15 Nov 2010 1528
Facility: NNMC Bethesda, MD Clinic: SOCIAL WORK MG Provider: PIACQUADIO,MICHELLE A

Disposition Written by PIACQUADIO,MICHELLE A @ 02 Dec 2010 1521 EST
Released w/o Limitations
Follow up: in the SOCIAL WORK MG clinic. - Comments: -Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent or critical duty limitations): NA

Signed By PIACQUADIO, MICHELLE A (Physician/Workstation) @ 02 Dec 2010 1521

Name/SSN: KLAY, ARIANA BEVIN/532948850

		Sex:	**F**	Sponsor/SSN:	KLAY, ARIANA BEVIN/532948850
FMP/SSN:	**20/532948850**	Tel H:	703-389-4046	Rank:	FIRST LIEUTENANT
DOB:	**07 Jan 1981**	Tel W:	410-293-1249	Unit:	54008011
PCat:	M11 USMC ACTIVE DUTY	CS:		Outpt Rec. Rm:	BH OUTPT RECORDS ROOM
MC Status:	TRICARE PRIME (ACTIVE DUTY)	Status:		PCM:	VEGA,JAIME
Insurance:	No			Tel. PCM:	3012954771;3012954771

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

Version LDB: 14 Apr 09

DATE: 28 Oct 2010; **DURATION**: 75 min; **Service Provided:** Individual Therapy/90808
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt was scheduled for a full intake evaluation by undersigned clinician today, however due to pt's distress level and need to share about acute concerns, a full evaluation will be completed at pt's next scheduled session.
Chief complaint/Brief Summary: Pt describes severe sexual harassment at duty station that resulted in unresolved emotional pain, anxiety and depression. She also used alcohol to cope. She feared reporting the sexual harassment due to embarrassment, but "when lies were spread about her, she was unable to cope and slapped a Marine who was berating her in public regarding these lies". This resulted in non judicial punishment by her superior and an investigation was ordered by him when pt shared the sexual harassment. Pt reports problems with sleep, loss of sex drive, racing thoughts, low concentration, no enjoyment, headaches and heart pounding at times. Pt comes to therapy to resolve these issues and also to address any unresolved issues from childhood regarding sexual abuse. She continues in AA to address alcohol dependence. She also has a diagnosis of Bulimia Nervosa per hx with denial of binge-purge cycle since college many years ago, however continues to struggle with poor body image.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****
PAIN: Hx of knee and back pain
SESSION SUMMARY:

OBJECTIVE: Mental Status Exam:
ORIENTATION: Alert and Oriented x 4.
BEHAVIOR/RELATEDNESS: Pt was cooperative, attentive, and hygiene WNL. Pt was quite open about abovementioned issues and the emotional distress she has been experiencing for the harassment;
MOOD: Sad, distraught, tearful, anxious;
THOUGHT CONTENT: WNL, No Psychotic SxS;
THOUGHT PROCESS: Coherent; Logical and linear;
EYE CONTACT: WNL;
SPEECH: WNL;
JUDGMENT: WNL;
IMPULSE CONTROL: WNL;
INSIGHT: WNL;
PSYCHOMOTOR: WNL;
SLEEP: "Always has trouble falling or staying asleep";
INTERESTS: "Sometimes lacks interest";
ENERGY: Denied problems;
CONCENTRATION: Decreased;
APPETITE: No problems reported;
LIBIDO: Decreased;
SI: Denied SI;
HI: Denied HI; **RISK LEVEL (SI/HI): No hx,** Minimal

ASSESSMENT:

Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx
R/O PTSD

Axis II – Deferred – 799.9

Axis III – See AHLTA

PLAN: Pt to return to MHC for full intake evaluation on 15 Nov 2010 and to start to develop tx goals.
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

PROFILE/ LIMITATIONS:
Released without limitations

DETAILS TX PLAN: *Identify and express unresolved feelings and thoughts re: sexual assault and sexual abuse hx*
Referrals: None

P: PREVENTION / EDUCATION: Pt encouraged to make healthy lifestyle choices such as: healthy thinking, regular sleep/rest, nutrition, exercise, socializing, family time, couple time, recreations, stress mgt to help prevent exacerbation of symptoms. Pt indicated understanding of above.

