

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation - ED Behavioral Health**

LORazepam : LORazepam ; Status: Documented ; Ordered As Mnemonic:
 LORazepam 2 mg oral tablet ; Simple Display Line: 1 mg, 0.5
 tab, PO, qHS, prescribed as 1T,QHS;prn, PRN: sleep ; Catalog
 Code: LORazepam ; Order Dt/Tm: 08/21/2015 16:25:30

losartan : losartan ; Status: Documented ; Ordered As Mnemonic:
 losartan 100 mg oral tablet ; Simple Display Line: 100 mg, 1
 tab, PO, daily ; Catalog Code: losartan ; Order Dt/Tm:
 08/21/2015 16:25:18

losartan : losartan ; Status: Completed ; Ordered As Mnemonic:
 losartan 100 mg oral tablet ; Simple Display Line: 100 mg, 1
 tab, PO, daily ; Catalog Code: losartan ; Order Dt/Tm:
 12/06/2014 00:30:11

LORazepam : LORazepam ; Status: Completed ; Ordered As Mnemonic:
 LORazepam 2 mg oral tablet ; Simple Display Line: 2 mg, 1
 tab, PO, qHS ; Catalog Code: LORazepam ; Order Dt/Tm:
 12/06/2014 00:29:37

BH Disposition

BH Clinical Overview : Patient is a 65 year-old MWM brought to Kent ED via rescue. Patient reportedly placed a gun on the table after argument with wife and stated "Just shoot me. Put me out of my misery". Cranston Police was called to the home.

Upon assessment, Patient pacing in room was fully cooperative with Writer. Patient right away expressed eagerness to discharge home. States that Dr Graves had told him he could go home. Patient reported that he felt at a loss that his wife called the Police. He explained that he had an insignificant argument with her last night over a coffee mug. Wife left for the night and returned this morning. States that he placed the gun on the table, and had removed the magazine prior to this. Admitted that he made the statement but denied feeling suicidal or homicidal before, during, or after this incident. Patient stated that wife made similar statement when she was hospitalized for major pain issue last year. Patient was adamant that

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: 08/02/1950

FIN: 562037430

MRN: 000489436

ED Documentation - ED Behavioral Health

contractor. Blaming of his wife for "changing since her mother died a year ago".

Writer interviewed Patient's wife over a half hour. Wife had to be taken to ED's family room for therapeutic intervention due to mood lability while this clinician attempted to obtain collateral information. Wife denied feeling unsafe. States that she is not concerned that her husband would attempt suicide. States "he is too narcissistic for that". Wife confirmed Patient's report as depicted above. Wife informed that the patient drinks more than he is reporting. States that in addition to the 2 beers reported, Pt also drinks a couple little nips "it only starts affecting him after the 4 or 5th nip." Wife c/o tearfully that she does not feel supported or understood by her husband. Wife discussed that she started seeing a therapist with whom she has been on the phone for several hours last night and today. Complained that her husband would not support her in this endeavor, nor agreeable to join her in spousal counseling. Wife shared that her hope was that her husband could get some help here in the ER. Wife was adamant that the Police had removed both guns from the home while her husband was in the rescue vehicle. States that he would be upset to know this, but insisted that she still felt safe. Writer recommended to wife to continue seeking her therapist advice, and to call 911 if any concerns for her safety or the safety of her husband. Wife informed that she is planning to return to hotel tonight.

Writer informed Patient that the Police had removed the guns from the home. Patient received news calmly and took list of outpatient mental health resources offered by Writer.

BH Disposition : Patient was discharged to home with resources to follow up with outpatient mental health services.

Disposition discussed with, and approved by ED Attending Physician.

Axis I : Unspecified Depressive Disorder 311 (F32.9)

Axis II : Deferred 799.99

Axis III : None reported

BH Clinical Assessment : Patient was alert and oriented x3. Patient denied suicidal and homicidal thoughts, intent, or plan.

Patient denied past attempts. Patient denied history of mental illness or past psychiatric hospitalization. Patient denied auditory, visual, or tactile hallucinations. Denied mania and substance abuse issue. There was no evidence of mania, paranoid ideation, or delusions. Patient and wife endorsed feeling safe. Patient brushed off suicidal gesture as "a misunderstanding". Writer and other staff felt confident that the guns had been confiscated by Police. Additionally, Patient's wife indicated that she would not be home tonight. Based on this, and based on Patient/ Wife's presentation, there is at this time no evidence that the Patient is a danger to self or others. Thus, Patient does not meet criteria for involuntary commitment to psychiatric hospitalization.

Axis IV : Marital dispute, interpersonal relationship; social environment

Axis V GAF : 45

Smith, Jeanne - 08/21/2015 19:08

**MEDICAL RECORD ASSOCIATES, LLC**

2 BATTERYMARCH PARK, SUITE 204
QUINCY, MA 02169
617.698.4411

SHIP TO:

ATTENTION TO : EDWARD CANIGLIC
EDWARD CANIGLIC
[REDACTED]
CRANSTON, RI 02920

BILL TO:

ATTENTION TO : EDWARD CANIGLIC
EDWARD CANIGLIC
[REDACTED]
CRANSTON, RI 02920

PRE-PAYMENT INVOICE

THE INFORMATION YOU REQUESTED WILL BE RELEASED AS SOON AS PAYMENT IS RECEIVED.

THIS INVOICE IS FOR RETRIEVING, PROCESSING AND DELIVERING THE MEDICAL RECORDS YOU REQUESTED. THANK YOU FOR PROMPTLY PAYING THIS INVOICE.

