Name: Joseph Fabozzi | DOB MRN PCP: MUBINA SHAH, MD | Legal Name: Joseph Fabozzi

ED Provider Notes

Kimberly A. Vanesko at 3/4/2022 21:20

CHIEF COMPLAINT

Chief Complaint
Patient presents with
- Anxiety
- Laceration
  Superficial right 5th digit

Patient history from patient

Pt arrived: ambulatory

HPI

43 y.o. male presenting with anxiety and obsessive thoughts starting earlier this week. Pt reports that he was recently accused of molesting his friend's daughter and has recently been obsessed with the situation. He states that he feels like he is in a constant loop of thoughts. Throughout the interview the patient acted as if we knew each other and I was part of his life despite redirection from me. Pt denies any SI, HI, or acute ingestions. Pt also c/o a laceration to the left index finger from opening a can. He denies any signs of infection or any other injuries

Symptoms began earlier this week and are About the same.

Symptoms are described as persistent.

Symptoms still present: Yes

Severity moderate

Current/associated symptoms: agitation, anxiety, obsessive thoughts

Similar symptoms previously: No

Recently seen: Yes

REVIEW OF SYSTEMS

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.
Genitourinary: Negative for flank pain and hematuria.
Musculoskeletal: Negative for arthralgias, back pain and neck pain.
Neurological: Negative for dizziness, syncope, weakness and headaches.
Psychiatric/Behavioral: Positive for agitation. Negative for confusion. The patient is nervous/anxious.
All other systems reviewed and are negative.

PAST MEDICAL HISTORY

Past Medical History:

Diagnosis	Date
• Brain injury (HCC)	
• Diabetes mellitus (HCC)	
• Elevated cholesterol	
• Fibromyalgia syndrome	
• PTSD (post-traumatic stress disorder)	
• Sleep apnea	

SURGICAL HISTORY

Past Surgical History:

Procedure	Laterality	Date
• ANKLE SURGERY		
• NASAL BONES		

CURRENT MEDICATIONS

No current facility-administered medications for this encounter.

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• Cholecalciferol (VITAMIN D3) 50 MCG (2000 UT) TABS	4,000 Units		
• glipiZIDE (GLUCOTROL) 10 MG tablet	glipiZIDE 10 MG Oral Tablet QTY: 0		

	Days: 30 Refills: 0 Written: 01/12/21 Patient Instructions:		
• loratadine (CLARITIN) 10 MG tablet	20 mg		
• mometasone furoate (ASMANEX, 60 METERED DOSES,) 220 MCG/INH inhaler	Asmanex Twisthaler 220 mcg/actuation(60 doses) breath activated inhalr		
• rosuvastatin (CRESTOR) 5 MG tablet			
• albuterol HFA (PROVENTIL, VENTOLIN, PROAIR) 108 (90 Base) MCG/ACT inhaler	ProAir HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution QTY: 0 Days: 0 Refills: 0 Written: 02/03/21 Patient Instructions:		
• clotrimazole (LOTRIMIN) 1 % cream	Apply to area twice a day	60 g	1
• gabapentin (NEURONTIN) 300 MG capsule	Take 300 mg by mouth 2 (two) times a day		
• escitalopram (LEXAPRO) 20 MG tablet	Take 20 mg by mouth daily		
• metFORMIN (GLUCOPHAGE) 1000 MG tablet	Take 500 mg by mouth 2 times daily (with meals)		
• gabapentin (NEURONTIN) 100 MG capsule	Take 600 mg nightly by mouth Indications: Fibromyalgia Syndrome		

ALLERGIES

No Known Allergies

FAMILY HISTORY

No family history on file.

