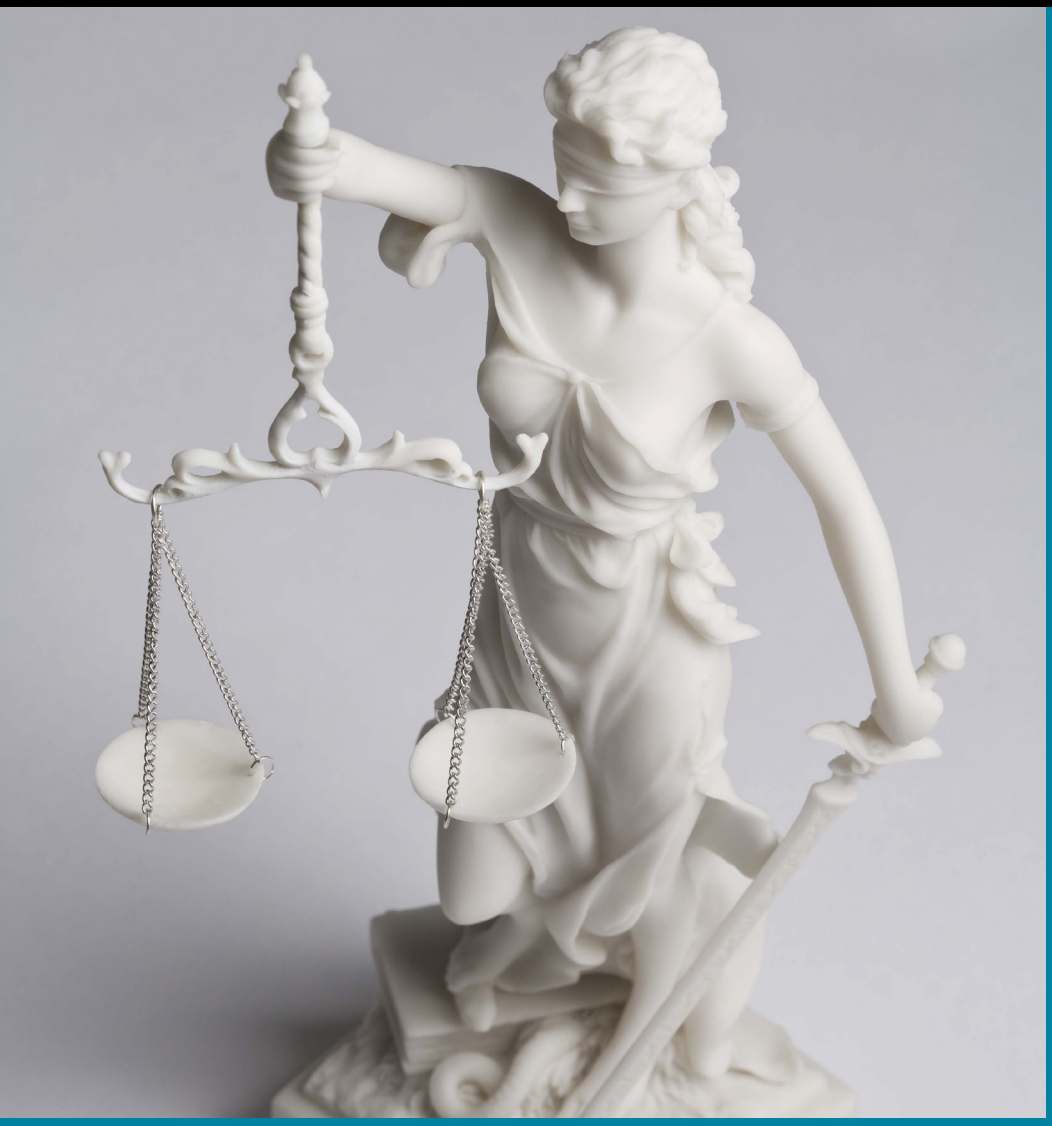
NEW YORK STATE BAR ASSOCIATION



WORKSHOP H.

Moving Towards Civil Gideon

2014 Legal Assistance Partnership Conference

Hosted by:
The New York State Bar Association
and The Committee on Legal Aid

NYSBA

NEW YORK STATE BAR ASSOCIATION
2014 PARTNERSHIP CONFERENCE

H. PROVING YOUNG ADULT DISABILITY CLAIMS: MOCK HEARING

AGENDA

September 12, 2014
10:45 a.m. – 12:15 p.m.

1.5 Transitional CLE Credits in Skills.
Under New York's MCLE rule, this program has been approved for all attorneys, including newly admitted.

Panelists:
Lynda (LJ) Fisher, Esq., Senior Attorney, Empire Justice Center
Jocelyne Martinez, Esq., Supervising Attorney, The Legal Aid Society
Emilia Sicilia, Esq., Director of Disability Benefits Advocacy, Urban Justice Center

I. Age 19 Reconsideration Procedures **10:45 am – 11:05 am**

a. Initial Review
b. Reconsideration Step
c. Interim Benefits
d. Face-to-face Reconsideration Hearing

II. Hearing Techniques **11:05 am – 11:25 am**

a. Art of Direct Examination
b. Mental Impairment cases
c. Drug and Alcohol Addiction cases
d. Adaptive functioning issues
e. Credibility
f. Questioning techniques

III. Mock Hearings **11:25 am – 12:15 pm**

a. Introduction of Mock Case/Claimant
b. Direct Examination of Claimant and Witness
c. Cross Examination of VE
d. Review and Critique

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Substantive Outline

H. PROVING YOUNG ADULT DISABILITY CLAIMS: MOCK HEARING OUTLINE

INTRODUCTION

Hearings involving young adult claims present unique issues for advocates. An 18 year old whose benefits are being terminated is entitled to a hearing at the reconsideration stage, as well as a hearing before an Administrative Law Judge (ALJ). There are differences and similarities between these types of hearings, and there are proactive strategies to deal with issues that may rise at either type of hearing, including ways in which advocates can better elicit helpful testimony on direct examination. A sample – or "mock" – direct examination will be conducted. *Sample case summary is attached as Appendix #1*; *Hearing Exhibit File is Appendix #2*

I. AGE-EIGHTEEN REVIEW PROCEDURES

A. Initiation of Review

1. Notice [20 C.F.R. § 416.987(d)(1)]
    a. "*We will notify you in writing before we begin your disability redetermination.* We will tell you:
        i. [(i)] That we are redetermining your eligibility for payments;
        ii. [(ii)] Why we are redetermining your eligibility;
        iii. [(iii)] Which disability rules we will apply;
        iv. [(iv)] That our review could result in a finding that your SSI payments based on disability could be terminated;
        v. [(v)] That you have the right to submit medical and other evidence for our consideration during the redetermination; and
        vi. [(vi)] That we will notify you of our determination, your right to appeal the determination, and your right to request continuation of benefits during appeal."
    b. Initial Determination [20 C.F.R. 416.987(d)(2)]
        i. "*We will notify you in writing of the results of the disability redetermination*. The notice will tell you what our determination is, the reasons for our determination, and your right to request reconsideration of the determination. If our determination shows that we should stop your SSI payments based on disability, the notice will also tell you of your right to request that your benefits continue during any appeal. Our initial disability redetermination will be binding unless you request a reconsideration within the stated time period or we revise the initial determination."
        ii. Sample continuation determination (SSA 832-C3/U3) attached (*Appendix #3, p.1*)
        iii. Sample termination determination attached (*Appendix #3, pp. 2-3*)
        iv. Sample Notice of Disapproved Claim attached (*Appendix #3, 4-7*)

B. Reconsideration Step

1. Reconsideration applicable in Age 18 Reviews even in prototype state such as New York
    a. *See* Disability Redesign Prototype Model
        i. POMS DI 12015.100

ii. https://secure.ssa.gov/poms.nsf/lnx/0412015100

b. Age Reviews excluded from prototype

i. http://www.ssa.gov/disability/Documents/Prototype_Operating_Instructions.doc

a) *See* page 10

2. Special Request for Reconsideration (Form SSA-789-"Request for Reconsideration Disability Cessation")

a. http://www.ssa.gov/forms/ssa-789.pdf

C. Continued "Interim" Benefits During the Appeal Process [20 CFR §416.996]

1. Benefits must be specifically elected (and re-elected at each stage of the appeal process, as discussed *infra*) within 10 days of initial notice
2. Request for Reconsideration within 10 days alone is not enough; beneficiary must ask and/or be informed by claims representative about special written election.
3. Late filings/requests for continued benefits are considered under the "good cause" provisions at 20 C.F.R. §§ 404.911, 416.1411.
4. To receive continued benefits through the ALJ level, the recipient must file an appeal within 10 days and specifically request continued benefits.
5. Benefits paid during appeal process can be assessed as an overpayment if the appeal is unsuccessful.
6. Recovery subject to waiver provisions if appeal made in "good faith." [20 CFR §§404.1597a(j)(3), 416.996(g)(2)]
7. "Good faith" assumed unless claimant fails to cooperate, etc. *Id*.
8. The usual 60-day appeal period still applies if continued benefits are not requested.

D. "Face-to-Face" Reconsideration Step

1. Disability hearings are "available" in Age 18 Review cases at the reconsideration step in cessation cases. [20 CFR §§404.913(b)-918, 416.1413(d)-1418]
2. Video teleconferencing or telephone hearings permissible, with consent of claimant
   a. POMS DI 332025.080, DI 32025.085
   b. https://secure.ssa.gov/poms.nsf/lnx/0433025080 et seq
   c. Telephonic hearings permissible only if
      i. No witnesses other than claimant
      ii. No need for an interpreter
      iii. "Relatively simple" claim
3. These hearings are limited to medical factors:
   a. Reconsideration disability hearings are not applicable to new applications (but a denial of a new application can be combined with disability hearing). [20 CFR §§404.914(d) and 416.414(d)]
   b. Per preamble to publication of regulations, they are not available in closed period cases. 51 Fed. Reg. 290 (January 3, 1986). 53 Fed. Reg. 29012 (August 2, 1988).
   c. They are not applicable to nonmedical cessation issues (i.e., Title XVI excess resources, SGA, etc.). In such terminations, continuation of benefits is provided only through the first level of appeal. 20 C.F.R. §416.1336(b).

E. Reconsideration Procedures. [20 CFR §§404.916 & 416.1416]

1. After a special Request for Reconsideration is filed, the file is transferred to DHU (Disability Hearing Unit)
   a. Sample Transmittal – SSA-832-C3/U3 -attached (Appendix #3, pp. 8-9)

2. Remember that, as outlined *supra*, the request must be filed within 10 days of the cessation notice in order for the recipient to get continued "interim" benefits.
3. The file is then forwarded to a "disability hearing officer" (DHO)
    a. Disability Hearing Officers are generally state agency/DDS employees [20 CFR §§404.915, 416.1415]
    b. Disability Hearing Officers can send a file back to the original DDS component for further development. [20 CFR §§416.916(c), 416.1416(c)]
    c. The Disability Hearing Officer, or DHO, can issue a favorable decision at any time, even if a hearing has not been held yet. [20 CFR §404.916(d), 416.1416(d)]
4. In cases where "Disability Hearings" are held, many of the procedures are similar to or the same as ALJ hearing procedures:
    a. Right to representation. [20 CFR §§ 404.916(b)(2), 416.1416(b)(2)]
    b. Notification of time and place:
        i. Notice at least 20 days prior.[20 CFR §§404.914, 416.1414]
        ii. Reimbursement for travel of more than 75 miles. [*Id*]
        iii. Same rights for request of change of time and/or place as with ALJ hearings. [20 CFR §§ 404.936(c) & (d) and 416.1436(c) & (d) ("good cause" provisions)]
    c. Opportunity to review evidence in file in advance and present additional evidence. [20 CFR §§404.916(b)(3) and 416.1416(b)(3)]
        i. Query re current difficulties obtaining files/CDs?
        ii. Problems with submission of SSA-1696 (Appointment of Representative) to local District or Field Office versus DDD?
        iii. Use of SSA-3288 in lieu of 1696?
            a) *See* POMS DI 22010.065
    d. Opportunity to request a subpoena.[20 CFR §§ 404.916(b)(1) and 416.1416(b)(1)]
    e. Opportunity to present and question witnesses.[20 CFR §§404.916(b)(4) and 416.1416(b)(4)]
5. But some of the procedures for reconsideration disability hearing are either more restrictive or more specifically spelled out than in the ALJ hearing process:
    a. Hearings are not recorded
    b. Opportunity to submit additional evidence after the hearing [20 CFR §§ 404.916(e) and 416.1416(e)]
        i. But DHO may allow only 15 days for receipt of evidence.
        ii. This time will be allowed only if the DHO determines that the evidence has a direct bearing on the outcome and could not have been obtained before the hearing.
    c. Opportunity to comment on additional evidence obtained or received by DDS after the hearing. [20 CFR §404.916(f) and 416.1416(f)]:
        i. Written notice.
        ii. 10 day comment period.
        iii. Provision for supplemental hearing if necessary..

F. <u>Disability Hearing Officer's Reconsideration Decision [20 CFR §§404.917, 416.1417]</u>

1. The DHO's decision must contain findings of fact and reasons for decision. A decision "format" is used.
    a. Sample DHO Decision attached (*Appendix #3, pp. 9-16*)

2. The DHO's written decision is accompanied by a Notice of Reconsideration. The Notice contains the usual 60-day appeal rights regarding a request for an ALJ hearing.
    a. Sample Reconsideration Notice Attached (*Appendix #3, pp. 16-18*)
3. Once again, to receive continued benefits through the ALJ level, the recipient must file an appeal within 10 days and specifically request continued benefits. [20 CFR §§404.1597a(g), 416.996(d)]
4. The DHO's decision has the effect of a reconsidered decision, unless reviewed by the Associate Director for Disability Determinations. [20 CFR §§404.917&918, 416.1417&1418]
    a. The director can return the file to DDS or the DHO, or issue a new written decision.
    b. The recipient must be given the opportunity to comment on any proposed new decision.
5. The disability hearing does not affect the right to present new evidence at the ALJ level. *See* preamble to regulations 51 Fed. Reg. 291
6. The disability hearing does not alter any later appeal rights. A subsequent unfavorable ALJ decision can be reviewed by the Appeals Council. If the Appeals Council remands a case where benefits had been previously elected at the ALJ level, the benefits should be reinstated automatically. [20 CFR §§404.1597a(i), 416.996(e)]

II. HEARINGS TECHNIQUES

A. Direct Examination – The Art of Storytelling

B. Preparation

1. Assessment of credibility, limitations
2. Explain procedures
    a. What to expect
    b. What to do and not do
    c. Video teleconference (VTC)?
        i. Client's choice
        ii. *See supra*
    d. VE (vocational expert) or ME (medical expert)
        i. Not applicable in Age 18 Reconsideration hearings?

C. Ethical considerations

1. *See*, Horse-shedding, Lecturing and Legal Ethics, by Edward Carter, 2008
2. *Appendix #4*

D. Crafting questions

1. Know the theory of your case
    a. Listing, RFC, combination of impairments?
2. Know the exhibit file!

E. Mental impairment cases

1. Review basic demands of work
    a. Understand, carry out, and remember simple instructions;
    b. Make judgments that are commensurate with the functions of unskilled work, i.e., simple work-related decisions.
    c. respond appropriately to supervision, coworkers and work situations; and
    d. deal with changes in a routine work setting.

e. 20 C.F.R. §§ 416.921(b)(3)-(6)
f. POMS DI 25020.010
i. https://secure.ssa.gov/apps10/poms.nsf/lnx/0425020010

F. DAA (Drug and Alcohol Addiction) issues?

1. *See Cage v. Commissioner of Social Security*, 692 F.3d 118 (2d Cir. 2012)
   a. Claimant has burden of proving DAA immateriality
   b. Commissioner does not have to produce medical opinion of materiality
2. SSR 13-2p – Evaluating Cases Involving Drug Addiction and Alcoholism (DAA)
   a. http://socialsecurity.gov/OP_Home/rulings/di/01/SSR2013-02-di-01.html
   b. *See also* SSA Consolidates DAA Policies - http://www.empirejustice.org/issue-areas/disability-benefits/rules--regulations/ssa-consolidates-daa-policies.html

G. Deficits in adaptive functioning/intellectual disability

1. *See Talavera v. Astrue*, 697 F.3d 145 (2d Cir. 2012)
   a. *See* attached questionnaire (*Appendix #5*)

H. Credibility

1. Review factors
   a. The individual's daily activities;
   b. The location, duration, frequency, and intensity of the individual's pain or other symptoms;
   c. Factors that precipitate and aggravate the symptoms;
   d. The type, dosage, effectiveness, and side effects of any medication the individual takes or has taken to alleviate pain or other symptoms;
   e. Treatment, other than medication, the individual receives or has received for relief of pain or other symptoms;
   f. Any measures other than treatment the individual uses or has used to relieve pain or other symptoms (e.g., lying flat on his or her back, standing for 15 to 20 minutes every hour, or sleeping on a board); and
   g. Any other factors concerning the individual's functional limitations and restrictions due to pain or other symptoms
2. 20 C.F.R. § 416.929(4) – How We Evaluate Symptoms
3. SSR 96-7p
   a. Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements
   b. http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-07-di-01.html
4. Credibility of claimant versus that of the witnesses (i.e., family members)?
   a. *See*, e.g., *Dodrill v. Shalala*, 12 F.3d 915, 919 (9th Cir. 1993) (lay witnesses can be found credible even if claimant not)
   b. *Cf. Briggs ex rel. Briggs v. Massanari*, 248 F.3d 1235, 1239 (10th Cir.2001) (If the child claimant is unable to adequately describe his symptoms, the ALJ must accept the testimony of the person most familiar with the child's condition).

I. **Pace of questioning**
J. **Leading questions**
K. **Compound questions**
L. **Listen to the answers!**
M. **Dealing with surprises**

III. MOCK HEARING

A. **Sample young adult case distributed and introduced *(Appendix #1)***
B. **Direct examination of claimant and witness**
C. **Cross examination of VE and ME**
D. **Review and critique**

Appendix 1

Young Adult Case Summary

APPENDIX 1

September 11-12, 2014

DAP SESSIONS

TYPICAL AGE-18 REVIEW CASE SUMMARY

Justin Young was awarded SSI at the age of 14 and is now appealing the denial of his age-18 redetermination. His childhood featured domestic abuse and trauma. At age 5, he was thrown against a sink and witnessed his father choke his mother. When he was 12, he was diagnosed with major depressive disorder, recurrent with social phobia.

Justin entered junior high school but his performance suffered due to absences. At age 14, testing revealed full scale IQ of 99, difficulty with short-term memory, speed, and attention. Recommendations included small class size, extra time, separate test locations, and assistive devices such as tape recorders, charts and written instructions. He was awarded SSI at this time based on depression with social phobia, and a learning disorder.

By the 9th grade, Justin was experiencing extreme social phobia and refused to go to school. He attended 2 high schools before being transferred to a residential school. For that year and the 2 that followed, Justin re-enrolled in school but stopped attending after a few months because of anxiety. He was homeschooled for the remainder of each year.

By age 17, Justin's symptoms had increased. Treatment records for this time period note depressed mood, anhedonia, insomnia, appetite changes, and social phobia. He was prescribed Lexapro. He found his first job as a salesperson at a busy bakery, but he was fired after less than two months for taking too many breaks. He began experiencing an increase in anxiety-related symptoms, including being startled by noises. His diagnosis was major depressive disorder, mild but with recent onset of generalized anxiety disorder.

An IEP was issued recommending general education with special education teacher support services 3 periods per week. It found his behavior was not interfering with his education because although he suffered from social phobia, medications prescribed were only for insomnia.

At age 18, Justin re-enrolled in school but began skipping therapy, finding it a "waste of time." He was also using marijuana with frequency. His therapist contracted with him to enter a substance abuse program if he used during the week and continued to miss class. Justin ultimately dropped out of both school and therapy. He found a job at a clothing store, but the position ended after 2 months, following a disagreement with his boss. The following year, Justin was hospitalized for 5 days; he wasn't getting out of bed and reported suicidal ideation.

At age 20, Justin obtained a GED. He also found a job taking orders in a café, but he was fired for being too slow. His age-18 reconsideration is denied at this time.

At age 21, Justin resumed therapy, but attended only sporadically. His diagnoses included ADHD, major depressive disorder, mild with anxiety, learning disorder and cannabis abuse.

Justin is now 22 and working towards a bachelor's degree. Accommodations from the Office for Students with Disabilities include double time and special quiet room for tests. He also receives assistance from a program aimed to support "at risk" students with counseling and other supports. His grades ranged from B+ to F in the first year but now range from B- to A.

Justin is no longer in treatment because the clinic he was attending closed. He is ambivalent about finding a new therapist and about his claim for benefits. His mother reports that he sleeps all day and is able to achieve good grades because he has chosen easy classes in the afternoon.

Appendix 2

Young Adult Exhibit File Pt. 1

33 West 42nd Street
New York, NY 10036-8003

(212) 780-4960

University Optometric Center

Learning Disabilities Unit

CONFIDENTIAL

Neuropsychological and Psychoeducational Evaluation

Name:
Age: 14
Grade: 9th
MR #: 278684

Date of Birth: 4/1/89
Dates of Evaluation: 9/24, 9/29, 10/1,10/7, 2003
Date of Conference: 11/7/03
Examiner: Sarah Bench, Ph.D.

Reason for Referral

was referred to the Learning Disabilities Unit due to concerns about his academic performance. His mother reported that his main difficulty is completing large tasks, explaining that he has trouble staying focused on big projects. More recently, has been refusing to go to school. An evaluation was requested to determine the nature of s academic difficulties and school refusal, and to provide recommendations to address these issues.

Pertinent Background Information

The following information was obtained through an interview with 's mother.

Family History

is a 14-year-old boy in the 9th grade. He lives with his mother and 16-year-old sister His parents are divorced. lived with both his mother and his father until he was about 5 years old, but has not seen his father in about 9 years. sister attends on scholarship, and is described as an excellent student. disclosed that father has a history of mental illness. When his father developed his mental illness he stopped working, and became physically abusive toward the whole family. His symptoms included hearing voices, and she recalled an incident where he tried to choke her in front of the children. was in counseling from ages 10-12, but has not been in psychotherapy more recently. He has significant sleep disturbance and has been treated at Montifiore sleep clinic.

Birth and Developmental History

reached all developmental milestones within normal limits. His medical history is unremarkable. He does not take any medications but has previously been prescribed Ambien for sleep. reported that experiences a lot of symptoms of anxiety in addition to his sleep disturbance, including a high level of worry.

She explained that has said in the past that he thinks he has Obsessive-Compulsive Disorder (OCD), reporting that he has to recheck things a lot, including when he is reading.

Educational History

reported that id not display learning difficulties in elementary school and did not have trouble learning to read. Prior to 6th grade he was in a special progress accelerated program. She said that his grades began to decline but were still adequate in 6th and 7th grade. His grades dropped significantly in 8th grade, and he finished the year with a 70 average. does not have a history of behavior problems. He is described as social, at times the class clown, and popular among his peers. His mother reported that he has never been evaluated before.

began the current school year at LaSalle Academy Catholic School in Manhattan. His mother reported that he was very anxious about going to La Salle and worried that he wouldn't be able to wake up on time in the morning. got accepted to on a partial scholarship and was therefore not able to attend. His sister currently attends on a full scholarship.

tarted LaSalle in September, but soon after the year began he said that he hated it and refused to go. He then began attending Bernard Rustin High School for the Humanities. At his new school he also stated that he hated school, and was reportedly frequently cutting classes before refusing to go. explained that has trouble articulating more specifically why he refuses to go to school. He does not have a history of oppositional or defiant behaviors.

Optometric Findings

was seen for an optometric examination and visual/perceptual evaluation in our Vision Therapy Service. There was no evidence of ocular disease or abnormality. is nearsighted in both eyes and has a lens prescription, but glasses are not required for close work. He reportedly does not wear his glasses.

Results of the perceptual evaluation indicated adequate eye movements and accommodative facility (the ability to make rapid and accurate changes in focus), and deficits in binocularity (eye teaming). However it was noted that when tracking skills were assessed, eread each line of text for meaning. Yet his comprehension of the material was on a 9 grade level and at the 90th percentile. During the perceptual evaluation, the optometrist observed drastic variability in s attention span, noting the following observations:

"At any time seemed to totally lose attention without being aware of it. He would be doing well on a test and all of a sudden give answers that were completely wrong. On the next part he would do quite well even though it would be more difficult. This pattern revealed itself often enough that the scores were negatively affected."

Following the optometric evaluation, was referred to the Learning Disabilities Unit for a complete neuropsychological and psychoeducational evaluation to clarify his need to reread, despite adequate eye tracking skills and reading comprehension skills, and to determine if a learning disability or attention deficit disorder is contributing to his difficulties.