EDUCATION MATERIALS: None given

M. Piacquadio LCSW

Michelle A. Piacquadio, A.C.S.W., L.C.S.W.
Mental Health Flight, MGMC
Andrews AFB

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
MGMC	**AD**	**USAF**	
SPONSOR'S NAME	UNIT	RELATIONSHIP TO SPONSOR	

PATIENTS IDENTIFICATION:	WORK PHONE	HOME PHONE
LAST_NAME, First, Klay, Arian **SS#: 532-94-8850** **DOB: 7 Jan 1981** **Seen On: 28 Oct 2010**		

Patient: **KLAY, ARIANA BEVIN**
Treatment Facility: **779TH MEDICAL GROUP**
Patient Status: **Outpatient**

Date: **28 Oct 2010 0830 EST**
Clinic: **PSYCHIATRY MG**

Appt Type: **ROUT**
Provider: **THODE,KIRSTIN T**

Reason for Appointment: Med MH REF from IAS
Appointment Comments:
alb

LMP: 15 Jun 2010. Date Basis: unknown.

Vitals
Vitals Written by CHAVEZ,OSCAR R @ 28 Oct 2010 0848 EDT
BP: 132/84, HR: 54, HT: 69 in, WT: 160 lbs, BMI: 23.63, BSA: 1.879 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by THODE,KIRSTIN T @ 29 Oct 2010 1809 EST
Chief complaint
The Chief Complaint is: Anxiety.
Reason for Visit
Visit for: Patient presents to MGMC as an NPE on referral by intensive outpatient addictions program. AHLTA/CHCS & addictions chart reviewed. She was discharged from the addictions program on 20 Oct 10 & was started on fluoxetine & hydroxyzine during the program. Lt Klay is scheduled to see Ms. Pia for an individual therapy intake appt immediately following appt with this provider.
History of present illness
The Patient is a 29 year old female.

This morning, patient discusses the events leading up to her involvement in the addictions program at MGMC. Reviewed current & recent symptoms. Please see MH chart & attached note for full details.
Allergies
No allergies.
Past medical/surgical history
Current Meds: Pt report and CHCS reconciled as follows:
1. Fluoxetine 10mg PO qHS
2. Hydroxyzine 25mg PO qHS.
3. Pre-natal vitamins.
Reported History:
Medical: Patient denies active medical problems. She reports mild intermittent back & knee pains that are exacerbated by exercise. Lt Klay denies current pain. She denies currently taking medications for medical problems. Patient may be re-starting birth control pills in the near future but has not yet made an appt with PCM or GYN. She denies Hx of head injuries, LOCs, or seizures.
Psychiatric history - Patient reports seeing a counselor in High School 2/2 bulimia.
Surgical / procedural: Surgical / procedural history 1. Repair of broken L foot (2000).
2. PRK.
Personal history
Please see MH chart & attached for full details.
Family history
Patient reports that father has been treated for skin cancer & testicular cancer. She denies family Hx of diabetes, thyroid disorders, strokes or MIs before the age of 50yrs
Substance abuse - Patient denies
Mental illness (not retardation) - Patient denies Hx of mood, anxiety or psychotic disorders. She also denies family Hx of suicide attempts.
Physical findings
Psychiatric Exam:
Performance Of A Mental Status Exam: • A mental status exam was performed - Well-groomed adult, appearing stated age, wearing casual civilian clothes, no apparent distress, carefully applied eye makeup. Appropriate behavior and cooperative. Mildly increased psychomotor activity. The patient's speech was fluent and non-pressured. Good eye contact. Mood anxious with congruent affect of mildly restricted range & intensity, non-labile. (+) appropriate tearfulness. Fully alert and oriented. Average to above average intelligence based on vocabulary. Thoughts are clear, logical, and goal-directed without loosening of associations or flight of ideas. No auditory or visual hallucinations or delusions. The patient denies any suicidal or homicidal ideation. Good insight and judgment as patient recognizes that there is a problem and is seeking help + abstinent from EtOH & complying with treatment plan.
Tests

OQ-45: Total score = 88, indicates moderate level of distress; question 8 = NEVER; question 32 = SOMETIMES; & question 44 = RARELY.

