AHLTA

Release of Information

P//F: (240) 857 - 5614 // (240) 857 - 8631

For Staff Use Only
NRIF: ✓ Rec Room:
Vol: Vol # Copied
Request for: Labs: Rads:

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

ROI

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
Klay, Ariana B	20110218	532948850 ⇐Sponsors

4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)
2010Sept10 - Present	[X] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE Malcolm Grow Medical Center, 779th Med Group (Release of Info) TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN (only if information is being requested or forward to your physician)	b. ADDRESS (Street, City, State and ZIP Code)
	729 10th St. SE. Washington, D.C. 20003
c. TELEPHONE (Include Area Code) 7033894046	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)
[X] PERSONAL USE [ ] CONTINUED MEDICAL CARE [ ] SCHOOL [ ] OTHER (Specify)
[ ] INSURANCE [ ] RETIREMENT/SEPARATION [ ] LEGAL

8. INFORMATION TO BE RELEASED
(List all dependents under 18 with birth date)
Medical + Mental Health (ADAPT)

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION DATE (YYYYMMDD) [ ]	[ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)
[signature]	Self	20110218

SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE
Pickup: X Mail: Fax: _____
I give my spouse: _____ permission
to received my medical information signature: _____
Other: _____

Date Record Received: _____
Printed: Labs [ ] Rads [ ] Ahlta [ ]
Date: Copied _____ Initial: _____
Date: Called _____ Initial: _____

Adobe Professional 7.0

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

Date: **28 Feb 2011 0847 EST**
Clinic: **SOCIAL WORK MG**

Appt Type: **ACUT**
Provider: **PIACQUADIO,MICHELLE A**

Reason for Appointment: 30-min phone consultation with LtCol Hudspeth

AutoCites Refreshed by PIACQUADIO,MICHELLE A @ 28 Feb 2011 0849 EST

Problems

Chronic:
- Bulimia nervosa
- Alcohol dependence in remission
- Anxiety disorder NOS
- Major depression, single episode
- Inquiry and counseling
- Patient education
- Patient education about a proper diet
- Insomnia
- Alcoholism
- Visit for: administrative purposes
- Compression arthralgia of the knee / patella / tibia / fibula

Acute:
- Acute pharyngitis streptococcus

Family History
- Family history unchanged (General FHx)
- Family history reviewed (General FHx)
- Family medical history (General FHx)
- Of mental illness (not retardation) (General FHx)
- Of substance abuse (General FHx)

Allergies
- No Known Allergies

Active Medications

Active Medications

	Status	Sig	Refills Left	Last Filled
PRAZOSIN HCL, 2 MG, CAPSULE, ORAL	Active	TAKE ONE CAP PO QHS FOR 4 DAYS, THEN TAKE TWO CAPS PO QHS FOR 4 DAYS, THEN TAKE THREE CAPS PO QHS FOR 4 DAYS, THEN TAKE 4 CAPS PO QHS #100 RF0	NR	18 Feb 2011
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T3 CAP PO DAILY #100 RF0	NR	18 Feb 2011
Menthol 3mg + Cetylpyridinium Chloride, Lozenge, Mouth or throat	Active	DISSOLVE 1 LOZENGE IN MOUTH Q2H PRN FOR SORE THROAT #2 RF0	NR	04 Feb 2011
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

LMP: 15 Jun 2010. Date Basis: unknown.

SO Note Written by PIACQUADIO,MICHELLE A @ 28 Feb 2011 0849 EST

Subjective

Pt signed a release of information for this clinician to talk with LtCol Hudspeth about pt's mental health. LtCol Hudspeth is investigating pt's allegations of sexual harrassment. Clinician spoke with LtCol Hudspeth by phone on 24 and 25 Feb. Pt was informed by this clinician about the phone consultation.