Behavioral Observations

presented as a suitable young adolescent with a friendly demeanor. He was initially somewhat quiet and did not initiate conversation, but he responded appropriately in a friendly manner, displaying good social skills, and got more comfortable as the evaluation progressed. was cooperative throughout the evaluation with all tasks, and took few breaks. His level of motivation was somewhat variable, but he appeared to remain attentive on most tasks and put forth adequate effort. However he tended to shy away from elaborating on verbal responses. At times he expressed insecurities about his responses. for example stating, " I guess" or "I don't know" after giving a response. However became less self-conscious as the evaluation progressed.

Once comfortable, was willing to talk about his difficulties. He explained that he takes a long time to read because he needs to reread to "read something right". He added that this does not happen when he reads aloud, but only when reading silently. Rereading was observed during the perceptual evaluation when his eye movements were being recorded, but was not observed when reading aloud during this evaluation. explained that he does not need to reread when he reads aloud, but only when reading silently.

When asked about his school refusal, acknowledged that he doesn't like school. He said that he is unable to get up on time in the morning, and refuses to go in late. He did state that he does not think a different school would make a difference, saying he would probably have trouble going to any school every day.

When discussing his school refusal with the evaluator, he did not appear angry or defiant. He was frank in discussing his sleep difficulties with the evaluator but resisted self- revelation and did not want to talk about what was bothering him. At the same time he also expressed that he did not understand the source of his school difficulties, and seemed to genuinely lack insight into the nature of his distress.

Cognitive Functioning

cognitive skills were assessed using the Wechsler Intelligence Scale for Children-Third Edition (WISC-III). This test consists of several subtests measuring different areas of ability, which highlight an individual child's cognitive strengths and weaknesses. performance on the WISC-III indicated that his verbal and non-verbal reasoning skills are evenly developed. Verbal Scale IQ Score of 102, Performance Scale IQ Score of 95, and Full Scale IQ Score of 99 all fell in average range.

demonstrated good verbal reasoning ability and a good understanding of verbal concepts, performing average or above average on all tasks within the Verbal Comprehension Factor. His strongest skills were his logical verbal abstract thinking skills, assessed with a task requiring him to identify relationships between pairs of words, and his range of general factual knowledge, both above average for his age. He performed in the average range defining vocabulary words, and answering questions about his knowledge of social conventions. It was noted that on many items he answered correctly but hesitated to elaborate on his responses when asked to do so, resulting in scores that may underestimate his verbal abilities, which are likely more solidly in the high average range.

demonstrated a relative weakness on tasks involving auditory attention and short-term working memory, although still performing within normal limits. He had much more difficulty repeating a list of numbers backwards than forwards in sequence. When asked to mentally solve mathematics calculations, had difficulty holding the question read to him in memory, and repeated the questions to himself orally to retain the information he needed to solve the problem.

On subtests involving spatial reasoning and perceptual organization, such as reproducing geometric designs with blocks and completing puzzles, performance was in the average range. He performed in the average range on all tasks within the Perceptual Organization factor. These were all timed tasks, and got most or all of the items correctly but worked slowly. Thus his skills may be higher than reflected in his scores within the performance scale as well.

demonstrated a relative weakness on a task emphasizing speed of processing, assessing his ability to copy symbols in a sequence by matching symbols to numbers. On this task he worked very slowly and demonstrated a significant weakness, in the borderline range. This indicates that he works slowly under timed conditions and therefore needs extra time to complete assignments, especially when copying written work.

Memory Skills

memory skills were assessed using the Wide Range Assessment of Memory and Learning (WRAML), an instrument that evaluates memory competency in both verbal and visual modalities. visual memory skills are stronger than his verbal/auditory memory skills. On visual memory tasks he performed in the higher end of the average range, while on verbal memory tasks he consistently performed in the lower end of the average range. He performed in the superior range on a task requiring the ability to remember sound-symbol associations using abstract shapes and nonsense sounds, a task which tends to be difficult for children with poor phonemic awareness but on which performance was strong. Overall, has trouble holding verbal information that he hears in his memory, as well as manipulating information in short term memory, and his ability to retain information improves with visual aids.

Language Skills

demonstrated well developed expressive and receptive language skills. When telling stories his themes were organized and creative, and he included details to make the stories more interesting. Throughout the evaluation he understood directions involving multiple steps and complex language. He performed adequately on a task of phonological processing. This task assesses phonological segmentation skills at the level of letter sounds and word segments, skills that are critical for the development of reading skills. did not have difficulty with this task.

Visual-Motor Skills

On tasks measuring visual-motor integration skills, ; performed in the average range. He successfully solved puzzles and integrating geometric patterns with blocks on the WISC-III. On a task where he was required to copy geometric designs with pencil and paper, he performed in the average range. He worked slowly on timed visual motor tasks

which impacted his scores, but his scores were still in the average range. He had the most difficulty on a visual-motor task requiring the ability to copy symbols quickly. He worked slowly on this task and demonstrated a significant weakness. performance improves significantly when he is not under timed conditions.

Attention and Concentration

On tasks requiring sustained and selective attention performance varied. He demonstrated mild weaknesses in auditory attention and the ability to hold verbal information in short term memory. His performance was stronger on tasks of visual attention.

exhibited a normal activity level and took few breaks during the evaluation He required minimal redirection to stay on task and did not have difficulty ignoring outside distractions. However at times ppeared to lose focus due to internal distractions (which might have been, for example, due to having a headache or having thoughts about something else on his mind). This was even more pronounced during the perceptual evaluation. ability to attend improved when he was directly engaged with the evaluator or actively participating in a task, such when he was reading aloud.

Attention and executive functioning was assessed with a task requiring the ability to shift cognitive sets and use organized search strategies. On a complex task requiring the ability to shift and maintain focus on the sequential processing of numbers and letters, had significant difficult shifting his focus from sequencing numbers to sequencing letters. Throughout the evaluation had a difficult time manipulating information mentally and planning ahead mentally. This suggests that remaining attentive to verbal instructions is difficult for him.

Academic Achievement

Reading:

emonstrated mild reading weaknesses. His ability to read single words in isolation from a list was estimated at a 9.4 grade level. His reading comprehension skills were on an 8.3 grade level. had more difficulty sounding out nonsense words, where he performed on a 6.0 grade level, suggesting a weakness in using the phonological code to sound out unfamiliar words. However when reading orally errors most often consisted of misreading small words, such as the and was, while decoding much more difficult words with ease. delivery was fluent and smooth, but slow. His oral reading rate was estimated at a 7.7 grade level and his accuracy was estimated at a 7.1 grade level. He explained that when he reads silently he needs to reread to "read it right," but does not need to double check what he reads when reading aloud.

Mathematics:

athematical reasoning skills were a relative strength. He had difficulty on the WISC-III mentally solving arithmetic problems without the aid of pencil and paper. However his ability to reason mathematically when he could use visuals or reread the problem were very strong, on an 11.8 grade level. When solving basic equations on paper, he performed much lower, on a 7.8 grade level. Many of his errors were minor calculation errors on simple problems where he was following sequential procedures correctly. His answers were frequently only off by one digit.

Writing:

written language skills are in the average to high average range. When writing single words in isolation, his spelling ability was estimated at 7.2 grade level, suggesting a mild weakness. However when he produced a writing sample, he spelled most age appropriate words correctly. His writing sample contained correct sentence structure and grammar and his sentences followed a logical order. He used age appropriate vocabulary and made few errors in spelling and punctuation.

vas able to create a well-developed story with a developed plot and adequate detail.

Personality and Social/Emotional Functioning

The Conners' Parent Rating Scale – Revised (L) was used to assess the frequency with which exhibits various problem behaviors common in school-age children. The parent scale was filled out by 's mother. endorsed many items on the scale as pretty much or very much true, indicating that she is extremely concerned about behavior and emotional symptoms. Only items pertaining to his social skills and capacity to make friends were endorsed as not at all true, agreeing with all other items on the scale as being true to some degree. Items endorsed with the greatest frequency were with regard to psychsomatic symptoms.

Projective personality assessment included creating stories in response to pictures and completing sentences describing himself. responses to projective tests indicate that he is experiencing a tremendous amount of anxiety. Symptoms include a high degree of worry, a strong tendency to double check, and possible obsessive and compulsive symptoms that he may not have felt comfortable disclosing. stated that he believes he has OCD, but did not provide examples in addition to his need to double check words when reading. His responses revealed that he has had experiences in his past that were upsetting or frightening, and indicate that he may be experiencing intrusive thoughts, feelings, or images.

s family has a history of significant trauma brought on by the unexpected changes in his father's behavior due to mental illness, including violent behavior, and the later abandonment he experienced from his father. As a result of these early experiences, expects that very traumatic events can occur at any time, without warning, which no doubt leaves him with a higher generalized anxiety level. In his stories adversity seemed to come out of nowhere, occurring suddenly in the story without warning, such as someone suddenly dying in a car accident in the middle of the night, and several stories concluded with the trauma occurring in the final sentence, with no closure or resolution to the story.

s anxiety has increased now that he is entering adolescence. Adding to his anxiety is difficulty separating from his mother and ambivalence about developing into an adult male, which makes sense given his lack of a positive father figure. s very attached to his mother and fears the separation that increases in adolescence. He is extremely angry at his father. On the sentence completion test he stated, "My mother and I…have a great bond" and stated "I sure wish my father… would die." s discomfort with separation and fears about entering adolescence may be contributing to his refusal to go to school. When he does not go to school, his anxiety may be reduced because he is at home with his mother.

does not feel comfortable talking about his feelings, so they are more likely to be communicated indirectly. He stated, "Most of my friends don't know that I'm afraid of… nothing. I'm a robot." He also completed the following sentence, "When I'm feeling unhappy…I don't talk." Because oes not express his feelings verbally, they are expressed more subtly through his behavior and through his symptoms.

Integration and Summary

Results of this evaluation indicate that s currently functioning in the average range of intelligence. The difference between his verbal and performance scale scores was not significant. demonstrated a relative weakness in auditory short-term memory. He also demonstrated slow graphomotor speed, indicating the need for extra time to complete written work. He demonstrated relative strengths in his range of factual knowledge and verbal reasoning skills.

s ability to sustain attention is variable. He does not display impulsivity or hyperactivity. He does not have difficulty avoiding outside distractions, but has difficulty attending to auditory information without visual aids. as difficulty holding auditory information in memory, and benefits from having directions repeated.

mother raised concerns that as difficulty remaining focused on large projects. Given his high level of anxiety, it makes sense that large projects would be difficult for him. ppears to become distracted by his anxiety, contributing to his need to recheck what he reads. He did not display behaviors suggesting attention deficit hyperactivity disorder.

demonstrated mild weaknesses in decoding and spelling. His oral reading speed is slow but he reads fluently, and his phonological processing skills area age appropriate. These weaknesses are considered mild and do not completely account for his need to reread or for his poor school performance. However these weaknesses may be contributing to his perception that he cannot perform at the level of his sister, who is described as a straight A student. need to reread is more likely due to a high level of anxiety and possible intrusive thoughts. When he reads aloud he is distracted from other thoughts, as it is harder for his mind to wander, and thus he does not feel compelled to reread.

is refusing to go to school for many reasons that he may not be aware of. His intellectual capacity is adequate but because of mild learning weaknesses he may feel that he cannot compete with the achievements of his sister. He may be afraid that if he fully used his intellectual capacity he would achieve greater success, which would place him in direct competition with sister and need to meet higher expectations, which he feels he can't live up to.Applying himself academically and succeeding in school would also stir up anxiety about further separation from his mother.

struggles with conflicts about entering adolescence and anxieties about entering the adult world. He feels that he lacks the skills necessary to cope with the challenges that lie ahead, and may worry about his mother's ability to cope when he, her youngest child, leaves home. lso has ambivalence about taking on a more adult male role given the painful history with his father.

It is essential that return to school on a consistent basis. This will increase his sense of confidence and autonomy, which will bolster his self-esteem. Currently he is staying at home during the day with his mother, and this is not beneficial for his self

esteem and interferes with the process of separation and increased autonomy expected at his age. It is also essential that egin psychotherapy with a licensed psychologist or social worker immediately, to develop a plan to first get him attending school regularly, and then develop insight into the reasons contributing to his resistance to academic tasks, of which learning weaknesses are a small component.

Diagnostic Impressions (DSM-IV TR)

300.02 Generalized Anxiety Disorder
315.9 Learning Disorder NOS

Recommendations

1. It is essential that return to school. Home schooling is not recommended. He would do best in a smaller class size that will allow for accommodations as listed below.
2. In the classroom, should be given extra time to copy down information from the chalkboard. He should also be given extra time to complete classroom reading and writing assignments.
3. Testing modifications including extended time (time and a half) on tests and separate test locations to avoid distractions are indicated.
4. Written instructions should accompany oral directions whenever possible.
5. should be permitted to use assistive devices such as a tape recorder and a laptop computer in the classroom, and a word processor with a spell check function for writing assignments.
6. Use of visuals and charts is recommended to capitalize on well-developed visual memory.
7. It is essential that begin treatment with a licensed psychologist or clinical social worker, to facilitate his return to school. A structured behavior plan can be developed to reward school attendance. In addition, it is essential that he begin a process of insight-oriented therapy to address the many factors contributing to his high anxiety level. If is in fact experiencing intrusive thoughts they can be explored in therapy as well.
8. Continued consultation with a psychiatrist is recommended. s currently taking Zoloft, and the effectiveness of the medication and the extent of his sleep disturbance should continue to be monitored.

Conference

A conference was held on November 7, 2003 at the SUNY State College of Optometry Learning Disabilities Unit to discuss the assessment results and recommendations. The conference was attended by s mother, and Sarah Bench, Ph.D., licensed psychologist.

Sarah A. Bench, Ph.D.
Licensed Psychologist
NYS License # 015090

SUMMARY OF SCORES

Wechsler Intelligence Scale for Children – Third Edition (WISC-III)

IQ Scores	Standard Score*	Percentile	Standard Score Range
Verbal Scale:	102	55th	96-108
Performance Scale:	95	37th	87-103
Full Scale:	99	47th	93-105

Factor Scores	
Verbal Comprehension	107
Perceptual Organization	102
Freedom from Distract.	90
Processing Speed	93

Subtest Scaled Scores

Verbal Scale	Scaled Score	Performance Scale	Scaled Score
Information	14	Picture Completion	11
Similarities	13	Coding	5
Arithmetic	7	Picture Arrangement	10
Vocabulary	10	Block Design	9**
Comprehension	8	Object Assembly	11
(Digit Span)*	9	(Symbol Search)	12

*7 forward - 3 backward

**solved all items correctly, but did not get extra points for speed.

Wide Range Assessment of Memory and Learning (WRAML)

Memory Subtest	Scaled Score
Picture Memory	12
Design Memory	10
Sound Symbol	14
Verbal Learning	8
Story Memory	7
Sentence Memory	7

Trail making Test

Part A: 33 seconds, 1 error (WNL)
Part B: 95 seconds, 2 errors (below average)

Rosner Auditory Analysis Test

Total Score: 34/40 (WNL)

The Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI)

	Standard Score
VMI	97

Wechsler Individual Achievement Test-Second Edition (WIAT-II)

Subtests	Standard Score*	Grade Equivalent
Word Reading	103	9.4
Reading Comprehension	96	8.3
Pseudoword Decoding	96	6.0
Numerical Operations	94	7.8
Math Reasoning	106	11.8
Spelling	93	7.2

Gray Oral Reading Tests-Third Edition – Form B (GORT-3)

	Scaled Score	Grade Equivalent
Rate	8	7.7
Accuracy	7	7.1

Test of Written Language-Third Edition (TOWL-3)

Subtest	Score
Contextual Conventions	11
Contextual Language	13
Story Construction	12

Social/Emotional Functioning and Behavior

Conners' Parent Rating Scale-Revised (L)
Thematic Apperception Test
Sentence Completion Test

University Optometric Center
Learning Disabilities Unit

33 West 42nd Street
New York, NY 10036-8003
(212) 780-4960

EDUCATIONAL REEVALUATION

Name:
Age: 16-7
Grade: 11th
MR #: 278684

Date of Birth: 4/1/89
Date of Evaluation: 11/29/05
Examiner: Sarah Bench, Ph.D.

Wechsler Individual Achievement Test-Second Edition (WIAT-II)

Age Based Scores

Subtests	Standard Score	Percentile	Grade Equivalent
Word Reading	108	70th	>12.9
Reading Comprehension	100	50th	10.8
Pseudoword Decoding	91	27th	5.8
Numerical Operations	83	13th	7.0
Math Reasoning	93	32nd	8.4
Spelling	88	21st	7.2

Composites	Standard Score	Percentile
Reading	97	42nd
Mathematics	86	18th

Summary and Recommendations

academic achievement was re-assessed using the Wechsler Individual Achievement Test-Second Edition (WIAT-II). academic skills were last assessed as part of comprehensive psychoeducational evaluation conducted two years ago, in Sept. and Oct. of 2003.

Over the past two years, word reading ability and reading comprehension skills have improved. However his decoding skills continue to be an area of weakness. In mathematics, has actually shown a regression of skills, due at least in part to a lack of formal instruction since he reported that he has missed a substantial amount of school over the past two years. His spelling skills have essentially remained the same.

initial evaluation was conducted while he was in 9th grade. At that time he was not attending school due to his anxiety. He reported that after receiving home instruction, he began attending the Community School in New Jersey for the remainder of 9th grade and began 10th grade there as well, but stopped going to school and resumed

Home Instruction for the remainder of 10th grade. He explained that he started 11th grade in a public school, but began re-experiencing intense anxiety symptoms and stopped attending school altogether. His mother reported that she is once again seeking Home Instruction for explained that he is interested in furthering his education, but does not want to return to school because of the extreme anxiety he experiences in a school environment.

Results of the current evaluation indicate that continues to meet the diagnostic criteria for a Learning Disorder. In addition, he presents with generalized symptoms of anxiety meeting the criteria for Generalized Anxiety Disorder, as well as extreme and intense anxiety in a school setting meeting the criteria for School Phobia, making it literally impossible for him to attend school.

Since skills have already began to regress in Mathematics, he is at risk for further regression of skills if he does not begin receiving formal academic instruction immediately. as been unable to function in a formal school setting, but clearly has the potential to excel academically. While Home Instruction appears necessary as a short-term solution, as xpressed that at this time he continues to find the anxiety he experiences in a school environment intolerable, the long term goal should be to have anxiety treated and continually managed, so that he can return to school as soon as possible. However in order to be available for learning, will require a school placement that will meet his emotional as well as educational needs, and where supports are in place to help manage his anxiety symptoms. If home instruction continues long-term, his anxiety will become worse because the more he avoids a school setting, the more anxiety provoking school will become.

requires a placement that can afford him as much support as possible and provide him with the protections he needs. Due to his learning weaknesses, he will continue to require accommodations, including extended time (time and a half) on tests, as listed in his initial evaluation. needs a school offering a rich staffing ratio and school staff that have an understanding of how his anxiety interferes with his functioning. is a kind and personable young man, but he is also very vulnerable, and his transition back to school will require careful planning and extensive support.

Sarah Bench PhD

Sarah A. Bench, Ph.D.
Chief Psychologist, Learning Disabilities Unit
NYS License # 015090

2005-2006 SCHOOL YEAR

Student's Name: Last: _____ First: _____ Middle: _____

Male: X Female: ____ D.O.B: 4/1/89

Borough: Manhattan Region: 9 School: High School for Environmental Studies Grade: 11 Class: 000

School Address: 444 West 56th St., N.Y., N.Y. 10019 Zip Code: 10019

Physician's Statement for Requested Educational Services (if applicable):

1. Describe the nature of the concern: has learning deficits and an anxiety disorder, and requires accommodations to benefit from instruction and participate in state and local assessments.

2. Medical Diagnosis/Disability: (DSM-IV-TR Diagnoses)

300.02 Generalized Anxiety Disorder

315.9 Learning Disorder NOS

3. Describe how the disability affects the student's educational performance: difficulty performing in an educational setting, maintaining focus, due to anxiety + learning deficits, prior hx of school refusal

4. List/describe the educational service(s) that are being requested: Extended time (time and a half) on tests, Separate test locations, use of a tape recorder + laptop computer in the classroom, extended time for reading + writing assignments

Sarah Bench Ph.D. - Chief Psychologist — Sarah Bench, Ph.D.

Physician's Name (Print) — Physician's Signature

Learning Disabilities Unit
SUNY College of Optometry

Physician/Clinic's Address

33 W 42nd St., NYC
10036

Zip Code

NYS License # 015090 — 9/23/05

NYS Registration No. — Date Signed

212-780-4960 — 212-780-4963

Physician/Clinic's Telephone No. — Physician/Clinic's Fax No.

Parent's Statement for Requested Educational Services

1. Describe the nature of the concern: My son, [redacted], has learning disabilities and suffers from anxiety disorder. He needs special accommodations to be successful in school and testing. He has a history of school refusal.

2. Describe how the disability affects the student's educational performance: Greg has difficulty performing the classroom, staying focused and concentrated due to learning disab. and anxiety.

3. List/describe the educational service(s) that are being requested: Extended time (time and a half) on tests, separate test locations, use of tape recorder + laptop computer in the classroom, extended time for reading and writing assignments

If it is determined that educational services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school. This plan must be reviewed annually.

By submitting this Request for Educational Services, I am requesting that my child be provided with specific educational service(s) by the New York City Department of Education (the "Department"). I have provided the full and complete information regarding this request for educational service(s) in this form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested educational service(s) are relying on the accuracy of the information that I have provided in this form to determine whether and to what extent my child will be provided with nal services.

Please Print Parent/Guardian's Name & Address Below:

Parent/Guardian's Signature

9/14/05

Date Signed

Daytime Telephone No.

5-06

THIS IEP INCLUDES:
☐ Transition
☐ Interim Service Plan

NEW YORK CITY BOARD OF EDUCATION

INDIVIDUALIZED EDUCATION PROGRAM

CONFERENCE INFORMATION
CSE Case# 02-32282
Home District 2 Service District 2
Date 5/16/2006
Type CSE REVIEW

STUDENT INFORMATION

*Age as of the date of the conference.

Name ..... NYC ID# 254-223-498 Date of Birth 4/1/1989 Gender MALE
Address ..... Age* 17 YEARS 2 MONTHS
Phone ..... English LAB NR Spanish LAB ..... Year ..... Grade 11
Language(s) Spoken/Mode of Communication ENGLISH
Primary Agency with whom student is involved .....
Name of Contact ..... Phone ..... Agency Case # .....

PARENT/GUARDIAN INFORMATION

Name ..... Relationship to Student MOTHER
Address .....
Phone (Home) ..... Phone (Work) ..... Interpreter Required ☐ Yes ☑ No
Preferred Language/Mode of Communication ENGLISH

SPECIAL MEDICAL/PHYSICAL ALERTS

(Refer to Health & Physical Development Page for additional details.)

The student has ☐ medical conditions and/or ☐ physical limitations which affect his/her ☐ learning ☐ behavior and/or ☐ participation in school activities.

The student requires ☐ medication and/or ☐ health care treatment(s) or procedure(s) during the school day.

Other alerts: ALLERGIC TO SOCLAS, TAKES AMBIEN, 5MG AND WEARS GLASSES

SUMMARY OF RECOMMENDATIONS

Eligibility ☑ Yes ☐ No
Classification of Disability LEARNING DISABILITY

Recommended Services

GENERAL EDUCATION WITH SPECIAL EDUCATION TEACHER SUPPORT SERVICES WITH COUNSELING

Staffing Ratio 8 :1:

Twelve Month School Year ☐ Yes ☑ No Recommended Services for the Twelve Month School Year

Staffing Ratio

Other Recommendations (Check all that apply) *Details are provided in relevant sections of IEP

☐ Program Accessibility* ☐ Adaptive Phys. Ed.* ☐ Bilingual Instruction
☑ Related Services* ☐ Assistive Technology* ☐ Monolingual Services with ESL ☐ Monolingual Services without ESL
☐ Special Education Transportation - Comment .....

Students who are blind or visually impaired:
Braille instruction needed ☐ Yes ☑ No

Students who are deaf or hard of hearing:
Language of Instruction .....
Mode of Communication .....

Copy for ☐ CSE ☐ PARENT ☐ SCHOOL ☐ STUDENT ☐ OTHER

Student _____ NYC ID# 254-223-4988 CSE # 02-32282 Date of Conference 5/16/06

CONFERENCE INFORMATION

Referral Type:	☐ Initial	☐ Annual Review	ConferenceType:	☐ EPC	☐ Annual Review
	☐ Triennial	☒ Requested Review		☒ CSE Review	☐ CPSE Review

Attendance at Conference

Please note that your signature reflects your participation at the conference and does not necessarily indicate agreement with the Individualized Education Program.

Signature/Title	Role (Indicate if Bilingual)	Signature/Title	Role (Indicate if Bilingual)
✓	✓ Parent/Legal Guardian	_____	Parent/Legal Guardian
Nicole Pierce	District Representative	L. Watrous	Special Education Teacher or Related Service Provider
_____	General Education Teacher	Charles Robinson	Parent Member (CPSE/CSE)
_____	Student	_____	_____ Other
_____	[redacted]	_____	_____ Other
Nicole Pierce*	School Psychologist	_____	_____ Other
_____	School Social Worker	_____	_____ Other

Use an asterisk (*) to signify the participant who interprets the instructional implications of evaluation results.
Use the letter (T) to signify participation by teleconference.