KENT HOSPITAL

INVOICE # : INV035597 - RF

DATE : 9/10/2015

PATIENT : CANIGLIC, EDWARD

MR # : 9119361

REF # :

CLAIM # :

CASE # :

DOS : 8/21/2015

CERTIFIED : NO

DESCRIPTION	QUANTITY	RATE	AMOUNT
PAGES 1-100	79	\$0.70	\$55.30
SHIPPING	1	\$5.05	\$5.05
PAYMENT IS DUE UPON RECEIPT OF THIS INVOICE			INVOICE TOTAL
			\$60.35
			PAYMENTS
			\$0.00
			BALANCE DUE
			\$60.35

NOTE:

MAKE CHECKS PAYABLE TO

PLEASE WRITE THIS INVOICE NUMBER ON YOUR PAYMENT

MEDICAL RECORD ASSOCIATES, LLC

INV035597 - RF

Inpt Admit Date/Time: Reg Date/Time: 08/21/2015 10:49 Encntr Type: Emergency Department
Visit Type: Emergency Reg Clerk: Bardi , Brianna R
Visit Source: Non-Healthcare Facility
Visit Reason: S1
Estimated Date of Arrival:
Admitting Physician:
Attending Physician: McAteer MD, Kristina E
Primary Care Physician: Wilson MD, Jeffrey M
Referring Physician:
VIP Indicator:



10136

10136 (3-2015)

AUTHORIZATION TO RELEASE HEALTH INFORMATION

FOR INPATIENTS: AFFIX PATIENT LABEL OR
WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR #: _____

1 Patient name: Edward Canalis ("Patient") Date of Birth: [REDACTED] Telephone: [REDACTED]
Address: [REDACTED] Cranston RI 02920 Med. Rec. # _____
State Zip

2. The undersigned hereby authorizes the following CNE Provider Kent County Hosp
(Insert Hospital/Facility/Physician name) (the "Provider")
Address: 455 Toll Gate Rd Warwick RI 02884
Street City State Zip
Telephone: _____ Fax: _____

☐ to release/disclose to the individual and/or entity named in Section 3 ("Recipient")

AND/OR

☒ to request/receive from the individual and/or entity named in Section 3 ("Disclosing Party")

the protected health information ("Health Information") specified in Section 4

3. Recipient or Disclosing Party: SELF (Insert Individual/Entity Name)
Telephone: _____ Fax Number (if Health Information is to be faxed): _____ BY: _____
Address: _____
Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> X-Ray/Imaging Results	<input type="checkbox"/> Psychiatric Exam
<input checked="" type="checkbox"/> Emergency Dept. Records**	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Psychological Tests
<input type="checkbox"/> Registration Record	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Treatment Plan(s)
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Entire Record

OTHER (Please specify): _____

**An authorization for Emergency Department Records may include any of the above listed Health Information records.

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
For the period from 8/21/15 (insert start date) through 8/21/15 (insert end date);
OR ALL DATES OF TREATMENT EBC (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify) _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
☐ Medical Care ☒ Legal ☐ Insurance ☒ Personal
Other (Please describe): _____

8. The undersigned acknowledges and understands each of the following:

- authorizing the release of the Patient's Health Information is voluntary;
- refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
- this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
- unless previously revoked, this authorization will automatically expire SIX (6) months from the date of this authorization;

RECEIVED
SEP 08 2015
H.I.S.

Kent Hospital

455 Toll Gate Road, Warwick, RI 02886

Patient Name:	Caniglia, Edward A	MRN:	000489436
FIN:	562037430	Registration Date:	08/21/2015
Birth Date/Age/Sex:	██████████ 65 years Male	Discharge Date:	08/21/2015
Admitting Provider:		Patient Type:	Emergency Department
Attending Provider:	McAteer MD, Kristina E		
PCP:	Wilson MD, Jeffrey M		

ED Documentation

Document Type:	ED Initial Evaluation
Document Subject:	ED Initial Evaluation
Service Date/Time:	08/21/2015 11:39
Result Status:	Auth (Verified)
Performed Information:	Lesiuk RN, Tonya L (08/21/2015 11:45)
Electronically Signed by:	Lesiuk RN, Tonya L (08/21/2015 11:45)

ED Initial Evaluation Entered On: 08/21/2015 11:44
Performed On: 08/21/2015 11:39 by Lesiuk RN, Tonya L

ID Risk Screen

**Recent Travel History :* No recent travel
**Family Member*
Travel History : No recent travel

Lesiuk RN, Tonya L - 08/21/2015 11:39

Reason for Visit

(As Of: 08/21/2015 11:44:21 EDT)

Diagnoses(Active)

psych eval	<i>Date:</i> 08/21/2015 ; <i>Diagnosis Type:</i> Reason For Visit ; <i>Confirmation:</i> Complaint of ; <i>Clinical Dx:</i> psych eval ; <i>Classification:</i> Medical ; <i>Clinical Service:</i> Non-Specified ; <i>Probability:</i> 0
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General

Chief Complaint Description : pt brought in by EMS for psych eval.
Patient Reports Pain : No
Preferred Language of Care : English
Urinary catheter present on ED arrival : No
MOLST : No
Primary Pain Intensity : 0
Disease Alert Results : Disease Alert
 *** View Only ***
Isolation Precautions Order Detail : Standard

Lesiuk RN, Tonya L - 08/21/2015 11:45

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation****ESI**

ESI Level 1 : No

ESI Level 2 : No

ESI Level 3 : Many

Vital Signs ESI : No

Lesiuk RN, Tonya L - 08/21/2015 11:39

DCP GENERIC CODE

Kent ED Trcking Grp : Kent ED Trcking Grp

Recommended ESI Level : 3 Urgent

Lesiuk RN, Tonya L - 08/21/2015 11:39

Health History KEDCardiovascular Past Medical History Grid

High Blood Pressure : Self, borderline

Lesiuk RN, Tonya L - 08/21/2015 11:39

Gastrointestinal Past Medical Hx Grid

Ulcer Disease : Self, duodenal

Lesiuk RN, Tonya L - 08/21/2015 11:39

Previous Surgery History Grid

Surgery Description :	Tonsillectomy	Other: bleeding duodenal ulcer repair
	Lesiuk RN, Tonya L - 08/21/2015 11:39	Lesiuk RN, Tonya L - 08/21/2015 11:39

ED Screens

Unable or unwilling to follow commands : No

History of Fall in Last 3 Months Morse : No

Sensory Motor Deficits : No

Fall Safety Protocol KED : Bed in low position, Wheels locked, Side rails up

Suicide Risk : Denies

Homicide Risk : Denies

Patient unable to Communicate/ Non-verbal : No

Do you drink beer, wine, alcohol beverages : No

Domestic Violence Risk : Denies

Lesiuk RN, Tonya L - 08/21/2015 11:45

Nurse Progress Summary

Nurse Progress Summary : pt brought in by EMS for psych eval. Pt states him and his wife had an arugment last night, during the argument the husband admits to taking out his anger on his wife.