SOCIAL HISTORY

Social History

Tobacco Use
- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics
- Alcohol use: Not Currently

PHYSICAL EXAM

Physical Exam

Vitals and nursing note reviewed.
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance. He is normal weight. He is not ill-appearing or toxic-appearing.
Musculoskeletal:
Left hand: Laceration **(Superficial along left index finger)** present.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time.
Psychiatric:
Mood and Affect: Mood is anxious.
Behavior: Behavior normal. Behavior is cooperative.
Thought Content: Thought content normal. Thought content does not include homicidal or suicidal ideation. Thought content does not include homicidal plan.
Comments: **Looping thoughts and excitable, explosive when speaking about the police**

VITAL SIGNS: BP 167/99 | Pulse 81 | Temp 99.2 °F (37.3 °C) | Resp 22 | Ht 1.778 m (5' 10") | Wt (!) 163 kg (359 lb 4.8 oz) | SpO2 99% | BMI 51.55 kg/m²

Nursing note and vitals reviewed.

Pulse ox: 99% on room air
Pulse ox interpreted by me and is Not Hypoxic

LABS

Labs Reviewed - No data to display

RADIOLOGY/PROCEDURES

No orders to display

ED COURSE & MEDICAL DECISION MAKING

2146 Pt presents with anxiety an delusion, he acts as if I am part of his life and know his maid and friend Joey. He also demonstrates escalation of anger when speaking about law enforcement. Pt reports that he has send multiple emails to the people and law enforcement that were involved with him being interrogated for child molestation including claims of posting also in face book. Pt relayed that he is up all night on the computer finding out information about the people involved and he cannot stop. Pt also relayed that he found the woman who accused him of child molesting address through voter registration in a continuous research on goggle. Labs ordered. Ativan ordered. Will reassess.

MDM

ADMITJoseph Fabozzi is a male 43 y.o. who presented with obsessive thoughts.

Work-up, including labs and imaging, were reviewed. Pt was found to have obsessive thoughts.

Pt will be admitted to Behavioral service. Pt requires admission for delusional and obsessive thoughts. Options were discussed and pt consents to voluntary admission.

Pt/family counseled.

CLINICAL IMPRESSION

No diagnosis found.

Procedures

CHART REVIEW:

Medications - No data to display

New Prescriptions

No medications on file

Records Review:

I have reviewed documentation of the medications, allergies and past medical history sections for this patient. Nursing notes reviewed.

I have reviewed all labs that were completed and resulted in the emergency department during patient's visit.

Prior visits were reviewed by me.

All medical record entries made by the Scribe were at my direction. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, assessment and plan.

Electronically signed by: KIMBERLY A. VANESKO, APN, 3/4/2022 21:20

Kimberly A. Vanesko, APN
03/05/22 1804

ED Notes

Maria G at 3/6/2022 17:17

Called barnabas behavior health, spoke to Patty Trebaur, RN and given report about patient's condition and status .
Made aware that patient wears CPAP at night and Patient to bring his own.
Given information about all medications taken in the past 8 hours.

Lindsey C at 3/6/2022 17:17

Per Courtney at HMH transfer center confirmed 1830hrs pick up

Maria G at 3/6/2022 17:04

socialworker at bedside

Maria G at 3/6/2022 14:35

Patient on cpap and sleeping at this time

Maria G at 3/6/2022 12:13

Patient sitting up on the chair eating lunch

Maria G at 3/6/2022 12:05

Patient awake sitting up in recliner , removed cpap

Dawn M at 3/6/2022 11:57

BS-169

Maria G at 3/6/2022 11:26

Patient asleep at this time with CPAP on

Sybil S at 3/6/2022 7:30

Report rec'd from Krystle RN, pt is resting quietly in room w/ CPAP on, breathing even and unlabored, Q 15 min checks maintained.

Krystle W at 3/6/2022 7:15

Report given to Sybil RN. NAD. Pt resting quietly with eyes closed; arousable. Call bell within reach. Q15 minute checks continued.

Krystle W at 3/6/2022 2:50

Pt laying in bed on left side resting quietly with eyes closed; arousable. Breathing even and unlabored on Bi-PAP machine; NAD. Call bell within reach. Q15 minute checks continued for safety.