Conference Result

☐ Initiate Service ☐ Modify Service ☐ Change Recommended Service ☐ No Change

Indicate Modifications _____

Initiation, Duration and Review of IEP

Projected Date of Initiation of IEP 6/1/06 Projected Date of Review of IEP 6/1/07

Duration of Services One year

Contacts with Parent/Legal Guardian

Date Notice of Meeting Sent _____

Date of Follow-up (if any) _____

Type of Follow-up ☐ Letter ☐ Telephone

Date IEP and Notice of Recommendation

☐ Given to Parent _____

☐ Sent to Parent _____

ACADEMIC PERFORMANCE AND LEARNING CHARACTERISTICS

Describe the student's present levels of academic achievement, language development, cognitive development and learning style in English and the other than English language for LEP students. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

PRESENT PERFORMANCE

OVER THE PAST TWO YEARS, WORD READING ABILITY AND READING COMPREHENSION SKILLS HAVE IMPROVED. HOWEVER, HIS DECODING SKILLS CONTINUE TO BE AN AREA OF WEAKNESS. IN MATHEMATICS, HE DEMONSTRATED A REGRESSION IN SKILLS, WHICH MAY BE ATTRIBUTED TO THE FACT THAT HE HAS NOT ATTENDED SCHOOL FOR TWO YEARS. SPELLING SKILLS REMAINED THE SAME.

READING AND WRITING

AREA	DATE	TEST/EVALUATION	SCORE	INSTRUCTIONAL LEVEL
WORD READING	11/29/2005	WIAT-II	70.0%	GE >12.9
READING COMPREHENSION	11/29/2005	WIAT-II	50.0%	GE 10.8
PSEUDOWORD DECODING	11/29/2005	WIAT-II	27.0%	GE 5.8
SPELLING	11/29/2005	WIAT-II	21.0%	GE 7.2

MATH

AREA	DATE	TEST/EVALUATION	SCORE	INSTRUCTIONAL LEVEL
NUMERICAL OPERATIONS	11/29/2005	WIAT-II	13.0%	GE 7.0
MATH REASONING	11/29/2005	WIAT-II	32.0%	GE 8.4

ACADEMIC MANAGEMENT NEEDS

(Environmental modifications and human/material resources)

Student [redacted] NYC ID# 254-223-498 CSE # 02-32282 Date of Conference 5/16/2006

SOCIAL/EMOTIONAL PERFORMANCE

Describe the student's strengths and weaknesses in the area of social and emotional development in English and the other than English language for LEP students. Consider the degree and quality of the student's relationships with peers and adults, feelings about self and social adjustment to school and community environments. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

PRESENT PERFORMANCE

HAS A HISTORY OF ANXIETY DISORDER AND LEARNING DISORDER. HE SEES A PSYCHIATRIST FOR MEDICATION MANAGEMENT; HOWEVER, HIS ONLY MEDICATION IS FOR A SLEEP DISORDER. HE HAS NOT BEEN IN SCHOOL FOR OVER TWO YEARS; PURPORTEDLY BECAUSE OF SCHOOL PHOBIA AND GENERALIZED ANXIETY DISORDER. HE IS NOT RECEIVING AGGRESSIVE TREATMENT FOR THE ANXIETY DISORDER OR ALLEGED SCHOOL PHOBIA.

BEHAVIOR AND THE INSTRUCTIONAL PROCESS

☐ Behavior is age appropriate.

☑ Behavior does not seriously interfere with instruction and can be addressed by the ☑ general education and/or ☑ special education classroom teacher.

☐ Behavior seriously interferes with instruction and requires additional adult support.

☐ Behavior requires highly intensive supervision.

Describe present levels of support including personnel responsible for providing behavioral support.

SOCIAL/EMOTIONAL MANAGEMENT NEEDS

(Environmental modifications and human/material resources)

A behavior intervention plan has been developed. ☐ Yes ☑ No

Student _____ NYC ID# 254-223-498 CSE # 02-32282 Date of Conference 5/16/2006

HEALTH AND PHYSICAL DEVELOPMENT

Describe the student's health and physical development including the degree or quality of the student's motor and sensory development, health, vitality and physical skills or limitations which pertain to the learning process, behavior and participation in physical education or other school activities. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

PRESENT HEALTH STATUS AND PHYSICAL DEVELOPMENT

MEDICAL/HEALTH CARE NEEDS

During the school day, the student requires:

Medication ☐ Yes ☑ No
(If yes, functionally describe the condition for which medication is required.)

Treatment(s) or other health procedure(s) ☐ Yes ☑ No
(If yes, functionally describe the condition for which treatment(s) or procedure(s) are required.)

Health as a related service ☐ Yes ☑ No
(If yes, specify in related service recommendations.)

PHYSICAL NEEDS

The student ☐ does ☑ does not have mobility limitations.
(If yes, functionally describe the limitation(s).)

The student requires:

Accessible program ☐ Yes ☑ No

Adaptive physical education ☐ Yes ☑ No
(If yes, indicate staffing ratio: _____)

Assistive technology device(s) ☐ Yes ☑ No

Assistive technology service(s) ☐ Yes ☑ No
(If assistive technology device(s) or service(s) are required, specify in management needs.)

HEALTH/PHYSICAL MANAGEMENT NEEDS

(Environmental modifications, human/material resources or specialized equipment)

Student ..... NYC ID# 254-223-498 CSE # 02-32282 Date of Conference 5/16/2006

ANNUAL GOALS AND SHORT-TERM OBJECTIVES

There will be 4 report(s) of progress per year.

ANNUAL GOAL

THE STUDENT WILL IMPROVE HIS MATHEMATICAL SKILLS TO MEET THE NEW YORK STATE STANDARDS AT HIS GRADE LEVEL

SHORT-TERM OBJECTIVES

THE STUDENT WILL SOLVE MATH PROBLEMS INVOLVING ALGEBRAIC EXPRESSIONS WITH 80% ACCURACY.

THE STUDENT WILL IDENTIFY,UNDERSTAND AND SOLVE WORD RELATED PROBLEMS USING THE FOUR BASIC MATH OPERATIONS WITH 80% ACCURACY.

THE STUDENT WILL SOLVE PROBLEMS INVOLVING GEOMETRICAL FIGURES BY USING FORMULAS WITH 80% ACCURACY.

ANNUAL GOAL

THE STUDENT WILL IMPROVE HIS READING SKILLS TO MEET THE NEW YORK STATE STANDARDS AT HIS GRADE LEVEL

SHORT-TERM OBJECTIVES

WILL GENERATE APPROPRIATE SENTENCES USING NEW VOCABULARY WORDS WITH CORRECT SPELLING WITH 80% ACCURACY.

WILL READ AND SPELL WORDS WITH VOWEL DISGRAPHS AND DIPTHONGS WITH 80% ACCURACY.

WILL USE A DICTIONARY TO IDENTIFY THE CORRECT PRONUNCIATION AND DECODE VOCABULARY WORDS APPROPRIATELY WITH 80% ACCURACY.

Student _____ NYC ID# 254-223498 CSE # 02-32252 Date of Conference 5/16/06

SCHOOL ENVIRONMENT AND SERVICE RECOMMENDATIONS

GENERAL EDUCATION ENVIRONMENT

Area of Instruction	Language of Instruction Communication Mode	Periods per week	Supplementary Aids and Service	Program Modifications and Supports for School Personnel
All	English	All	Special Education Teacher Support Services 3 periods per week (direct service)	

SPECIAL CLASS ENVIRONMENT

Area of Instruction	Language of Instruction Communication Mode	Periods per week	Special Class Staffing Ratio	Supports	Reason for Non-Participation in General Education Environment

OTHER PROGRAMS/SERVICES CONSIDERED AND REASONS FOR REJECTION

Provide an explanation of the programs/services considered and the reason for rejection. Specify why the student can not achieve the goals of his/her IEP within a general education program with the assistance of supplementary aids and services.

GENERAL EDUCATION WAS CONSIDERED AND REJECTED DUE TO THE ACADEMIC DIFFICULTIES OF THE STUDENT.

SPECIAL CLASS IS TOO RESTRICTIVE AT THIS POINT.

Second Language Instruction: If the student is exempt from second language instruction, explain why:

Student ____ NYC ID# 254-223-495 CSE # 02-31232 Date of Conference 5/16/06

PARTICIPATION IN SCHOOL ACTIVITIES, RELATED SERVICE RECOMMENDATIONS AND PARTICIPATION IN ASSESSMENTS

PARTICIPATION IN SCHOOL ACTIVITIES

If the student cannot participate in lunch, assemblies, trips and/or other school activities with non-disabled students, indicate the activity and reason(s) for non-participation.

Not Applicable

RELATED SERVICE RECOMMENDATIONS

Status*	Related Service	Language of Service	Location**	Sessions/ Week	Duration	Group Size
I	Counseling	English	Separate	1	30	1
I	Counseling	English	Separate	1	30	3

* Indicate status of recommendation: Initiate; Continue; Modify; or Terminate.

** Indicate whether service is provided outside the general education classroom.

PARTICIPATION IN ASSESSMENTS

☑ The student WILL PARTICIPATE in State and local assessments.

☐ Without Accommodations ☑ With Accommodations

Describe accommodations, if any, that will be used consistently throughout the student's educational program:

Separate Location. Time extended on city and state tests to time and a half with 10 minute breaks after 40 minutes

☐ The student will participate in Alternate Assessment.

Reason for participation in Alternate Assessment:

In addition to Alternate Assessment, describe how the student will be assessed:

PROMOTION

Promotion ☑ Standard Criteria ☐ Modified Criteria*

*Describe the modified promotion criteria:

Student _____ NYC ID# 254-223-498 CSE # 02-32282 Date of Conference 5/16/2006

TRANSITION

LONG TERM ADULT OUTCOMES

(Beginning at age 14 or younger if appropriate, state long term outcomes based on the student's preferences, needs and interests.)

Community Integration: STUDENT WILL INTEGRATE INTO THE COMMUNITY INDEPENDENTLY.

Post-Secondary Placement: STUDENT WILL ATTEND A CONTINUING EDUCATION PROGRAM.

Independent Living: STUDENT WILL LIVE INDEPENDENTLY.

Employment: STUDENT WILL BE COMPETITIVELY EMPLOYED.

DIPLOMA OBJECTIVE

☒ Regents Diploma ☐ Advanced Regents Diploma ☐ Local Diploma ☐ IEP Diploma

Expected High School Completion Date 6/07 Credits Earned _____ As of Date _____

TRANSITION SERVICES

(Required for students 15 years of age and older.)

Instructional Activities

WILL IDENTIFY PERSONAL LEARNING STYLES AND PARTICIPATE IN A HANDS ON ACADEMIC PROGRAM

Responsible Party: ☑ Parent ☑ School ☑ Student ☐ Agency
☑ Fall ☑ Spring ☐ Summer

Community Integration

"LL PARTICIPATE IN A VOLUNTEER COMMUNITY SERVICE EXPERIENCE BASED ON ABILITIES AND INTERESTS

Responsible Party: ☑ Parent ☑ School ☑ Student ☐ Agency
☑ Fall ☑ Spring ☐ Summer

Post High School

WILL RELATE SCHOOL SUBJECTS TO POTENTIAL CAREERS AND MEET WITH APPROPRIATE SCHOOL PERSONNEL TO FORMULATE A CAREER PLAN AND TRAINING

Responsible Party: ☑ Parent ☑ School ☑ Student ☐ Agency
☑ Fall ☑ Spring ☐ Summer

TRANSITION SERVICES (cont.)

(Required for students 15 years of age and older.)

Independent Living

WILL ASSESS PERSONAL VALUES AND NEEDS AND LEARN TO MANAGE HEALTH AND MONETARY NEEDS

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency
☐ Fall ☐ Spring ☐ Summer

☐ **Acquisition of Daily Living Skills** ☐ **Functional Vocational Assessment**

Responsible Party: ☐ Parent ☐ School ☐ Student ☐ Agency
☐ Fall ☐ Spring ☐ Summer

Saint Vincent Catholic Medical Centers
St. Vincent's Hospital Manhattan

ASSESSMENT

MR#: 701982-4
Invision MR#: 557188
Program: OUTPT CHILD

Assessment Date: 03/20/2006 2:59 PM
By: John Samanich MD ESOF
Reviewed by: George Kowallis MD ESOF

Attending M.D.: LOW,JULIE MD
Primary Therapist: SHEN,MICHAEL MD
Referral Source: Mother
Outpatient Clinician: none
Informants: pt and mother

CHIEF COMPLAINT/REASON FOR REFERRAL
"I am depressed and anxious"

HISTORY OF PRESENT ILLNESS
Pt is a 17 yo m with past psychiatric hx of Major Depressive Disorder, Mild Recurrent and Social Phobia. Pt has been followed psychiatrically off and on since the age of 6yo at this clinic recieving mainly individual therapy for these disorders as well as breif periods of medication managemnt. Pt notes that he decided to return to treatment with worsening symptoms of depression since breaking up with his girlfriend a few weeks ago. Pt notes he has experienced some depressed mood and anhedonia with difficulty with sleep and some changes in appetite. Pt's depressive symptoms are not desribed as severe and pt has had no suicidal or homicidal ideations. Pt with no history of these problems as well.
In addition to pt's depressive symptoms pt has had problems in school secondary to a learning disorder as well as social phobia. Mother maintains pt was tested when he was younger and found to have probles with auditory and visual processing. Pt is bright and has always been in regular education classes but his learning issues have complicated things for him. Pt also describes some problems with social phobia including anxety in meeting new people and being scrutinized and embarrassed, exposure to these situations causes intense anxiety, pt feels this anxiety is unreasonable, social situations are avoided, and this avoidance significantly effects his life. Pt has has extreme difficulty intergrating into the public school system secondary to his social phobia.
Pt was exposed to physical abuse when he was a small child perpertrated by his father. Pt denies any symptoms of PTSD associated with these events. Pt denies any symptoms of mania or any psychotic symptoms.

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ALCOHOL/SUBSTANCE ABUSE HISTORY
A 'YES' answer to any of the following CAGE screening questions indicates abuse:

1. Have you ever attempted to Cut down on drinking or using substances? No
2. Have people Annoyed you with criticism about your using? No
3. Do you feel Guilty about drinking or using substances? No
4. Have you ever had a drink or used first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)? No

Substances Used

Alcohol:	Yes
Amphetamine/Ecstasy:	No
Cannabis:	Yes
Cocaine/Crack:	No
Hallucinogens:	No
Inhalants:	No
Opioids:	No
PCP/Ketamine:	No
Sedatives/Anxiolytics:	No

Substances Used Intravenously
None

Details
1 40oz beer every other weekend
shares a joint with friens every other weekend

Previous Detox/Rehab:	No
AA/NA Attendance:	No
Currently Abstinent:	No

PAST HISTORY/TREATMENT HISTORY
As per pt and pt's mother he started to attend the SVH, outpatient program in 2002,after the parents got divorsed, underwent family therapy and individual psychotherapy, w/o big effect and was seen by psychiatrist at least once but never was tried on any psychotrops and never was hospitalized.

Past History/Risk Assessment
Has the patient ever been physically abused? **Yes**
Has the patient ever been sexually abused? No
Mother described that patient was physically abused by his father and that was the cause of the divorse,pt did not elaborate on that.
Has the patient ever been accused of coercive, predatory, or other inappropriate sexual behavior? No
Has the patient ever attempted suicide? No
Has the patient ever been violent to others? No

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MEDICAL HISTORY
Primary Physician: unknown

Allergies/Drug Sensitivities:
NKDA
Smoking: Yes *Duration:* 2 year *Packs per day:* 1/2
Last PPD: Negative
Sickle Cell Status: Negative
Immunizations: Up To Date

Sexual History
Has the patient been sexually active within the last year? When? Yes
Sexual activity has been with: females
Has the patient been involved in risk-taking sexual behavior? No

Significant Medical/Surgical History
none

CURRENT MEDICATIONS
none

NUTRITION SCREEN
Weight change of 10 lbs in three months: No
Is patient pregnant: No
New onset Diabetes Mellitus: No
Eating disorder: No
Dialysis/Kidney disease: No
Liver disease: No
A 'Yes' answer to any of the above identifies nutritional risk.

PAIN ASSESSMENT
Does the patient have a pain problem? No
If yes, answer the following questions:
Location of pain:
On a scale from 0 to 10, intensity of pain now:
On a scale from 0 to 10, patient's goal:
What, if any, other treatment does the patient receive for pain?
Is the patient's pain satisfactorily controlled now?

MENTAL STATUS
Appearance and Behavior
Pt is well dressed and groomed
Attitude: Cooperative
Eye Contact: Good
Motor Activity: Normal
Movement Disorder: No
Speech
Rate: Regular

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MENTAL STATUS - Continued
Volume: Normal
Quantity: Normal
Quality: Normal
Cognitive Functioning and Intelligence
Oriented to Person: Yes
Oriented to Date: Yes
Oriented to Place: Yes
Serial Subtraction or Spell 'EARTH' Backwards: Easily
Out of 3 Objects, Can Repeat Immediately: Three
Out of 3 Objects, Can Repeat at 5 Minutes: Three
Long Term Memory: Good
Fund of Knowledge: Good
Intelligence: Average
Thought Process: Coherent
Thought Content
Delusions: No
Hallucinations: No
Phobias/Obessions: No
Suicidal Ideation: No
Homicidal Ideation: No
Mood: Depressed
Affect: Constricted
Insight: Fair
Judgment: Fair

EDUCATIONAL NEEDS
Understanding of patient's psychiatric illness
Understanding of triggers and consequences of substance abuse
none

ADDITIONAL EVALUATIONS
none

DIAGNOSIS
Axis I: Major depression, recurrent, mild - 296.31
Social phobia - 300.23
Axis II: None
Axis III: none
Axis IV: Educational
Axis V: GAF at Admission: 60

RISK ASSESSMENT
Substance Abuse
Does the patient have a history of substance abuse? **Yes**
Alcohol; Cannabis
Past History
Has the patient ever been physically abused? **Yes**
Has the patient ever been sexually abused? No

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Mother described that patient was physically abused by his father and that was the cause of the divorse,pt did not elaborate on that.

Has the patient ever been accused of coercive, predatory, or other inappropriate sexual behavior?	No
Has the patient ever attempted suicide?	No
Has the patient ever been violent to others?	No

Mental Status

Patient's current mood: Depressed	
Does the patient have suicidal ideation?	No
Does the patient have homicidal ideation?	No

CURRENT RISKS

Suicide/self harm	No
Violence	No
Aggressive sexual behavior	No
Alcohol/drug withdrawal	No
Acute medical illness	No

DISPOSITION
Admit To: Outpatient Child Program

Initial Treatment Plan: Physical Examination And Labs
Individual Treatment, Family Involvement
Psychiatric Medications

Initial Treatment Plan
-Pt will be seen for weekly individual therapy by this MD
-Consider an SSRI in the future for symptoms of anxiety and depression

UPDATES

John Samanich MD ESOF 03/21/2006

Patient Name
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

Note Written By: John Samanich MD ESOF On: 03/20/2006
Note Type : Resident MD Note Time: 3:04 PM

Initial Evaluation on 03/20/2006 for 60 minutes provided by John Samanich MD

See Assessment Parts I and II for full evaluation

Note Written By: John Samanich MD ESOF On: 03/29/2006
Note Type : Resident MD Note Time: 3:09 PM

45 Min Psychotherapy on 03/29/2006 for 45 minutes provided by John Samanich MD

Pt seen today for initial therapy session. Today explored pt's academic hx. Pt reports school was good until pt enetered Junior High at which point py did began to feel that school was "a waste of time" and his performance trailed off. Pt then went to Farrell HS after this and only spent 3 weeks there then transferring to Humanities. This again did not work out well and pt went to the Community School in Teaneck NJ which was geared with children with special needs. Pt felt out of place there as his educational difficulties were not severe. Pt was then homeschool ed for quite some time before again going to humanities and dropping out. Pt at this time is not in school.
The general theme of pt's difficulties is a sense of being out of place and anxiety in social situations. Pt tends to overemphasize this as a sennse of anxiety but his discussion lends to pt feeling out of place and isolated.
Pt at this time notes his mood is stable and denies any suicidal or homicidal ideation'

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 04/21/2006
Note Type : Resident MD Note Time: 2:51 PM

45 Min Psychotherapy on 04/21/2006 for 45 minutes provided by John Samanich MD

Pt seen today for individual seesion. Pt maintains his mood has been better since the last time we met. Today discussed with pt his sense of awkwardness in social situaitions and how difficult it is for him. Pt has insight that his concerns are out of proprtion to possible consequences and is able to discuss this. Pt is also able to discuss that one of the few memeories of his father is when he was 4-5 yo and he was scolded by another parent in the playground for taking a toy. Pt's

father began to argue with this woman in front of pt. Pt remebers the intense anxety and awkwardness he felt at this time and this is one of the few memeories he has of his father

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 04/27/2006
Note Type : Resident MD Note Time: 3:01 PM

Missed Visit on 04/27/2006 for 45 minutes provided by John Samanich MD

Note Written By: John Samanich MD ESOF On: 05/04/2006
Note Type : Resident MD Note Time: 1:11 PM

45 Min Psychotherapy on 05/04/2006 for 45 minutes provided by John Samanich MD

Pt seen today alone for individual therapy. Pt notes mood has been good but pt has been struggling with his relationship with his ex-girlfriend. Both have the same circle of friends and pt is struggling with the awkwardness of being around her as well as his desire not to have any further contact with her. Pt appears to independently not want to have contact with her outside of his issues with awkwardness. Pt reports that this girl has been having serious emotional and cocaine problems after her brother commited suicide shortly after they became involved (no connection)

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 05/19/2006
Note Type : Resident MD Note Time: 2:57 PM

45 Min Psychotherapy on 05/19/2006 for 45 minutes provided by John Samanich MD

Pt seen today for individual session. Pt notes he has been doing well and his mood has been stable. Today we discussed pt's relationship with his siste, whom he mentioned for the first time today. Pt discribes a very difficult relationship with his siter as they were growing up as they did not gety along well and were always fighting. Pt describes her sister as a high achiever and someone who is the opposite of him. Growing up they would often fight and she would take a parental role towards him at time which upset pt. Pt notes he actually did not like hissister growing up for the way she treated him.

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

He reports that they do not talk much to this day and will only see her when she comes home from . Pt reports that she invited him up to school thgis weekend and it appears to be an opportunity to discuss there relationship and work towards improving it

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 05/25/2006
Note Type : Resident MD Note Time: 3:01 PM

45 Min Psychotherapy on 05/25/2006 for 45 minutes provided by John Samanich MD

Pt seen for individual session today. Pt notes that he has been expeiencing episodes of anxiety at night when he hears planes flying low. Pt notes that his heart begins to beat rapidly and he becomes acutely anxious for about 5 minutes, thinink it may be a bomb. Discussed with pt relaxation techniques. Pt also discussed his sister. Pt mainatins that he hads a good weekend with her. He did not discuss some of the issues he had with her but they enjoyed each others company instead. Pt also reports that he feels much better when he is out of the city. He does not feel many of the same pressures of his life and his uncertaianties about his future when he is away

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 06/01/2006
Note Type : Resident MD Note Time: 3:06 PM

45 Min Psychotherapy on 06/01/2006 for 45 minutes provided by John Samanich MD

Pt seen today for individual session. Today's session focused on pt's apprehension towards novel experiences. Pt continues to give repeated fears of rejection and cognitive distortions. Today pt relayed a story in which he asked a stranger for a cigarrete. when pt was rejected he became upset out of proprtion to the rejection. Pt began to ruminate on this rejections and expounded that his life is so insignificant he has the time to focus on such small incidents such as these. Pt tends to catastophize his experiences secondary to his sensitivity to rejection and today we discussed increased awareness of this occurrence

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Saint Vincent Catholic Medical Centers
St. Vincent's Hospital Manhattan

Run Date : 07/10/2009 Page : 4

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

Note Written By: John Samanich MD ESOF On: 06/08/2006
Note Type : Resident MD Note Time: 2:47 PM

45 Min Psychotherapy on 06/08/2006 for 45 minutes provided by John Samanich MD

Pt seen today for individual session. Pt notes has been more despondent over the past week secondary to feeling overwhelmed with his lack of direction. Pt notes what concerns him most is not his lack of motivation in pursuing the things he wants but his lack of desire to want anything

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 06/15/2006
Note Type : Resident MD Note Time: 3:06 PM

45 Min Psychotherapy on 06/15/2006 for 45 minutes provided by John Samanich MD

Pt seen today for individual seesion. Pt notes he has been sleeping better and has been in a better mood

A/P
Pt is a 17yo m with MDD, Recurrent and mild as well as social phobia

Note Written By: John Samanich MD ESOF On: 06/22/2006
Note Type : Resident MD Note Time: 3:24 PM

Missed Visit on 06/22/2006 for 45 minutes provided by John Samanich MD

Note Written By: John Samanich MD ESOF On: 06/29/2006
Note Type : Resident MD Note Time: 12:53 PM

45 Min Psychotherapy w/Med Mgt on 06/29/2006 for 45 minutes provided by John Samanich MD

Pt is a 17yo m with MDD, mild and recurrent, Social Phobia, and recent developement of GAD. Pt has been seen by this MD over the past few months for individual therapy. The focus of therapy was surrounding his peer relations as well as his not being currently enrolled in school. in addition pt has been reporting increased anxiety and startle over loud noises during the past few months. Pt does not suffer from PTSD but is an overly anxious individual. Today pt reports that the anxiety is worsening and would like to try medication. Pt reports that he had been

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

on Zoloft in the past for depression but had the sensation of "electric shocks". and discontinued meds. Today we discussed Lexapro and its risks in benfits. In particular we discussed the current black box warning of this pill for suicidal ideation in children and adolescentys. Pt reports understanding of this risk and notes he would be able to alert MD if this was a problem.

