N323 Care Plan

Lakeview College of Nursing

Name

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
3/29/22	KM	34	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Technician at Christian Mental Health Center	Single	Mirtazapine (Hives) Thorazine (Hives)
Code Status	**Observation Status**	**Height**	**Weight**
Full	Q15 minute monitoring	172.7cm	54.4kg

Medical History (5 Points)

Past Medical History: Hypothyroidism/Anorexia.

Significant Psychiatric History: Obsessive compulsive disorder/Bipolar 1/Anorexia.

Family History: Grandmother paternal (bipolar), father (depression and obsessive compulsive disorder), Brother (anxiety).

Social History (tobacco/alcohol/drugs): Patient has no history of tobacco, alcohol, or drug use.

Living Situation: Patient lives alone in her apartment.

Strengths: Client is aware of their current situation and is determined to find a solution. The client understands they need help in their recovery, either pharmacological or therapy. The client understands what lead to her admission to the hospital and wants to get better at managing her depression. The client stated she “just wants to be normal and does not want to feel sad anymore.”

Support System: Client’s parents

Admission Assessment

Chief Complaint (2 points): The client has been dealing with bipolar disorder and experiences severe depression and anxiety from her obsessive-compulsive disorder.

Contributing Factors (10 points): The client overdosed on Ativan in a suicide attempt and was taken to the emergency department and later brought to the Pavilion on 3/29/22 for admission.

The client was attending licensed practical nurse (LPN) school and dropout due to her anxiety resulting in depression. The client stated she was experiencing anxiety because she was not performing as well as she wanted in school. The anxiety had become overwhelming and got to a point where she had to dropout. The client stated she felt like a failure especially when everyone else in her family was successful. The client explained she had a similar previous experience when attending college at Illinois Wesleyan, but it had resulted in a manic episode her sophomore year (20 years-old). The manic episode entail the client believing she is being hunted by the CIA and that there are listening devices hidden everywhere. The client received electroconvulsive therapy (ECT) to treat her mania as well as one other maintenance ECT to prevent another manic episode. The client appeared to be depressed and rated her depression a 6 on a scale of 1-10. The client also rated her anxiety a 5 on a scale of 1-10. The client explained she is compliant in taking medications for her bipolar disorder and OCD, but believes the medication are not working anymore because she has built up a tolerance. The client stated she wants to change her medication and hopefully be able to “feel normal”.

Factors that lead to admission: The client overdosed on 180 tablets of Ativan in a suicide attempt. Client stated she dropped out of LPN school because of overwhelming anxiety and became severely depressed. Client has a history of bipolar disorder. Client has a history of OCD.

History of suicide attempts: Patient has had one suicide attempt 3/29/22.

Primary Diagnosis on Admission (2 points): Suicide attempt by overdosing on Ativan and severe depression related to diagnosed bipolar disorder.

Psychosocial Assessment (30 points)

History of Trauma				
Lifetime experience: No history of trauma **Witness of trauma/abuse: N/A**				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	No	N/A	N/A	N/A
Sexual Abuse	No	N/A	N/A	N/A
Emotional Abuse	No	N/A	N/A	N/A
Neglect	No	N/A	N/A	N/A
Exploitation	No	N/A	N/A	N/A
Crime	No	N/A	N/A	N/A
Military	No	N/A	N/A	N/A
Natural Disaster	No	N/A	N/A	N/A
Loss	No	N/A	N/A	N/A
Other	No	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	
Depressed or sad mood	**Yes**	**No**	The client states that they feel depressed all the time and are a burden to their family. Client also stated they	

			felt like a failure at life.
Loss of energy or interest in activities/school	**Yes**	**No**	The client felt that there is no point in school or activities because she would fail.
Deterioration in hygiene and/or grooming	**Yes**	**No**	The client stated she has no motivation to shower or maintain adequate self-care. The client stated she felt stuck in a cycle; she wants to shower or get dressed but feels she does not have the ability.
Social withdrawal or isolation	**Yes**	**No**	The client states some of the other clients in the Pavilion increases her anxiety. The client isolates herself from the other clients.
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	**No**	The client clearly stated she would never have an intimate relationship because she did not want anyone to be stuck with her mood swings.
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	**Yes**	**No**	The client states they sleep an average of 10 hours a night. The client cannot wake up without an alarm or they would sleep longer.
Difficulty falling asleep	**Yes**	**No**	N/A
Frequently awakening during night	**Yes**	**No**	N/A
Early morning awakenings	**Yes**	**No**	N/A
Nightmares/dreams	**Yes**	**No**	N/A
Other	**Yes**	**No**	N/A
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	**Yes**	**No**	The client states that they had an eating disorder (anorexia) that started at the age of 18. The client also stated she still restricts her eating, but has been feeling less motivated to eat.
Binge eating and/or purging	**Yes**	**No**	N/A
Unexplained weight loss?	**Yes**	**No**	N/A