A/P Written by PIACQUADIO,MICHELLE A @ 28 Feb 2011 0933 EST

1. POST-TRAUMATIC STRESS DISORDER

Procedure(s): -Psychiatric Therapy Environmental Intervention x 1

Disposition Written by PIACQUADIO,MICHELLE A @ 28 Feb 2011 0933 EST

Released w/o Limitations

Signed By PIACQUADIO, MICHELLE A (Physician/Workstation) @ 28 Feb 2011 0934

Name/SSN: KLAY, ARIANA BEVIN/532948850

FMP/SSN: **20/532948850**
DOB: **07 Jan 1981**
PCat: M11 USMC ACTIVE DUTY
MC Status: TRICARE PRIME (ACTIVE DUTY)
Insurance: No

Sex: **F**
Tel H: 703-389-4046
Tel W: 410-293-1249
CS:
Status:

Sponsor/SSN: KLAY, ARIANA BEVIN/532948850
Rank: FIRST LIEUTENANT
Unit: 54008011
Outpt Rec. Rm: BH OUTPT RECORDS ROOM
PCM: VEGA,JAIME
Tel. PCM: 3012954771;3012954771

28 Feb 2011 0849

Facility: NNMC Bethesda, MD Clinic: SOCIAL WORK MG Provider: PIACQUADIO,MICHELLE A

Name/SSN: KLAY, ARIANA BEVIN/532948850

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

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS M

Version LDB: 04 Jun 09

DATE: 18 Feb 2011; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
SUBJECTIVE: Pt is a 29-yr-old, married, Caucasian female. She is a Marine, 1LT, stationed at Henderson Hall. Pt was initially referred for individual therapy by Major Morganstein from MGMC Addiction Services. Pt reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt continues to be significantly impacted by symptoms of PTSD (avoidance, reliving and hyper arousal) related to sexual harassment/assault. Anger, sadness, tearfulness, anxiety is easily triggered, particularly as she is facing the investigation of her allegations and some of what she reported cannot be proven. She continues to struggle with falling asleep as she obsesses about the harassment, assault and the investigation.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt reported that her feelings are constantly on the surface and she finds herself sobbing about what is being addressed in the investigation and hearing from the investigator that she can't prove that some things happened. Pt finds herself debating and getting defensive when she thinks that others are supporting or accepting sexual harassment/assault in the military. Discussed with pt not sharing details of the harassment/assault with those (other than necessary) who cannot be supportive or validating as it is another way for her to feel victimized.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: "Tired and anxious";
SLEEP: "Continues to cry prior to falling asleep and has some sleep disruption as she thinks about the sexual harassment/assault. Prazosin helps with sleep.
THOUGHTS: Without Psychoses; preoccupied with intrusive memories and obsessive thoughts;
APPETITE: "Up and down";
ENERGY: "Low";
CONCENTRATION: "Pretty good";
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this; is enjoying her SW classes;
SI: She has thought about whether others would be better off without her because she has caused so much pain (for example, husband), but when questioned, she has no intent or plan;
HI: Denied HI
RISK LEVEL (SI/HI): Minimal/Mild

ASSESSMENT:
Axis I – *PTSD – 309.81*

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

PATIENTS IDENTIFICATION:	WORK PHONE	HOME PHONE
LAST_NAME, First, Klay, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 18 Feb 2011**		

Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx

Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis;
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: internal/external boundaries; address how she wants to tell husband about the sexual assault; decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *sleep hygiene/relaxation techniques*
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: Self help readings

M A Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, 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, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 18 Feb 2011**		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

Version LDB: 04 Jun 09

DATE: 11 Feb 2011; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
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 reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Overall, mood is fairly good, but pt continues with some anxiety, particularly related to sexual harassment/assault issues and investigation of allegations made by her. Pt is working on coping with a range of emotions that are triggered on a daily basis regarding the harassment/assault. She finds herself crying uncontrollably at times.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt reported that she was counseled by commander for an email she sent to Public Relations regarding a Marine that sexually harassed her. Pt reports being highly upset that he was chosen for a commercial to represent the Marine Corps. When she saw the video, she became enraged. "I was too made to comprehend how it could have impacted me". Clinician and pt discussed ways to develop stronger internal boundaries to avoid situations where she could be reprimanded.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Some anxiety; anger and shame;
SLEEP: "Continues to cry prior to falling asleep and has some sleep disruption as she thinks about the sexual harassment/assault. Prazosin helps with sleep.
THOUGHTS: Without Psychoses; preoccupied with intrusive memories and obsessive thoughts;
APPETITE: Appetite decreases with stress;
ENERGY: "Good";
CONCENTRATION: "Too much going on";
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this; is enjoying her SW classes;
SI: She has thought about whether others would be better off without her because she has caused so much pain (for example, husband), but when questioned, she has no intent or plan;
HI: Denied HI
RISK LEVEL (SI/HI): Minimal/Mild

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; R/O Depressive Disorder NOS
Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis;
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: internal/external boundaries; address how she wants to tell husband about the sexual assault; decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *sleep hygiene/relaxation techniques*
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: Self help readings

M. Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

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

Date: **25 Jan 2011 1401 EST**
Clinic: **PSYCHIATRY MG**

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

Reason for Appointment: f/u

AutoCites Refreshed by THODE,KIRSTIN @ 25 Jan 2011 1402 EST

Allergies
• No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T3 CAP PO DAILY #90 RF1	1 of 1	04 Jan 2011
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

Labs
No Labs Found.
Vitals
No Vitals Found.