Lesiuk RN, Tonya L - 08/21/2015 11:39

- Set in chair (FAC)

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

ED Documentation

Document Type: ED Note-Physician
Document Subject: Psychiatric Problem *ED
Service Date/Time: 08/21/2015 11:23
Result Status: Modified
Performed Information: McAteer MD,Kristina E (08/21/2015 18:50); Graves MD,Peter F (08/21/2015 11:23)
Electronically Signed by: McAteer MD,Kristina E (08/21/2015 18:50); Graves MD,Peter F (08/21/2015 14:32)

Addendum by McAteer MD, Kristina E on 21 August 2015 18:50

bp elevated in the ED per patient takes losartan 100 mg qam and complaint w such. he has no symptoms of hypertensive emergency. he is asked to follow up with his PMD next week for bp recheck. seen by psych for further eval and felt safe for disposition. given further counseling resources for the marital issues that he is experiencing. asked to fu w PMD and outpatient counseling and return for worsening symptoms or further concerns.

Condition: stable

Discharge: home

Diagnosis: situation depression

Patient counseled on test results, treatments, plan of care, follow up recommendations, indications to return to the ED.

Electronically Signed McAteer MD, Kristina E 08/21/15 06:50 P

Psychiatric Problem *ED

Patient: Caniglia, Edward A MRN: 000489436

Age: 65 years Sex: Male DOB: [REDACTED]

Author: Graves MD, Peter F

Basic Information

Time seen: Date & time 08/21/15 11:23:00.

History source: Patient.

Arrival mode: Private vehicle.

History limitation: None.

Additional information: Pt BIB police for eval. Pt tells me that he and his wife have been arguing recently, she has been in tx for psych issues related to loss of her mother abot a year ago, and last night they got into an argument about a minor issue. He became increasingly frustrated about this, and eventually went and got his unloaded gun and made a comment to his wife that she should just shoot him and put him out of his misery. He then went for a drive, wanted to figure out a way to apologize to his wife, bought a plant, and came home to find her packing her bags to leave which she then did. He called her later in the evening to talk with her and say goodnight, and had some tequila then went to bed. Called her this AM and left her a message about how he didnt think this was a good way to handle their disagreements, and then he got a call from CPD telling him that they were on the way over to check on him, and when CPD arrived there

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

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ED Documentation

factor is family problems. The relieving factor is none. Risk factors consist of none. Prior episodes: none. Therapy today: none. Associated symptoms: none. Additional history: none.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.

Skin symptoms: Negative except as documented in HPI.

Eye symptoms: Negative except as documented in HPI.

ENMT symptoms: Negative except as documented in HPI.

Respiratory symptoms: Negative except as documented in HPI.

Cardiovascular symptoms: Negative except as documented in HPI.

Gastrointestinal symptoms: Negative except as documented in HPI.

Musculoskeletal symptoms: Negative except as documented in HPI.

Neurologic symptoms: Negative except as documented in HPI.

Psychiatric symptoms: Negative except as documented in HPI.

Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status

Allergies:

Allergic Reactions (Selected)

NKA.

Past Medical/ Family/ Social History

Medical history

Cardiovascular: hypertension.

Surgical history: Reviewed as documented in chart.

Family history: Not significant.

Social history: Alcohol use: Occasionally, Tobacco use: Denies, Drug use: Denies, Family/social situation: Married.

Physical Examination

Vital Signs

Vital Signs

08/21/2015 11:07

Peripheral Pulse Rate	91 bpm	
Respiratory Rate	23 breaths/min	HI
Systolic Blood Pressure	195 mmHg	HI
Diastolic Blood Pressure	114 mmHg	HI
Mean Arterial Pressure	141 mmHg	
Temporal Artery Temp	36.7 degC	
Peripheral Pulse Rate	84 bpm	

08/21/2015 10:54

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation**

08/21/2015 10:54

Oxygen Saturation

98 %

General: Alert and no acute distress.**Skin:** Warm, dry, pink and intact.**Neck:** Supple, trachea midline and no tenderness.**Cardiovascular:** Regular rate and rhythm, No murmur and Normal peripheral perfusion.**Respiratory:** Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal and Symmetrical chest wall expansion.**Chest wall:** No tenderness and No deformity.**Back:** Nontender, Normal range of motion and Normal alignment.**Musculoskeletal:** Normal ROM, normal strength and no tenderness.**Gastrointestinal:** Soft, Nontender, Non distended and Normal bowel sounds.**Neurological:** Alert and oriented to person, place, time, and situation.**Psychiatric:** Cooperative and appropriate mood & affect.**Medical Decision Making****Differential Diagnosis:** Depression, alcohol intoxication.**Documents reviewed:** Emergency department nurses' notes, emergency medical system run report, prior records.**Results review:** Lab results : Lab View

08/21/2015 11:36

WBC	8.1 x10(3)/mcL
RBC	4.41 x10(6)/mcL
Hemoglobin	14.7 g/dL
Hematocrit	43.2 %
MCV	97.9 fL
MCH	33.3 pg/dL
MCHC	34.0 g/dL
RDW	13.3 %
Platelet	265 x10(3)/mcL
MPV	8.4 fL
Neutrophils	47.9 % LOW
Lymphocytes	41.6 %
Monocytes	7.9 %
Eosinophils	1.5 %
Basophils	1.1 %
Neutrophil #	3.9 #
Lymphocyte #	3.4 #
Monocyte #	0.6 #
Eosinophil #	0.1 # LOW
Basophil #	0.10 #
Glucose	130 mg/dL HI
Urea Nitrogen	14 mg/dL
Creatinine	0.88 mg/dL

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

ED Documentation

Calcium	9.5 mg/dL
Amphetamine, Urine	Negative
Barbiturate, Urine	Negative
Cocaine, Urine	Negative
Opiate, Urine	Negative
PCP, Urine	Negative
Benzodiazepine, Urine	Negative
Cannabinoid, Urine	Negative
Acetaminophen	<10.0 mcg/mL
Ethanol	NEG g/dL
Salicylate	<2.5 mg/dL

Impression and Plan

behavioral issue, resolved.