Amount of weight change:			
Use of laxatives or excessive exercise	**Yes**	**No**	N/A
Anxiety Symptoms	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	The client stated she is terrified of doing something wrong and will rock in place and pace.
Panic attacks	**Yes**	**No**	Client did not go into detail about her panic attacks because they were hard to describe. She does get panic attacks, but not very often.
Obsessive/ compulsive thoughts	**Yes**	**No**	The client stated she obsesses over things that are imperfect. She wants to fix the imperfect things such as cleaning and organizing.
Obsessive/ compulsive behaviors	**Yes**	**No**	The client stated that she obsessive over several things such as cleaning. She has to clean and cannot stop until everything is perfect. She also obsesses over work and school, by trying to complete tasks perfectly and upset and depressed when they are not.
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	The client stated she avoid the other clients in the Pavilion because they increase her anxiety. She also stated she obsesses over perfection and avoids drawing because her anxiety develops over her drawing not being perfect.
Rating Scale			
How would you rate your depression on a scale of 1-10?		**6**	
How would you rate your anxiety on a scale of 1-10?		**5**	
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	**Yes**	**No**	The client states she works at a mental health center as a tech for schizophrenia patients. The client wants to help the clients and when she

			feels she cannot help them it triggers her anxiety.
School	**Yes**	**No**	The client states she obsesses over getting good grades and when she does not meet those standards her anxiety increases.
Family	**Yes**	**No**	**N/A**
Legal	**Yes**	**No**	**N/A**
Social	**Yes**	**No**	**N/A**
Financial	**Yes**	**No**	The client states that finances are always stressful. She said the health bills are expensive and she has to pay them.
Other	**Yes**	**No**	**N/A**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/ MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/ Outcome**
Carle Bromenn Medical Center ~about 5 years ago	**Inpatient Outpatient Other:**	Outpatient	Treated with electroconvulsive therapy for manic episode.	**No improvement** **Some improvement** **Significant improvement**
Therapist ~continuing	**Inpatient Outpatient Other:**	Outpatient	The client is seeing a therapist to help client manage her anxiety, compulsions, and depression.	**No improvement** **Some improvement** **Significant improvement**

Pavilion (client is currently admitted) 03/29/22	**Inpatient** **Outpatient** **Other:**	Inpatient	Suicidal attempt and feelings of depression	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
N/A	N/A	N/A	**Yes**	**No**
If yes to any substance use, explain: N/A				
Children (age and gender): None **Who are children with now?** N/A				
Household dysfunction, including separation/divorce/death/incarceration: N/A				
Current relationship problems: No relationship problems **Number of marriages:** None				
Sexual Orientation: Heterosexual	**Is client sexually active?** **Yes** **No**		**Does client practice safe sex?** **Yes** **No**	
Please describe your religious values, beliefs, spirituality and/or preference: The client is Christian faith and used to be very religious, but does not go to church anymore. Client stated she used to obsess with being the perfect Christian, which caused her a lot of anxiety and depression.				
Ethnic/cultural factors/traditions/current activity: The client did not state any information on ethnic/cultural factors/traditions/current activities. **Describe:** N/A				
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers,				

pending charges, or course dates): The client has no past or current legal issues.
How can your family/support system participate in your treatment and care? The client's parents are a part of their daughter's support system. They want to help their daughter recover and ensure her mental health. The parents can help the client's care by checking in on their daughter more and learning the signs and symptoms of her manic episodes. They can also be made aware of any triggers to her anxiety.
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Significant childhood issues impacting current illness: N/A
Atmosphere of childhood home: **Loving** **Comfortable** **Chaotic** **Abusive** **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Grandmother: Bipolar Father: OCD / Depression Brother: Anxiety
History of Substance Use: N/A
Education History: **Grade school** **High school**

College **Other:** The client completed two years of college before dropping out and a semester of LPN school.
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: The client stated they obsessed over perfection in school and when they did not get a perfect score, they became depressed. The client stated she felt that she would never be able to handle the stresses of school.
Discharge
Client goals for treatment: The client stated "I know I can get better once I find a treatment that works for me. I want to live a normal life."
Where will client go when discharged? The client will live with her parents for a short time before returning to her apartment.