Krystle W at 3/5/2022 23:15

Received report from Celina RN. NAD. Pt awaiting bed assignment. Pt calm and cooperative. Denies SI and HI. Call bell within reach. Q15 minute checks continued for safety.

Krystle W at 3/6/2022 1:12

Pt yelling in room stating,"I'm going to walk out of here. You can't keep me here. I want to go home". Pt observed walking out of room and trying to find an exit to leave hospital. Stating, "I'm trying to find and exit". Pt education provided on hospital protocol; pt verbalizes understanding, needs re-enforcement. De-escalation attempts unsuccessful; pt escorted by to room by security, 2 RN's, and ED physician aware. New orders received. Security at bedside for safety.

Maria G at 3/5/2022 23:16

Given report about patient to Krystal RN

Maria G at 3/5/2022 23:12

Patient requesting to shower and complaining of inguinal itching. Vanesko, APN was made aware
Per APN, unsafe for patient to shower

Alicia L at 3/5/2022 20:28

Pt request cookies, peanut, and ginger ale. Items provided.

Maria G at 3/5/2022 18:22

Patient wore his CPAP and stated that he is going to sleep at this time

Amber F at 3/5/2022 15:09

Dana LCSW at bedside.

Maria G at 3/5/2022 14:30

Patient sitting up in recliner chair watching TV

Maria G at 3/5/2022 12:27

Patient applied CPAP on and asleep right now

Amber F at 3/5/2022 12:21

Home medication reviewed with patient. Requesting missed morning doses of po blood sugar management medication to regulate blood sugar. Patient takes triseba at night, pharmacy verified autosub of Lantus 15units.

Seth G at 3/5/2022 12:05

Blood glucose 335 mg/dL at this time.

Maria G at 3/5/2022 11:35

Patient sitting up recliner chair and watching TV. Calm and cooperative

Amber F at 3/5/2022 11:22

Security at bedside, patient with increased anxiety and verbal escalation due to length of stay and uncomfortable behavioral scrubs. De escalated, agreeable to plan of care. Provided with larger behavioral scrubs for comfort. q15min checks maintained.

Mitchell L at 3/5/2022 7:39

Pt is sleeping. No distress noted. rr regular, unlabored, equal chest rise and fall. Skin dry/pink.

Baily Y at 3/5/2022 7:13

Report endorsed to Mitch RN

Baily Y at 3/5/2022 5:15

pt resting in stretcher eyes closed, easy respirations, no signs of acute distress. room remain clear of ligature risks, q 15 maintained

Baily Y at 3/5/2022 3:36

pt resting in stretcher eyes closed, easy respirations, no signs of acute distress. room remain clear of ligature risks, q.15 maintained

Baily Y at 3/5/2022 1:50

Pt requesting his cpap for sleep, as he wears one at home. md made aware

Baily Y at 3/5/2022 1:00

pt resting in recliner eyes open, easy respirations, no signs of acute distress. room remain clear of ligature risks, Q 15 maintained.

Kelly F at 3/4/2022 22:50

Handoff report given to Baily RN

Baily Y at 3/4/2022 22:46

Report received from Kelly RN. Q. 15 maintained. Pt calm and cooperative.

Kelly F at 3/4/2022 22:32

Patient A&O*3, respirations even and unlabored. VS stable. Patient appears to be having a flight of ideas and is anxious. Patient sated they have been dealing with an undergoing issue that he was claimed to have sexually assaulted a friends daughter. Patient has this loop of thoughts of bring up issues with the police and cannot seem to stop. Patient put in paper scrubs. Patient denies SI/HI. Patient placed on Q15 minute checks.

Kelly F at 3/4/2022 22:19

Security collected Patients belongings

Kelly F at 3/4/2022 22:14

Handoff report received from Maritza RN