Plan

Condition: Stable.

Disposition: Patient care transitioned to: Time: 08/21/15 14:32:00, McAteer MD, Kristina E, psych eval and dispo pending.

Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.

Electronically Signed Graves MD, Peter F 08/21/15 02:32 P

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

MRN: 000489436; 009119361

FIN: 562037430

* Auth (Verified) *



10000

KENT HOSPITAL

Warwick, RI 02886

EMERGENCY SERVICES ORDERS

ED (401) 736-4288

Rapid Assessment Area (401) 736-4289

Caniglia, Edward A

MRN: 489436 DOB: [REDACTED]

65M

DOS: 08/21/2015

FIN: 562037430

678-50.36 (4-2015)

CHIEF COMPLAINT:

ED NURSING PROTOCOLS

Please use ink pen AND highlight when sent

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abd pain, lower | <input type="checkbox"/> Chest pain or dyspnea (non-cardiac) | <input type="checkbox"/> Flank pain | <input type="checkbox"/> Urinary symptoms (male) |
| <input type="checkbox"/> Abd pain, upper | <input type="checkbox"/> Diabetic complaint (hyperglycemia) | <input type="checkbox"/> Overdose | <input type="checkbox"/> Vaginal bleeding (non-pregnant) |
| <input type="checkbox"/> Alcohol intoxic | <input type="checkbox"/> Fever (adult, sepsis) | <input type="checkbox"/> Psychiatric (no overdose) | <input type="checkbox"/> Vaginal bleeding (pregnant) |
| <input type="checkbox"/> Altered mental status | <input type="checkbox"/> Fever (pediatric < 120 days) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vomiting/diarrhea (adult) |
| <input type="checkbox"/> Chest pain or dyspnea (cardiac) | | <input type="checkbox"/> Syncope | <input type="checkbox"/> Vomiting/diarrhea (pediatric) |
| | | <input type="checkbox"/> Urinary symptoms (female) | <input type="checkbox"/> Weak/dizzy |

INITIAL ORDER SETS

- ☐ **Cardiac/Dyspnea** (CBC/diff, BMP, troponin series, IV x 2, O2, monitor), STAT EKG & Prior
Optional (Circle): CPK/MB D dimer BNP PCT Portable CXR CXR PA/LAT PT/INR PTT
- ☐ **Sepsis** (EKG & Prior, CBC/diff, CMP, Blood Cx x 2, Cath UA, Urine Cx, lactate, PCT, Portable CXR, IV x 2, O2, monitor)
Optional (Circle): NS 2 L bolus STAT antibiotics as ordered Activate Sepsis Team D dimer CXR PA/LAT
- ☐ **Stroke** (STAT noncon CT head, FSBS, EKG/prior, CBC/diff, BMP, PT/INR, PTT, IV x 2, O2, monitor, Type/screen, NPO)
Optional (Circle): Activate Stroke Team Portable CXR CXR PA/LAT CPK/Troponin
- ☐ **Abdominal** (CBC/diff, CMP, lipase, UA)
Optional (Circle): serum HCG (qualitative) serum HCG (quantitative) amylase KUB AXR flat/upright Cath UA ED POC UCG lab UCG NPO
- ☐ **Altered Mental Status** (FSBS, EKG & Prior, CBC/diff, CMP, UA, UDS, etOH, monitor)
Optional (Circle): Cath UA Ammonia ABG Noncontrast CT head Portable CXR PA/Lat CXR COHgb NPO
- ☒ **Behavioral** (CBC/diff, BMP, UDS, ASA, APAP, etOH)
Optional (Circle): UA UCG Medication: _____ level ☒ Behavioral health eval ☐ Social services eval for _____
- ☐ **Trauma** (CBC/diff, BMP, etOH, UDS, UA, Type & Screen, IV x 2, O2, monitor, PT/INR, PTT)
Optional (Circle): Type and Cross _____ units PRBC UCG HCG NPO
- ☐ **Pre-Op** (CBC/diff, BMP, EKG & Prior, CXR PA/Lat, Type & Screen, UCG if female <50, NPO)
Optional (Circle): PT/INR

INITIAL INDIVIDUAL ORDERS

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Blood Glucose - ED POC | <input type="checkbox"/> Troponin Series | <input type="checkbox"/> Rh type | <input type="checkbox"/> Hepatitis panel |
| <input type="checkbox"/> EKG | <input type="checkbox"/> BNP | <input type="checkbox"/> Type/screen | <input type="checkbox"/> TSH |
| <input type="checkbox"/> Cardiac Monitor | <input type="checkbox"/> D dimer | <input type="checkbox"/> Type/cross _____ units PRBC | <input type="checkbox"/> ESR (sed rate) |
| <input type="checkbox"/> CBC/Diff | <input type="checkbox"/> ABG on _____ %O2 | <input type="checkbox"/> Amylase | <input type="checkbox"/> Uric Acid |
| <input type="checkbox"/> BMP | <input type="checkbox"/> UA, C+S if indicated | <input type="checkbox"/> Lipase | <input type="checkbox"/> Rapid Strep/culture - ED POC |
| <input type="checkbox"/> CMP | <input type="checkbox"/> UCG - ED POC | <input type="checkbox"/> LFT's | <input type="checkbox"/> Rapid Strep/Culture - LAB |
| <input type="checkbox"/> Ca | <input type="checkbox"/> UCG - LAB | <input type="checkbox"/> EtOH | <input type="checkbox"/> Rapid Flu |
| <input type="checkbox"/> Mag/Phos | <input type="checkbox"/> Blood Cx x 2 | <input type="checkbox"/> UDS | <input type="checkbox"/> GYN wet prep |
| <input type="checkbox"/> PT/INR | <input type="checkbox"/> Lactic | <input type="checkbox"/> ASA | <input type="checkbox"/> GYN GC/Chlamydia |
| <input type="checkbox"/> PTT | <input type="checkbox"/> PCT | <input type="checkbox"/> APAP | <input type="checkbox"/> Urine GC/Chlamydia |
| <input type="checkbox"/> CPK (non-cardiac) | <input type="checkbox"/> Serum Qual HCG | <input type="checkbox"/> Lyme Ab w/Reflex confirm K | <input type="checkbox"/> Med.: _____ level |
| <input type="checkbox"/> Troponin x 1 | <input type="checkbox"/> Serum Quant HCG | <input type="checkbox"/> Monospot | |