Outpatient Resources (15 points)

Resource	Rationale
1. Psychiatric therapy	**1.** Talking to a psychiatrist helps clients to understand their mental health issues. The psychiatrist guides the client on how to adapt, manage emotions, and improve their skills manage their mental health issues.
2. Dialectical behavior therapy	**2.** Dialectical behavior therapy helps improve skills to manage negative emotions. This therapy focuses on helping clients control their emotions and improve tolerance to negative emotions and thoughts.
3. Cognitive behavioral therapy	**3.** Cognitive behavioral therapy teaches clients how to manage their mental health issues with techniques. The techniques help the client to relax and cope with negative emotions or triggers. The client learns to become more resilient and manage their stress appropriately.

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/ Generic	Trintellix/ vortioxetine	Levothyroxine/ eltroxin	Ativan/ Lorazepam	Zoloft/ Sertraline Hydrochloride	Vraylar
Dose	10mg	75mg	1mg	100mg	4.5mg
Frequency	Once Daily	Four times a day	Three times a day PRN	Three tablets a day	Once daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharm: Serotonin modulator Therapeutic: Antidepressant	Pharmacological class: synthetic thyroxine Therapeutic class: Thyroid hormone replacement	Pharmacological class: Benzodiazepine Therapeutic class: Anxiolytic	Pharmacological class: Selective serotonin reuptake inhibitor Therapeutic class: Antianxiety, antidepressant, anti-obsessant	Pharmacological class: atypical antipsychotic Therapeutic class: antipsychotic
Mechanism of Action	Inhibits the reuptake of serotonin and enhancing the serotonergic activity	Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis.	May potentiate the effects of GABA and other inhibitory neurotransmitters by binding to specific Benzodiazepine receptors	Inhibit reuptake of the neurotransmitter serotonin by CNS neurons. This allows an increased level of	May produce antipsychotic effects through partial agonist and antagonist actions. Acts as a agonist to dopamine

			in cortical and limbic areas of CNS. Inhibiting GABA helps control emotional behaviors.	serotonin and results in an elevated mood and reduce depression.	and serotonin receptors. Acts as an antagonist at 5-HT24serotonin receptors.
Therapeutic Uses	To manage depression	Treats hypothyroidism	To treat anxiety	To treat obsessive-compulsive disorder	To treat manic or mixed episodes associated with bipolar 1 disorder.
Therapeutic Range (if applicable)	N/A	TSH level between 0.5 to 2.5 mU/L	N/A	N/A	N/A
Reason Client Taking	To treat depression	To treat hypothyroidism	To treat anxiety	To treat obsessive compulsive disorder	To treat manic and mixed episodes associated to bipolar 1 disorder.
Contraindications (2)	Hypersensitivity to vortioxetine or its components and use within 14 days of a MAO inhibitor	Hypersensitivity to levothyroxine or its components and uncorrected adrenal insufficiency	Hypersensitivity of lorazepam and acute angle closure glaucoma	Concurrent use of disulfiram or pimozide, use within 14 days of MAO inhibitors	Hypersensitivity to cariprazine and its components.
Side Effects/ Adverse Reactions (2)	Serotonin syndrome and Suicidal ideation	Anxiety and seizures	Suicidal ideation and delusions	Serotonin syndrome and suicidal ideation	Suicidal ideation and seizures
Medication/ Food Interactions	Aspirin, NSAIDS, warfarin, other anticoagulants, buspirone,	Dietary fiber, walnuts, 5-fluorouracil, clofibrate, estrogen	Aminophylline, theophylline, clozapine, CNS	Aspirin, clopidogrel, heparin, NSAIDs, warfarin,	CYP3A4 inducers such as carbamazepine,

