## 1 PATIENT INFORMATION

NAME
Julian R. Okonkwo-Beck

DATE OF SERVICE
August 6, 2026

DOB
12/04/1994 (31 yrs)

PROVIDER
Elena Marchetti, MD

AGE / SEX
31 / Male

CREDENTIALS
MD, Board-Certified Psychiatrist

MRN / PATIENT ID
PSY-618305

VISIT TYPE
Psychiatry Follow-Up — hospital discharge follow-up, medication management

CARE SETTING
Outpatient

REFERRAL SOURCE
Northshore Behavioral Health inpatient unit, discharged 07/29/2026

PRIMARY CARE PROVIDER, IF APPLICABLE
Dr. Ruth Ellery, Family Medicine

THERAPIST / COUNSELOR, IF APPLICABLE
Not currently engaged — referral pending

## CC CHIEF COMPLAINT

"I'm flat, I'm shaky, and I still can't believe what I did. I don't know if I trust the diagnosis or the medication." First outpatient visit eight days after discharge from a 14-day inpatient admission for a manic episode with psychotic features.

## S SUBJECTIVE

### 3a REASON FOR PSYCHIATRIC EVALUATION

Post-hospitalization follow-up and medication management following a first documented manic episode with psychotic features, which resulted in a diagnostic revision from major depressive disorder to bipolar I disorder. Purposes of this visit: assess post-manic depressive symptoms and safety, review lithium tolerability and obtain a level, address his active ambivalence about the diagnosis and treatment, and begin repairing the occupational and interpersonal fallout.

### 3b MOOD SYMPTOMS

Currently describes his mood as “flat, like the volume is turned down.” Reports prominent anhedonia — he has not played guitar, previously a daily activity, since discharge. Significant guilt and shame, rated as the most distressing symptom, centered on his behavior during the manic episode: he spent approximately $19,000 on credit cards, sent accusatory late-night messages to colleagues, and was found by police directing traffic at an intersection at 3 a.m. He describes feeling “not like myself, and also somehow exactly like myself, which is worse.” Denies current elevated or expansive mood. Some irritability with his partner, which he attributes to frustration rather than mood elevation. Mood is reactive to some degree — he brightened briefly discussing his younger sister’s visit.

### 3c ANXIETY SYMPTOMS

Persistent anticipatory anxiety about returning to work and about a pending disciplinary review. Reports rumination on the manic episode and worry about recurrence — “What if it happens again and I don’t notice?” No panic attacks, no agoraphobia, no social phobia beyond situation-specific avoidance of colleagues. Some somatic anxiety with chest tightness and restlessness, partially confounded by the lithium tremor.

### 3d MANIA / HYPOMANIA SYMPTOMS

No current manic or hypomanic symptoms. Retrospective history of the index episode, corroborated by his partner: approximately 3 weeks of decreased need for sleep (2–3 hours nightly without fatigue), markedly increased energy and goal-directed activity (started three business ventures), pressured speech, racing thoughts, grandiosity (believed he had “solved a problem in logistics that no one had solved”), impulsive spending, and hypersexuality. Psychotic features emerged in the final week with grandiose delusions and ideas of reference from radio broadcasts. Critically, on careful retrospective review, he described two prior episodes at ages 24 and 27 lasting 4–5 days each with reduced sleep and heightened productivity, which were never reported to a clinician and which he had considered “good weeks.” These almost certainly represented hypomania, which was missed.

### 3e PSYCHOTIC SYMPTOMS

No current hallucinations, delusions, or paranoia. Reality testing is intact today. During the index episode he experienced grandiose delusions and referential thinking; these resolved within approximately 9 days of starting olanzapine inpatient. He retains full recall of the psychotic content and finds it disturbing, describing it as “watching a recording of someone else in my body.” No negative symptoms, no disorganization.