INITIAL DIAGNOSTIC IMAGING

Xray:

- ☐ Portable CXR ☐ CXR PA/Lat ☐ Pelvis
- ☐ C spine ☐ T spine ☐ L spine

CT:

- ☐ CT head non-con for ICH/Fx

Patient Name: Caniglia, Edward A
Date of Birth: [REDACTED]

MRN: 000489436; 009119361
FIN: 562037430

* Auth (Verified) *

Patient Visit Summary

Edward Caniglia has been given the following list of patient education materials, prescriptions and follow-up instructions:

Patient Education Materials:

Diagnosis

DEPRESSION

HYPERTENSION, Established, Out of Control

Follow-Up Instructions:

Follow Up With:

Jeffrey Wilson

Where:

65 Sockanossett Cross Road; Suite
301

Cranston, RI 02920

(401) 943-6910 Business (1)

When:

Within A Few Days,
If Not Improved

Comments:

Please continue all your medications as prescribed. Please follow up with your doctor next week for blood pressure recheck. Return to the ED at anytime for worsening symptoms or further concerns.

If you had any cultures or x-rays performed during your visit, your final reports will be reviewed. You will be contacted if any further instructions are needed.

I, Edward Caniglia, understand that the treatment I have received was rendered on an Emergency basis only and that further treatment may be necessary. I have been given a copy of the above instructions and I will arrange for follow-up care as outlined above. If my condition worsens, I will call my doctor or return to the Emergency Department.

Medication Reconciliation List given to patient. YES NA

"You may receive a survey in the mail about your emergency care today from Press-Ganey, a nationally recognized quality improvement organization. At Kent Hospital, we take the opinion of our patients very seriously, and strive to continually improve the quality of care that we deliver. Please take the opportunity to provide feedback to us about your experience in the Kent Hospital Emergency Department if you receive this survey. Thank you."

  
Patient Signature Date Nurse/Provider Date

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

ED Documentation

Document Type:	ED Discharge Summary
Document Subject:	ED Discharge Summary
Service Date/Time:	08/21/2015 19:05
Result Status:	Modified
Performed Information:	Lesiuk RN,Tonya L (08/21/2015 19:05)
Electronically Signed by:	Lesiuk RN,Tonya L (08/21/2015 19:05); Lesiuk RN,Tonya L (08/21/2015 18:58)

ED Discharge Summary

NOTIFICATION OF ADMISSION FOR EMERGENCY DEPARTMENT SERVICES KENT HOSPITAL EMERGENCY DEPARTMENT

455 Toll Gate Road

Warwick, Rhode Island 02886

Dear Doctor:

The purpose of this notice is to advise you of Emergency Department Services provided for:

Patient: Caniglia, Edward A

Birthdate: [REDACTED] 12:00 AM

MR#: 009119361

Address: [REDACTED] Cranston RI 029203837

Phone: [REDACTED]

To Kent Hospital on 8/21/2015 10:49 AM.

Chief Complaint: psych eval; SI

Orders placed are listed below. To view results, please contact the Health Information Management Department (Medical Records).

Laboratory Orders

Name	Status	Details
Acetamin	Completed	Blood, Stat, 08/21/15 11:36:00, Collected, ST - Stat, 08/21/15 11:36:00, Lesiuk RN, Tonya L, Print label Y/N, Print Label By Order Location

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation**

Urine, Stat, 08/21/15 11:36:00, Nurse collect, ST - Stat, 08/21/15
 UTHC Completed 11:36:00, Lesiuk RN, Tonya L, Print label Y/N, Print Label By Order
 Location
 Blood, Stat, 08/21/15 11:36:00, Nurse collect, Collected, ST - Stat,
 xeGFR Completed 08/21/15 11:36:00, Lesiuk RN, Tonya L, 68968867.000000, Print Label
 By Order Location

Radiology Orders

No radiology orders were placed.

Cardiology Orders

No cardiology orders were placed.

Discharge Dx:

DEPRESSION; HYPERTENSION, Established, Out of Control

The following physicians are designated as participating on this admission:

REFERRING ED PHYSICIAN: Graves MD, Peter F**Prescriptions and historical medications include:**

Home Meds	Display
LORazepam (LORazepam 2 mg oral tablet)	1 mg 0.5 tab, PO, qHS, PRN sleep, prescribed as 1T;QHS;prn
losartan (losartan 100 mg oral tablet)	100 mg 1 tab, PO, daily
multivitamin	1 tab, PO, daily
multivitamin (Vitamin B Complex oral tablet)	1 tab, PO, qPM

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

ED Documentation

With:

Jeffrey Wilson

Address:

65 Sockanossett Cross Road, Suite 301
Cranston, RI 02920
(401) 943-6910 Business (1)

When:

Within A Few Days,
If Not Improved

Comments:

Please continue all your medications as prescribed. Please follow up with your doctor next week for blood pressure recheck. Return to the ED at anytime for worsening symptoms or further concerns.