	MAO inhibitor, SNRIs, SSRIs, tramadol, triptans, tryptophan	containing oral contraceptives, heroin, methadone, mitotane, tamoxifen, proton pump inhibitor	depressants, fentanyl, probenecid, valproate, opiods	desipramine, buspirone, fentanyl, lithium, MAO inhibitor, triptan, SNRIs	rifampin (decrease drugs effect). CYP3A4 strong inhibitors such as itraconazole and ketoconazole.
Nursing Considerations (2)	-Watch for mania, which may result from use of an antidepressant in a susceptible patient. -Be aware that MAO inhibitors 14 days must elapse before administering Trintellix	-Should not be used to obesity or for weight loss -Administer levothyroxine 30 to 60 minutes before breakfast.	-before administering to a patient with depression ensure they are taking an antidepressant -Instruct patient to take lorazepam exactly as prescribed and to not stop taking the drug due to risk of withdrawal	-Watch closely for suicidal tendencies, especially when therapy starts and dosage changes -Monitor patient closely for evidence of serotonin syndrome, such as agitation, coma, diarrhea, hallucinations, nausea, tachycardia, and vomiting.	-Should not be given to clients with severe hepatic or renal impairment. -Monitor clients for difficulty swallowing or excessive somnolence, which can cause aspiration

Brand/Generic	N/A	N/A	N/A	N/A	N/A

Dose	N/A	N/A	N/A	N/A	N/A
Frequency	N/A	N/A	N/A	N/A	N/A
Route	N/A	N/A	N/A	N/A	N/A
Classification	N/A	N/A	N/A	N/A	N/A
Mechanism of Action	N/A	N/A	N/A	N/A	N/A
Therapeutic Uses	N/A	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	N/A	N/A	N/A	N/A	N/A
Contraindications (2)	N/A	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	N/A	N/A	N/A	N/A	N/A
Medication/Food Interactions	N/A	N/A	N/A	N/A	N/A
Nursing Considerations (2)	N/A	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	**The client is a 34-year-old female. The client was calm, engaged, and attentive. She was well groomed and dressed appropriately with no acute distress. She appeared sad and energy was down. Her speech was clear and proper. The client participated in the interview willingly and appreciatively.**

MAIN THOUGHT CONTENT: **Ideations: None** **Delusions: None** **Illusions: None** **Obsessions: Yes** **Compulsions: Yes** **Phobias: None**	**The client did not have any suicidal ideation, delusions, illusion, or hallucinations. The client expressed she was experiencing anxiety from her compulsion to clean, but was able to remain calm and pleasant. The client does not have any phobias that she is aware.**
ORIENTATION: **Sensorium: Conscious** **Thought Content: Realistic**	**The client is alert and oriented to person, place, time, and situation. The spoke intelligently and calmly with a clear voice. The client appeared calm and not in acute distress.**
MEMORY: **Remote:**	**The client's memory is intact, but cannot recall past events from childhood due to ECT adverse effects.**
REASONING: **Judgment: WDL** **Calculations: WDL** **Intelligence: WDL** **Abstraction: WDL** **Impulse Control: WDL**	**The client is able to reason with their mental health issues and understand the reasoning for their admission to the Pavilion. The client states she wants help in treating her mental health issues and is ready to take the steps to get better. The client has goals to manage her mental health issues.**
INSIGHT: Good	**The client understands and accepts her current diagnosis, but feels her medication is not working. The client understands that she needs help in understanding mental health issues. She is also ready to work with health professionals to establish an appropriate plan of care. The client has shown improvement since arriving at the Pavilion.**
GAIT: **Assistive Devices: None** **Posture: WDL** **Muscle Tone: WDL** **Strength: WDL** **Motor Movements: WDL**	**The client has an even and steady gait. She does not use any assistive devices. Posture and muscle tone are within defined limits. The client's strength is strong and equal bilaterally. The client has no motor movement deficiencies.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

Admission	72	104/70	16	97.8° F Temporal	100% on room air
1600	78	110/72	18	98.0° F Temporal	100% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
Admission	**0**	**N/A**	**N/A**	**N/A**	**N/A**
1630	**0**	**N/A**	**N/A**	**N/A**	**N/A**

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast: 50%** **Lunch: 50%** **Dinner: N/A**	**Oral Fluid Intake with Meals (in mL)** **Breakfast: 200mL (water)** **Lunch: 250mL (water)** **Dinner: N/A** **=450mL**