A/P
Pt is a 17 yo m with MDD, mild and recurrent, Social phobia and GAD
-Pt started on Lexapro 10mg po qd, dispense 30:NR
-Pt should continue weekly individual therapy
-Incoming MD should contact Pt ASAP to set up f/u appointment

Note Written By: Michael Shen MD ESOF On: 07/05/2006
Note Type : Resident MD Note Time: 3:50 PM

Called patient -> left message requesting patient to contact MD to schedule appointment

Note Written By: Michael Shen MD ESOF On: 07/28/2006
Note Type : Resident MD Note Time: 3:02 PM

45 Min Psychotherapy w/Med Mgt on 07/28/2006 for 45 minutes provided by Michael Shen MD

Patient came to appointment by self. Has no new complaints today. Reports "I've been doing fine, very well" but also states that the effect of lexapro seem to "faded alittle". States occasionally feels anxious, especially in morning and when floor has trembled. Reports he sleeps in a cramped room and bed is attached to wall so shakes a lot. States would like to move out of his apartment but is unable to do so financially at this time. Has been compliant with medication. Denies adverse rxn to meds. Is looking forward to going on trip with mother to CT for 3 wks. Spoke to patient regarding relaxation strategies.

Appearance: groomed
Speech: wnl
Cognition: A&OX3
TP: coherent
TC: denies SI/HI
I/J: fair
Axis I MDD, anxiety disorder NOS
II defer
III none
Plan
1) increase Lexapro to 15mg PO qAM
2) c/w individual psychotherapy

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

3) f/u 8/17/ 2PM

Note Written By: Michael Shen MD ESOF On: 08/18/2006
Note Type : Resident MD Note Time: 10:59 AM

Cancelled Appointment - Individual on 08/17/2006 for 30 minutes provided by SHEN,MICHAEL MD

Mother called MD to cancel appt (family is out of state at this time) and states will call to reschedule

Note Written By: Michael Shen MD ESOF On: 09/27/2006
Note Type : Resident MD Note Time: 4:55 PM

Missed Visit on 09/27/2006 for 45 minutes provided by SHEN,MICHAEL MD

Did not show up for appt. Did not call to cancel or reschedule

Note Written By: Michael Shen MD ESOF On: 10/02/2006
Note Type : Resident MD Note Time: 5:11 PM

Medication Management on 10/02/2006 for 30 minutes provided by Michael Shen MD

Patient came to appt on time. Reports that he is doing well. Has no new complaints. Denies new stressors since last visit. Reports is now in last year of HS and is looking forward to graduating. Plans to work after graduation. Reports occasionally has anxiety when hears loud noise worring that it may be terrorist attack. States feels safe and is not worried about this issue in general but would like lexapro to be raised to see if that would help. Patient states would like to receive medication management only and wish to discontinue psychotherapy as he is better and does not have time to meet once a week.

Axis I MDD
II defer
III none

Plan
1) increase Lexapro to 20mg PO qAM (#30)
2) f/u appointment on 11/1/06 3PM
3) patient and family to contact MD if require assistance before appt

Note Written By: Michael Shen MD ESOF On: 11/01/2006
Note Type : Resident MD Note Time: 4:21 PM

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

Medication Management on 11/01/2006 for 30 minutes provided by Michael Shen MD

Patient came to appt on time. Reports that he is doing well. Denies new stressors since last visit. Reports that anxiety level is decreased but he is having difficulty falling asleep at night. Reports that he often toss and turn and notice many involuntary movements in his legs before falling asleep and this prevents him from falling asleep. States he thinks he may have "restless leg syndrome" and was told by his pediatrician to speak with MD about this. Patient also wonders if drinking alocohol has caused this - states he drinks about 6 cans of beer on weekends - usually with friends or in social situations. Denies drinking on weekdays or drinking alone. Provided psychoeducation regarding sleep hygiene and adverse effect of alcohol on sleep and that it may worsen involuntary movements at sleep. Patient states will decrease alcohol use.

Axis I MDD
II defer
III none

Plan
1) c/w Lexapro to 20mg PO qAM (#30)
2) f/u appointment on 12/4/06 3PM
3) patient and family to contact MD if require assistance before appt

Note Written By: Michael Shen MD ESOF On: 12/04/2006
Note Type : Resident MD Note Time: 3:51 PM

Medication Management on 12/04/2006 for 30 minutes provided by Michael Shen MD

Patient came to appointment on time. Reports that he has been sleeping too much and unable to wake up to go to school. States has missed many days of school and feels this is a problem. Upon on further questions patient admits that he has been using "a couple" of joints of MJA on a daily basis. Provided patient psychoeducation regarding the adverse effect of MJA on health, mental health, and sleep. Patient admits to lack of motivation but does not feel MJA is the cause of this. Spoke to patient regarding referral for substance abuse counseling but patient states wants more time to think about it. Appears ambivalent about quitting at this time. States mother is aware of this problem but does not suspect that he is using every day.

Axis I MDD in partial remission, MJA abuse

Plan

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

1) c/w Lexapro 20mg PO qAM (#30)
2) f/u with me on 12/19 3PM
3) encourage patient for substance abuse treatment
4) will call mother
5) patient to contact MD if require assistance before appointment.

Note Written By: Michael Shen MD ESOF On: 12/19/2006
Note Type : Resident MD Note Time: 5:37 PM

Missed Visit on 12/19/2006 for 30 minutes provided by Michael Shen MD

Did not show up for appoitnment - did not call to cancel or reschedule.

Note Written By: Michael Shen MD ESOF On: 01/09/2007
Note Type : Resident MD Note Time: 4:50 PM

Missed Visit on 01/09/2007 for 30 minutes provided by Michael Shen MD

Did not show up for appointment/call

Plan
1) will call to reschedule

Note Written By: Michael Shen MD ESOF On: 01/23/2007
Note Type : Resident MD Note Time: 5:22 PM

Medication Management on 01/23/2007 for 30 minutes provided by Michael Shen MD

Patient and mother came to appointment on time. Patient reports he is no longer going to school and will probably drop out but plans to get a GED. Reports continues to smoke MJA every other day "a ball" each time. Admits that drug use has resulted in erratic sleep pattern, lack of motivation, and "wasting time". Spoke with patient and mother together regarding the adverse effect of MJA use and provided motivational interview - patient appears ambivalent to stop using and states that he can stop anytime if he wish. Agree with MD that if he smokes even once in the next 3 wks he would agree to commit to substance abuse treatment.

Axis I MJA abuse, depressive disorder NOS
II defer
III none
Plan
1) motivational interview
1) c/w Lexapro 20mg PO qAM (#30)
2) encourage patient to agree to substance abuse treatment

Patient Name :
Med Record # : 701982-4
Invision MR# : 557188
Admission Date : 03/20/2006 Discharge Date : 04/04/2007

3) f/u on 2/13/07 3:30PM
4) mother to contact MD if require assistance

Note Written By: Michael Shen MD ESOF On: 03/14/2007
Note Type : Resident MD Note Time: 9:49 AM

Received message from mother -> reports that patient's prescription is running out and requests MD to call in new prescription at pharmacy -> called for 30 day supply.

Called mother yesterday and left message requesting mother to contact MD to schedule follow up appointment.

Note Written By: Michael Shen MD ESOF On: 03/19/2007
Note Type : Resident MD Note Time: 3:16 PM

Called and left message instructing mother and patient to contact MD.

Note Written By: Michael Shen MD ESOF On: 03/23/2007
Note Type : Resident MD Note Time: 2:02 PM

Still has not heard from family/patient - mailed letter to family requesting family to contact MD. Explained in letter that if MD does not hear from them by 4/5/07 Patient's chart will be closed.

Note Written By: Michael Shen MD ESOF On: 04/04/2007
Note Type : Resident MD Note Time: 11:17 AM

Received message from mother -> states that patient has started seeing a new provider and requests MD to close patient's case.

Plan
1) will close patient's case

Four Winds HOSPITAL
800 Cross River Rd • Katonah, NY 10536
1-914-763-8161 • 1-800-528-6624

Woodview-Adult 45494
Male Adm 10/30/08
dob 4/01/89 Patient# 45494-1

DISCHARGE INSTRUCTIONS AND PLAN

Discharge Date: November 4, 2008 **Discharge Time:** 4:15 pm

In order to maintain the gains you have made at Four Winds Hospital, the treatment team recommends the following:

1. **Medication follow-up:** Dr. Jonathan Dobkin (MD) 212-989-2990 The Fifth Avenue (Name, Date, Appointment Time)
2. **Therapist:** Miles Neale, PhD 212-989-2990 - message left by FWH rc d/c. (Name, Date, Appointment Time)

Patient to call for appointment

3. **Medical Follow-up:** _____ (Name, Date, Appointment Time, Reason)

Copies of Outside Consultation(s) and Imaging Studies given to Patient. Yes____ No____ N/A____

4. **Support Network:** return to reside w/ mother; recommend AA or NA meetings (include living arrangements, education/leisure, career)

Fax to: Name_____ **Fax #**_____ **Labs:** Yes____ No____

Fax to: Name_____ **Fax #**_____ **Labs:** Yes____ No____

Fax to: Name_____ **Fax #**_____ **Labs:** Yes____ No____

Your physician has prescribed the following medications to be continued after discharge:

Name	Dose	Time	Route
Lexapro	20 mg	morning	by Mouth
Wellbutrin	75 mg	morning and dinner	by Mouth

☑ I agree to follow the above recommendations upon discharge from Four Winds Hospital.

☐ I do not agree to follow the above recommendations upon discharge from Four Winds Hospital

My signature shows that I am being given a copy of this discharge plan and instructions.

Dr Jamison — Patient / Guardian Signature — 11/4/08 — Date

[signature] — Staff Signature — 11/4/08 — Date

revised ca6/23/08

Woodview-Adult MR#
Male Adm 10/30/08
dob 4/01/89 Patient# 45494-1

FOUR WINDS - KATONAH
PSYCHIATRIC ASSESSMENT, Part 1

PATIENT'S NAME: AGE: 19 DATE/TIME: 10/30/08 12:30 PM

PSYCHIATRIC HISTORY

PATIENT IDENTIFICATION AND SOURCE OF REFERRAL (Include patient's age, gender, ethnicity and marital status):

19 yo SWM referred by his therapist in NYC for admission. Lives at home with mom. GED student. Athiest.

CHIEF COMPLAINT (Expressed in the patient's own words):

"I'm unhappy, miserable and a failure in life."

HISTORY OF PRESENT ILLNESS:

This is pt's first psychiatric hospitalization but has been depressed since middle school and reports a h/o ADD and learning disability (Neuropsych testing done 2003 showed no formal dx of ADD but dx with Learning Disorder NOS and GAD). He has been in outpt therapy for 2 years with current psychologist and with the clinic psychiatrists as well taking medications. Depression has interfered with his functioning leading to his failure to complete HS (last grade completed was 9th) and having extensive absences and lates. He has had some work experience but non recently due to his impairment. Currently he admits to depressed mood, anhedonia, increased sleep (12-14 hrs a day), decreased appetite, feeling detached "floating by watching life go by", no motivation or energy, suicidal thoughts but no plan/intent, poor concentration (better w/ adderall), poor short term memory. He notes worsening depression in the winter. He admits to episodes of increased anxiety lasting a few minutes triggered by loud noises in which he feels his heart racing, butterflies in his stomach, a fear that something bad will happen, overwhelmed (better since lexapro); he can't recall last time this happened. He denies agoraphobia. He denies manic or hypomanic episodes. He denies HI/I/P. He has had visual hallucinations from drug use and occasionally reports seeing "trails" which may be lingering effects of some of those drugs. He denies AH/paranoia or other psychotic symptoms. He admits to a long h/o substance abuse including regular MJ smoking, occasional ETOH use and abuse of various other drugs in the past including pain meds (oxycontin, morphine), sedative/hypnotics (xanax, klonopin, ambien), mushrooms, LSD. He was started on adderall to help him focus better in GED class and it is working. He notes appetite suppression with adderall and also has used it for socialization b/c it makes him feel more comfortable and more verbal. He reports significant stressor at age of 5 when father left. Father was physically abusive of him, his older sister and his mother. He recalls his dad hitting his head against the bathtub when he was a baby. He believes father had an untreated mental illness. Other stressors include 2 deaths of friends over the summer (one possible suicide). The patient expresses a wish to be "healthy" to "enjoy life" again

Pt's mother adds that she has wanted him to get into a program that would address both his depression and drug abuse and he has been unwilling to do so until now. She is concerned b/c for the last few years he has not been functional and not taking care of himself.

Trauma Assessment (relation of past or present trauma to present illness): ☐ N/A ☐ See above ☑ Describe below:

Physical abuse by father to pt and his mother and sister.
Mother's life was threatened and pt witnessed father choke mother.
He recalls episode where father threw him against a bath tub (mother says sink) but no significant injury sustained. There was an order of protection which was violated once and father went to jail.

Woodview-Adult MR#
Male Adm 10/30/08
dob 4/01/89 Patient# 45494-1

PAST PSYCHIATRIC HISTORY (outpatient treatment, hospitalizations, medication trials, plus relevant developmental history for children & adolescents):

No prior admissions.
Outpt therapy weekly and medication management monthly at 5th Avenue Clinic.
Treatment with lexapro.
Adderall started in September to help with GED program.
Ambien prescribed in the past for sleep aid and had sleep clinic evaluation for sleeping disorder.

CHEMICAL DEPENDENCY HISTORY: ☐ None

TYPE OF SUBSTANCE	AMOUNT/FREQUENCY	LAST USE	FIRST USE
☑ Alcohol	2x 40 ounce beers 3-4 times a week	10/27/08 night	6th grade
☑ Marijuana	one blunt daily	10/29/08 evening	6th grade
☐ Cocaine (crack, etc.)			
☑ Hallucinogens (LSD, mushrooms, etc.)		1 year ago	8th grade
☐ Stimulants (amphetamines, Ritalin, etc.)			
☑ Opiates *(Specify)*:	oxycontin, morphine (friend)	2 months ago	8th grade
☑ Other:	ambien (rx middle school); klonopin 0.5-1.0 mg (1x)	summer 08 (ambien); 1 week ago (klonopin)	6th grade

Symptoms experienced previously in withdrawal/while using:
☑ Anxiety ☑ Sleep Disturbance ☐ Tremors ☐ Blackouts
☑ Irritability ☐ Vomiting ☐ Nausea ☑ Tolerance
☐ Seizures ☐ Sweats ☐ Hallucinations

Previous Treatment for Substance Abuse	
Where	*When*
N/A Has been referred in the past by mom.	
AA/NA: ☐ Yes ☑ No Frequency:	Sponsor:

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY:

Sister 22 yrs old drinks ETOH.
Father has undiagnosed mental illness likely with psychosis.
Mother and sister with depression and anxiety tx with lexapro.

CSW, Ph/Psy.D., RN, MD, NPP Signature:	Print Name:	Title:	Date/Time:
	Jessica Nowillo	DO	10/30/08 3PM
Reviewed by Psychiatrist/NPP (If completed by CSW, Ph/Psy.D., RN):	Print Name:	Title:	Date/Time:

PSYCHIATRIC ASSESSMENT, Part 2

wd dview-Adult MF-
Male Adm
dob 4/01/89 Patient# 45494-1

PSYCHIATRIC EVALUATION

MEDICAL HISTORY

Has the patient experienced any of the following conditions?

- ☐ Autoimmune Disease
- ☐ Bone Disease
- ☐ Cancer or Tumors
- ☐ Cardiovascular Disease
- ☑ Other: NA
- ☐ Congenital Deformities
- ☐ Diabetes
- ☐ Gastrointestinal Disorders
- ☐ Kidney Disease
- ☐ Pulmonary Disease/Asthma
- ☐ STD's
- ☐ Tuberculosis
- ☐ Bleeding Tendencies

Current Health Problems and Treatments Needs (including interaction between medical & psychiatric condition):

Weight loss from appetite loss.

Allergies/Adverse Drug Reactions: Antibiotic- can not recall name but taken off market per pt.

MENTAL STATUS EXAMINATION

APPEARANCE

- ☐ Well nourished
- ☐ Well developed
- ☐ Alert
- ☐ Well Groomed
- ☐ Overweight
- ☑ Stated age
- ☐ Sickly
- ☑ Underweight
- ☐ Older than age
- ☑ Unkempt
- ☐ Drowsy
- ☐ Younger than age

Describe:

ATTITUDE

- ☑ Attentive
- ☑ Cooperative
- ☑ Friendly
- ☐ Guarded
- ☐ Evasive
- ☐ Apathetic
- ☐ Ingratiating
- ☐ Hostile
- ☐ Interested
- ☐ Uncooperative
- ☐ Belligerent
- ☐ Indifferent

Describe:

MOTOR/BEHAVIOR

- ☑ Appropriate for age
- ☐ Fidgety
- ☐ Restless
- ☐ Accelerated
- ☑ Slowed
- ☐ Agitated
- ☐ Mannerisms
- ☐ Tremors
- ☐ Poor eye contact
- ☐ Tics
- ☐ Stereotypies

Describe:

SPEECH

- ☑ Fluent
- ☐ Soft
- ☐ Loud
- ☐ Mumbled
- ☑ Spontaneous
- ☐ Emotional
- ☐ Slow
- ☐ Hesitant
- ☐ Pressured
- ☐ Rapid
- ☑ Monotonous
- ☐ Slurred
- ☐ Dysarthric
- ☐ Stutter

Describe:

MOOD

- ☑ Sad
- ☑ Depressed
- ☑ Empty
- ☐ Numb
- ☑ Nervous
- ☑ Anxious
- ☐ Distressed
- ☑ Hopeless
- ☐ Fearful
- ☐ Panicky
- ☐ Guilty
- ☐ Other:
- ☐ Irritable
- ☐ Angry
- ☐ Embarrassed
- ☐ Ashamed
- ☐ Cheerful
- ☐ Elated

Describe:

AFFECT

- ☐ Neutral
- ☑ Congruent w/mood
- ☐ Constricted
- ☐ Blunted
- ☐ Flat
- ☐ Inappropriate
- ☐ Intense
- ☐ Expansive
- ☐ Labile
- ☐ Volatile

Describe:

THOUGHT PROCESS

☑ Logical ☐ Perseverative ☐ Circumstantial ☐ Loose association ☐ Blocking
☑ Coherent ☐ Tangential ☐ Slowed ☐ Flight of ideas ☐ Incoherent
☐ Disorganized ☐ Distracted ☐ Other:

Describe:

PERCEPTIONS

☐ Appropriate ☐ Dissociation ☐ Depersonalization ☐ Illusions ☐ Derealization

Describe: detached feeling from life

THOUGHT CONTENT

☑ Relevant/Appropriate ☐ Obsessions ☐ Confabulation ☐ Paranoid delusions ☐ Nihilism
☐ Congruent w/mood ☐ Compulsions ☐ Ideas of reference ☐ Grandiose delusions ☐ Phobias
☐ Irrelevant ☐ Preoccupations ☐ Ideas of influence ☐ Somatic delusions
☐ Hallucinations: ☐ Auditory ☑ Visual ☐ Olfactory ☐ Tactile

Describe: sees "trails" sometimes which he relates to past drug use of LSD

SUICIDALITY *(If patient has a plan, please specify.)*

☐ No suicidal ideation ☑ Passive suicidal ideation ☐ Active suicidal ideation
☐ No suicidal intent ☐ Has suicidal intent ☐ Has suicide plan ☐ Has available means
☐ Able to contract for safety in the hospital ☑ *Yes* ☐ *No* ☐ Able to contract for safety out of the hospital ☑ *Yes* ☐ *No*

Describe: states he would never do it b/c it's the "easy way out" and "selfish"

HOMICIDALITY *(If patient has a plan, please specify.)*

☑ No homicidal ideation ☐ Passive homicidal ideation ☐ Active homicidal ideation
☑ No homicidal intent ☐ Has homicidal intent ☐ Has homicide plan ☐ Has available means

Describe:

ORIENTATION

☑ Person ☑ Place ☑ Time ☑ Situation

Unable to test because:

ATTENTION / CONCENTRATION

☐ Normal ☑ Impaired

As evidenced by age appropriate: ☐ Serial Subtraction ☐ Digit Repetition ☑ Word/Month Reversal
☐ Simultaneous task performance ☐ Ability to follow directions ☐ Ability to ignore extraneous stimuli
☐ Other:

Unable to test because:

MEMORY

Short-term (5 minutes) ☑ Good ☐ Fair ☐ Poor ☑ As evidenced by 3 /3 in five minutes

Recent Past (2-3 days) ☑ Good ☐ Fair ☐ Poor ☑ As evidenced by: this past week's activities told in history

Remote (months-years) ☐ Good ☐ Fair ☑ Poor ☑ As evidenced by: can't recall certain details of history

Unable to test because:

ABILITY TO ABSTRACT AND GENERALIZE

☑ Good ☐ Fair ☐ Poor

As evidenced by age appropriate: ☑ Ability to see similarities/opposites ☐ Ability to make inferences ☑ Proverb interpretation
☐ Concrete thinking ☐ Overgeneralizes/Vague ☐ Use of language

Describe:

INTELLECTUAL FUNCTIONING

☐ Above Average ☑ Average ☐ Below Average

As evidenced by age appropriate: ☐ Vocabulary ☐ Fund of knowledge ☐ Responses to questions
☐ School performance ☑ IQ (If testing results are available)

Describe: Done in 2003 at SUNY College of Optometry

INSIGHT AND JUDGMENT

Insight:	☑ Good	☐ Fair	☐ Poor
Judgment:	☑ Good	☐ Fair	☐ Poor

As evidenced by age-appropriate:
☑ Awareness of problem ☑ Acceptance of help ☑ Understanding cause and effect
☐ Self-defeating/endangering behavior w/o regard to consequences ☐ Denial/blames others
☐ Other

Describe:

IMPULSE CONTROL

☑ Good ☐ Fair ☐ Poor

As evidenced by: no self harm despite SI; behavior during session and per mom

RISK ASSESSMENT (Suicide/Homicide):

The patient currently has a highly lethal plan with obtainable means.	☐ Yes	☑ No
The patient has a history of highly lethal attempts in the last six months.	☐ Yes	☑ No
The patient is cut off from resources, is depressed, and uses alcohol/drugs to excess.	☑ Yes	☐ No
The patient is threatened with a serious loss (unemployment, divorce, failure in school).	☑ Yes	☐ No
The patient lives alone or within a new environment.	☐ Yes	☑ No
The patient has a family history of suicide.	☐ Yes	☑ No
The patient is a male over 60 or a female over 60.	☐ Yes	☑ No

DIAGNOSIS:

Axis I: Major depres.recur.,severe,w/o psych.fea

Axis II: Diagnosis or condition deferred on Axis II

Axis III: None

The patient's Axis II diagnosis ☐ contributes ☑ does not contribute to the patient's psychiatric illness.