### 3f TRAUMA-RELATED SYMPTOMS

No history of childhood or adult trauma disclosed. However, he describes the involuntary hospitalization and police involvement as traumatic — intrusive recollections of being restrained, avoidance of the intersection where he was found, and heightened startle around police vehicles. These symptoms are subthreshold for PTSD but are clinically significant and are contributing to his treatment ambivalence, as he associates psychiatric care with that experience.

### 3g SLEEP AND APPETITE

Sleep has normalized in duration but not quality — 7–8 hours nightly with olanzapine, but he describes it as “heavy and drugged” with morning grogginess lasting until midday. No early awakening, no nightmares. Appetite markedly increased on olanzapine with an 11 lb weight gain in 5 weeks, which he finds distressing and which he named as the single most likely reason he would stop the medication. Eating pattern otherwise regular.

### 3h ATTENTION / COGNITIVE SYMPTOMS

Reports concentration difficulty and word-finding pauses that he attributes to medication. Difficulty reading more than a few pages. Some forgetfulness with appointments. These are consistent with post-manic depressive cognitive symptoms compounded by olanzapine sedation, and he is understandably worried about returning to a cognitively demanding role.

### 3i FUNCTIONAL IMPACT

Substantial across domains. Occupationally he is a logistics operations manager, currently suspended pending a disciplinary review related to conduct during the manic episode; HR has requested medical documentation. Relationally his partner of 4 years is supportive but described by him as "watching me constantly," which he finds both reassuring and infantilizing. Financially the $19,000 debt is unresolved and generating ongoing stress. Self-care is adequate — showering and dressing daily. Socially withdrawn, declining contact with friends who witnessed the episode.

### 3j PSYCHOSOCIAL STRESSORS

Multiple and compounding: pending disciplinary review with genuine risk of job loss; $19,000 of consumer debt from manic spending; strain in his primary relationship; loss of driving privileges pending psychiatric clearance; shame within his professional network; and disruption of identity as a high-performing person. No housing insecurity — he lives with his partner in a stable rental. No legal charges filed from the police encounter. No caregiving burden. Family is geographically distant but supportive.

### 3k MEDICATION HISTORY AND TREATMENT RESPONSE

**Current:** lithium carbonate 900 mg nightly (started inpatient day 4, titrated), olanzapine 10 mg nightly, and lorazepam 0.5 mg as needed (used twice since discharge). **Adherence:** reports taking both consistently but volunteered that he has "thought about stopping the olanzapine" because of weight gain and sedation. **Critically important prior history:** he was treated for presumed major depressive disorder from 2022, trialed on sertraline (inadequate response), then escitalopram, then venlafaxine 225 mg — which was escalated approximately 6 weeks before the manic episode when he was labeled "treatment-resistant." The antidepressant monotherapy, in an undiagnosed bipolar patient, is the probable precipitant of the manic switch. He was never asked about periods of elevated mood or reduced sleep need. No prior psychiatric hospitalization before this admission. No neuromodulation. No prior mood stabilizer trial. Therapy: brief counseling in 2022, discontinued after 4 sessions.

### 3l SUBSTANCE USE

Cannabis: near-daily use for approximately 5 years, typically 1–2 grams weekly by vaporizer, last used 3 days before admission and abstinent since discharge — he stopped independently, believing it "might have made things worse." No cravings reported. Alcohol: 3–4 drinks weekly socially, none since discharge. Tobacco: never. No stimulant, opioid, sedative (other than prescribed lorazepam), or hallucinogen use. No withdrawal symptoms. No formal recovery supports. Cannabis is clinically relevant here as an independent risk factor for psychotic symptoms and mood destabilization, and his spontaneous abstinence is a meaningful protective development worth reinforcing.