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

The client is going to be discharged to her parent's home with her natural parents. The client is to follow-up and continue psychiatric therapy with their therapist from before current admission. The client does not require any home health care or equipment. The

client and family will be educated on all medications and the importance of adhering to the provider's prescription orders and potential adverse effects. The client and their family will also be educated on potential triggers of the clients OCD and bipolar disorder and strategies to manage stress.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	Rational • Explain why the nursing diagnosis was chosen	Immediate Interventions (At admission)	Intermediate Interventions (During hospitalization)	Community Interventions (Prior to discharge)
1. Risk for ineffective coping related to impulsive use of extreme solutions as evidence by overdose of Ativan in suicide attempt	The client attempted suicide and expressed feelings of depression. The client is not coping with their emotions appropriately.	1.Provide a safe environment for the client that is free of any potentially harmful obejects. 2. Assess the client's potential for suicide. 3. Observe the client closely after receiving antidepression medication.	1.Talk with the client about coping strategies used in the past that are helpful and those that are not (Videbeck, 2020). 2. Encourage the client to vent their feelings and emotions and remain with client listening and accepting the feelings (Videbeck, 2020). 3. Approach the client with a moderate tone of voice and to not be overly cheery (Videbeck, 2020).	1. Provide the client and family with the suicide hotline number. 2. Set a follow-up appointment with the client's psychiatrist. 3. Encourage the client to attend group therapy
2. Risk for	The client	1. Identify the	1. Use silence,	1. Encourage

hopelessness related to a stressful event as evidence by dropping out of school	experienced severe depression after dropping out of LPN school which led to her suicide attempt. Hopelessness must be addressed to help the client manage their emotions.	client's mental status and if they are having any suicidal ideations 2. Ask the client if they are having thoughts of killing themselves or hearing voices. 3. Reorient the client to reality (Videbeck, 2020).	active listening and let the client know you are concerned for their about them (Videbeck, 2020). 2.Allow the client to cry, providing privacy if wanted (Videbeck, 2020). 3. Teach the client problem solving techniques to help manage stress and avoid feelings of hopelessness (Videbeck, 2020).	the client to pursue dialectical behavior therapy to manage negative emotions. 2. Encourage the client to confide a trusted family member or health care professional with feeling and emotions that overwhelming. 3. Educate the client on the medications prescribed and any adverse effects may occur.
3. Self-care deficit related to anergia as evidence by depression and expression of no motivation.	The expressed they had no energy to do any social activities or activities of daily living. The client lives alone and needs to be able to take care of herself.	1. Encourage the client to attend group therapy 2. Lay out the client clothes for them to change into for the day. 3. Identify the client's mental status and thoughts of suicide.	1. Provide activities that require minimal concentration. 2. Offer the client snacks to ensure adequate nutrition (Videbeck, 2020). 3. Show the client how to perform activities that they may have difficulty accomplishing (Videbeck, 2020).	1. Educate the family and client to monitor for impulsive behavior. 2. Encourage the client make a routine to follow each day, such as making their bed. 3. Encourage the client to attend their

				follow-up appointment with their psychiatrist and voice any concerns or questions they may have.

Other References (APA):

Videbeck, S.L. (2020). *Psychiatric mental health nursing* (8th ed.). Wolter Kluwer Health Lippincott Williams & Wilkins.

Concept Map (20 Points):

Subjective Data

Chief complaint: The client has been dealing wi bipolar disorder and experiences severe depression and anxiety from her obsessive-compulsive disorder.
Anxiety: 5/10 Depression: 6/10
The client appeared depressed and down, but no acute distress. The client lives alone in a apartment. She overdosed on Ativan in a suicide attempt.

Nursing Diagnosis/Outcomes

Risk for ineffective coping related to impulsive use of extreme solutions as evidence by overdose of Ativan in suicide attempt
Client will adhere to prescription order directions and attend therapy sessions.
Risk for hopelessness related to a stressful event as evidence by dropping out of school
Client will learn appropriate strategies to manage negative emotions.
Self-care deficit related to anergia as evidence by depression and expression of no motivation.
Client will be able to perform all activities of daily living without assistance.

Nursing Interventions

Provide a safe environment for the client that is free of any potentially harmful object
Assess the client's potential for suicide.

Observe the client closely after receiving antidepression medication.
Reorient the client to reality
Encourage the client make a routine to follow each day, such as making their bed.
Encourage the client to pursue dialectical behavior therapy to manage negative emotions.
Teach the client problem solving techniques to help manage stress and avoid feelings of hopelessness
Use silence, active listening and let the client know you are concerned for their about them

Objective Data

Recent vital signs: Pulse:78 B/P: 110/72 Respiration: 18 Temperature: 98.0 F Oxygen saturation: 100% room air. Client expressed 0/10 pain. Client medications: Trintellix, Levothyroxine, Ativan, Zoloft, Vraylar.

Patient Information

Client is a 34 year old female. She was admitted 3/29/22 for a suicide attempt by overdosing on Ativan. She was depressed after dropping out of LPN school. Client has a medical history of hypothyroidism, bipolar 1, OCD, and anorexia.