INFORMATION FOR CODERS

Checkin Date and Time: 8/21/2015 10:49 AM

Checkout Date and Time: 8/21/2015 6:58 PM

Dispo Type: Home

Discharge Date and Time:

Provider Information:

Provider	Role	Assigned	Unassigned
Graves MD, Peter F	ED Physician	8/21/2015 11:23 AM	8/21/2015 2:34 PM
Lesiuk RN, Tonya L	ED Nurse	8/21/2015 11:38 AM	
McAteer MD, Kristina E	ED Physician	8/21/2015 2:34 PM	

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

ED Documentation - Emergency Department PowerForms

ED Initial Evaluation Entered On: 08/21/2015 11:44
Performed On: 08/21/2015 11:39 by Lesiuk RN, Tonya L

ID Risk Screen

*Recent Travel History : No recent travel

*Family Member

Travel History : No recent travel

Lesiuk RN, Tonya L - 08/21/2015 11:39

Reason for Visit

(As Of: 08/21/2015 11:44:21 EDT)

Diagnoses(Active)

psych eval

Date: 08/21/2015 ; Diagnosis Type: Reason For Visit ;
Confirmation: Complaint of ; Clinical Dx: psych eval ;
Classification: Medical ; Clinical Service: Non-Specified ;
Probability: 0

General

Chief Complaint Description : pt brought in by EMS for psych eval.

Patient Reports Pain : No

Preferred Language of Care : English

Urinary catheter present on ED arrival : No

MOLST : No

Primary Pain Intensity : 0

Disease Alert Results : Disease Alert

*** View Only ***

Isolation Precautions Order Detail : Standard

Lesiuk RN, Tonya L - 08/21/2015 11:39

(As Of: 08/21/2015 11:44:21 EDT)

Allergies (Active)

NKA

Estimated Onset Date: Unspecified ; Created By: Olawale
RN, Clementinah; Reaction Status: Active ; Category: Drug ;
Substance: NKA ; Type: Allergy ; Updated By: Olawale RN,
Clementinah; Reviewed Date: 08/21/2015 11:23

ESI

ESI Level 1 : No

ESI Level 2 : No

ESI Level 3 : Many

Vital Signs ESI : No

Lesiuk RN, Tonya L - 08/21/2015 11:39

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation - Emergency Department PowerForms***High Blood Pressure :* Self, borderline

Lesiuk RN, Tonya L - 08/21/2015 11:39

Gastrointestinal Past Medical Hx Grid*Ulcer Disease :* Self, duodenal

Lesiuk RN, Tonya L - 08/21/2015 11:39

Previous Surgery History Grid

<i>Surgery Description :</i>	Tonsillectomy	Other: bleeding duodenal ulcer repair
	Lesiuk RN, Tonya L - 08/21/2015 11:39	Lesiuk RN, Tonya L - 08/21/2015 11:39

ED Screens*Unable or unwilling to follow commands :* No*History of Fall in Last 3 Months Morse :* No*Sensory Motor Deficits :* No*Fall Safety Protocol KED :* Bed in low position, Wheels locked, Side rails up*Suicide Risk :* Denies*Homicide Risk :* Denies*Patient unable to Communicate/ Non-verbal :* No*Do you drink beer, wine, alcohol beverages :* No

Lesiuk RN, Tonya L - 08/21/2015 11:45

Domestic Violence Risk : Denies

Lesiuk RN, Tonya L - 08/21/2015 11:39

Nurse Progress Summary

Nurse Progress Summary : pt brought in by EMS for psych eval. Pt states him and his wife had an argument last night, during the argument the husband admits to taking out his gun which he say is empty and put it on the table and told his wife to go ahead kill me, get me out of my misery. Pt states he then left the house and when he returned wife had bags packed and she left for the night. Pt admits to 4 shots of tequila last night. This morning patient states he was sitting at table having a cup of coffee when the police showed up at his door. Pt has been calm and cooperative. Denies SI. Denies any pain.

Lesiuk RN, Tonya L - 08/21/2015 11:45

ED Documentation - ED Behavioral Health**BH Emergency Services Screening Form Entered On:** 08/21/2015 17:27**Performed On:** 08/21/2015 17:25 by Smith, Jeanne

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation - ED Behavioral Health**

Smith, Jeanne - 08/21/2015 19:08

Date/Time of Evaluation : 08/21/2015 17:25*Preferred Language of Care :* English*BH Gender :* Male*BH Age < 18 y/o :* No*Marital Status :* Married*Education Level :* Not applicable*Disease Alert Results :* Disease Alert**** View Only *****Isolation Precautions Order Detail :* Standard

Smith, Jeanne - 08/21/2015 17:25

BH Somatic Function*Appetite Changes :* Denied*Sleep Changes :* Yes*Sleep Changes Type :* Difficulty falling asleep*Energy Changes :* Denied*Libido Changes :* Denied*Impaired Functioning :* Denied

Smith, Jeanne - 08/21/2015 19:08

BH Risk Assessment*Danger to Others :* Denied*Asocial/Antisocial Behavior Exhibits :* Denied*Self-Injurious Behavior :* Denied*Suicidal/Self Destructive Thoughts :* Denied*Access to Weapons or Pills :* No*Describe Access and Plan :* Pt's guns were removed from the home by CPD.