### 3m SAFETY CONCERNS

Endorses **passive suicidal ideation** — "Sometimes I think it would be easier if I just wasn't here to deal with the mess I made." Frequency roughly 2–3 times weekly, brief, and he can distract from it. **No active ideation, no plan, no intent, no preparatory behavior.** He identifies strong protective factors: his partner, his sister, his dog, and explicitly states he "would never do that to them." No history of suicide attempt or self-harm. **Access to lethal means:** no firearms in the home; medications are held and dispensed by his partner, which was arranged at discharge and which he accepts. No homicidal ideation, no aggression, no violence history. No abuse or neglect concerns. Does not currently require a higher level of care.

### 3n PERTINENT NEGATIVES

Denies active suicidal ideation with plan or intent, homicidal ideation, self-harm thoughts or behaviors, current hallucinations, current delusions, paranoia, and current manic or hypomanic symptoms. Denies substance misuse since discharge. Denies medication nonadherence to date, though ambivalence is openly expressed. No acute safety concerns requiring hospitalization today. No lithium toxicity symptoms — denies vomiting, diarrhea, coarse tremor, ataxia, confusion, or slurred speech.

## ROS PSYCHIATRIC REVIEW OF SYSTEMS

**DEPRESSION**

Positive — depressed and flat mood, anhedonia, prominent guilt, low motivation

**ANXIETY**

Positive — anticipatory anxiety and rumination; denies panic attacks or agoraphobia

**MANIA / HYPOMANIA**

Negative currently; positive by history (index episode plus two missed hypomanic episodes)

**PSYCHOSIS**

Negative currently; positive by history during the index episode, resolved on olanzapine

**TRAUMA SYMPTOMS**

Positive — subthreshold intrusion, avoidance, and startle related to the involuntary hospitalization

**OBSESSIONS / COMPULSIONS**

Negative — no obsessions, compulsions, or repetitive behaviors

**SLEEP / APPETITE**

Positive — sedated non-restorative sleep, markedly increased appetite, 11 lb weight gain

**COGNITION**

Positive — concentration difficulty, word-finding pauses, forgetfulness

**SUBSTANCE USE**

Cannabis near-daily for 5 years, abstinent since discharge; no cravings or withdrawal

**SAFETY**

Positive for passive suicidal ideation without plan or intent; denies HI, self-harm, or aggression

## O OBJECTIVE / MENTAL STATUS EXAMINATION

### 5a VITALS, IF OBTAINED

**TEMPERATURE**

36.7 °C

**RESPIRATORY RATE**

14 / min

**BLOOD PRESSURE**

124/78 mmHg

**OXYGEN SATURATION**

99% on room air

**HEART RATE**

78 bpm, regular

**WEIGHT / BMI IF RELEVANT**

198 lb; BMI 27.6 — up 11 lb over 5 weeks on olanzapine

### 5b MENTAL STATUS EXAMINATION

**GENERAL APPEARANCE**

Casually dressed in clean clothing, adequately groomed though he notes he “made an effort” for the appointment; appears his stated age; mildly overweight; no acute distress but visibly subdued

**BEHAVIOR**

Cooperative and forthcoming, notably candid about ambivalence and shame. Good eye contact, occasionally downcast when discussing the manic episode. Psychomotor activity mildly retarded. No agitation, guardedness, or restlessness. A fine bilateral hand tremor is evident at rest and with outstretched hands.

**SPEECH**

Normal rate and volume, fluent and articulate, with slightly increased latency of response. Coherent and goal-directed. No pressured speech, no poverty of speech, normal prosody.

MOOD

"Flat — and ashamed" (patient-reported)

AFFECT

Constricted in range, congruent with stated mood, mildly reduced intensity, with some reactivity — brightened appropriately when discussing his sister

THOUGHT PROCESS

Linear, logical, and goal-directed. No circumstantiality, tangentiality, flight of ideas, looseness of associations, blocking, or perseveration. Notably organized compared with the documented inpatient presentation.

THOUGHT CONTENT

Passive suicidal ideation as described — no plan, intent, or preparatory behavior. Prominent guilt and shame with ruminative quality. No homicidal ideation, delusions, paranoia, obsessions, or phobias. Preoccupied with occupational consequences and diagnostic uncertainty.

