Patient Name: XXX

MRN: XXX

**Date of Service: 01-27-2020**

**Start Time:** 10:00 **End Time:** 10:54

**Billing Code(s):** 90213, 90836

*(be sure you include strictly psychotherapy codes or both E&M and add on psychotherapy codes if prescribing provider visit)*

**Accompanied by:** Brother

**CC:** follow-up appt. for counseling after discharge from inpatient psychiatric unit 2 days ago

**HPI:** 1 week from inpatient care to current partial inpatient care daily individual psychotherapy session and extended daily group sessions

**S-** Patient states that he generally has been doing well with depressive and anxiety symptoms improved but he still feels down at times. He states he is sleeping better, achieving 7-8 hours of restful sleep each night. He states he feels the medication is helping somewhat and without any noticeable side-effects.

Crisis Issues: He states he has no suicide plan and has not thought about suicide since the recent attempt. He states has no access to prescription medications, other than the fluoxetine. He believes the classes he participated in while inpatient have helped him with coping mechanisms.

 Reviewed Allergies: NKA

 Current Medications: Fluoxetine 10mg daily

 ROS: no complaints

**O-**

Vitals: T 98.4, P 82, R 16, BP 122/78

PE: (not always required and performed, especially in psychotherapy only visits)

Heart- RRR, no murmurs, no gallops

Lungs- CTA bilaterally

Skin- no lesions or rashes

Labs: CBC, lytes, and TSH all within normal limits

Results of any Psychiatric Clinical Tests: BAI=34

MSE:

Gary Davis, a 36-year-old white male, was disheveled and unkempt on presentation to the outpatient office. He was wearing dirty khaki pants, an unbuttoned golf shirt, and white shoes and appeared slightly younger than his stated age. During the interview, he was attentive and calm. He was impatient, but polite in his interactions with this examiner. Mr. Davis reported that today was the best day of his life, because he had decided he was going to be better and start his own company. His affect was labile, but appropriate to the content of his speech (i.e., he became tearful when reporting he had “bogeyed number 15” in gold yesterday). His speech was loud, pressured at times then he would quickly gain composure to a more neutral tone. He exhibited loosening of associations and flight of ideas; he intermittently and unpredictably shifted the topic of conversation from golf, to the mating habits of geese, to the likelihood of extraterrestrial life. Mr. Davis described grandiose delusions regarding his sexual and athletic performance. He reported no auditory hallucinations. He was oriented to time and place. He denied suicidal and homicidal ideation. He refused to participate in intellectual- or memory-related portions of the examination. Reliability, judgment, and insight were impaired.

**A -** with (ICD-10 code)

**Differential Diagnoses:**

**1. choose 3 differential diagnoses**

**2.**

**3.**

**Definitive Diagnosis:**

Major Depressive Disorder, recurrent, without psychotic features F33.4

Generalized Anxiety Disorder F41.1

**P-** Continue Fluoxetine increasing dose to 20mg.

Continue outpatient counseling: partial inpatient program continued with individual and group sessions

Non-pharmacological Tx: Psychotherapy Modality used: CBT

Pharmacological Tx: (be specific and give detailed Rx information)

Education: discussed smoking cessation

Reviewed medication side effects and adherence importance

Follow-up: in one week or earlier if any depressive symptoms worsen.

Referrals: none at this time