51
Oct 5, 2018	INSUFFICIENT FUNDS FEE FOR CHECK #170 IN THE AMOUNT OF $51.04	Fee	−$34.00	−$80.51
	CHECK # 170	Check	−$51.04	−$46.51
Oct 4, 2018	NON-CHASE ATM WITHDRAW 841028 10/048440 ST P	ATM transaction	−$63.00	$4.53
Oct 2, 2018	NON-ATM CASH FEE	Fee	−$34.50	$67.53
	CASH BANK OF CLARENDON MANNING SC 10/01	Misc. debit	−$1,150.00	$102.03
Oct 1, 2018	Online Payment 7434160057 To OCWEN LOAN SERVICING 10/01	Bill payment	−$1,227.67	$1,252.03