PERCEPTION

No auditory, visual, or tactile hallucinations. No illusions. No dissociation, depersonalization, or derealization. Reality testing fully intact.

COGNITION

Alert and oriented to person, place, time, and situation. Attention and concentration mildly reduced — serial sevens completed slowly with one self-corrected error. Registration intact; 2 of 3 objects recalled at 5 minutes. Fund of knowledge appropriate. Abstraction intact on proverb interpretation. Findings consistent with post-manic depression plus medication sedation rather than a primary cognitive disorder.

INSIGHT

Partial and evolving — the clinically pivotal finding. He accepts that the manic episode occurred and was abnormal, but remains genuinely ambivalent about the bipolar I diagnosis and about indefinite mood-stabilizer treatment, saying "Maybe it was just the venlafaxine and it will never happen again." He is engaged and reasoning, not dismissive.

JUDGMENT

Currently intact — attended the appointment independently, accepted partner-supervised medication dispensing, and stopped cannabis of his own accord. Judgment was severely impaired during the index episode.

IMPULSE CONTROL

Intact at present. Severely impaired during the index manic episode, with impulsive spending and hypersexuality.

SAFETY

No acute safety concerns today. Passive ideation without plan or intent, robust protective factors, means restriction already in place, and a supportive partner. Safety plan updated and documented; outpatient management appropriate.

## AS STANDARDIZED SCREENING / ASSESSMENT TOOLS

PHQ-9 (SCORE / SEVERITY / CHANGE)

16 — moderately severe depression (was 21 at discharge; improving)

GAD-7 (SCORE / SEVERITY / CHANGE)

12 — moderate anxiety (was 14 at discharge)

C-SSRS (SI LEVEL / RISK CATEGORY)

Positive for passive ideation (item 2); negative items 3–5; no lifetime attempt — low-to-moderate risk

PCL-5 (SCORE / INTERPRETATION)

24 — subthreshold; symptoms clustered around the hospitalization experience

MDQ (RESULT)

Positive — 13 symptom items endorsed with clustering

YMRS (SCORE)

3 — no current manic symptoms (was 32 on admission)

and severe functional impairment; retrospectively positive for the two prior missed hypomanic episodes

ASRS (SCORE)

Not administered — attention symptoms attributed to mood state and medication; defer until euthymic

AUDIT-C / DAST (SCORE)

AUDIT-C 2 (low risk); DAST 3 (moderate, cannabis-driven; abstinent since discharge)

AIMS (SCORE)

0 — no abnormal involuntary movements; baseline established for ongoing antipsychotic monitoring

SLEEP, FUNCTIONAL, OR DIAGNOSIS-SPECIFIC SCALES

Sleep diary initiated at discharge — 7–8 hours nightly, non-restorative

**Interpretation and limitations:**

The MDQ is retrospectively positive and, together with the corroborated index episode and two previously unrecognized hypomanic periods, substantiates the bipolar I diagnosis. PHQ-9 has fallen from 21 to 16 and YMRS from 32 to 3, indicating meaningful improvement without a switch into elevated mood. The elevated PHQ-9 partly reflects somatic items (sleep, appetite, concentration) confounded by olanzapine, so the true depressive burden may be somewhat lower than the raw score suggests. PCL-5 is subthreshold and should be re-administered once mood improves, as depressive states inflate trauma symptom reporting.

## RA RISK ASSESSMENT

**Suicidal ideation, plan, intent, means, access to lethal means, past attempts, and protective factors:**

Passive ideation 2–3 times weekly, brief and distractible, framed around guilt over the manic episode's consequences rather than a wish to die. No active ideation, no plan, no intent, no preparatory behavior, no rehearsal. No lifetime suicide attempt and no family history of suicide. Means restriction is already in place — no firearms in the home and medications held and dispensed by his partner. Protective factors are strong and specific: his partner, his sister, his dog, future orientation toward returning to work, help-seeking behavior demonstrated by attending this appointment, and explicit moral objection to suicide.