LMP: 15 Jun 2010. Date Basis: unknown.

Vitals
Vitals Written by THODE,KIRSTIN @ 25 Jan 2011 1614 EST
Pain Scale: 0 Pain Free

SO Note Written by THODE,KIRSTIN T @ 25 Jan 2011 1551 EST
Reason for Visit
Visit for: Patient presents to MGMC MH clinic for medication management of anxiety. AHLTA/CHCS & MH chart reviewed. She was last seen by this provider on 4 Jan 11, at which time fluoxetine increased & prazosin titration initiated. Lt Klay continues to see Ms. Pia for individual therapy. She had planned to meet briefly with this provider briefly today to discuss response to prazosin.
History of present illness
The Patient is a 30 year old female.
She reported: Past medical history reviewed, problem list reviewed, and medication list reviewed.

This afternoon, patient reports running out of prazosin approximately 3 days ago. Prior to running out of meds, she endorses compliance with prazosin 4mg PO qHS & being able to fall asleep easily. Lt Klay did, however, report that dreams have been more vivid since beginning prazosin. She denied other side effects to the prazosin, to include AM dizziness or grogginess. Patient reports compliance with fluoxetine, denies side effects, & describes interval feelings of being less inhibited. She gave examples of more freely sharing personal information & having decreased anxiety about this as compared to 3 months ago. Lt Klay continues to report improvement in depressive symptoms (see prior note for details). She also denies changes to chronic lack of sexual desire. Patient denies coping with the continued stress/symptoms by relapsing on EtOH use or binging/purging behaviors & continues to participate in AA meetings weekly with a sponsor. She denies current impairing depressive symptoms, to include SI; HI; AVH; manic symptoms; & psychotic symptoms.
Briefly reviewed her educational goals after getting out of the USMC. Discussed current legal hold & updates to case. Patient states that lawyers may seek access to mental health records. Discussed ROI procedures & need for specific questions from lawyers.
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. Appropriate behavior and cooperative. Psychomotor activity neither increased nor decreased. The patient's speech was fluent and non-pressured. Good eye contact. Mood largely euthymic with some appropriate expressions of anxiety. Affect congruent, full range & intensity, non-labile. Fully alert and oriented. 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.

A/P Written by THODE,KIRSTIN @ 25 Jan 2011 1614 EST

1. ANXIETY DISORDER NOS: IMPRESSION: 30y/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 reports improvement in anxiety & depressive symptoms in the context of fluoxetine titration, individual therapy, continued abstinence from EtOH & decreased occupational stressors. Patient's sleep somewhat improved with initiation of prazosin except for more vivid dreams. Prazosin well-tolerated, but patient noncompliant x3 days 2/2 running out of meds. Fluoxetine well-tolerated without impairing side effects. Current MSE with minimal evidence of anxiety. 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, treatable medical causes of current symptoms, 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 = 70

PLAN:
1. Medication - Re-initiate prazosin titration to 6mg PO qHS (dispensed 2mg #60 RF 0) off-label use for anxiety-related sleep disturbance. Continue fluoxetine to 60mg PO qAM (none dispensed at this time, sufficient supply remaining) for anxiety symptoms. 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 to continue individual therapy with Ms. Pia in this clinic.
3. Labs/referral - None indicated at this time. Defer management of brith control & low Mg level to PCM/GYN. Consider repeat electrolyte levels + Mg given Hx of binging-purging.
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 weekly AA meetings + contact with sponsor.
5. Safety - No current indication to add patient to the MH flight High Risk/Interest Log or 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. Patient to touch base with this provider in person or over the phone after legal submits ROI request to review questions & provider's anticipated response. Anticipate next formal, scheduled appt with this provider in 2 weeks with VS & PCL-M. She will to see Ms. Pia for individual therapy as previously scheduled.