Smith, Jeanne - 08/21/2015 19:08

BH Substance Use Screen*Criticized for Drinking/Drug Use? :* Denied*Has Client Ever Attempted to Quit? :* Denied*Client Acknowledged Substance Issue :* Yes

Smith, Jeanne - 08/21/2015 19:08

Substance Use History Grid

<i>Substance Use Type :</i>	Alcohol
<i>Amount Used :</i>	2 beers +couple nips
<i>Frequency of use :</i>	daily
<i>Duration of Use :</i>	years

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**ED Documentation - ED Behavioral Health**

	08/21/2015 19:08]
)
	Smith, Jeanne - 08/21/2015 19:08

Withdrawal Symptoms : Denied*BH Family Hx Risk Details* : Mental health issues*Family History Details* : Uncle completed suicide after returning from service 20 years ago*History of Abuse/Trauma* : Denied*Current Suspected/Actual Abuse/Trauma* : Denied

Smith, Jeanne - 08/21/2015 19:08

BH Mental Status Exam*BH Patient Appearance* : Normal: Appears stated age, appropriately dressed and groomed, good eye contact, no distinct physical features.*BH Attitude* : Cooperative*BH Motor Function* : Normal: No abnormalities in motor function evident.*BH Speech/Language* : Normal: Speech normal rate, rhythm and volume.*BH Thought Process and Content* : Normal: Thought processes well organized and linear, no delusions evident.*BH Perception and Hallucinations* : Normal: Denies perceptual abnormalities and hallucinations*Mood* : Anxious, Irritability*Affect* : Situation congruent*BH Sensorium* : Alert*Orientation* : Oriented x 3*BH Concentration* : Able to attend to interview*BH Memory* : Recalls personal history and recent events*BH Intellectual Functioning* : Normal*BH Insight and Judgment* : Insight impaired, Judgment impaired*BH Patient Strengths* : Self confident, Self directed, Complies with rules, Able to maintain residential stability

Smith, Jeanne - 08/21/2015 19:08

ED Medication ListMedication List

(As Of: 08/21/2015 20:09:53 EDT)

Home Meds

multivitamin

: multivitamin ; Status: Documented ; Ordered As Mnemonic:
multivitamin ; Simple Display Line: 1 tab, PO, daily ; Catalog

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**Clinical Diagnoses****Diagnosis:** psych eval (Qualifier:)**Last Reviewed Date:** 08/21/2015 11:42 ; Lesiuk RN, Tonya L **Responsible Provider:****Diagnosis Date:** 08/21/2015 **Status:** Active**Clinical Service:** Non-Specified; **Classification:** Medical; **Confirmation:** Complaint of; **Type:** Reason For Visit; **Code:****Diagnosis:** DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED (Qualifier:)**Last Reviewed Date:** **Responsible Provider:****Diagnosis Date:** **Status:** Active**Clinical Service:** ; **Classification:** ; **Confirmation:** ; **Type:** Final; **Code:** 311 (ICD-9-CM)**Diagnosis:** DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED (Qualifier:)**Last Reviewed Date:** **Responsible Provider:****Diagnosis Date:** **Status:** Active**Clinical Service:** ; **Classification:** ; **Confirmation:** ; **Type:** Admitting; **Code:** 311 (ICD-9-CM)**Diagnosis:** Suicidal ideation (Qualifier:)**Last Reviewed Date:** **Responsible Provider:****Diagnosis Date:** **Status:** Active**Clinical Service:** ; **Classification:** ; **Confirmation:** ; **Type:** Reason For Visit; **Code:** V62.84 (ICD-9-CM)**Diagnosis:** UNSPECIFIED ESSENTIAL HYPERTENSION (Qualifier:)**Last Reviewed Date:** **Responsible Provider:****Diagnosis Date:** **Status:** Active**Clinical Service:** ; **Classification:** ; **Confirmation:** ; **Type:** Final; **Code:** 401.9 (ICD-9-CM)

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

Provider Documentation - Consultation Notes

Document Type:	BH Emergency Services Screening Form
Document Subject:	BH Emergency Services Screening Form
Service Date/Time:	08/21/2015 17:25
Result Status:	Auth (Verified)
Performed Information:	Smith, Jeanne (08/21/2015 19:08)
Electronically Signed by:	Smith, Jeanne (08/21/2015 19:08)

BH Emergency Services Screening Form Entered On: 08/21/2015 17:27

Performed On: 08/21/2015 17:25 by Smith, Jeanne

BH Emergency Services Screen

Client Number : 2,296,715

BH Clients Occupation : Retired

Insurance Coverage : Medical Assistance

Income Supplementation : SSI

Support Person's Name : Kim Caniglia

Relationship to Patient : Spouse

Smith, Jeanne - 08/21/2015 19:08

Date/Time of Evaluation : 08/21/2015 17:25

Preferred Language of Care : English

BH Gender : Male

BH Age < 18 y/o : No

Marital Status : Married

Education Level : Not applicable

Disease Alert Results : Disease Alert

**** View Only ****

Isolation Precautions Order Detail : Standard

Smith, Jeanne - 08/21/2015 17:25

BH Somatic Function

Appetite Changes : Denied

Sleep Changes : Yes

Sleep Changes Type : Difficulty falling asleep

Energy Changes : Denied

Libido Changes : Denied

Impaired Functioning : Denied

Smith, Jeanne - 08/21/2015 19:08

BH Risk Assessment

Danger to Others : Denied

Asocial/Antisocial Behavior Exhibits : Denied

Self-Injurious Behavior : Denied

Suicidal/Self Destructive Thoughts : Denied

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**Provider Documentation - Consultation Notes***Client Acknowledged Substance Issue :* Yes

Smith, Jeanne - 08/21/2015 19:08

Substance Use History Grid

<i>Substance Use Type :</i>	Alcohol
<i>Amount Used :</i>	2 beers +couple nips
<i>Frequency of use :</i>	daily
<i>Duration of Use :</i>	years
<i>Date of Last Use :</i>	08/20/2015
<i>Comments</i>	(Comment: 4-5 shots Tequila last nigh [Smith, Jeanne - 08/21/2015 19:08])
	Smith, Jeanne - 08/21/2015 19:08

Withdrawal Symptoms : Denied*BH Family Hx Risk Details :* Mental health issues*Family History Details :* Uncle completed suicide after returning from service 20 years ago*History of Abuse/Trauma :* Denied*Current Suspected/Actual Abuse/Trauma :* Denied

Smith, Jeanne - 08/21/2015 19:08

BH Mental Status Exam*BH Patient Appearance :* Normal: Appears stated age, appropriately dressed and groomed, good eye contact, no distinct physical features.*BH Attitude :* Cooperative*BH Motor Function :* Normal: No abnormalities in motor function evident.*BH Speech/Language :* Normal: Speech normal rate, rhythm and volume.*BH Thought Process and Content :* Normal: Thought processes well organized and linear, no delusions evident.*BH Perception and Hallucinations :* Normal: Denies perceptual abnormalities and hallucinations*Mood :* Anxious, Irritability*Affect :* Situation congruent*BH Sensorium :* Alert