**Self-harm thoughts, urges, behaviors, triggers, frequency, and intent:**

None currently and none historically. No cutting, burning, or other self-injurious behavior at any point.

**Homicidal ideation, plan, intent, target, means, and protective factors:**

None. No violent ideation, no identified target, no history of violence toward others. The accusatory messages sent during mania were verbal and non-threatening in content.

**Psychosis-related safety concerns:**

None currently — psychotic symptoms fully resolved with no residual delusional conviction and intact reality testing. During the index episode, grandiose delusions did drive genuinely dangerous behavior (directing traffic on a live roadway), which establishes that his psychosis-related risk in a future manic episode is high and argues strongly for relapse prevention.

**Mania-related impulsivity or risk-taking behavior:**

None currently. Historically severe — $19,000 in impulsive spending, hypersexuality, and hazardous behavior in traffic. Financial safeguards discussed today, and his partner already has visibility of accounts.

**Substance-related risk, intoxication, withdrawal, or relapse risk:**

Not intoxicated and no withdrawal. Cannabis abstinent since discharge with no cravings. Relapse risk is moderate given a 5-year near-daily pattern and significant current stressors; cannabis resumption would meaningfully raise the risk of mood destabilization and psychotic recurrence.

**Abuse, neglect, exploitation, or domestic violence concerns:**

None identified. The relationship with his partner appears supportive; his description of feeling "watched" reflects his own loss of autonomy rather than controlling behavior, and was explored directly.

OVERALL RISK LEVEL

Moderate

CLINICAL RATIONALE FOR RISK LEVEL

Passive ideation with strong protective factors and means restriction places acute risk low; however, the post-manic depressive phase carries elevated suicide risk in bipolar I, and diagnostic ambivalence with concrete medication-discontinuation intent creates meaningful medium-term relapse risk. Moderate reflects that medium-term risk, not imminent danger.

**Safety plan, crisis resources, lethal means restriction, emergency instructions, or higher level of care recommendation:**

Collaborative safety plan written with the patient today and a copy given to him and, with his consent, to his partner. Warning signs identified in his own words. Coping strategies: guitar, walking the dog, calling his sister. Social contacts and crisis lines listed, including the 988 Suicide and Crisis Lifeline. Means restriction continued — no firearms, partner-dispensed medication. Explicit instruction to present to the emergency department or call 988 for active ideation, intent, or return of manic symptoms. Higher level of care not indicated today; criteria for escalation reviewed with him directly.

## L LABORATORY AND DIAGNOSTIC RESULTS

**Medication Monitoring Labs:**

**Lithium level 0.62 mmol/L** drawn today as a true 12-hour trough — within the therapeutic maintenance range of 0.6–0.8. TSH 2.1 mIU/L (normal; baseline established, as lithium can induce hypothyroidism). Creatinine 0.95 mg/dL with eGFR above 90 — normal renal function, essential for ongoing lithium use. Calcium 9.4 mg/dL (normal; lithium can cause hyperparathyroidism). CBC unremarkable. LFTs normal. Fasting glucose 104 mg/dL and A1c 5.8% — prediabetic range, clinically important given olanzapine. Fasting lipids: LDL 128, triglycerides 172, HDL 38 — an emerging metabolic picture. Prolactin not indicated on olanzapine unless symptomatic.

**Substance / Toxicology Testing:**

Urine drug screen today negative for cannabinoids, cocaine, amphetamines, opiates, and benzodiazepines other than prescribed — objectively corroborating his reported abstinence, which was shared with him as positive reinforcement.

**Neurologic / Medical Workup:**

B12 486 pg/mL and folate normal. Vitamin D 28 ng/mL (insufficient). No EEG or neuroimaging indicated — the presentation is characteristic of bipolar I with a clear precipitant, no focal neurologic findings, and no atypical features requiring organic workup. No sleep study indicated.