This provider met with patient for 15 minutes & >50% of appointment time spent counseling &/or coordinating care.
Procedure(s): -Psychoactive Medication Management x 1
Medication(s): -PRAZOSIN--PO 2MG CAP - TAKE ONE CAP PO QHS FOR 4 DAYS, THEN TAKE TWO CAPS PO QHS FOR 4 DAYS, THEN TAKE THREE CAPS PO QHS #6 Qt: 60 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T

2. ALCOHOL DEPENDENCE IN REMISSION: 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, symptoms have improved.

Category: Baseline

Risk Level: Not elevated.

3. BULIMIA NERVOSA

Disposition Written by THODE,KIRSTIN @ 25 Jan 2011 1614 EST
Released w/o Limitations
Follow up: 2 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.

Signed By THODE, KIRSTIN (Physician, 79th MEDICAL WING, ANDREWS AFB, MD 20762) @ 25 Jan 2011 1614

THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 (PL-93-579). UNAUTHORIZED ACCESS TO THIS INFORMATION IS A VIOLATION OF FEDERAL LAW. VIOLATORS WILL BE PROSECUTED.

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

25 Jan 2011 1402

Facility: NNMC Bethesda, MD Clinic: PSYCHIATRY MG Provider: THODE,KIRSTIN T

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

Date: **18 Feb 2011 1300 EST**
Clinic: **PSYCHIATRY MG**

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

Reason for Appointment: F/UP
Appointment Comments:
CMM

AutoCites Refreshed by THODE,KIRSTIN @ 18 Feb 2011 1303 EST

Allergies
- No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
Menthol 3mg + Cetylpyridinium Chloride, Lozenge, Mouth or throat	Active	DISSOLVE 1 LOZENGE IN MOUTH Q2H PRN FOR SORE THROAT #2 RF0	NR	04 Feb 2011
PRAZOSIN HCL, 2 MG, CAPSULE, ORAL	Active	TAKE ONE CAP PO QHS FOR 4 DAYS, THEN TAKE TWO CAPS PO QHS FOR 4 DAYS, THEN TAKE THREE CAPS PO QHS #60 RF0	NR	25 Jan 2011
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T3 CAP PO DAILY #90 RF1	0 of 1	25 Jan 2011
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

Labs

Test Name	Site Specimen	Result	Units	Ref Range
04 Feb 2011 1430				
Streptococcus Group A Ag Rapid	**Site Specimen**	**Result**	**Units**	**Ref Range**
Streptococcus pyogenes Culture	PHARYNX	negative for group a beta streptococcus <i>		(NEG)

Microbiology Results
Throat Culture

Order #	110204-23612 (NNMC Bethesda)
Filler #	110204 WBA 12210 (NNMC Bethesda)
Status:	Final
Ordering Provider:	MAZER, KENNETH ROY
Priority:	ROUTINE
Date Ordered:	0
Date Resulted:	09 Feb 2011 1044
COLLECT_SAMPLE:	THROAT
BACTERIOLOGY RESULT:	
BACTERIOLOGY RESULT:	02.08.11
BACTERIOLOGY RESULT:	REINCUBATED FOR FURTHER EVALUATION
BACTERIOLOGY RESULT:	02.09.11 NO BETA HEMOLYTIC STREPTOCOCCI ISOLATED
Specimen:	Pharynx
Collected:	04 Feb 2011 1430
Results:	
	Final report

Vitals
No Vitals Found.

LMP: 15 Jun 2010. Date Basis: unknown.

Vitals
Vitals Written by POBLANO,JACQUELINE @ 18 Feb 2011 1311 EST
BP: 131/79, HR: 68, HT: 5' 9", WT: 164 lbs, BMI: 24.22, BSA: 1.899 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

SO Note Written by THODE,KIRSTIN T @ 18 Feb 2011 1638 EST
Reason for Visit
Visit for: Patient presents to MGMC MH clinic for medication management of anxiety. AHLTA/CHCS & MH chart reviewed. She was last seen by this provider on 25 Jan 11, at which time fluoxetine dose continued without change & prazosin titration re-initiated. Lt Klay continues to see Ms. Pia for individual therapy.
History of present illness
The Patient is a 30 year old female.
She reported: Past medical history reviewed, problem list reviewed, and medication list reviewed.