Axis IV: Psychosocial and Environmental Problems: Check all that apply and include on the Treatment Plan

☐ Problems with primary support group. *Specify:*

☑ Problems related to the social environment. *Specify:* death of 2 friends over this summer

☑ Health and Educational problems of patient and family. *Specify:* did not complete high school

☑ Occupational problems. *Specify:* unemployed

☐ Housing problems. *Specify:*

☑ Economic problems. *Specify:*

☐ Problems with access to health care services. *Specify:*

☐ Problems related to interaction with the legal system/crime. *Specify:*

☑ Other psychosocial and environmental problems, coping skills, sexuality. *Specify:* poor coping skills

Axis V: Global Assessment of functioning: Current: 30 Past year: 50

91-100 Superior functioning 81-90 Good functioning/Minimal symptoms 71-80 Slight functional impairment/Mild, transient symptoms 61-70 Difficulty functioning in single area/Mild symptoms 51-60 Variable functioning/Moderate symptoms 41-50 Moderate functional impairment/Serious symptoms 31-40 Major functional impairment/Impaired reality testing 21-30 Unable to function/Serious impairment in communication, judgment 11-20 Needs supervision to prevent hurting self or others/Difficulty maintaining self-care 1-10 Needs constant supervision to prevent severe aggression or self-destruction behavior/Unable to maintain self-care

Woodview-Adult
Male
dob 4/01/89 Patient# 45494-1

Four Winds-Katonah Integrated Assessment, Part A 6

PATIENT STRENGTHS

☑ Communicates feelings well ☐ Intellect ≥ average ☑ Motivated for treatment ☑ Normal developmental milestones
☑ Supportive family/significant other ☑ Successful relationships ☑ Established outpatient team and supports
☐ Energetic ☐ Resilient ☑ Engaging ☑ Curious about his/her environment ☑ Good sense of humor
☐ Academic/vocational achievements ☐ Other achievements:
☑ Patient is interested in: skateboarding
☑ Patient reports strengths as: skateboarding
☑ Others report patient strengths as: art and music (mom)

PATIENT WEAKNESSES ☑ Intellect <average ☐ Not motivated for treatment ☑ Not able/willing to maintain self-care
☐ Has difficulty making decisions ☐ Interacts minimally with others ☐ Cannot describe accomplishments
☑ Has limited skills ☐ Has limited social support ☐ Poor impulse control
☐ Low frustration tolerance ☐ Impaired reality testing ☐ Poor communication skills
☐ Other:

PATIENT DISABILITIES

Cognitive: Learning disability NOS; r/o ADD

Physical: None

INITIAL TREATMENT PLAN:

☑ Admit to Inpatient Program ☐ Admit to Partial Hospital Program ☐ Refer for Outpatient Treatment
☑ Individual Therapy ☑ Group Therapy ☑ Family Therapy ☑ Milieu Therapy ☑ Pharmacotherapy
☑ Alcoholism/Substance Abuse Treatment ☐ Therapeutic School ☑ Dietary Consultation
☐ Other:

Estimated length of stay: 1-2 wks

OUTCOME: Document outcome of discussion with outpatient provider and/or referral source, with insurance and/or managed care company. ***Document outcome of initial intervention with family/significant others, including informed consent:***

Left message with outpt provider and no call back yet.
Will contact St. Vincent's clinic where he gets primary medical treatment.
Insurance approved 4 days and review will be on Monday.
Mom is in agreement with treatment plan and was present during intake to provide collateral information.

Psychiatrist/NPP Signature:	Print:	Title:	Date/Time:
	Jessica Nowillo	DO	10/30/08 3:30 PM

revised ca10/2/06

Four Winds HOSPITAL

MEDICATION VERIFICATION AND RECONCILIATION FORM

Woodview-Adult
Male
dob 4/01/89

MR# 45494
Adm 10/30/08
Patient# 45494-1

☒ MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC'S AND HERBALS
☐ ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MEDICATION LIST
☐ MEDICATIONS TO BE CONTINUED AT DISCHARGE AND REVIEWED WITH PATIENT/FAMILY

Source of Patient Medication List:

☒ Patient/Family recall
☐ Pharmacy _____
☐ Medication Administration Record from Facility
☐ Physician/Therapist _____
☐ Previous Discharge Paperwork
☐ Other: _____

Med. Allergies / ADR's: Seroquel ? Amantadine

	Medication Name (Write Legibly)	Dose (mg, mcg)	Route (PO, IM, SC, PR)	Frequency	Last Dose Date/Time	PLAN (Circle one and write order on Order Form) C=Continue DC=Discontinue ↑=Increase ↓=Decrease
1.	Lexapro	20 mg	PO	daily	10/30/08	C DC ↑ ↓
2.	Adderall XR	10 mg	PO	daily	10/30/08	C DC ↑ ↓
3.						C DC ↑ ↓
4.						C DC ↑ ↓
5.						C DC ↑ ↓
6.						C DC ↑ ↓
7.						C DC ↑ ↓
8.						C DC ↑ ↓
9.						C DC ↑ ↓
10.						C DC ↑ ↓
11.						C DC ↑ ↓
12.						C DC ↑ ↓
13.						C DC ↑ ↓
14.						C DC ↑ ↓

CONFIDENTIAL INFORMATION – FURTHER DISCLOSURE PROHIBITED

MD/NPP Signature: _____ Print Name: J. Nowillo MD Date/Time: 10/30/08 1:30pm

- At admission, a physician or nurse practitioner should take as thorough a medication history as possible. Consultation with the outpatient provider, pharmacy, and family members may be necessary to generate the most accurate medication list.
- The physician/NP responsible for the patient should carefully consider whether to continue (C) or discontinue (DC) each medication, medication dose or form, and circle the appropriate letters/symbol. The "Medications Prior To Admission" box should be checked.
- New medications, new doses of medication the patient is already taking, continued medications, or substitute medications for those discontinued due to unavailability are ordered on the medication order form.
- If additional medication history is made available after admission, the medication history may be updated by completing a second reconciliation form noting the addition or changes, and checking the Addendum/Revision box.
- At discharge, this form should be reviewed together with the Medication Administration Record (Kardex). The "Medications at Discharge" box should be checked. The provider should list all the medications the patient will be taking after discharge, including the dose of each medication and the date they started that dose. "C" (Continue) should be circled for all discharge medications. All medications and instructions should also be recorded on the discharge paperwork.

Four Winds

Discharge/Referral Summary

ALLERGIES:

Send to:

1. Patient's Name: Program: Woodview-Adult

Admission Date: 10/30/08 Discharge Date: 11/04/08

2. **Treatment Modalities:**

☐	Individual Therapy	☑	Self-Help Meetings	☑	Art Therapy
☑	Group Therapy	☐	Education	☐	Other:
☐	Family Therapy	☑	Medication		
☐	Multifamily Group	☑	Recreation Therapy		
☑	Substance Abuse Group	☑	Psychodrama		

3. **Multiaxial Diagnosis:**

AXIS I: Clinical Disorders ***Other Conditions That May Be a Focus of Clinical Attention***

Diagnostic code	DSM-IV name
296.33	Major depression, recurrent, severe without psychosis
304.30	Cannabis dependence

AXIS II: Personality Disorders Mental Retardation

Diagnostic code	DSM-IV name
799.9	deferred

AXIS III: General Medical Conditions

ICD-9-CM code (optional)	Name
	none identified

AXIS IV: Psychosocial and Environmental Problems Check:

- ☐ Problems with primary support group Specify:
- ☑ Problems related to the social environment Specify: death of 2 friends summer of 2008
- ☑ Educational problems Specify: was not able to complete high school (now in GED program)
- ☑ Occupational problems Specify: not employed
- ☐ Housing problems Specify:
- ☐ Economic problems Specify:
- ☐ Problems with access to health care services Specify:
- ☐ Problems related to interaction with the legal system/crime Specify:
- ☐ Other psychosocial and environmental problems Specify:

AXIS V: Global Assessment of Functioning Scale Current 050 ___ ___ ___ Admission 030 ___ ___ ___

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ca12/12/05

4. **Course in Hospital** (including progress made toward Treatment Plan goals, described in behavioral terms, and mental status at discharge):

Patient is a 19 year old single male referred by outpatient provider for evaluation and treatment of depression and substance abuse. Patient stated at admission "I'm unhappy, miserable and a failure in life." This is first psychiatric hospitalization but patient reports depression since he was in middle school. He reports he also has history of ADD and learning disability. He did have testing done in 2003 that indicated support for learning disorder nos and generalized anxiety disorder but no formal diagnosis of ADD. Patient in outpatient treatment and taking medication. He states he has depressed mood, no motivation, increased sleep, decreased appetite and has been abusing substances. He has a history of trauma by father who reportedly abused patient, mother and sister. Father is no longer in the family but patient suspects father had mental illness. Mother and sister have depression and anxiety and are receiving treatment.

Patient was admitted to the adult unit on 10/30. Mother was present during intake process to provide collateral information. Messages were left with the outpatient providers and with the primary medical care provider. The treatment plan in hospital included medication evaluation and management, full group program, 12 step meetings, psychodrama group, therapeutic activities.

By 10/31 patient reported no suicidal ideation, no homicidal ideation. He reported good appetite and poor sleep the previous night. Patient was encouraged to work on changing sleep/wake cycle (which had been dysregulated prior to admission), to participate in group program. Treatment team continued to provide patient with structure, support and psychoeducation. Patient taking wellbutrin and lexapro.

On 11/01 patient did not attend afternoon group program and submitted a request for immediate discharge. He stated he had no urges to harm self or others and wanted to return to home with outpatient treatment. Patient's mother was visiting patient on the unit and the doctor discussed the request for discharge with her and patient. Patient continued to deny suicidal and homicidal ideation and said that he had a low level of anxiety. Discharge was planned for 11/4 with mother stating she would pick patient up at discharge. Social worker contacted the outpatient providers to inform them that patient had continued to request discharge, that family was supportive of this and would be picking patient up to go home. Since providers could not be reached directly, detailed message was left. Patient and family were instructed to contact the providers to confirm appointments.

EXHIBIT NO. 5F
PAGE: 10 OF 11

Discharge/Referral Summary

Patient's Name:

Woodview-Adult
Male
dob 4/01/89

MR# 45494
Adm 10/30/08
Patient# 45494-1

5. Medical Information:
See Medication Verification & Reconciliation Form for list of current medications

Med. Blood Levels
Name of Med: N/A Level: Date:
Name of Med: Level: Date:

Previous Medication Trials During Hospital Stay:
Medication: N/A Reason for discontinuing:
Medication: Reason for discontinuing:
Medication: Reason for discontinuing:

General Health Status: [X] Good ☐ Fair ☐ Poor
If Fair or Poor - Explain:

Abnormal Movements: [X] Neg. ☐ Pos. - (describe)

Physical Activity: [X] Full ☐ Partial ☐ Restricted

If Partial or Restricted - Explain:

Any physical disabilities or prostheses (include glasses, dentures, etc.) ☐ No ☐ Yes
If Yes - Explain:

Any Developmental Delays or Abnormalities: [X] No ☐ Yes
If Yes - Explain:

Lab Values: [X] Normal ☐ Abnormal **Date of Last CBC & LFT's:** 10/31/08
If Abnormal - Explain:

Recommendations for follow up on any Medical Illness or Medications:
f/u c PCP as needed

6. Discharge Plan:

a. Vocational/Educational Plans: Ongoing GED program
b. Living Arrangements: home w/ family 269 W. 12th Street NY NY 10014 212-929-4383
(Name) (Address, Phone)
c. Psychotherapy Follow-up: Miles Neale PhD 212-989-2990
(Name, including discipline and affiliation)
message left for therapist to provide appt. Pt. was
(Address, Phone)
d/c to home on "Request for Immediate Discharge" note
(Appt. Date & Time)
d. Medication Follow-up: Jonathan Tobbs, MD The Fifth
(Name)
Avenue Center 212-989-2990
(Address, Phone)
Pt. to call for appointment.
(Appt. Date & Time)

e. Support Services/Groups:
f. Physical Activity: full
g. Diet: regular

Late entry

Primary Therapist: [signature] Wallace LCSW	**Date:** 1/26/09
Social Worker (if other than primary therapist):	**Date:**
Physician/NPP: [signature]	**Date:** 11/4/08

ca12/12/05

Four Winds HOSPITAL

MEDICATION VERIFICATION- AND RECONCILIATION FORM

MR# 45494
Woodview-Adult Adm 10/30/08
Male
dob 4/01/89 Patient# 45494-1

- ☐ MEDICATIONS PRIOR TO ADMISSION INCLUDING OTC'S AND HERBALS
- ☐ ADDENDUM TO OR REVISION OF PREVIOUSLY COMPLETED MEDICATION LIST
- ☐ MEDICATIONS TO BE CONTINUED AT DISCHARGE

Source of Patient Medication List:

- ☐ Patient/Family recall
- ☐ Pharmacy
- ☒ Medication Administration Record from Facility
- ☐ Physician/Therapist
- ☐ Previous Discharge Paperwork
- ☐ Other:

Allergies: Seclor

	Medication Name (Write Legibly)	Dose (mg, mcg)	Route (PO, IM, SC, PR)	Frequency	Date Started	Last Dose Date/Time	C=Continue DC=Discontinue
1.	Wellbutrin	75	PO	BID		AM 11/4	C DC
2.	Lexapro	20	PO	Daily		AM 11/4	C DC
3.	Adderall						C DC
4.							C DC
5.							C DC
6.							C DC
7.							C DC
8.							C DC
9.							C DC
10.							C DC
11.							C DC
12.							C DC
13.							C DC
14.							C DC

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MD/NPP Signature: [signature] Print Name: Sranillo Date/Time: 11/4/08 1pm

- At admission, a physician or nurse practitioner should take as thorough a medication history as possible. Consultation with the outpatient provider, pharmacy, and family members may be necessary to generate the most accurate medication list.
- The physician/NP responsible for the patient should carefully consider whether to continue (C) or discontinue (DC) each medication, medication dose or form, and circle the appropriate letters/symbol. The "Medications Prior To Admission" box should be checked.
- New medications, new doses of medication the patient is already taking, continued medications, or substitute medications for those discontinued due to unavailability are ordered on the medication order form.
- If additional medication history is made available after admission, the medication history may be updated by completing a second reconciliation form noting the addition or changes, and checking the Addendum/Revision box.
- At discharge, this form should be reviewed together with the Medication Administration Record (Kardex). The "Medications at Discharge" box should be checked. The provider should list all the medications the patient will be taking after discharge, including the dose of each medication and the date they started that dose. "C" (Continue) should be circled for all discharge medications. All medications and instructions should also be recorded on the discharge paperwork.

revised ca 12/5/05

Fifth Avenue Center for Counseling & Psychotherapy
915 Broadway, 7th Floor
New York, NY 10010
(212) 989-2990

Comprehensive Intake Assessment- *Children*

Intake Date: 3/8/07

Referral Source: ( )Self (✓)Family ( ) School ( ) Other _____

IDENTIFYING INFORMATION

Child's Name: (LAST) O (FIRST) J DOB 4/1/89

Home
Address _____

Home Phone _____
Languages spoken at home English Primary language "

Mother/Guardian Name: (LAST) O (FIRST) O
Address (if different) same

Home Phone: same Work: Ø Cell: Ø
Education: college
Occupation Unemployment
Religion Catholic Ethnicity Caucasian
Relationship to Child: (✓) biological parent ( ) adoptive parent ( ) foster Parent ( )other
Length of time child has been with this caregiver whole life

Father/Guardian Name: (LAST) (FIRST)
Address (if different) Unknown

Home Phone: " Work: " Cell: "
Education: "

Occupation ?
Religion Catholic Ethnicity Caucasian
Relationship to Child: (✓) biological parent ( ) adoptive parent ( ) foster parent ( )other
Length of time child has been with this caregiver 0 thru

If parents are married- date of marriage _____
If not, parents are ( ) separated Date of separation 1994
(✓) divorced Date of divorce 1999
( ) deceased Mother/date _____ Father/date _____
( ) never married

Persons who have legal guardianship of child _____

Siblings and/or Others Residing at home:

Child's Name	Age	Relation	Grade or Occupation
	20	(S)	college

PRESENTING ISSUES

Child's Presenting **Symptoms** & Issues

Pt is a 17 year old Caucasian heterosexual male who reports depressed mood, ↓ concentration, ↓ sleep, ↓ appetite, anxiety "panic attacks" while asleep, "ADHD" lazy and "unproductive piece of shit", and fatigue. Pt reports daily cannabis use and weekly alcohol use. Pt reports basically dropped out of school by refusing to attend despite enrollment. Pt reports desire to get GED but does not attend any GED classes per (S). Pt reports close to (M) but she is "difficult to connect with" sometimes due to a perceived intolerance of other views + lifestyles. Pt reports he + she often "mags" but admits that he gives her reason to when he stays out all nite + calling. Pt has history of depression and anxiety and received counseling through school since 5th grade. Pt reports that most of his friends are older + have been since he took up skateboarding. Pt reports currently in a heterosexual relationship w a female but does not elaborate or indicate any problems relationship currently.

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Has your child ever been hospitalized? Please give place, dates and reasons.
Pt hospitalized 1x in 2002 at NY Presbyterian for fractured right arm for surgery.

Has your child ever been brought to an emergency room? Please give place, dates and reasons.
Pt's arm broken - 2002 - St. Vincent's — while skateboarding

Current Medications including Psychotropics:

Medication Name	Physician Name	Physician Phone
Lexapro	Dr. Shen @ St. Vincent's	

Comments (including medication history)
Pt reports sudden D in psychiatrists, because I to psychotrist's rotation was over ~ 2 weeks waiting, and pt felt "abandoned" per (m).

Other Mental Health Contacts

Reason for TX	Outpatient or Inpatient	Duration of TX
Depression/anxiety	St Vincent's OP	past year to current
counseling @ school	MS104	

Is there any family history of mental illness? If so, please describe.
Depression c (m) and (s), anxiety c (m)+(s), (f) - abusive and may have been psychotic. Reports [maternal] aunt + [maternal] uncle who either have "bipolar" or "schizophrenia"

Sexual History

Currently sexually active?	Sexually active with multiple partners?	Engaging in risky sexual practices?	HIV Status
✓	7 in hx (currently 2 partners)	"usually use protection"; "don't know" if female	pt denies ever being tested

SCHOOL HISTORY

Name of School	Age/Grade	Services Receiving (physical therapy, occupational therapy, speech, resource room, 1:1 para, counseling)
PS41	K - 5th	counseling
~~Scuola~~ MS 104	6th - 8th	counseling (off + on)
La Salle -	(2 weeks)	- attended only 2 weeks
~~Hora~~ Humanities Community High School Home Instruction		- rarely attended - due to broken arm

Are there any identified or suspected learning disabilities?
yes - "processing" and pt described difficulty w/ understanding what he is reading + has to re-read lines often + over.

Is there an Individualized Education Plan (IEP) currently in place? If so, what are the recommendations?
yes - Extra time taking test is only recommendation mentioned or remembered by (m).

Has the child received educational testing? If so, what are the test and scores?
yes - "don't know results but indicated disability in "processing". Pt's (m) reported would bring results + recommendations

Have there been any disciplinary problems at school (including suspensions and expulsions)? Please provide details on behaviors, consequences and any school recommendations.
Non-attendance/truancy since 5th grade. Pt denies any other school problems.

Parent/Guardian assessment of any school issues "a nightmare." Pt repeatedly refuses school since 5th grade. Pt reports difficulty w/ understanding what he reads. Pt also reports anxiety problems and both pt + mom of schools - i.e. Humanities, were low quality schools.

SOCIAL HISTORY

Child's Name	Get along with other children?	Activities/hobbies enjoyed.	Special talents and strengths	Extracurricular activities
	"Well w/ older kids"	skateboarding computer music + art video games	"nothing"	Ø

DEVELOPMENTAL HISTORY

Pre-natal/Pregnancy/Birth

Child's Name	Pre-natal care? (yes or no)	Pregnancy complications? If so, describe.	Duration of pregnancy (in weeks)	Any delivery complications? If so, describe.	Any health issues for newborn?
	yes	D	full	no	no

Infant Temperament

Please check if applicable

Child's Name	Easy baby	Slow to warm	Difficult baby	Eating probs	Sleeping probs	Did not enjoy body contact	Swallowing And/or sucking problems	Baby limp or stiff	Baby overly sensitive to sound
	✓			✓	✓				

may have had salmonella → 4 mos

Developmental Skills

	Child's Name					
		Age	Early	Normal	Late	Not Yet
Held head up				✓		
Sat without help				✓		
Crawled	never	crawled		~~✓~~		
Stood				✓		
Cruised				✓		
Walked				✓		
Ran				✓		
Rode a tricycle				✓		
Tied shoes				✓		
Fed self				✓		
Toilet trained				✓		
First words				✓		
Named objects				✓		

RISK TO SELF/OTHERS

Risk to Self

Child's Name	Current suicidal ideation? With intent or plan or means? Describe.	Previous suicide attempts (y or n). Indicate date.	Response to suicide attempt(s) - hospitalization, diagnosis, medications etc,	Previous suicidal ideation? (y or n) (None current)	Suicide risk (high, medium, low, none apparent)
	pt denies	N	pt denies	~~plan~~ plan & intention	Low

Comments:
Pt admits to "thinking about death" and having "brief thoughts "pop up" but denies any plan or intention. Pt stated re "would not commit suicide" stating one is "going to die anyway". Pt denied current SI.

Does child/adolescent engage in any self-injurious behaviors such as cutting or burning self? Please describe behavior, frequency, history and any treatment.
pt denies

Risk to Others

Child's Name	Current assaultive/homicidal Ideation? With intent or plan or means? Describe.	Previous assault/homicide attempts? (y or n). Indicate date.	Response to assaultive/homicidal attempts- hospitalization, medication, legal consequences etc.	Previous assaultive/homicidal ideation? (y or n)	Assault/homicide risk (high, medium, low, none apparent)
	No pt denies	pt denies charges	0	pt denies	low

Comments:
Pt reports punched (5) "in face" at X-MAS (12/06) but describes incident as rare and denies past aggression

Alcohol/Drug Abuse

Child's Name	Current substance abuse? If so, list drugs	History of substance abuse? If so, list how long & what drugs.	If HX of substance abuse, note current remission and long remission times.	Describe current and/or HX of substance abuse treatment.
	(1) Cannabis - Daily since 9/96 (2) Alcohol - "every weekend" - enough to "get wasted"	(1) LSD - 10-11x total (last x 9/06) (5) "Mushrooms" - 5-6x total - (last x 9/06)	- stable currently using cannabis + alcohol	pt denies tx

Comments
Pt using cannabis daily + alcohol weekly "to get wasted" "on weekends." Pt may be using alcohol more often to be described as he stated "in average day may include alcohol.

Family History of use: (✓) yes ( ) no, if yes, describe: 2 maternal aunts + 2 grandfathers

Domestic Violence

Child/Parent Name	Note current or history of victimization by violence in family. Please provide basic details.	Note current or history of perpetration of violence in family. Please provide basic details.
—	abused pt (S), + (M) until pt was 5 years old where pt's (M) was choked	
(M) + (Pt) - (F) →	abused by (F)	

Legal History

Child/Parent's Name	Pending court action (y or n)? When?	On probation (y or n)? List Probation officer.	On parole (y or n)? List Parole officer.	Number of arrests and list charges.	Number of incarcerations.	Total time incarcerated
(F)	?	?	?	? arrested for choking (M) when pt = 5	?	?
(M) + pt deny legal hx	per them					

Please describe how children are disciplined in the home. Are current methods working?
Pt reports that (M) complains of "bitches" but does not use any formal system of rewards or punishments.

FAMILY HISTORY

( ) Intact Family (/) Single Parent Family (1) Number of siblings

Pt reports (F) physically abusive to him, older (S), and (M) until he choked (M) in front of pt when pt was 5. Pt saw (F) in scheduled supervised visits until he yelled anti-semitic statements to person supervising + had to be forcibly removed from room. Pt state that (F) is still alive but he "wishe he was dead." Pt reports abuse ~~as~~ included. "smoking ~~pot~~" my head in the bathtub" and pouring cayenne pepper in (S)'s" Pt reports very little regarding childhood, stating he tends to "block out things mentally." Pt reports (S) "used to be harsh" and described by as a "jock." Pt reportedly stated at one point, per (M), that he "can't connect w/ her, or why try" in regards to schooling and, athletics + possibly behavior. Pt stated that he punched (S) in face 2/06

bit they talked about it. Pt describes that aggression as unchallenged. Pt reports "close", but "not very close" to (S) currently. Pt reports "close" to (M) but sees her as "weak" and "stubborn" and intolerant of alternative lifestyles. Pt reports he sometimes finds it "hard to connect" with her. Pt denies any hx of sexual abuse.

Diagnostic Impressions (including suitability for treatment at FAC)

Pt appears suitable for tx but admitted that his compliance & attending tx goes down once he feels better. Pt's (M) believes pt craves a strong + relatable male role model. Pt would not appear to prefer being housed well in advance of any upcoming termination or transference due to feelings of abandonment & previous male therapist/psychiatrist who he bonded w/ + then left giving him 2 weeks notice. Pt may also be emotionally affected by daily cannabis use + minimal consequences outside of nagging (for instance (M) still provides money) re: whether he attends school or follows home rules.

DSM IV RO Reading Disorder (comprehension - Substance induced mood disorder
RO Panic Disorder; RO MDD ~~due to general med~~

AXIS I Major Depressive Disorder, recurrent, moderate (296.32); (305.0 Alcohol + Cannabis Abuse (305.20)

AXIS II Deferred

AXIS III "innocent murmur", "Stomachaches"

AXIS IV Minimal ~~conflict~~ setting in home;

AXIS V GAF: 55

SUMMARY Pt is 17 year old Caucasian male who report depressive Sx's and anxiety Sx's (+ possible panic attacks at times). Pt reports daily cannabis abuse and weekly alcohol abuse. Pt reports school refusal since 8th grade + endorsing to parents of school ~~dropping~~ out in recent years. Pt reports "productive" activities and has yet to start GED classes. Pt reports prior physical abuse by (F) until 5 where pt witnessed (F) choke (M). Pt's (F) moved in pt's life for years.