**Cardiac Monitoring:**

ECG performed today: normal sinus rhythm, rate 76, QTc 428 ms — within normal limits and providing a baseline for ongoing antipsychotic monitoring. No conduction abnormality.

**Prior Records Reviewed:**

Complete 14-day inpatient record from Northshore Behavioral Health including admission mental status, YMRS of 32 on admission, medication titration, the discharge summary, and nursing observations. Primary care records from 2021 forward documenting the depression treatment sequence — which established that no clinician had screened for manic or hypomanic symptoms before venlafaxine escalation. Pharmacy fill history. Emergency department record from the night of police involvement. Collateral obtained by telephone from his partner with written consent, corroborating the three-week prodrome and the two prior brief episodes at ages 24 and 27.

## A ASSESSMENT

**Bipolar I disorder, most recent episode manic with psychotic features, currently in a post-manic depressive phase with partial remission — a diagnostic revision from major depressive disorder.** This reclassification is the central clinical fact of the case. He carried a depression diagnosis for four years and progressed through three antidepressants; a manic switch occurred roughly six weeks after venlafaxine was escalated to 225 mg for presumed treatment resistance. Retrospective history, corroborated by his partner, identified two unrecognized hypomanic episodes at ages 24 and 27. The diagnosis was almost certainly present from the outset and was missed because elevated-mood periods were never asked about — a common and consequential diagnostic failure, and one he deserves to have explained to him honestly rather than glossed over.

**Differential considered.** Substance-induced mood disorder was weighed given 5 years of near-daily cannabis, but the episode's severity, three-week duration, psychotic features, and persistence beyond cannabis clearance argue against it; cannabis is best understood as a contributing destabilizer rather than the cause. Schizoaffective disorder is excluded — psychotic symptoms occurred exclusively within the mood episode and resolved with it. Primary psychotic disorder excluded for the same reason. Organic and medical causes are excluded by normal labs, a normal neurologic examination, and the absence of atypical features. Antidepressant-associated mania is definitionally subsumed under bipolar I once a full manic episode has occurred.

**Current clinical status: improving but not remitted.** PHQ-9 has fallen from 21 to 16 and YMRS from 32 to 3. Mood is depressed and flat with anhedonia and prominent guilt, but thought process is organized, psychosis has resolved, and there is no switch into elevated mood on lithium. The depressive phase following mania is expected and is also the period of highest suicide risk in bipolar I — which is why the passive ideation, though currently low-acuity, is taken seriously.

**Treatment response and the adherence problem — the main threat to his outcome.** Lithium at 0.62 mmol/L is therapeutic and appears effective. But he has two concrete, credible reasons to stop treatment: an 11 lb weight gain in 5 weeks with metabolic drift (A1c 5.8, triglycerides 172) driven by olanzapine, and genuine diagnostic ambivalence — "maybe it was just the venlafaxine." He volunteered the discontinuation thought unprompted, which is a gift clinically: it is far better to hear it now than to discover it at a relapse. Non-adherence in bipolar I carries a high probability of recurrence, and the index episode demonstrated that his manic behavior is genuinely dangerous.

**Contributing and complicating factors:** a fine lithium tremor affecting a guitarist, which is not trivial to him; subthreshold trauma symptoms from the involuntary hospitalization that are actively fueling treatment aversion; substantial and unresolved psychosocial stressors including a pending disciplinary review, $19,000 of debt, and suspended driving; social withdrawal; and no current therapist. **Protective and favorable factors:** spontaneous cannabis abstinence confirmed by negative screen, a supportive and engaged partner, preserved insight into the episode having occurred, help-seeking behavior, normal renal and thyroid function permitting long-term lithium, and a clear identifiable precipitant.