This afternoon, patient reports running out of prazosin approximately 3 days ago. Prior to running out of meds, she endorses compliance with prazosin 6mg PO qHS, sleeping better & having fewer weird & disturbing dreams as compared to lower doses. Lt Klay denies side effects to the prazosin, to include lightheadedness, dizziness or grogginess. She reports compliance with fluoxetine, denies side effects, & describes feelings of being less inhibited when speaking her opinions to other & feeling more apathetic to small stressors. Patient generally reports a "better sense of well-being," decreased daytime anxiety, improved ability to cope with stress & more empathic since beginning treatment in the MHC. She denies interval EtOH use or binging-purging. Lt Klay continues to participate in AA meetings with a sponsor. She denies current impairing depressive symptoms, to include SI; HI; AVH; manic symptoms; & psychotic symptoms. Chief complaint is continued difficulty getting restful sleep & nighttime PTSD symptoms. Briefly reviewed PCL-M (see below). Patient also describes feeling cynical toward others & the military. Reviewed her educational goals after getting out of the USMC. Patient reports choosing fieldwork for MSW as working with the elderly on Capitol Hill. Briefly discussed current legal hold & updates to case.
Physical findings
Psychiatric Exam:
Performance Of A Mental Status Exam: • A mental status exam was performed - Well-groomed adult, appearing stated age, wearing dress casual civilian clothes, no apparent distress. Appropriate behavior and cooperative. Psychomotor activity neither increased nor decreased. The patient's speech was fluent and non-pressured. Some disinhibition of speech & increased rate of speech. Fair eye contact. Mood euthymic to anxious. Affect congruent, full range & intensity, non-labile. Fully alert and oriented. 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
PCL-M: Total score = 64, above threshold for a diagnosis of PTSD by score & symptoms clusters. All re-experiencing symptoms rated as "quite a bit" or "extremely." Feeling distant/cut off from other people rated as "extremely" & avoidance of reminders rated as "quite a bit." Sleep disturbance & irritability rated as "extremely" & super-alert rated as "quite a bit.".

A/P Written by THODE,KIRSTIN @ 18 Feb 2011 1652 EST
1. POST-TRAUMATIC STRESS DISORDER: IMPRESSION: 30y/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 reports improvement in anxiety & depressive symptoms in the context of fluoxetine titration, individual therapy, continued abstinence from EtOH & decreased occupational stressors. Patient's sleep improved with titration of prazosin Prazosin well-tolerated, but patient noncompliant x3 days 2/2 running out of meds. Fluoxetine well-tolerated without significant impairing side effects. Current MSE with minimal evidence of anxiety. PCL-M strongly supports a PTSD diagnosis. Presentation most consistent with PTSD along with well-established Acohol Dependence & Bulimia by Hx. No current indication of malingering, treatable medical causes of current symptoms, 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 - PTSD; Alcohol Dependence in Early Full Remission; Bulimia by Hx
AXIS II - No current diagnosis
AXIS III - Low Mg level by labs
AXIS IV - Occupational & legal stressors

18 Feb 2011 1302
Facility: NNMC Bethesda, MD Clinic: PSYCHIATRY MG Provider: THODE,KIRSTIN T

Suicide / Violence Risk Assessment
Risk Factors: Axis I diagnosis, anxiety, Hx of abuse, Hx of substance dependence, occupational & legal 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, symptoms have improved.
Category: Baseline
Risk Level: Not elevated.

Procedure(s): -Psychiat Therapy Indiv Appr 45-50 Min W/ Med Eval Managemt x 1
Medication(s): -FLUOXETINE--PO 20MG CAP - T3 CAP PO DAILY #100 RF0 Qt: 100 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T
-PRAZOSIN--PO 2MG CAP - TAKE ONE CAP PO QHS FOR 4 DAYS, THEN TAKE TWO CAPS PO QHS FOR 4 DAYS, THEN TAKE THREE CAPS PO QHS FO Qt: 100 Rf: 0 Ordered By: THODE,KIRSTIN Ordering Provider: THODE, KIRSTIN T

2. ALCOHOL DEPENDENCE IN REMISSION: PLAN:
1. Medication - Re-initiate prazosin titration to 8mg PO qHS (dispensed 2mg #100 RF 0) off-label use for anxiety-related sleep disturbance. Continue fluoxetine to 60mg PO qAM (dispensed 20mg #100 RF0) for anxiety & depressive symptoms. 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 to continue individual therapy with Ms. Pia in this clinic.
3. Labs/referral - None indicated at this time. Defer management of brith control & low Mg level to PCM/GYN. Consider repeat electrolyte levels + Mg given Hx of binging-purging.
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 weekly AA meetings + contact with sponsor.
5. Safety - No current indication to add patient to the MH flight High Risk/Interest Log or 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. Patient to return for f/u with this provider in 4 weeks. She will continue to see Ms. Pia for individual therapy as previously scheduled.