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0849 EST

CBC W/o Diff	**Site/Specimen**	**13 Sep 2010 1354**
WBC	BLOOD	7.7
RBC	BLOOD	4.59
Hemoglobin	BLOOD	13.5
Hematocrit	BLOOD	39.0
MCV	BLOOD	85.0
MCH	BLOOD	29.4
MCHC	BLOOD	34.5
Platelets	BLOOD	318 <i>
RDW CV	BLOOD	12.8
MPV	BLOOD	**7.1 (L)**

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Alanine Aminotransferase	**Site/Specimen**	**13 Sep 2010 1354**
Alanine Aminotransferase	SERUM	44

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Aspartate Aminotransferase	**Site/Specimen**	**13 Sep 2010 1354**
Aspartate Aminotransferase	SERUM	26

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Gamma Glutamyl Transferase	**Site/Specimen**	**13 Sep 2010 1354**
Gamma-Glutamyl Transferase	SERUM	27

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Urinalysis	**Site/Specimen**	**04 Oct 2010 1414**
Color	URINE	YELLOW
Ketones	URINE	NEGATIVE
Blood	URINE	NEGATIVE
Nitrite	URINE	NEGATIVE
pH	URINE	6.0
Protein	URINE	NEGATIVE
Appearance	URINE	CLEAR
Leukocyte Esterase	URINE	NEGATIVE
Specific Gravity	URINE	1.016
Urobilinogen	URINE	0.2
Glucose	URINE	NEGATIVE
Bilirubin	URINE	NEGATIVE

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Magnesium	**Site/Specimen**	**19 Oct 2010 0754**
Magnesium	SERUM	**1.5 (L)**

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Drug Abuse Screen	**Site/Specimen**	**19 Oct 2010 0754**
Amphetamines	URINE	NEGATIVE <i>
Barbiturates	URINE	NEGATIVE <i>
Benzodiazepines	URINE	NEGATIVE <i>
Cocaine	URINE	NEGATIVE <i>
Opiates	URINE	NEGATIVE <i>
Phencyclidine	URINE	NEGATIVE <i>
Cannabinoids	URINE	NEGATIVE <i>

Lab Result Cited by THODE,KIRSTIN @ 28 Oct 2010 0848 EST

Ethyl Glucuronide/Sulfate	**Site/Specimen**	**19 Oct 2010 0754**
Ethyl Glucuronide	URINE	<100
Ethyl Sulfate	URINE	<50 <i>

A/P Last Updated by THODE,KIRSTIN @ 29 Oct 2010 1756 EST

1. ANXIETY DISORDER NOS: IMPRESSION: 29y/o Caucasian F AD USMC O2 without significant genetic loading for illness or substance use disorders + personal Hx of sexual abuse, bulimia, & alcohol dependence who presents for medication management of anxiety & depressive symptoms following completion of intensive outpatient substance abuse treatment program at MGMC. Patient's current chief complaints are excessive anxiety with physical symptoms & sleep disturbance 2/2 ruminations. Duration of current symptoms is 5 months & exacerbating factors include heavy EtOH use, occupational stress (harassment investigation & transfer of duty) & sexual assault. She endorses abstinence from EtOH since beginning addictions program. Current MSE with evidence of anxiety. Labs & physical symptoms do not suggest treatable medical causes of current symptoms. Working diagnosis is Anxiety Disorder NOS along with well-established Acohol Dependence & Bulimia by Hx. Differential diagnosis includes PTSD, Generalized Anxiety Disorder, Adjustment Disorder, & Substance-Induced Anxiety Disorder. No current indication of malingering or drug-seeking behaviors. No current or historical evidence of mania or psychosis. As per risk assessment below, patient does not currently represent an imminent threat to self or others.