## P PLAN

**Medication plan:**

**Continue lithium carbonate 900 mg nightly** — level therapeutic at 0.62; no dose change. Lithium is the appropriate long-term agent given its anti-suicidal effect, which is particularly relevant to his risk profile, and his normal renal and thyroid function. **Begin cross-tapering olanzapine.** Rather than dismissing his weight-gain concern, treat it as a legitimate reason to change: reduce olanzapine from 10 mg to 7.5 mg nightly now, with a planned further reduction to 5 mg in 2 weeks if mood remains stable, transitioning toward a more weight-neutral agent such as aripiprazole or lurasidone if continued antipsychotic cover is needed. Making his stated concern the driver of the plan is the single most effective adherence intervention available here. **Address the lithium tremor:** the fine tremor is dose-related and affects his guitar playing; propranolol 10 mg twice daily as needed offered and accepted. **Lorazepam 0.5 mg as needed** continued short-term with a clear plan to discontinue; usage to be monitored. **Venlafaxine and all antidepressant monotherapy are contraindicated** — documented prominently and communicated to primary care.

**Therapy plan:**

**Referral placed for bipolar-specific psychotherapy** — he is currently unengaged, which is a significant gap. Preference for a therapist experienced in bipolar disorder for psychoeducation, mood charting, and illness-management work. Interpersonal and Social Rhythm Therapy specifically indicated given the central role of sleep and routine disruption in his prodrome. CBT components to address guilt and shame, which he identifies as his most distressing symptom. Couples session offered to include his partner in relapse-prevention planning and to address the "being watched" dynamic constructively; he accepted. Trauma-focused work regarding the hospitalization deferred until mood is more stable, but flagged for future attention.

**Safety plan:**

Collaborative written safety plan completed today, copies to patient and (with consent) partner. Means restriction continued — no firearms in the home, partner-dispensed medications. Crisis resources including 988 provided in writing. Explicit escalation criteria reviewed: active suicidal ideation, intent, plan, or return of reduced sleep need and elevated mood. Partner briefed with consent on early warning signs of mania, with sleep reduction identified as his most reliable prodromal marker. Follow-up interval deliberately shortened to 1 week given moderate risk.

**Substance use plan:**

Reinforced his independent cannabis abstinence explicitly and with specificity — the negative urine screen was shown to him. Explained the evidence linking cannabis to mood destabilization and psychosis risk in bipolar disorder, framing continued abstinence as directly protective rather than as a moral requirement. Brief motivational interviewing conducted; he expressed firm intention to remain abstinent. Relapse-prevention planning around his current stressors, which are the likeliest trigger for resumption. Formal substance treatment not indicated at this time. No medication-assisted treatment required. Monitoring by periodic urine screen with his agreement.

**Sleep and lifestyle plan:**

**Sleep regularity is a clinical intervention, not general advice** — explained that reduced sleep need is both his prodromal signal and a potential trigger, and that protecting a consistent schedule is genuinely preventive. Continue the sleep diary begun inpatient. Consistent bed and wake times including weekends. Morning-grogginess concerns will be addressed by the olanzapine reduction. Encouraged resumption of guitar as behavioral activation with intrinsic value to him — the propranolol for tremor supports this directly. Graded exercise for mood and metabolic benefit. Structured daily routine given work suspension, as unstructured time is a relapse risk.

**Laboratory or monitoring plan:**

Lithium level, renal function, and electrolytes in 2 weeks, then every 3 months once stable. TSH and calcium every 6 months. Given the metabolic findings — A1c 5.8 and triglycerides 172 — repeat fasting glucose, A1c, and lipids in 3 months, with weight and waist circumference at every visit; the olanzapine reduction is expected to help. AIMS every 6 months while on an antipsychotic, baseline of 0 documented today. Repeat ECG if the antipsychotic is switched. Vitamin D supplementation started for a level of 28.