This provider met with patient for 45 minutes & >50% of appointment time spent counseling &/or coordinating care.
3. BULIMIA NERVOSA

Disposition Written by THODE,KIRSTIN @ 18 Feb 2011 1653 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.

Signed By THODE, KIRSTIN (MD, Capt, USAF, Mental Health Clinic, Joint Base Andrews) @ 18 Feb 2011 1654

Version LDB: 04 Jun 09

DATE: 31 Jan 2011; **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 reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt reports ongoing anxiety as she deals with issues related to being a victim of sexual assault and the investigation by NCIS.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt shared details of sexual assault by a Marine and how she felt during sting operation in which he implied he had been the perpetrator. Pt continues to feel anxious about telling husband about the assault. Pt also shared details of being sexually assaulted at the Naval Academy. She has a long hx of poor body image and sexual issues related to being molested in childhood by a teacher. Discussed with pt that sexual assault is about power/violence whereby sex is used as the tool to perpetrate.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Some anxiety; anger and shame;
SLEEP: "Cries each night prior to falling asleep as she thinks about the sexual harassment/assault. She doesn't want to get out of bed in the morning. Prazosin helps with sleep.
THOUGHTS: Without Psychoses; some thoughts of guilt/shame about the sexual assault since she was under the influence;
APPETITE: Appetite decreases with stress;
ENERGY: "Pretty good";
CONCENTRATION: "Too much going on";
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this;
SI: She has thought about whether others would be better off without her because she has caused so much pain (for example, husband), but when questioned, she has no intent or plan;
HI: Denied HI
RISK LEVEL (SI/HI): Minimal/Mild

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; R/O Depressive Disorder NOS

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, Ariana B **SS#: 20/532-94-8850** **DOB: 07 Jan 1981** **DATE SEEN: 31 Jan 2011**		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis;
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: address how she wants to tell husband about the sexual assault; decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Pt to address what it is that she avoids facing daily regarding the trauma*
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: Discussed Prolonged Exposure and self-help books

M A Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

Version LDB: 04 Jun 09

DATE: 25 Jan 2011; **DURATION**: 60 min; **Service Provided:** Individual therapy/90806;
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 reports symptoms of anxiety connected to unresolved feelings/thoughts related to previous sexual harassment/assault. Treatment is individual therapy with emphasis on Prolonged Exposure Therapy and a primary treatment goal of: decreasing anxiety, building self esteem, decreasing PTSD-like symptoms associated with the unresolved trauma and resolving any underlying contributing factors related to her symptoms.
PROGRESS:
Pt reports that mood is anxious, but hopeful. She has experienced some suicidal ideation "thinking that husband and others would be better off if she were not alive because of the hurt she's caused". She adamantly denies any intent or plan. Pt continues to undergo stress related to NCIS investigation related to her sexual assault. She reports that her ongoing sobriety has significantly enhanced her life and marriage.
-New information for pt's medical provider(s): Pt will continue to see Dr. Thode for psychotropic medication management.
******Due to patient privacy concerns, more complete documentation is kept in separate Mental Health record.** *****

SESSION SUMMARY: *Pt discussed sting operation that she will be involved in today related to perpetrator of her sexual assault. She is highly anxious. She is also afraid of the hurt husband will feel when she tells him about the assault. She plans to utilize counseling to prepare prior to telling him.*
Homework/Results: N/A
PAIN: Not reported or indicated.
Outcome Measures, Monitoring Measures: NA

OBJECTIVE: Mental Status Exam:
Overall: - No unusual or noteworthy change from previously documented MMSE, e.g., appearance, orientation, behavior, interpersonal relatedness, speech patterns, thought content, etc.
MOOD: Some anxiety; anger and shame;
SLEEP: "Not good"; plans to discuss with her psychiatrist today;
THOUGHTS: Without Psychoses; some thoughts of guilt/shame about the sexual assault since she was under the influence;
APPETITE: Appetite decreases with stress;
ENERGY: "Pretty good";
CONCENTRATION: "Too much going on";
LIBIDO: "Low";
INTERESTS: Accepted to Grad School and is excited about this;
SI: She has thought about whether others would be better off without her because she has caused so much pain (for example, husband), but when questioned, she has no intent or plan;
HI: Denied HI
RISK LEVEL (SI/HI): Minimal/Mild