AXIS I - Anxiety Disorder NOS; Alcohol Dependence in Early Full Remission; Bulimia by Hx
AXIS II - No current diagnosis
AXIS III - Low Mg level by labs
AXIS IV - Occupational stressors
AXIS V - Current GAF = 60

PLAN:
1. Medication - Increase fluoxetine to 20mg g PO daily (dispensed #30 RF0) for anxiety & depressive symptoms. Continue hydroxyzine 25-50mg PO qHS PRN insomnia (dispensed 25mg #60 RF0). Sleep medication intended to improve patient's sleep while during fluoxetine titration. Patient may benefit from the use of prazosin in future with further diagnostic clarification (i.e. PTSD). Discussed risks, benefits, & side effects of medications as well as possibility of no treatment. Patient verbalizes understanding & agrees with plan. She is advised to refrain from alcohol while taking any psychotropic medication.
2. Therapy - Supportive with this provider. Patient scheduled to begin individual therapy with Ms. Pia in this clinic. Discussed bibliotherapy with patient & recommended Caroline Knapp's "Appetites" & "Drinking: A Love Story."
3. Labs/referral - None indicated at this time. Defer management of brith control & low Mg level to PCM/GYN.
4. Prevention - Patient encouraged to abstain from EtOH & illicit drugs, continue cutting back on cigarette smoking, & utilize healthy diet & routine cardiovascular exercise. She plans to continue 3 times weekly AA meetings + contact with sponsor.
5. Safety - No current indication to add patient to the High Risk/Interest Log. No current indication for inpatient psychiatric hospitalization. Safety plan reviewed. Patient instructed & agrees to report to or call the mental health clinic (240-857-7186) during duty hours or call ER at 240-857-2333 or 911 after hours for thoughts of harming self or others.
6. Disposition - Patient released without additional duty or mobility limitations. Will check PIMR system for a profile & add S4T with code 31 & add one PRN. Patient to return to clinic to see this provider in 4 weeks or sooner if needed. Anticipate completion of PCL-M & vital signs at f/u. She will to see Ms. Pia for individual therapy.

This provider met with patient for 80 minutes & >50% of appointment time spent counseling &/or coordinating care.
Procedure(s): -Psychiat Therapy Indiv Appr 75-80 Min W/ Med Eval Managemt x 1
Medication(s): -FLUOXETINE--PO 20MG CAP - T1 CAP PO DAILY #30 RF0 Qt: 30 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T
-HYDROXYZINE HCL--PO 25MG TAB - TAKE 1-2 TABS AS NEEDED BEFORE BEDTIME FOR SLEEP #60 RF0 Qt: 60 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T

2. ALCOHOL DEPENDENCE IN REMISSION
3. BULIMIA NERVOSA

Disposition Last Updated by THODE,KIRSTIN @ 29 Oct 2010 1808 EST
Released w/o Limitations
Follow up: 4 week(s) in the PSYCHIATRY MG clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by THODE,KIRSTIN @ 28 Oct 2010 1038 EST
Additional A/P Information:
Discontinued FLUOXETINE--PO 10MG CAP - T1 CAP PO QD UD #30 RFO RF0

Note Written by THODE,KIRSTIN @ 28 Oct 2010 1115 EST
Suicide / Violence Risk Assessment
Risk Factors: Axis I diagnosis, anxiety, Hx of abuse, Hx of substance dependence, occupational stressors, young, Caucasian.

Protective Factors: No personal or family Hx of suicide attempts, no past psychiatric hospitalizations, no current suicidal ideation/intent/plan, no psychosis, employed, engaged in treatment, future-oriented, female, strong support from husband, spirituality.

28 Oct 2010 0809
Facility: NNMC Bethesda, MD Clinic: PSYCHIATRY MG Provider: THODE,KIRSTIN T

Category: Acute.

Risk Level: Mildly elevated above baseline due to psychosocial stressors & early remission of EtOH dependence.