TREATMENT RECOMMENDATION

Modality: (X) individual ( ) family ( ) group

Frequency: ( ) weekly ( ) bi-weekly ( ) monthly

Other:

Intake Worker's Name Dr. Whitten, MA Date 3/6/07

Child Psychiatrist's Name _____ Date _____

Fifth Avenue Center for Counseling and Psychotherapy
Mental Health Status Examination
(check all that apply)

Client's Name: ___

A. INITIAL APPEARANCE, BEHAVIOR AND ATTITUDE TOWARD THE INTERVIEW

Appearance [✓] Looks stated age [ ] Looks older [ ] Looks younger

Body Build [✓] Good muscular development [ ] Underdeveloped [ ] Conspicuous disability

Weight [✓] Well-nourished [ ] Thin [ ] Frail [ ] Heavy [ ] Obese

Attitude [✓] Cooperative [ ] Uncooperative (circle type: hostile, argumentative, evasive, resistant)
[✓] Warm/friendly [ ] Cold/unfriendly [ ] Guarded [ ] Belligerent [ ] Suspicious
[✓] Assertive [ ] Passive (circle type = helpless, submissive)
[✓] Appropriate [ ] inappropriate (circle type: eager to please, manipulative)
[✓] Relaxed [ ] ill-at-ease [ ] Makes good eye contact [ ] poor eye contact [ ] demanding

Activity [✓] Calm [ ] Overactive (circle: restless, pacing, agitated, hyperactive)
[ ] Under active (circle: immobile, rigid, lethargic)

Abnormal Movements [✓] None [ ] Weakness [ ] Tremor [ ] Tics [ ] Gestures [ ] Unusual mannerisms
[ ] Paralysis Describe:

Dress Grooming [ ] Neatly Groomed [ ] Sloppy/unkept [ ] Dirty [ ] Clean [ ] Bizarre [✓] Unique style

Gait [✓] Good coordination [ ] Poor coordination [ ] Unsteady gait

B. MOOD AFFECT

Dominant Mood [ ] Neutral [ ] Calm [ ]Happy [ ]Irritable [✓]Anxious [ ] Frightened [ ] Angry [✓]Depressed [ ]Expansive/Euphoric [ ]Apathetic [ ] Empty [ ] Other

Mood Stability [ ] Stable [ ]Unstable [✓]Variation

Affects Expressed [✓]Sadness [ ] Anger (hostility) [✓]Anxiety (fear) [✓]Shame (guilt) [ ] Elation (joy)

Mood Affect - continued

Facial Expression [✓]Apprehensive [ ] Angry [ ]Sad [✓]Frowning [ ]Smiling [✓]Composed

Range of Affect [ ] Full [✓] Constricted [ ] Expansive

Affect to Content Link [✓]Appropriate [ ] Inappropriate

Affect Intensity [ ] Flat [✓]Blunted [ ] Shallow [ ] Exaggerated

Affective Reactivity [✓]Responsive [ ] Non-responsive to events

Other [ ] Where appropriate, briefly describe behavior, verbalizations and physiological signs indicate of mood and affect:

C. *PERCEPTION*

Delusions [✓]No [ ] Yes If yes, describe

Hallucinations [✓]No [ ] Yes If yes: [ ] Auditory [ ] Visual [ ] Olfactory [ ] Other, describe

Depersonalization Derealization [✓]No [ ] Yes If yes, describe

Dissociative Events or Flashbacks [✓] No [ ] Yes If yes, describe

D. COGNITION

Awareness [✓]Alert [ ] Drowsy [ ] Intoxicated [ ]Comatose [ ] Delirious

Oriented to [✓]Time [✓]Place [✓]Person [✓]Purpose of Interview [ ] If disoriented, describe

Attention [✓]Attentive [ ] Distractible [ ] Other

Cognition – continued
Concentration [✓] Sustained [ ] Unable to concentrate [ ] Other

Memory Recent: [✓] Intact [ ] Impaired Past: [✓] Intact [ ] Impaired [ ] Amnesia [ ] Blackouts

Estimated Intelligence [✓] Above average [✓] Average [ ] Below average [ ] Severely limited

Reasoning [✓] Capable of abstract reasoning [ ] Not capable/literal/concrete

Further comments:

E. THOUGHT PROCESS/CONTENT

Speech Tone/Rhythm [✓] Within normal limits [ ] Loud [ ] Soft [ ] Monotone [ ] Affected [ ] Stutters [ ] Lisps [ ] Slurred [ ] Mumbled [ ] Hesitant [ ] Accented [ ] Other

Organization of Verbalizations [✓] Well-organized [ ] Clear [ ] Goals-oriented [ ] Vague [ ] Incoherent [ ] Irrelevant [ ] Loosened association [ ] Flight of ideas [ ] Circumstantial [ ] Tangential [ ] Other

Thought Process [✓] Within normal limits [ ] Perseverative [ ] Blocked [ ] Derailed [ ] Confused [ ] Racing thoughts [ ] Thought insertion [ ] Broadcasting [ ] Withdrawal [ ] Other

Content/Major Preoccupations(s) [ ] Fear [ ] Phobias [ ] Obsessions [ ] Compulsions [ ] Guilt [ ] Hopelessness [ ] Negativism [ ] Overvalued ideas [ ] Bizarre ideas [ ] Magical thinking [ ] Ideas of reference [ ] Hostility [ ] Jealousy [ ] Suspiciousness [ ] Egocentric [ ] Somatic Specify Content:

Suicidal Thought [✓] No [ ] Yes If Yes, see relevant section of assessment

Homicidal Thought [✓] No [ ] Yes If Yes, see relevant section of assessment

F. JUDGEMENT, IMPULSE CONTROL INSIGHT

Judgment [ ] Sound [✓] Impaired in some area(s) [ ] Globally impaired
Indicate areas(s) of impairment: [ ] Work [ ] Finance [ ] Family relations
[ ] Ethical [✓] Goal directed activities
Describe: Pt refused school and does not work
Impulse Control [✓] Adequate [ ] Occasional loss of control [ ] frequent loss of control
Describe precipitants and manifestations: _____
Understands consequences of action [✓] Usually [ ] Sometimes [ ] Rarely
If relevant, note limitations:
Insight regarding illness [✓] Acknowledges has problems [ ] Blames others
[ ] Denies need [✓] Recognizes need for treatment [ ] Ambivalent about treatment, describe:

F. SELF-ESTEEM, IDENTITY, RELATEDNESS

Self-Esteem [ ] Appropriate [ ] Inflated [✓] Lowered [ ] Self-deprecating
Describe positive or negative examples of self – esteem:
Identity [ ] Firmly established [✓] Vulnerable [ ] Diffuse
Ability to Relate to Interviewer [✓] Open/related [ ] Closed /unrelated
Further comments:

G. PREDOMINATE DEFENSE MECHANISM

[ ] Denial [ ] Projection [ ] Splitting [ ] Regression [ ] Introjection
[ ] Dissociation [ ]Externalization [ ] Displacement [ ] Isolation [ ] Repression [ ] Reaction Formation [ ] Identification [ ] Sublimation [ ] Humor [ ] Suppression
[ ] Altruism [✓] Further Assessment Needed
Comments:

Intake Completed by: Dr Intake BHA **Date:** 3/8/07

Initial Review

Client Name: [redacted]	**Date:** 3-15-07
Intake Worker: Mary Whitmore, MA, & Intern	

Presenting Problem: Pt c̄ a 17 y/o, Caucasian, single male c̄ s/o depressed mood, poor concentration ↓ sleep + appetite, ↓ SE, ↑ anxiety w/ d. panic attacks that wake him. Reports daily cannabis use + weekly alcohol use. HS drop out. Has long h/o of depressive + anxiety sxs c̄ long h/x of OP MH counseling. Lives c̄ mother. Has one older sib. Current Rx: Lexapro. Family h/o of depression + anxiety. Has G.F. Pt reports difficulty processing info & understanding what he's reading. Has been tested. Attendance probs in school since fifth grade - most of his friends are older. Pt has vague SI - no plan or intent. F was phys. abusive until pt age 5 when F left house. Abusive to all members of family. No rel. c̄ father currently. Reports difficult rel c̄ mother. Pt's mother thinks pt needs strong male role model.

Initial Diagnostic Impression:

Major Dep D/O - recurrent 296.2 — Cannabis Abuse 305.20
R/O panic D/O - 300.01 — R/O Alcohol Abuse 305.00
R/O Learning D/O.

☑ **Approved for Admission**

Client has been assigned to: Niles Neale, Psy. D.

☐ **Not Approved for Admission**

Explain: Please obtain Release of Info from School including testing results.

Client has been referred to:

Intake Committee Team	**Title**
Madeleine Lerner, MSW	
[illegible], LCSW	

Fifth Avenue Center for
Counseling and Psychotherapy
50 West 23 Street, 9th Floor
New York, NY 10010
(212) 989-2990

HEALTH HISTORY
CONFIDENTIAL

Patient Name: _____ Today's Date: 3/12/09

Age: 19 Birthdate: 4/1/89 Date of last physical examination: March 09

Primary Care Physician: _____ Clinic: Phone: _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL	GASTROINTESTINAL	EYES, NOSE, EARS, THROAT	MEN Only
√ Chills	√ Appetite poor	Bleeding gums	Breast lump
√ Depression	√ Bloating	Blurred vision	Erection difficulties
√ Dizziness	√ Bowel changes	Crossed eyes	Lump in testicles
Fainting	√ Constipation	Difficulty swallowing	Penis discharge
√ Fever	Diarrhea	Double vision	Sore on penis
√ Forgetfulness	Excessive hunger	Earache	other
√ Headache	Excessive thirst	Ear discharge	
√ Loss of weight	Gas	Hay fever	**WOMEN only**
√ Nervousness	Hemorrhoids	Hoarseness	Abnormal Pap smear
√ Numbness	Indigestion	Loss of hearing	Bleeding between period
√ Sweats	Nausea	Nosebleeds	Breast lump
	√ Rectal bleeding	√ Persistent cough	Extreme menstrual pain
	√ Stomach Pain	√ Ringing in ears	Hot Flashes
MUSCLE/JOINT/BONE Pain, weakness, numbness in:	Vomiting	√ Sinus problems	Nipple Discharge
	Vomiting blood	√ Vision-Flashes	Pain Intercourse
√ Arms		√ Vision- Halos	Vaginal discharge
Back	**CARDIOVASCULAR**		Other
√ Feet	Chest pain	**SKIN**	**Date of last menstrual period:**
√ Hands	High blood pressure	Bruise easily	
Hips	Irregular heart bear	Hives	**Date of last Pap smear:**
√ Legs	Low blood pressure	Itching	
Neck	Poor circulation	Change in moles	**Have you had a mammogram?**
√ Shoulders	Rapid heart beat	Rash	
	Swelling of ankles	Scars	**Are you pregnant?**
GENITO-URINARY	Varicose veins	Sore that won't heal	
√ Blood in Urine	**"In the columns below"**		**Number of children?**
√ Frequent urination			
√ Lack of bladder control	CONDITION Check (√) condition you have or have had in the past.		
Painful urination			

Aids	Chemical Dependency	High Cholesterol	Prostate Problem
Alcoholism	Chemical Dependency	HIV Positive	Psychiatric Care
Anemia	Chicken Pox	Kidney Disease	Pneumatic Fever
Anorexia	Diabetes	Kidney Disease	Scarlet Fever
Appendicitis	Emphysema	Liver Disease	Stroke
Arthritis	Epilepsy	Measles	Suicide Attempt
Asthma	Glaucoma	Migraine Headaches	Thyroid Problems
Bleeding disorders	Goiter	Miscarriage	Tonsillitis
Brest Lump	Gonorrhea	Mononucleosis	Tuberculosis
Bronchitis	Gout	Multiple Sclerosis	Thyroid Fever
Bulimic	Heart Disease	Mumps	Ulcers
Cancer	Hepatitis	Pace Maker	Vaginal infections
Cataracts	Hernia	Pneumonia	Venereal Disease

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50 West 23rd Street, 9th Floor
New York, NY 10010

PSYCHIATRIC VISIT (BRIEF FORM)

Date of Service: 3/24/09 30 min Patient's Name:

Pt. did not show up for appt.
Please re-schedule
John Toska MD

5/5/09 Pt here for appt. In good spirits, just got GED and plans to begin college at BMCC; working w/ P. [illegible] in [illegible]; feels meds are helpful. [illegible] STs except possible "missing" feeling from Lexapro - pt expresses interest in possibly tapering it over the summer; takes [illegible] [illegible]. well-related, good range, [illegible], reflective, no evidence of S/H ideation, mood [illegible]; [illegible] / [illegible] / [illegible] - little ETOH, smokes MJ.
Plan: Continue current meds per sched
F/u in 1 month w/ Dr. Toska - explore med changes.
[illegible] MD

Date of Service: 5/28/09 30 min Patient's Name:

Pt. did not show up for appt. Please re-schedule
John Toska MD

8/6/09 Dear -

PT LEFT Rx's FOR PT ON 8/11/09
& SPOKE TO PT BY PHONE ON 8/11/09
TO MONEY.

I called Medicaid Prior Auth
+ they say that Adderall
XR does NOT require
authorization so I'm not sure
why he had problems picking
up the prescription

Here are his final prescriptions
for pick-up

Jennifer Tobkes

8/5/09

DR TOBKES -

RE:
Pt

I BELIEVE IT'S APPROPRIATE FOR CURRENTLY TO GET ADDERALL Rx's FOR LEXAPRO (20mg)
VENLAFAXINE XL (150mg)
& POSSIBLY ADDERALL XR (10mg)

AS HE TRANSITIONS TO OTHER CARE ELSEWHERE.

HIS MEDICAID # IS dnc9675j & IS NOW IN CHART.

LET ME KNOW HOW YOU WANT TO HANDLE.

THX,
Pam

Fifth Avenue Center for Psychotherapy
50 West 23rd Street, 9th Floor
New York, NY 10010

PSYCHIATRIC VISIT (BRIEF FORM)

Date of Service: 1/8/09 Patient's Name:

He is preparing for the GED and signed up for college transition classes. He is back together with his girlfriend. Therapy has been inconsistent with Bill McMenamy though last saw him on Tuesday. He has been taking Lexapro 20 mg QAM + has started on wellbutrin when he was at 4 Winds Hospital.

MSE unchanged.

Plan: Continue Lexapro 20 mg QAM + wellbutrin 75 mg BID F/U in 1 month.

Date of Service: Patient's Name:

Fifth Avenue Center for Psychotherapy
50 West 23rd Street, 9th Floor
New York, NY 10010

PSYCHIATRIC VISIT (BRIEF FORM)

Date of Service: 10/23/08 Patient's Name:

Pt. has generally been doing well. He broke up with his girlfriend because he "wasn't feeling it." He is taking a GED class (2 Math / writing sections) at BMCC and is preparing to take the test in the winter, and will then apply to college. Lexapro is working well & he is out of Adderall + has been having a hard time concentrating in school. MSE unchanged.

Max Continue Lexapro 20 mg QAM + Adderall XR 10 mg QAM. F/U in 1 Month

JT/JTobler MD

Date of Service: 12/4/08 Patient's Name.

Pt. did not show up. Please re-schedule

JT/J. Tobler MD

Fifth [illegible]nue Center for Counseling & [illegible]ychotherapy
50 West 23rd Street, 9th Floor
New York, NY 10010
(212) 989-2990

INITIAL/YEARLY TREATMENT PLAN

Date Effective: 3/12/09 **Client's Name:** _____
Therapist: PAUL JACOBI, LMSW

DIAGNOSIS *(Enter a P in front of principle diagnosis*		
DSM IV Codes		
Axis I	311	DEPRESSIVE D/O NOS
	314.01	ADHD, COMBINED TYPE
	305.20	CANNABIS ABUSE
	305.00	ALCOHOL ABUSE
Axis II	799.9	DEFERRED
Axis III		PT DENIES
Axis IV *Stressors:* ACADEMIC PROBLEMS, FAM SCHOOL SUPPORTS, FINANCIAL, H/O SUBST. ABUSE		*Severity:* ( ) None ( ) Mild (X) Moderate ( ) Severe ( ) Extreme ( ) Catastrophic ( ) Inadequate Info/ No Change *Duration:* ( ) Predominately Acute Event (X) Predominately Enduring Circumstances
Axis V *Global Assessment of Functioning*		*Enter two digit scores from (01-90)* A. Current GAF: 60 Past Year GAF: 60

MEDICATION THERAPY *(If applicable, give name, address and telephone number of physician and include names, dosages and frequency of medication).*
Rx. from Dr. TOSKES
ADDERALL 10mg
LEXAPRO 20mg
WELLBUTRIN 75mg

STRENGTHS, LIMITATIONS, MOTIVATIONS
(+): RESILIENT, SELF-REFLECTIVE, DESIRES BETTER RELATIONS
(−): MOTIVATION TO MAKE/MAINTAIN LIFESTYLE CHANGES UNCLEAR

DISCHARGE PLAN *(Describe the changes that must occur before the patient may be discharged. Identify the patient's service needs on discharge in the areas of mental health, physical health, rehabilitation and social supports, as needed)*
PT WILL BENEFIT SIGNIFICANT REDUCTION IN DEPRESSIVE & ADHD SYMPTOMS, MAINTAIN DAILY FUNCTIONING

CLIENT'S NAME: ____

1. Has client expressed a need or desire for increased outside support? ☐Yes ☒No
2. If yes, please include at least one objective in the treatment plan that relates to this issue.
3. Please specify this goal/objective): _____

GOALS *(Identify each specific client issue or behavior that is to be the focus of this client's treatment in the program based on the recommendations fr the initial intake, psychiatric evaluation, and input from your interviews with client. Goals may be defined in areas of mental health, physical health, rehabilitation and social support).*

Date Established: 3/12/09

ISSUE # 1: PT SUFFERS FROM DEPRESSIVE SYMPTOMS, INTERFERE INT DAILY FUNCTIONING

GOAL #1: (The client will...) PT WITH REPORT A SIGNIFICANT REDUCTION IN DEPRESSIVE SYMPTOMS, THUS INCREASE DAILY FUNCTIONING

OBJECTIVES *(List each outcome to be achieved by client toward completion of the goal stated above. Each objective must be specific and measurable)*

Objective (As evidenced by...)	Date Established	Target Date	Treatment Modalities	Frequency/Clinician(s) Responsible
1. PT WITH IDENTIFY BX'S STRATEGIES TO OVERCOME DEPRESSION	3/12/09	9/12/09	INDIVID. THERAPY	1X/WK W/ PAUL JACOBY, LCSW
2. PT WITH IDENTIFY & REPLACE COGNITIVE SELF-TALK THAT IS CONTRIBUTING TO IMPACT DEPRESSION.	3/12/09	9/12/09		
3. PT WITH BE COMPLIANT W/ MEDI REGIMEN.	3/12/09	9/12/09		

Date Established: 3/12/09

ISSUE # 2: PT SUFFERS FROM ADHD SYMPTOMS, INTERFERE W/ DAILY FUNCTIONING

GOAL #2: (The client will...) PT WITH REPORT A SIGNIFICANT REDUCTION IN ADHD SYMPTOMS, THUS INCREASE DAILY FUNCTIONING

OBJECTIVES *(List each outcome to be achieved by client toward completion of the goal stated above. Each objective must be specific and measurable)*

Objective (As evidenced by...)	Date Established	Target Date	Treatment Modalities	Frequency/Clinician(s) Responsible
1. PT WITH APPLY PROBLEM-SOLVING SKILLS TO INCREASE ADD BX'S THAT INTERFERE W/ FUNCTIONING	3/12/09	9/12/09	INDIVID THERAPY	1X/WK W/ PAUL JACOBY, LCSW
2. PT WITH REPORT SIGNIFICANT IMPROVEMENT, MAINTENANCE OR FULFILLMENT OF REDUCED SX (S) AUTOMATICALLY	3/12/09	9/12/09		
3. PT WITH BE COMPLIANT W/ MEDI REGIMEN	3/12/09	9/12/09		

CLIENT'S NAME: _____

Date Established:

ISSUE # 3:

GOAL # 3: (The client will…)

OBJECTIVES *(List each outcome to be achieved by client toward completion of the goal stated above. Each objective must be specific and measurable)*

Objective (As evidenced by…)	Date Established	Target Date	Treatment Modalities	Frequency/Clinician(s) Responsible
1.				
2.				
3.				

RISK ASSESSMENT/MANAGEMENT

SUICIDE	HOMICIDE	ABUSIVE BX	VICTIMIZATION	ALCOHOL/DRUGS	MEDICAL STATUS//HIV
X None Low Medium High	X None Low Medium High	X None Low Medium High	X None Low Medium High	None Low X Medium High	X None Low Medium High

If risk for any of the above, please describe preventative plan:

Risks will be monitored & Appropriate Counsel Given.

SIGNATURES

4/21/09

Client Signature/ Date

(I have participated in the formation and/or review of my (or my child's) treatment plan and have approved it.

LMSW 7/12/09

Therapist Signature/Date

Richard Mark LCSW 41609

Supervisor's Signature/Date

MD 4/21/09

Physician's Signature/Date

Fifth Avenue Center for Counseling and Psychotherapy
10 East 21 Street, New York, NY 10010

30 day Utilization Review

Client Name	Name of Therapist	Date of Admittance	Date of Review
	P. Jacoby, LMSW	2-2-09	4-2-09

Summary- Extent of Mental Health Issues: Pt is a 19 yr old single Caucasian male w/ sxs of Dep D/O NOS; ADHD combined type; and cannabis abuse + alcohol abuse. Pt. + passive/vague SI w/ no intent on 3/8/09 (at intake). Pt denies hx or current [illegible] HI.

a. Does the client have a mental health problem? **Yes** (circled) No

b. Is the client at risk? **Yes** (circled) No

If yes, lethality towards ☑ self ☐ others

plan: Therapist continues to monitor pt for SI.

c. Date psychiatric evaluation is scheduled? 4/3/09

d. Has supporting diagnosis been identified in intake? **Yes** (circled) No

e. Has supporting diagnosis been identified to Treatment Plan? Yes **No** (circled)

f. Does treatment plan address issues raised in intake? Yes **No** (circled)

g. Do progress notes reflect problems addressed in treatment plan? Yes **No** (circled)

h. Has the client approved and signed treatment plan? Yes **No** (circled)

i. Is medical signature (s) attained on?

☐ Health screening form — Yes No

☐ Treatment plan — Yes **No** (circled)

Comments: Health form missing primary care physician name + [illegible] Tx tmt plan missing from chart.

Returned to therapist 4/2/09

[illegible signature] 4/2/09

Fifth Avenue Center for Counseling & Psychotherapy
50 West 23rd Street, 9th Floor
New York, NY 10010
(212) 989-2990

QUARTERLY TREATMENT PLAN

Date Effective: 6/11/09

Therapist: Paul Jacoby, LMSW **Client's Name:** _____

Has the diagnosis changed since last treatment plan? _____ Yes __X__ No
If so, Please list new diagnoses with DSM IV Codes:

Has there been a change in the issues or goals? _____ Yes __X__ No
If "Yes," please explain on attached "New Goals/Issues" form.

Has input been received from all parties involved in the treatment? __X__ Yes _____ No
If "No," what action is needed?

New or additional clinical information obtained or received:
None

Patient's strengths, limitations and motivations:
(+): RESILIENT, SELF-REFLECTIVE
(−): MOTIVATED MAKE ADJUSTMENTS WORKPLACE CHANGES UNCLEAR

Has patient made progress toward discharge criteria stated in Initial Treatment Plan? Please check:
☐ None ☒ Minimal ☐ Significant ☐ Completed
If none, please explain revised discharge criteria:

RISK ASSESSMENT/MANAGEMENT

SUICIDE	HOMICIDE	ABUSIVE BX	VICTIMIZATION	ALCOHOL/DRUGS	MEDICAL STATUS//HIV
X None Low Medium High	X None Low Medium High	X None Low Medium High	X None Low Medium High	None Low X Medium High	X None Low Medium High

If risk for any of the above, please describe preventative plan:
CONTINUE MONITORING & APPROPRIATE COURSE CONSULTATION

Client's Name: _____

1. Has client expressed a need or desire for increased outside support? ☐Yes ☒No
2. If yes, please include at least one objective in the treatment plan that relates to this issue.
3. Please specify this goal/objective): _____

TREATMENT PROGRESS

Objectives must be revised at least every six months.