**Care coordination plan:**

Direct communication with primary care Dr. Ellery — with consent — conveying the diagnostic revision and the antidepressant-monotherapy contraindication, which is the most important piece of information to transmit and prevents a recurrence of the original error. **Occupational documentation provided** to HR at his request, confirming a medical condition, treatment engagement, and anticipated capacity for graded return, without disclosing diagnostic specifics beyond what he authorized. Therapy referral coordinated. Partner included with written consent. Discussion of driving: DVLA/DMV notification requirements reviewed and he was supported in completing it. Financial counseling referral offered for the manic-episode debt and accepted.

**Patient education:**

Spent substantial time on the diagnostic revision, and told him plainly that the earlier depression diagnosis was incomplete and that the manic episode was likely precipitated by an antidepressant given without a mood stabilizer — he was visibly relieved to hear this named directly rather than feeling the episode was an inexplicable personal failure. Explained bipolar I as a recurrent, treatable condition and reviewed why maintenance treatment is preventive rather than merely reactive. Discussed the specific rationale for lithium including its anti-suicidal effect. Reviewed lithium toxicity warning signs, NSAID and dehydration interactions, and the importance of consistent salt and fluid intake. Provided written materials and a mood chart. Addressed shame directly: distinguished the illness from his character, which he found meaningful. Validated his ambivalence as reasonable rather than resistant, and framed the next several visits as a shared evaluation of whether treatment is working.

## F FOLLOW-UP

Return in 1 week — interval deliberately short given moderate risk, active diagnostic ambivalence, and the olanzapine taper. Purpose: reassess mood and passive suicidal ideation, evaluate tolerance of the olanzapine reduction, confirm the tremor response to propranolol, and continue the adherence conversation. Lithium level, renal function, and electrolytes in 2 weeks. Therapy intake targeted within 2 weeks. Couples session within 3–4 weeks. Metabolic panel with A1c and lipids at 3 months. Visits weekly for the first month, then biweekly, extending to monthly once euthymic and adherent. Contact the clinic or present to the emergency department immediately for active suicidal ideation, intent, or return of reduced sleep need or elevated mood.

## TD TIME DOCUMENTATION, IF APPLICABLE

| | |
|---|---|
| TOTAL TIME SPENT | 80 minutes |
| CARE COORDINATION TIME | 15 minutes (primary care, HR documentation, therapy referral) |
| MEDICATION MANAGEMENT TIME | 25 minutes |
| SAFETY PLANNING TIME | 15 minutes |
| PSYCHOTHERAPY / COUNSELING TIME | 20 minutes (supportive and motivational interviewing regarding adherence and cannabis) |
| RECORDS REVIEW TIME, IF APPLICABLE | 20 minutes (inpatient record, primary care history, collateral call) |

## TB BILLING CONSIDERATIONS

**E/M LEVEL**

99215 — Established patient, high complexity

**PSYCHOTHERAPY CODE(S), IF APPLICABLE**

90833 — Psychotherapy, 30 minutes, with E/M service (add-on)

**PSYCHIATRIC DIAGNOSTIC EVALUATION CODE, IF APPLICABLE**

Not applicable — established patient; 90792 billed at the inpatient admission

**BASIS FOR BILLING**

Medical Decision Making (high), with add-on psychotherapy; total time 80 minutes documented

**PRIMARY PSYCHIATRIC DIAGNOSIS CODE + DESCRIPTION**

F31.2 — Bipolar I disorder, current or most recent episode manic, with psychotic features (currently depressed, partial remission)

**SECONDARY DIAGNOSIS CODE(S)**

F31.4 (bipolar I, current episode depressed, moderate); F12.20 (cannabis use disorder, moderate, in early remission); R45.851 (suicidal ideation); E66.9 (weight gain associated with medication); R25.1 (tremor); Z91.14 (patient noncompliance risk — documented ambivalence)

## SO SIGNATURE

| PROVIDER NAME | CREDENTIALS | SPECIALTY | DATE | TIME |
|---|---|---|---|---|
| Elena Marchetti, MD | MD, DFAPA | Psychiatry | 08/06/2026 | 15:05 |