Signed By THODE, KIRSTIN T (Physician, 59th Medical Wing Lackland AFB, TX 78236) @ 29 Oct 2010 1829

Note Written by THODE,KIRSTIN @ 03 Nov 2010 1118 EST
(Added after encounter was signed.)
History of present illness
This morning, patient reports compliance with daily fluoxetine for 2 weeks & denies subjective benefit & side effects. She endorses "constant anxiety" during the day, difficulty sleeping 2/2 ruminations, tearfulness, nervous & fearful about her future, stimulus-bound anxiety attacks (tremulousness, diaphoresis, mind going blank, headaches), flashbacks to sexual assault, nightmares about sexual assault & with recurring themes of slander/judgment/nudity, & sense of foreshortened future. Lt Klay also describes a "lifetime of body issues" as well as sex/intimacy issues. She denies disordered eating habits since college & endorses being bulimic beginning in high school with ongoing shame about her body. Patient also reports chronically being an anxious person. She currently denies sense of hopelessness, low energy, anhedonia, difficulty concentrating, SI, HI, AVH, & manic symptoms. Lt Klay denies current occupational impairment associated with anxiety symptoms & states that she is doing well when she can stay busy at work. She reports that discontinuing EtOH use was very positive for her life & reports participating in 2 AA meetings weekly with a sponsor. Patient states that her husband is very supportive. Discussed stressful life events leading up to her participation in MGMC intensive outpatient addictions program. See notes from Addictions for details of treatment course. Prior to Addictions, Lt Klay endorses seeing a battalion psychiatrist in the NCR x1 in early Sept 10. She denies prior use of psychotropic medications, suicide attempts, self-injurious behavior, & psychiatric hospitalizations. Patient reports brief episode of active SI with plan prior to attending addictions program & denies SI since that time.

Personal history
Early Family Life: Patient born & raised in Seattle, WA. Intact union with siblings. She describes being molested by a teacher from 3rd to 5th grade on several occasions. Lt Klay denies further Hx of emotional/physical/sexual abuse in childhood. One sexual assault during the preceding year while patient intoxicated. She describes a very religious upbringing & prominent guilt about losing virginity in college.

Education: Patient reports being withdrawn & having few friends in Jr & Sr High. She played soccer & was valedictorian & a National Merit Scholarship recipient. No behavioral/disciplinary problems. Lt Klay initially started college on a soccer scholarship to UC Irvine, majoring in Civil Engineering. She transferred to the Naval Academy in 2001-2 academic year & obtained a bachelor's degree in History. Patient reports that engineering was boring to her.

Military: Patient currently works as an assistant operations officer at Henderson Hall. She has no special duty status. Lt Klay was previously stationed at Camp Pendleton, CA for 2 years & has one deployment to Ramadi in 2008. As a result of an assault charge (described as slapping an enlisted Marine after he verbally provoked her while she was intoxicated), patient was NJP'd & not promoted in Aug 2010. She states that this event destroyed her career & denies further administrative actions against her. Lt Klay expresses preference to get out of the USMC & having a "jaded view" of leadership as a result of her experiences during the preceding year.

Marital / Family / Living Situation: Patient currently in first marriage. Met husband in Marines & married Jul 2009. He is no longer AD & works in the White House budget office. Lt Klay denies current or historical domestic violence. She reports some marital strain 2/2 intimacy & body image issues. No current sexual activity. No children. (+) dogs.

Substance Use: Patient reports abstinence from EtOH since intake at addictions program. She describes beginning EtOH use in college after stopping disordered eating habits. Lt Klay endorses heavy drinking in Marines due to the drinking culture. She reports decreasing EtOH use when she met her husband & increasing after administrative actions against her in Aug 10 as above. Patient describes binge-drinking 2-3x per week, skipping work-outs 2/2 EtOH use, EtOH-related depressed mood, cravings, needing eye openers, & withdrawal symptoms. She also reports having passive SI while intoxicated. No Hx of inpatient rehab or outpatient substance abuse treatment prior to MGMC addictions program. Lt Klay denies EtOH-related incidents or legal problems related to EtOH use prior to Aug 10. Please see addiction chart for further details of EtOH Hx. Patient denies current or historical use of tobacco products or illicit drugs & denies mis-use of prescription drugs. About 3 caffeinated beverages daily.

Legal / Financial: Legal actions in USMC as above. Patient denies current financial stressors.

Nutrition / Fitness: Patient reports return to regular exercise & well-balanced eating since abstaining from EtOH.

Spirituality: She reports getting back to her religion (Christian) since quitting EtOH use.