GOAL # 1

OBJECTIVE 1: ☐ Achieved ☒ Continued ☐ Discontinued
Progress toward objective: ☒ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan)*:
PT HAS BEEN ABLE TO ADDRESS BKG ISSUES CLOSELY THERAPEUTICALLY, TRAUMA MAY BE PRIMARY

If you checked "continued," please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☐ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
- ☐ Reality testing
- ☐ Reinforcement of ADLs
- ☒ Modeling
- ☐ Establishing safety
- ☐ SI/HI risk assessment
- ☐ Treatment compliance reinforcement
- ☐ Planning for increased socialization
- ☐ Confront delusional thinking
- ☐ Role playing
- ☐ Guided imagery
- ☐ ID/treatment of cognitive distortions
- ☒ Homework assignments
- ☐ Make lists
- ☐ Developing self-esteem
- ☐ Conflict resolution
- ☒ Identify consequences
- ☐ Advocacy
- ☐ Provide referrals
- ☐ Relapse prevention
- ☐ Debriefing
- ☒ Strengths-based reinforcement
- ☒ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☐ Developing (+) self-talk
- ☐ Developing communications skills

OBJECTIVE 2: ☐ Achieved ☒ Continued ☐ Discontinued
Progress toward objective: ☒ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan)*:
PT HAS MADE MUCH IMPROVEMENT IN POSITIVE SELF-TALK; HAS BEEN A FOCUS OF INTEREST THIS QTR.

If you checked "continued" please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☒ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☐ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
- ☐ Reality testing
- ☐ Reinforcement of ADLs
- ☐ Modeling
- ☐ Establishing safety
- ☐ SI/HI risk assessment
- ☐ Treatment compliance reinforcement
- ☐ Planning for increased socialization
- ☐ Confront delusional thinking
- ☐ Role playing
- ☐ Guided imagery
- ☐ ID/treatment of cognitive distortions
- ☐ Homework assignments
- ☐ Make lists
- ☐ Developing self-esteem
- ☐ Conflict resolution
- ☐ Identify consequences
- ☐ Advocacy
- ☐ Provide referrals
- ☐ Relapse prevention
- ☐ Debriefing
- ☐ Strengths-based reinforcement
- ☒ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☒ Developing (+) self-talk
- ☐ Developing communications skills

OBJECTIVE _3_: ☐ Achieved ☒ Continued ☐ Discontinued

Progress toward objective: ☒ Minimal ☒ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan)*:

PT REPORT MEDS COMPLIANCE

If you checked "continued" please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☒ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
- ☐ Reality testing
- ☐ Reinforcement of ADLs
- ☐ Modeling
- ☐ Establishing safety
- ☐ SI/HI risk assessment
- ☐ Treatment compliance reinforcement
- ☐ Planning for increased socialization
- ☐ Confront delusional thinking
- ☐ Role playing
- ☐ Guided imagery
- ☐ ID/treatment of cognitive distortions
- ☐ Homework assignments
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- ☐ Developing self-esteem
- ☐ Conflict resolution
- ☐ Identify consequences
- ☐ Advocacy
- ☐ Provide referrals
- ☐ Relapse prevention
- ☐ Debriefing
- ☐ Strengths-based reinforcement
- ☐ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☐ Developing (+) self-talk
- ☐ Developing communications skills

GOAL # _2_

OBJECTIVE _1_: ☐ Achieved ☒ Continued ☐ Discontinued

Progress toward objective: ☒ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan)*:

PT HAS [illegible]

If you checked "continued" please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☒ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
- ☐ Reality testing
- ☐ Reinforcement of ADLs
- ☐ Modeling
- ☐ Establishing safety
- ☐ SI/HI risk assessment
- ☐ Treatment compliance reinforcement
- ☐ Planning for increased socialization
- ☐ Confront delusional thinking
- ☐ Role playing
- ☐ Guided imagery
- ☐ ID/treatment of cognitive distortions
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- ☐ Make lists
- ☐ Developing self-esteem
- ☐ Conflict resolution
- ☐ Identify consequences
- ☐ Advocacy
- ☐ Provide referrals
- ☐ Relapse prevention
- ☒ Debriefing
- ☒ Strengths-based reinforcement
- ☒ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☐ Developing (+) self-talk
- ☐ Developing communications skills

OBJECTIVE _2_: ☐ Achieved ☒ Continued ☐ Discontinued

Progress toward objective: ☒ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan)*:

PT [illegible] HAS NOT YET [illegible]

If you checked "continued" please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☐ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
- ☐ Reality testing
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- ☒ Debriefing
- ☒ Strengths-based reinforcement
- ☒ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☐ Developing (+) self-talk
- ☐ Developing communications skills

OBJECTIVE 3: ☐ Achieved ☒ Continued ☐ Discontinued

Progress toward objective: ☒ Minimal ☒ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan):*

pt reports med compliance

If you checked "continued," please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☒ Support
- ☐ Explore History
- ☐ Relaxation techniques
- ☐ Psychopharmacology
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- ☐ Debriefing
- ☐ Strengths-based reinforcement
- ☐ Skills development
- ☐ Desensitization
- ☐ Assertiveness training
- ☐ Developing (+) self-talk
- ☐ Developing communications skills

GOAL #____

OBJECTIVE ____: ☐ Achieved ☐ Continued ☐ Discontinued

Progress toward objective: ☐ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan):*

If you checked "continued," please select the new clinical intervention(s) you will use to try to achieve the objective:

- ☐ Psychoeducation
- ☐ Identify feelings
- ☐ Ventilate feelings
- ☐ Support
- ☐ Explore History
- ☐ Relaxation techniques
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- ☐ Relapse prevention
- ☐ Debriefing
- ☐ Strengths-based reinforcement
- ☐ Skills development
- ☐ Desensitization
- ☐ Assertiveness training

☐ Modeling
☐ Establishing safety
☐ Developing self-esteem
☐ Conflict resolution
☐ Developing (+) self-talk
☐ Developing communications

OBJECTIVE ____: ☐ Achieved ☐ Continued ☐ Discontinued
Progress toward objective: ☐ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan):*

If you checked "continued," please select the new clinical intervention(s) you will use to try to achieve the objective:

☐ Psychoeducation
☐ Identify feelings
☐ Ventilate feelings
☐ Support
☐ Explore History
☐ Relaxation techniques
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☐ Assertiveness training
☐ Developing (+) self-talk
☐ Developing communications skills

OBJECTIVE ____: ☐ Achieved ☐ Continued ☐ Discontinued
Progress toward objective: ☐ Minimal ☐ Moderate ☐ Significant ☐ Regressive ☐ None

Describe progress toward objective *(since last treatment plan):*

If you checked "continued," please select the new clinical intervention(s) you will use to try to achieve the objective:

☐ Psychoeducation
☐ Identify feelings
☐ Ventilate feelings
☐ Support
☐ Explore History
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☐ Developing (+) self-talk
☐ Developing communications skills

SIGNATURES

Client Signature/Date

Therapist Signature/Date 6/7/09

Richard Machuca LCSW 60909
Supervisor Signature/Date

Psychiatrist Signature/Date 6/4/09

FIFTH AVENUE CENTER FOR COUNSELING AND PSYCHOTHERAPY
50 WEST 23RD STREET, NYC 10010

QUARTERLY UTILIZATION REVIEW

CLIENT NAME	THERAPIST NAME	DATE OF ADMISSION	DATE OF REV
	P. Jacoby, LMSW	2-2-09	7/14/09

SUMMARY- EXTENT OF MENTAL HEALTH ISSUES:
Pt. is presenting w/ DXS of Dep D/O NOS; ADHD, combined type; and Cannabis Abuse.

SUMMARY OF EFFECTIVENESS AND PROGRESS IN TREATMENT:

A. Is there documentation to establish continuing movement towards goals?	(✓) Yes	( ) No
B. Is further lethatlity assessment needed?	(✓) Yes	( ) No
If yes, describe: Tx continues to monitor for SI.		
C. Are services identified in the Treatment Plan appropriate to the clients needs?	(✓) Yes	( ) No
D. Is Treatment Plan modification needed?	( ) Yes	(✓) No
If yes, indicate date modification was made:		
E. Does DMS diagnosis remain the same as intake?	( ) Yes	(✓) No
If no, update Axis I- 311, 314.01, 305.20		
Axis II-		
Axis III-		
Axis VI-		
Axis V-		
F. Are there additional service(s) necessary?	( ) Yes	(✓) No
If yes, describe:		
G. Does progress notes reference problems identified in Treatment Plan?	(✓) Yes	( ) No
H. Is discharge criteria referenced in last Treatment Plan?	(✓) Yes	( ) No
I. Has the client approved and signed last Treatment Plan?	( ) Yes	(✓) No
J. Is medical signature and supervisory signature attained on last Treatment Plan?	(✓) Yes	( ) No
K. Has superior reviewed charts indicated on signed progress notes?	(✓) Yes	( ) No
L. Is the client approved for continued treatment?	( ) Yes	( ) No
If no, describe plan:		

Pt sig. missing from 6/09 tmt plan.
Health harm missing and health # - primary physician.

Recommendation(s):
continued Tx + med mgmt.

Signatures of Utilization Review Committee Members

Name: _____ Title: MD
Name: J. Issano, PsyD Title: ( ) Psychologist ( ) CSW
Name: _____ Title: ( ) Psychologist ( ) CSW

Psychiatric Referral Form

Patient: ___

Date of Birth: 4/1/89

Appointment Date: ~~5/28/09~~ 6/16/09

Appointment Time: ~~3:00 PM~~ 1:45 PM

Date of Last Therapy Appointment Attended: ~~5/6/09~~ 6/10/09

Appointment Scheduled with: Please circle one.

Dr. Anam Dr. Langer Dr. Rutter (Dr. Tobkes)

Length of Appointment:

___15 min (Routine med refill; only for stabilized patient coming to regular appts)

~~MED~~ 30 min (Assessment of side effects; change in dosage; new patient to this MD; any patient who has missed last appointment; just a little more time to talk)

X 45 min (Psychiatric Evaluation for new patient, or annual update)

Brief Identifying Information:

PT IS 20 Y.O. SINGLE, CAUCASIAN ♂ W/ DEPRESSED MOOD, APATHY & POOR CONCENTRATION. PT ATTENDANCE IN THERAPY HAS BEEN SPORADIC (4 X IN PAST 2 MO.). PT CURRENTLY ↓ ETOH USE CONTROL, & PT C/O "ALLERGY-LIKE" SYMPTOMS (FEELS "TOXIC" INSIDE, UNABLE TO RETAIN DETAILS).

Patient's current status/ effects of current meds:

LEXAPRO - 20 mg -

WB - 75 mg

ADDERALL - 10 mg

Questions/ Issues for this appointment:

MEDS CONSULT - PT WANTS TO CONSIDER COMING OFF (OR REDUCING) LEXAPRO

+

ANNUAL UPDATE

Therapist: PAUL JAGOE, LMSW

DISCHARGE SUMMARY

Must be completed prior to arrival of client at receiving program or within two weeks of discharge, whichever c

Client Name.	
Intake Date:	2/2/09
Discharge Date:	7/30/09

Reason for closing/transfer

- ☒ 1. non attendance (missed sessions)
- ☐ 2. relapsed
- ☐ 3. scheduling conflicts (school, training, job, etc.)
- ☐ 4. insurance problems/expired
- ☐ 5. patient desired to end treatment
- ☐ 6. relocation
- ☐ 7. patient needs higher level of care
- ☐ 8. mutual agreement that treatment is completed
- ☐ 9. Other ______

Comments: Pt attendance was sporadic, at best, + deteriorated even more so recently

Presenting Problem and other problems elicited or arising during treatment:

Pt c/o difficulty motivating himself, organizing his life + generalized deficits, concentration, + [illegible] [illegible]

Course of Treatment (include significant findings, therapeutic interventions, client's progress, assessment of final condition. Include all services provided including medication, if applicable).

Clinician engaged Pt in exploring his [illegible], his current [illegible] [illegible] [illegible] his motivation for future [illegible] his current + [illegible] [illegible] [illegible] his [illegible]

Diagnostic History:

Admission diagnosis		***Discharge Diagnosis***	
Axis I	Depressive Dis NOS; ADHD combined type; Cannabis abuse; Alcohol abuse	Axis I	Depressive Dis NOS, ADHD combined type, Cannabis abuse, Alcohol abuse
Axis II	Deferred	Axis II	Deferred
Axis III	Pt denies	Axis III	Pt denies
Axis IV	Academic, social, family, [illegible] abuse	Axis IV	Current [illegible] [illegible] poor social [illegible]
Axis V (GAF)	60	Axis V (GAF)	60

- **Discharge plan and follow up arrangements if appropriate. Include all referrals**

Pt referred to St Vincent's Hosp 717-[illegible]

[illegible] 717-838-7333

[illegible]

If referred, did client make contact? [ ] Yes [ ] No When was discharge sent:__________

Follow up necessary? [ ] Yes [ ] No If yes, describe plan,

[signature]	8/4/09	[signature] MD	8/4/09
Clinician, Title	**Date**	**Reviewing Psychiatrist**	**Date**
[signature] LCSW	8-4-09		
Supervisor's signature	**Date**		

Fifth Avenue Center for Counseling and Psychotherapy
50 West 23rd Street, 9th Floor New York, NY 10010

PSYCHIATRIC EVALUATION

Patient's Name: _____ Date of Birth: 4/1/89 Date of Service: 6/16/09

Presenting Symptoms & Current Situation Pt is a 20 y/o single Man with a h/o Long Disability, ADHD and Depression who has been coming to FAC for 3 years due to depression and ADHD. He has been taking Lexapro 20 mg for 2½ yrs and was started on wellbutrin during an inpatient admission @ 4 Winds (his first) in October '08. He has been prescribed Adderall for difficulty concentrating and organizational problems since June '08. At the current time he continues to smoke MJ on an almost daily basis and drinks alcohol every other week. He reports feeling "empty" and apathetic. Anxiety is "not that bad." He has memory problems and feels "zombie-like."

Identifying Information & Mental Status Pt is a short thin Caucasian Man with an afro, well-dressed + well-groomed, pleasant + cooperative. TP linear TC; No SI/HI/PI. Speech reg rate/vol. Mood depressed. Affect: full, reactive. Perc: WNL. Thought form: WNL. PMH: None Allergy: Cedar

Family: Mother → depression anxiety, on Lexapro + Klonopin. Father had psychiatric dx - "complete lunatic". Sister ☹ depression and anxiety, on Lexapro

Social: Pt passed GED and is applying to CUNY schools (BMCC). He just took ACT writing test and hopes to start school in fall. He lives ☺ Mom + Sister (who just graduated from Vassar)

Psychiatric History He has taken Zoloft in the past. No suicidal behavior. ☹ psych hospitalization in October '08 at 4 Winds (fed up with life style). He was started on Lexapro and Wellbutrin. Subsequently, he was treated @ PAC with Adderall. No suicide attempts.

Substance Abuse: He has a h/o regular and heavy MJ abuse (last yesterday). No other illicit drugs. ☺ Alcohol. Q2 weekends.

Diagnostic Impressions:

Axis I: Depressive D/O NOS (311)
ADHD, combined type (314.01)
Cannabis Abuse (305.20); Alcohol Abuse (305.00)

Axis II: Deferred 799.9

Axis III [If on anti-psychotics, or will be prescribed any today, see attached cardiometabolic risk screening sheet]: None

Axis IV: Chronic substance use; poor social support

Axis V: GAF Current 60 GAF Past 60

Recommendations (Including medication, if any): Pt would like to lower Lexapro dose because he's not sure what's it doing since he's been taking it for almost 3 years. Will hold off on Lexapro taper for today + Continue Lexapro 20 mg QAM ~~Taper Lexapro to 15 mg QAM~~ Change to (1) Wellbutrin XL 150 QAM + Adderall XR 10 mg QAM

F/U in one Month.

[signature] MD

FIFTH AVENUE CENTER FOR COUNSELING AND PSYCHOTHERAPY

PSYCHIATRIC EVALUATION

Name: ______ Last Name ______ First Name ______ DOB 4 / 1 / 89

Presenting symptoms & current situation Pt. is a 19 year old with a h/o Learning Disability and Depression (and possible ADHD) who has been coming to FAC for the last 2 years due to symptoms of depression. He has been taking Lexapro 20mg for the last 1½ years and finds it somewhat helpful in ameliorating anxiety (↓ panic attacks) but not as much for depression. He continues to feel down, unmotivated, anhedonic and has poor sleep + appetite. Regarding ADHD symptoms, he reports that he is unable to read even a page and he does not listen when people talk. He has problems with organization and has great difficulty winding down at the end of the day. No mania or psychotic sx.

Identifying information & mental status Pt is a short, thin Caucasian male, well-dressed + well-groomed, no PMA/PMR. Good eye contact. Speech reg. r/r/v. Mood depressed, affect reactive. TP linear. TC: no SI, HI, PI. Per: ∅ AH, VH. I/J: fair.
PMH: None. Allergy: Ceclor
Meds: Lexapro 20mg QAM. MVI
Family: Father has h/o psychiatric + mood disorder. Mother has depression + anxiety + trouble focusing. Sister c̄ depression/anxiety on Lexapro
Social: Completed JR year of H.S. He is applying for a job + taking GED classes. He is hoping to work at the Puma store. He lives with his mother + sister (home from [illegible] for summer)

Psychiatric History He has taken Zoloft in the past + tried Ambien for sleep in the past. No hospitalizations. No prior stimulant trials. He tried Adderall once + found it helpful. No h/o suicide attempts or SIB

Substance Abuse Hx: He smoked MJ in the past but allegedly stopped 2 weeks ago. He drinks alcohol on the weekends. His new job requires drug testing.

(311) (314.01)

Diagnostic Impressions Axis I Depressive d/o NOS ; ADHD, Combined ; MJ abuse Alcohol Abuse

Axis II Deferred (799.9)

Axis III None

Axis IV Moderate

Stressors Academic problems, poor social supports, h/o substance abuse

Axis V 60

GAF Current 60 GAF Past 60

Recommendations (including medication, if any) Given SIGNificant Symptoms of ADHD, combined, will start Tx with Adderall. Reviewed Risks, benefits, side effects + alternatives. He has no family history of sudden Cardiac death or cardiac conduction problems He has no symptoms of chest pain, syncope, exercise intolerance or palpitations. No h/o known Cardiac problems Start Adderall 5 mg BID. f/u in 2 weeks to assess efficacy + Monitor for side effects

Date 6/24/08 MD

MEDICATION LOG

Patient Name: [redacted] Birthdate: 4-1-89

Home Phone: [redacted] Work Phone:

Pharmacy: Pharmacy Phone:

MEDICAL/ALLERGY ALERTS:

DATE RX	MEDICATION	DOSAGE	QTY	FREQ	NUMBER OF REFILLS DATE AND INTIAL
4/[redacted]	Lexapro	20mg	#30	1QM	Rite Aid [illegible]
5/5/07	Lexapro	20mg	#30	1 QM	Rite Aid [illegible]
6/18/07	Lexapro	20mg	#30	1 QM	RK
7/18/07	Lexapro	20mg	#30	1 QM	RK
8/21/07	Lexapro	20mg	#30	1 QM	1 refill-PN
10 25 07	Lexapro	20 MG	30	TOD	SJZ
11/21/07	Lexapro	20mg	#30	1 QD	PR via M-Nile
1/3/08	Lexapro	20mg	#30	QAM	
2/7/08	Lexapro	20mg	#30	QAM	
3/6/8	Lexapro	20MG	30	1 AM	SJZ
4/23/08	Lexapro	20mg	#30	1 QAM	R.R.
5/24/08	Adderall	5mg	#30	BIDAM	
7/3/08	Adderall	5mg	#30	BID	
7/3/08	Lexapro	20mg	#30	QAM	1 refill
9/11/08	Lexapro	20mg	#30	QAM	Refill
11/11/08	Adderall XR	10mg	#30	QAM	
11/25/08	Lexapro	20mg	#30	QAM	Refill
12/25/08	Adderall XR	10mg	#30	QAM	
1/8/09	Lexapro	20mg	#30	QAM	
1/8/09	Wellbutrin	75mg	#60	BID	

TES:

Appendix 3

DHO Documents

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

2066 TITLE XVI

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1.A SOCIAL SECURITY NUMBER [redacted]

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233

1.B. TYPE CLAIM: [X] DI [ ] DS [ ] DC [ ] BI [ ] BS [ ] BC
1.C. OTHER ENTITLEMENT: [ ] TITLE II
2.A. NAME OF PAYEE(IF ANY)
B. NAME OF DISABLED OR BLIND INDIVIDUAL [redacted]
4. DATE OF BIRTH
5. DATE DISABILITY BEGAN
3. ADDRESS: 1 [redacted]
ESS
EASTOWN PLAZA
571 E. MAIN ST
BATAVIA NY 14020-2798
7. DO CODE 143 DDS CODE 338

8. A. [X] INITIAL B. [ ] RECON C. [ ] RECON DHU D. [ ] ALJ HEARING E. [ ] APPEALS COUNCIL F. [ ] U.S. DISTRICT COURT G. [ ] REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: [X] DISABILITY

X	A. CONTINUES DA AND A [ ] DOES [ ] DOES NOT CONTRIBUTE TO FINDING	MONTH, DAY, YEAR
	B. CEASED STATE PLAN LAST MET	
	C. ELIGIBILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF	

	I. 301 CASE	
	J. BLINDNESS	
	(1) CONTINUES BEGAN	MONTH, DAY, YEAR
	(2) CEASED	
	(3) CEASED OTHER IMPAIRMENT BEGAN	

10. BASIS FOR DETERMINATION
A. [X] MEDICAL/MEDICAL VOC. B. [ ] WORK-NO IRWE C. [ ] WORK-IRWE INVOLVED D. [ ] OTHER explain in item 24

11. REASON FOR CESSATION	CODE.	12. REASON FOR CONTINUANCE	CODE. 74	MEDICAL LIST NO.
13. [ ] CHECK IF ATTACHING A CONTINUATION SHEET	14. [ ] CHECK IF VOCATIONAL RULE MET		CITE RULE	
15. VOCATIONAL BACKGROUND		16. OCC. YEARS 00	17. EDUC. YEARS 10	18. SPECIAL USE
19. VR ACTION A. [ ] SC IN B. [ ] SC OUT C. [ ] PREV. REF. D. [ ] RE-REF.			20. WHY REVIEW WAS MADE-CODE. 29	

PRIMARY DIAGNOSIS:	BODY SYSTEM	CODE NO.	22. SECONDARY DIAGNOSIS	CODE NO.
Organic Mental Disorders(Chronic Brain Syndrome)	12	2940	Asthma	4930

23. DIARY A. TYPE	B. MONTH	B. YEAR	C. REASON
MRN	06	01	S

24. REMARKS
AGE 18 REDETERMINATION
P.L. 104-193

MULTIPLE IMPAIRMENTS CONSIDERED
24.A. COMBINED MULTIPLE NONSEVERE-SEVERE
24.B. COMBINED MULTIPLE NONSEVERE-NONSEVER

25. DISABILITY EXAMINER/CLAIMS REP.	26. DATE	27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	28. DATE
[redacted] 2066	07/11/00	See RFC / MRFC signed	7/11/00
29. LETTER/PARAGRAPH NUMBER	30. PHYSICIAN OR MEDICAL SPEC. NAME(STAMP, PRINT OR TYPE)		30.A. SPEC.CODE
D	M. Moses, MD # 2953		38
	31. SSA REPRESENTATIVE	32. SSA CODE	33. DATE

34. LIST NUMBER	A.	B.	C.	D.	E.	F.	35. FOLDER SENT TO
							143

Exhibit No. 2 Pg. 141

FORM SSA-832-U3 (6-85)

JUL 12 2000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

4142 | TITLE XVI

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1. A SOCIAL SECURITY NUMBER [redacted]

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233

1.B. TYPE CLAIM: [X] DI [ ] DS [ ] DC [ ] BI [ ] BS [ ] BC
1. C. OTHER ENTITLEMENT: [ ] TITLE II
2.A. NAME OF PAYEE(IF ANY)

3. NAME OF DISABLED OR BLIND INDIVIDUAL [redacted]
4. DATE OF BIRTH: 03/12/1992
5. DATE DISABILITY BEGAN: 09/01/07
3. ADDRESS: [redacted]
[redacted]
ROCHESTER NY 14605-
6. DO ADDRESS: 100 CHESTNUT STREET
ROOM 1400
ROCHESTER NY 14604-
7. DO CODE: 108 | DDS CODE: V02

8. A. [X] INITIAL B. [ ] RECON C. [ ] RECON DHU D. [ ] ALJ HEARING E. [ ] APPEALS COUNCIL F. [ ] U.S. DISTRICT COURT G. [ ] REOPENING
9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: [X] DISABILITY

	A. CONTINUES DA AND A [ ] DOES [ ] DOES NOT CONTRIBUTE TO FINDING	MONTH, DAY, YEAR
X	B. CEASED STATE PLAN LAST MET	09/07/10
	C. ELIGIBILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF	11/10

	I. 301 CASE	
	J. BLINDNESS	
	(1) CONTINUES	MONTH, DAY, YEAR
	BEGAN	
	(2) CEASED	
	(3) CEASED OTHER IMPAIRMENT BEGAN	

10. BASIS FOR DETERMINATION (explain in item 24)
A. [X] MEDICAL/MEDICAL VOC. B. [ ] WORK-NO IRWE C. [ ] WORK-IRWE INVOLVED D. [ ] OTHER

11. REASON FOR CESSATION	CODE.	12. REASON FOR CONTINUANCE	CODE.	MEDICAL LIST NO.
	97			

13. [ ] CHECK IF ATTACHING A CONTINUATION SHEET	14. [ ] CHECK IF VOCATIONAL RULE MET	CITE RULE

15. VOCATIONAL BACKGROUND	16. OCC. YEARS	17. EDUC. YEARS	18. SPECIAL USE
		11	

19. VR ACTION A. [ ] SC IN B. [ ] SC OUT C. [ ] PREV. REF. D. [ ] RE-REF.
20. WHY REVIEW WAS MADE-CODE: 29

21. PRIMARY DIAGNOSIS:	BODY SYSTEM	CODE NO.	22. SECONDARY DIAGNOSIS	CODE NO.	23. DIARY A. TYPE	B. MONTH	B. YEAR	C. REASON
Affective Disorder	12	2960	Asthma	4930				

24. REMARKS
VOCATIONAL RULE 203.25 USED AS A GUIDE

MULTIPLE IMPAIRMENTS CONSIDERED
24.A. COMBINED MULTIPLE NONSEVERE-SEVERE
24.B. COMBINED MULTIPLE NONSEVERE-NONSEVER

25. DISABILITY EXAMINER/CLAIMS REP.	26. DATE	27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	28. DATE
T Haresign	09/07/10	E KAMIN PHD	09/03/10
29. LETTER/PARAGRAPH NUMBER	30. PHYSICIAN OR MEDICAL SPEC. NAME(STAMP, PRINT OR TYPE) E KAMIN PHD		30.A. SPEC.CODE 38
	31. SSA REPRESENTATIVE	32. SSA CODE	33. DATE

34. LIST NUMBER	A.	B.	C.	D.	E.	F.	35. FOLDER SENT TO
							108

FORM SSA-832-U3 (6-85)

EXPLANATION OF DETERMINATION

Name of Claimant	W/E's Name (If CDB or DWB)	SSN	Type of Claim
[redacted]		[redacted]	XVI

This is a CD DI claim for an 18 year old male alleging disability due to ADHD, a mood disorder, asthma, sleep apnea, and Osgood Schlatter disease.