ASSESSMENT:
Axis I – *Anxiety Disorder NOS – 300.00 per hx*
Alcohol Dependency in early full remission – per hx
Bulimia Nervosa – per hx

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, Ariana B
SS#: 20/532-94-8850
DOB: 07 Jan 1981
DATE SEEN: 25 Jan 2011

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

R/O PTSD; R/O Depressive Disorder NOS
Axis II – Deferred – 799.9
Axis III – See AHLTA

PLAN: Pt to return to MHC for individual therapy on a weekly basis;
HIGH RISK LOG: No
SAFETY PLAN: Reviewed with pt emergency procedures and phone numbers (MHC 857-7186 during duty hours, ER 857-2333).

DISPOSITION: Pt returned to duty with no limitations
PROFILE/ LIMITATIONS:
-Sensitive Duties: SC
-Profile: No MH
-PCS: Yes
-Deployable: Yes
-Unit notification (if urgent limitations): NA

DETAILS TX PLAN: address how she wants to tell husband about the sexual assault; decrease shame/guilt regarding sexual assault; address bulimic behaviors in therapy and develop tx plan; *begin to identify what she needs/wants to resolve regarding sexual harassment/assault*
Homework: *Pt to address what it is that she avoids facing daily regarding the trauma*
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: Discussed Prolonged Exposure and self-help books

M.A. Piacquadio, LCSW

Michelle A. Piacquadio, ACSW, LCSW
Licensed Clinical Social Worker, Civ Contractor
Mental Health Clinic, MGMC
Andrews AFB

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

Date: **27 Jan 2011 1506 EST**
Clinic: **SOCIAL WORK MG**

Appt Type: **T-CON***
Provider: **PIACQUADIO,MICHELLE A**

Call Back Phone: **(703)-389-4046**

Reason for Telephone Consult: Pt called to diiscuss therapy issue

AutoCites Refreshed by PIACQUADIO,MICHELLE A @ 27 Jan 2011 1507 EST

Problems
Chronic:
- Bulimia nervosa
- Alcohol dependence in remission
- Anxiety disorder NOS
- Major depression, single episode
- Inquiry and counseling
- Patient education
- Patient education about a proper diet
- Insomnia
- Alcoholism
- Visit for: administrative purposes
- Compression arthralgia of the knee / patella / tibia / fibula

Family History
- Family medical history (General FHx)
- Of mental illness (not retardation) (General FHx)
- Of substance abuse (General FHx)

Allergies
- No Known Allergies

Active Medications	Status	Sig	Refills Left	Last Filled
Active Medications PRAZOSIN HCL, 2 MG, CAPSULE, ORAL	Active	TAKE ONE CAP PO QHS FOR 4 DAYS, THEN TAKE TWO CAPS PO QHS FOR 4 DAYS, THEN TAKE THREE CAPS PO QHS #60 RF0	NR	25 Jan 2011
FLUOXETINE HCL, 20 MG, CAPSULE, ORAL	Active	T3 CAP PO DAILY #90 RF1	0 of 1	25 Jan 2011
Ethinyl Estradiol 0.02mg + Drospirenone 3mg, Tablet, Oral, 28 Day Dose Pack	Refill	TAKE 1 TAB PO QD CONSECUTIVE X 63 DAYS #6 RF3	1 of 2	05 Nov 2010

LMP: 15 Jun 2010. Date Basis: unknown.

SO Note Written by PIACQUADIO,MICHELLE A @ 27 Jan 2011 1510 EST

Subjective
Pt called about NCIS investigation regarding her allegation of being sexually assaulted. She reports feeling validated that others are finally seeing that what she is saying is true, but that the investigation process is quite difficult and painful as it triggers pain about the trauma. Pt denied any SI/HI or safety concerns. Clinician will see pt on Monday at 0800 for a therapy session.

A/P Last Updated by PIACQUADIO,MICHELLE A @ 27 Jan 2011 1510 EST

1. Anxiety disorder NOS

Disposition Last Updated by PIACQUADIO,MICHELLE A @ 27 Jan 2011 1510 EST

Signed By PIACQUADIO, MICHELLE A (Physician/Workstation) @ 27 Jan 2011 1510