Kent Hospital**Patient Name:** Caniglia, Edward A**Date of Birth:** [REDACTED]**FIN:** 562037430**MRN:** 000489436**Provider Documentation - Consultation Notes**

Smith, Jeanne - 08/21/2015 19:08

ED Medication ListMedication List

(As Of: 08/21/2015 20:09:53 EDT)

Home Meds

multivitamin

: multivitamin ; *Status:* Documented ; *Ordered As Mnemonic:* multivitamin ; *Simple Display Line:* 1 tab, PO, daily ; *Catalog Code:* multivitamin ; *Order Dt/Tm:* 08/21/2015 16:26:30

multivitamin

: multivitamin ; *Status:* Documented ; *Ordered As Mnemonic:* Vitamin B Complex oral tablet ; *Simple Display Line:* 1 tab, PO, qPM ; *Catalog Code:* multivitamin ; *Order Dt/Tm:* 08/21/2015 16:26:51

LORazepam

: LORazepam ; *Status:* Documented ; *Ordered As Mnemonic:* LORazepam 2 mg oral tablet ; *Simple Display Line:* 1 mg, 0.5 tab, PO, qHS, prescribed as 1T;QHS;prn, PRN: sleep ; *Catalog Code:* LORazepam ; *Order Dt/Tm:* 08/21/2015 16:25:30

losartan

: losartan ; *Status:* Documented ; *Ordered As Mnemonic:* losartan 100 mg oral tablet ; *Simple Display Line:* 100 mg, 1 tab, PO, daily ; *Catalog Code:* losartan ; *Order Dt/Tm:* 08/21/2015 16:25:18

losartan

: losartan ; *Status:* Completed ; *Ordered As Mnemonic:* losartan 100 mg oral tablet ; *Simple Display Line:* 100 mg, 1 tab, PO, daily ; *Catalog Code:* losartan ; *Order Dt/Tm:* 12/06/2014 00:30:11

LORazepam

: LORazepam ; *Status:* Completed ; *Ordered As Mnemonic:* LORazepam 2 mg oral tablet ; *Simple Display Line:* 2 mg, 1 tab, PO, qHS ; *Catalog Code:* LORazepam ; *Order Dt/Tm:* 12/06/2014 00:29:37

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

Provider Documentation - Consultation Notes

BH Disposition

BH Clinical Overview : Patient is a 65 year-old MWM brought to Kent ED via rescue. Patient reportedly placed a gun on the table after argument with wife and stated "Just shoot me. Put me out of my misery". Cranston Police was called to the home.

Upon assessment, Patient pacing in room was fully cooperative with Writer. Patient right away expressed eagerness to discharge home. States that Dr Graves had told him he could go home. Patient reported that he felt at a loss that his wife called the Police. He explained that he had an insignificant argument with her last night over a coffee mug. Wife left for the night and returned this morning. States that he placed the gun on the table, and had removed the magazine prior to this. Admitted that he made the statement but denied feeling suicidal or homicidal before, during, or after this incident. Patient stated that wife made similar statement when she was hospitalized for major pain issue last year. Patient was adamant that he would never harm himself, his wife, or others. Patient stated that when he returned home after incident, wife was gone. "Next thing I know a Police squad was at my house. They offered me to go to hospital or I can stay home and get my guns confiscated". Patient denied all psychiatric symptoms. States that he saw what the suicide of his uncle 20 years ago, and the suicide of his friend Joey a year ago did to the survivors. Thus, he would never kill himself. Patient endorsed fleeting depression "because I am getting old and I worry about medical breakdown. Everybody does." States that he made an appointment with his PCP for a full workup. States that he is financially well off, having made a lot of money as a general contractor. Blaming of his wife for "changing since her mother died a year ago".

Writer interviewed Patient's wife over a half hour. Wife had to be taken to ED's family room for therapeutic intervention due to mood lability while this clinician attempted to obtain collateral information. Wife denied feeling unsafe. States that she is not concerned that her husband would attempt suicide. States "he is too narcissistic for that". Wife confirmed Patient's report as depicted above. Wife informed that the patient drinks more than he is reporting. States that in addition to the 2 beers reported, Pt also drinks a couple little nips "it only starts affecting him after the 4 or 5th nip." Wife c/o tearfully that she does not feel supported or understood by her husband. Wife discussed that she started seeing a therapist with whom she has been on the phone for several hours last night and today. Complained that her husband would not support her in this endeavor, nor agreeable to join her in spousal counseling. Wife shared that her hope was that her husband could get some help here in the ER. Wife was adamant that the Police had removed both guns from the home while her husband was in the rescue vehicle. States that he would be upset to know this, but insisted that she still felt safe. Writer recommended to wife to continue seeking her therapist advice, and to call 911 if any concerns for her safety or the safety of her husband. Wife informed that she is planning to return to hotel tonight.

Writer informed Patient that the Police had removed the guns from the home. Patient received news calmly and took list of outpatient mental health resources offered by Writer.

BH Disposition : Patient was discharged to home with resources to follow up with outpatient mental health services.

Disposition discussed with, and approved by ED Attending Physician.

Axis I : Unspecified Depressive Disorder 311 (F32.9)

Axis II : Deferred 799.99

Axis III : None reported

BH Clinical Assessment : Patient was alert and oriented x3. Patient denied suicidal and homicidal thoughts, intent, or plan. Patient denied past attempts. Patient denied history of mental illness or past psychiatric hospitalization. Patient denied

Kent Hospital

Patient Name: Caniglia, Edward A

Date of Birth: [REDACTED]

FIN: 562037430

MRN: 000489436

Provider Documentation - Consultation Notes

Axis IV: Marital dispute, interpersonal relationship, social environment

Axis V GAF: 45

Smith, Jeanne - 08/21/2015 19:08