The claim does not meet or equal a listing.

The claimant has an 11th grade education and no PRW.

The claimant retains the capacity to perform medium work with simple tasks in a low contact setting away from respiratory irritants.

Using vocational rule 203.25 as a guide, disability is ceased.

Three jobs the claimant could perform are:

579.687-018 Floor Attendant, Glass Mfg.

686.685-022 Cutter, Textile Products

641.686-026 Paper Bag Press Operator, Paper & Pulp

Analyst Haresign, T. Physician Date 9/7/10

Social Security Administration
Supplemental Security Income
Notice of Disapproved Claim

Date: September 07, 2010
Claim Number: [redacted]

[redacted] O. [redacted]
c/o [redacted]
Rochester, NY 14605

Important Notice – your SSI Will Stop

Earlier we told you that we were reviewing your case to see if you are disabled under the definition of disability for adults. After reviewing all the information carefully, we have decided that you are no longer qualify for Supplemental Security Income (SSI).

We urge you to read this entire letter. It includes important information about appeal rights and Medicaid eligibility. It also explains how you can continue to receive benefits if you appeal.

The Decision on your Case

We've enclosed a page that gives you more details on how we made the decision on the claim.

When your Checks Will Stop

Under the definition of disability for adults you are no longer disabled as of September 07, 2010. You will get SSI for that month and the next 2 months. Your last SSI payment will be for November 30, 2010 as long as you continue to meet all other eligibility requirements until then.

Information About Medicaid

For information about any change in your Medicaid eligibility caused by this action, you should get in touch with the local Social Services District Office.

You Have Important Appeal Rights

If you disagree with the decision, you have the right to appeal. We will review the case and consider any new facts you have. A person who did not make the first decision will decide the case.

- You can ask for an appeal anytime within 60 days. But if you want to keep getting payments while we decide the case, you must ask for an appeal within the first 10 days.
- The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- You must have a good reason for waiting more than 60 days to ask for an appeal.
- You have to ask for an appeal in writing. We will ask you to sign a form SSA-789, called "Request for Reconsideration -- Disability Cessation." To get this form, contact one of our offices. Address(es) and phone number(s) are shown on the last page of this letter. We can help you fill out the form.

See Next Page

Appeal In 10 Days To Keep Getting Your Payment

- The 10 days also start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
- If you lose your appeal, you might have to pay back some or all of this money. However, we may decide that you do not have to pay the money back.

How An Appeal Works

A Disability Hearing Officer will decide the appeal. We will call this person a DHO in the rest of our letter. The DHO will meet with you before making the decision on the appeal. The meeting works like this.

- The DHO will mail you a letter at least 20 days before the meeting to tell you its date, time and place.
- You can look at the file before the meeting.
- You can tell the DHO the reasons you think you are still disabled. You should give the DHO any information you think is missing from your file. You can bring someone to represent you at the meeting. And you can bring people to explain the reasons you are disabled.
- You can have the DHO ask people to come to the meeting to speak about your disability and bring important papers. You can question these people at the meeting.
- You do not have to go to the meeting in person. If you do not want to go, you can give the DHO more facts you may have. The DHO will decide your case using these facts, and what is now in the file. But if you go to the meeting, it may help the DHO decide the case.

If You Want Help With Your Appeal

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

See Next Page

If Your Health Gets Worse

If your health gets worse, please get in touch with us. You may be able to get SSI again. We can help you file a new application for SSI.

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. So, if you disagree with this decision, you should ask for an appeal within 60 days.

If You Have Any Questions

If you have any questions, call us toll free at 1-800-772-1213 or call your local Social Security office at 866-964-2045 . We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

District Office 108
SOCIAL SECURITY
100 CHESTNUT ST
SUITE 1400
ROCHESTER, NY 14604.

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly.

Beatrice M. Disman
Regional Commissioner
Social Security Administration

Enclosure:
Explanation of Determination
Your Right To Question the Decision Made on Your Claim

EXPLANATION OF DETERMINATION

Name of Claimant	W/E's Name (If CDB or DWB)	SSN	Type of Claim
[redacted] O. [redacted]		[redacted]	DI

The determination on your claim was made by a State agency based on Social Security law and regulation. It was NOT made by your own doctor or by other people or agencies providing reports about your condition. Any reports given us, however, were used in making this decision.

The State agency that decided your claim had the following: Genesee Mental Health Center, report for the period of 07/10/09-06/18/10; Rochester General Hospital, report for the period of 08/08/09-05/21/10; Strong Memorial Hospital, report of 07/19/09; Northstar Educational Program, report for the period of 03/11/09-06/25/10; Rochester CSD, report for the period of 02/07/09-07/21/09; Hillside Childrens Center, report for the period of 09/06/07-07/09/09; Industrial Medicine Associates, PC, examination report of 08/23/10; Industrial Medicine Associates, PC, examination report of 08/23/10. We did not obtain any other reports because no other reports were available.

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affects your ability to work.

You said you were disabled because of physical and mental impairments. The medical evidence shows that you have had a joint problem, asthma, depression, and some difficulty in concentrating and remembering. The reports did not show any conditions of a nature that would prevent you from working. We realize that at present you are unable to perform certain kinds of work. But based on your age of 18 years, your education of 11 years, and your experience, you can perform medium work (for example, you could lift a maximum of 50 lbs., with frequent lifting or carrying of objects weighing up to 25 lbs), a job in which you would have simple tasks, a job in which you would not work directly with the public, and a job in which the work situation would not make your condition worse.

If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

FORM SSA-4268-C4

4142 - Y004 - [redacted]

Social Security Administration

3211

TITLE XVI

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

1. A SOCIAL SECURITY NUMBER [redacted]

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233

1.B. TYPE CLAIM [X] DI [ ] DS [ ] DC [ ] BI [ ] BS [ ] BC

1. C. OTHER ENTITLEMENT [ ] TITLE II

2.A. NAME OF PAYEE(IF ANY)

B. NAME OF DISABLED OR [redacted]

3. ADDRESS [redacted]
ROCHESTER NY 14605-

4. DATE OF BIRTH 03/12/1992

5. DATE DISABILITY BEGAN 09/01/07

6. DO ADDRESS
100 CHESTNUT STREET
ROOM 1400
ROCHESTER NY 14604-

7. DO CODE 108 DDS CODE V25

8. A. [ ] INITIAL B. [ ] RECON C. [X] RECON DHU D. [ ] ALJ HEARING E. [ ] APPEALS COUNCIL F. [ ] U.S. DISTRICT COURT G. [ ] REOPENING

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED: [X] DISABILITY

	A. CONTINUES DA AND A [ ] DOES [ ] DOES NOT CONTRIBUTE TO FINDING	MONTH, DAY, YEAR
X	B. CEASED STATE PLAN LAST MET	09/01/10
	C. ELIGIBILITY TERMINATED AT THE CLOSE OF THE LAST DAY OF	11/10

	I. 301 CASE	
	J. BLINDNESS	
	(1) CONTINUES	MONTH, DAY, YEAR
	BEGAN	
	(2) CEASED	
	(3) CEASED OTHER IMPAIRMENT BEGAN	

10. BASIS FOR DETERMINATION (explain in item 24)
A. [X] MEDICAL/MEDICAL VOC. B. [ ] WORK-NO IRWE C. [ ] WORK-IRWE INVOLVED D. [ ] OTHER

11. REASON FOR CESSATION	CODE. 97	12. REASON FOR CONTINUANCE	CODE.	MEDICAL LIST NO.
13. [ ] CHECK IF ATTACHING A CONTINUATION SHEET	14. [ ] CHECK IF VOCATIONAL RULE MET		CITE RULE	
15. VOCATIONAL BACKGROUND		16. OCC. YEARS 00	17. EDUC. YEARS 12	18. SPECIAL USE
19. VR ACTION A. [ ] SC IN B. [ ] SC OUT C. [ ] PREV. REF. D. [ ] RE-REF.			20. WHY REVIEW WAS MADE-CODE. 29	

21. PRIMARY DIAGNOSIS:	BODY SYSTEM	CODE NO.	22. SECONDARY DIAGNOSIS	CODE NO.	23. DIARY A. TYPE	B. MONTH	B. YEAR	C. REASON
Affective Disorder	12	2960	Asthma	4930				

24. REMARKS

MULTIPLE IMPAIRMENTS CONSIDER
24.A. COMBINED MULTIPLE NONSEVERE-SEVERE
24.B. COMBINED MULTIPLE NONSEVERE-NONSEVER

25. DISABILITY EXAMINER/CLAIMS REP.	26. DATE 09/07/11	27. PHYSICIAN OR MEDICAL SPEC. SIGNATURE	28. DATE
29. LETTER/PARAGRAPH NUMBER	30. PHYSICIAN OR MEDICAL SPEC. NAME(STAMP, PRINT OR TYPE)		30.A. SPEC.CODE
	31. SSA REPRESENTATIVE S AGRO	32. SSA CODE	33. DATE

	A.	B.	C.	D.	E.	F.	35. FOLDER SENT TO
34. LIST NUMBER							108

FORM SSA-832-C3/U3 (5-1989) ef(10-2004)

EXPLANATION OF DETERMINATION

Name of Claimant	W/E's Name (If CDB or DWB)	SSN	Type of Claim
[redacted]		[redacted]	XVI

THIS CASE WAS REVIEWED IN PREPARATION FOR HEARING.

BENEFITS WERE CEASED ON 9/7/10 D/T CLMNT ATTAINED AGE 18 AND ADULT CRITERIA APPLIED, BASED ON EVIDENCE AS LISTED ON THE DSS 4080 DATED 6/16/10.

CLMNT WAS ORIGINALLY ALLOWED ON 12/14/07 FOR BIPOLAR DISORDER. FINDINGS: CLMNT HAD AN EXTREME MARKED IN DOMAIN #3 D/T SEVERE & SIGNIFICANT DIFFICULTY GETTING ALONG W/ADULTS, PEERS, AND FAMILY.

CLMNT IS AN 18 YO MALE WHO ALLEGES CONTINUING DISABILITY D/T ADHD, MOOD DISORDER, AND BIPOLAR DISORDER.

FINDINGS @CDR: CLMNT WAS ABLE TO PERFORM MEDIUM, ENTRY LEVEL WORK AWAY FROM RESPIRATORY IRRITANTS.

ADD'L ALLEGATIONS @PH LEVEL: NONE

NEW ADD'L EVIDENCE OBTAINED @PH LEVEL: GENESEE MENTAL HEALTH CTR, REPORT FOR THE PERIOD OF 5/3/10-9/22/10.

FINDINGS @PRESENT: WHILE CLMNT CONTINUES TO HAVE SOME BEHAVIORAL ISSUES, HIS SX ARE STABLE AND LAST MSE 9/22/10 UNREMARKABLE.

PRIOR AND CURRENT MEDICAL EVIDENCE HAS BEEN REVIEWED. CESSATION OF 12/31/08 IS UNCHANGED AND THIS CASE IS ROUTED TO DHU FOR APPROPRIATE ACTION.

Analyst McNaughton, M. Physician Date 11/15/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

DISABILITY HEARING OFFICER'S DECISION	CODE NUMBERS		
	DO	DDS	DHU
	108	338	V25

PRIVACY/PAPERWORK ACT NOTICE The Social Security Administration (SSA) is authorized to collect the information on this form under Section 205(a) 1631(e)(1)(A) and (B) and 1872 of the Social Security Act, as amended (42 U S C 405 1383, and 1395ii) Giving us this information is mandatory

SSA will use the information on this form as an official document of the Disability Hearing Officer's decision

CLAIMANT'S NAME				HEARING DATE	
[redacted]				9/6/11	
NUMBER HOLDER'S NAME				NUMBER HOLDER'S SSN	
Same				[redacted]	
TITLE II			TITLE XVI		
☐ DIB	☐ DWB	☐ CDB	☒ Disability	☐ Blind	☐ Child

The claimant was earlier notified that his/her disability

☒ Ceased 9/10 (month/year) ☐ Did not exist as previously established because. (Explain below)

Present at the disability hearing were the following

The claimant failed to appear for the face-to-face reconsideration hearing.

The basic issue to be determined by this disability hearing decision is whether the claimant is disabled/blind under the definition of disability/blindness contained in Section 223(d) and Section 1614(a) of the Social Security Act, taking into account, when applicable, the standard of review for termination of disability benefits contained in Section 223(f) and Section 1614(a)(5) of the Social Security Act

Other issues are:

N/A

The Summary of Evidence, attached, lists medical/vocational reports in the claims folder obtained prior to the disability hearing The Claimant has submitted additional documentary evidence which consists of the following

N/A

Following is a summary of the claimant's testimony

N/A

Following is a summary of relevant witness testimony

N/A

1207 No MIRS Based on SSA 1207 (5/92) and SSA-1207-Sup 3 (5/92) This form revised 12/10/99

ANALYSIS OF EVIDENCE AND FINDINGS OF FACT

The hearing officer has reviewed the medical, vocational and other information in the claimant's claims folder pertaining to the issue(s) described above The hearing officer has also reviewed the testimony and any additional documentary evidence submitted at the disability hearing After careful consideration of all evidence, the hearing officer makes the following findings

1. **Claimant was an initial Title XVI childhood disability beneficiary because of developmental delays. Date of established administrative onset-September 1, 2007. Claimant attained age-eighteen on March 12, 2010. Thereafter, an age-eighteen disability redetermination was conducted under Public Law 104-193 and resulted in a proposed cessation of benefits in September 2010. The claimant appeals the cessation and alleges continuing disability under the adult rules and regulations for disability evaluation under the Social Security Act. In accordance with the provisions of law for this claim type, the claimant is not entitled to adjudication of appeal under the medical improvement review standard (MIRS) for assessment of continuing disability (CDR). Therefore, comparison point (CPD) is not a relevant consideration at appeal.**

2. **Childhood medical history is summarized by July 2009 Committee on Special Education evaluation for the Rochester City School District. Document informed that the claimant had a history of special education and was classified as emotionally disturbed. He received instruction through the Northstar program, 3 hours daily. Due to significant social emotional needs, he did not participate in general education programs and required special instruction in an environment with a smaller student-to-teacher ratio and minimal distractions in order to progress in achieving the learning standards.**

3. **History of cognitive evaluations cited 4/02 Wechsler Intelligence Scales for Children-III, full scale IQ=93; 10/08 Wechsler Scales for Adults-IV: full scale IQ=84.**

4. **August 2009 Psychiatric Intake Summary by Genesee Mental Health Services informed that the claimant was a 17-year-old male who was expelled from Hillside Children's Center on May 20. 2009, after he assaulted a staff member. He had a history of' day treatment and two psychiatric hospitalizations, all because of significant physical aggression. He had a history of being bullied when he was younger in school and a history of multiple fights and suspensions. At one point he was arrested and sent to jail for attacking the Hillside worker. He completed community service. He had past diagnoses of oppositional defiant disorder, ADHD, and possibly mood problems.**

5. **July 2010 school report of claimant's functional adaptation for learning informed that the claimant was a 12th grade student. Instructional levels attained were 10th grade reading, 7th grade math, 8th grade written language.**

6. **For acquiring and using information and attending and completing tasks, minimal impairment was identified. Likewise, socialization skills and self-care skills were only mildly impaired. Claimant informed his teachers that he did not take his medications consistently, but when very upset would ask to leave.**

7. **At age-eighteen disability redetermination, updated record at Genesee Mental Health informs that the claimant remained in outpatient counseling through at least June 2010, and appeared to be maintained on Abilify and Lamictal.**

8. The state agency arranged for consultative examinations. Claimant was seen for psychiatric examination and internal medicine examination on 8/23/10 at Industrial Medicine Associates, Rochester, New York.

9. Psychiatric examination disclosed that the claimant remained in outpatient mental health counseling and was also treated for hypertension and sleep apnea. Medications included Perphenazine, 4 mg., twice daily and Intuniv, 3 mg. daily.

10. For functioning, the claimant reported that he had difficulty sleeping and a loss of appetite. He also reported depressive symptoms including dysphoric mood, hopelessness, and irritability. He had difficulty with loss of energy and loss of interest. He had social withdrawal. He reported anxiety with excessive worrying and restlessness, manic symptoms of pressured speech, decreased need for sleep, increased energy, and increased goal directed activity, elevated mood and excessive spending. He had difficulty with attention, concentration, and focus. He has some difficulty with learning.

11. Mental status examination was normal for appearance and thought processes. Mood and affect were flat.

12. Attention/concentration and recent/remote memory skills were mildly impaired to testing.

13. For mode of living, he was able to dress, bathe, and groom himself. He did not socialize with friends. He had a poor relationship with his family. He enjoyed working on the computer.

14. Based upon the results of evaluation, medical source statement concluded as follows: The claimant can follow and understand simple directions and perform simple tasks. He has difficulty with attention and concentration. He can maintain a regular schedule. He can learn new tasks and perform complex tasks with supervision. He has some difficulty making appropriate decisions. He has difficulty relating with others and dealing with stress. The results of the evaluation appear to be consistent with allegations.

15. Diagnostic conclusion: Bipolar disorder, anxiety disorder.

16. Internal medicine examination cited a very mild problem with asthma. Claimant used an inhaler pre-exercise at school. He had a sleep study but declined to use CPAP.

17. Also, knee problem: Osgood-Schlatter disease or syndrome with painful knees with exercise.

18. Physical examination found height: 5' 5", weight: 257 lbs, blood pressure 138/78.

19. Physical examination was entirely normal for all body systems including chest/lungs, musculoskeletal system, and neurologic.

20. Prognosis was termed: fair, with summary: He should be able to improve the status of his obesity and obstructive sleep apnea, should he wear the CPAP. That should all improve, as well as the BP improve, as his weight goes down, which will improve the asthma, and his exercise performance will be less influenced by inflammatory mediators produced by the adipose cells, reducing the amount of asthma. Good sleep provided by CPAP should also help his mood disorder.

21. Medical source statement conclusion as follows: The claimant has minimal to mild limitations for exertion, based on exercise induced asthma. This would only limit him from prolonged climbing stairs, running, brisk walking, and repetitive rapid bending and lifting. He also has minimal to mild limitations for kneeling, based on the Osgood-Schlatter condition. He has no apparent limitations for hearing, seeing, or speaking and, otherwise, has no significant limitations identified.

22. The claimant failed to appear for the face-to-face reconsideration hearing.

[redacted]

DISABILITY HEARING OFFICER'S DECISION (Medical Improvement Review Standard Not Applicable)	NUMBER HOLDER'S SSN [redacted]

Determination of Disability

1 The Social Security regulations require that a person's disability be determined through a series of evaluation steps The first step is to determine whether or not the person is presently engaging in substantial gainful activity (20 CFR 404 1520(b), 20 CFR 416 920 (b)) This decision was made by the Social Security office before the disability hearing decision was issued The decision was

☒ You are not engaging in substantial gainful activity

☐ You are engaging in substantial gainful activity but may be entitled to an extended period of eligibility for Social Security disability and/or to cash payments and/or Medical coverage under Supplemental Security Income

In making the determination of disability, the hearing officer will review the remaining evaluation steps Depending upon the evaluation of the evidence, the hearing officer may make a determination regarding the claimant's disability at various steps during the review

2 Does the claimant have a severe impairment?	☐ YES	☒ NO

If a person's impairment(s) is a slight abnormality or a combination of slight abnormalities which has no more than a minimal effect on a person's ability to do basic work activities, the hearing officer will determine that the person does not have a severe impairment Examples of work activities include walking, standing, sitting, lifting, carrying, pushing or handling Also involved are capacities for seeing, hearing, speaking, understanding, and carrying out simple instructions If a person does not have a severe impairment(s), he/she will be determined not to be disabled and the hearing officer will not continue to the next review step (20 CFR 404 1520-1523, 20 CFR 416 920-923, SSR 85-28)

Explain

In childhood, claimant had a history of emotional disturbance, oppositional disorder and ADHD. Severity of his symptoms necessitated placement in alternative education setting for schooling. He also had a history of outpatient mental health treatment.

In adulthood, documentation of record indicates continued outpatient mental health counseling through date of age-eighteen disability redetermination.
Also, consultative physical examination documents history of mild asthma, knee disorder and sleep apnea. However, none of clinically notable symptomology.

Therefore, in conclusion, absent claimant's presentation and testimony, the available medical record at age-eighteen disability redetermination is not indicative of a "severe" impairment within the meaning of that term per 20 CFR, Code of Federal Regulations for Social Security disability evaluations.

3 Does claimant's impairment(s) meet or equal a current listed impairment?	☐ YES	☐ NO

1207 No MIRS Based on SSA 1207 (5/92) and SSA-1207-Sup 3 (5/92) This form revised 12/10/99.

If a person has a severe impairment, the hearing officer will then determine whether the impairment meets or equals an impairment in the Listing of Impairments in the Social Security regulations The listing contains many medical conditions which would normally prevent a person from doing any gainful activity If a person's impairment(s) meets or equals an impairment in the listing, he/she will be found disabled If the impairment does not, the hearing officer will continue to the next review step
(20 CFR 404 1526, 1528, 20 CFR 416 926, 926)

Explain

4	What is claimant's residual functional capacity?	

If the person's impairment(s) does not meet or equal a listing, it is necessary to determine his/her residual functional capacity "Residual functional capacity" refers to those basic work activities a person can do despite his/her impairment(s) For the purpose of determining physical exertion requirements of work, jobs are classified as sedentary, light, medium, heavy, and very heavy (20 CFR 404 1545, 1567, 20 CFR 416 945, 967) After determining the person's residual functional capacity, the hearing officer will proceed to the next step

Explain

5	Does the claimant's impairment(s) prevent him/her from doing past relevant work?	☐ YES	☐ NO

Past relevant work refers to work that the claimant has done within the last 15 years, has done long enough to learn, and has done for profit or gain If a person has the residual functional capacity to perform past relevant work, he/she will be considered not disabled If he/she cannot do past relevant work, the hearing officer will continue to the next review step (20 CFR 404 1561, 20 CFR 416 961)

Explain

6	Does the claimant have a marginal education and work experience that is limited to arduous, unskilled physical labor?	☐ YES	☐ NO

Generally, if a person has a marginal education and work experience of 35 years or more of arduous, unskilled physical labor and the person is not working and cannot perform past work due to a severe impairment, he/she will be considered unable to do lighter work and the person will be considered disabled If he/she does not meet all of these criteria, the hearing officer will continue to the next review step
(20 CFR 404 1562, 20 CFR 416 962)

Explain:

7	Is the claimant of advanced age with a limited education and no work experience or no recent and relevant work experience?	☐ YES	☐ NO

Generally, a person of advanced age with no relevant work experience and a limited education or less will be considered disabled provided his/her impairment is severe If all of these criteria are not met, the hearing officer will continue to the next review step (SSR 82-63)

Explain

8	Does claimant's impairment(s) prevent him/her from doing other work?	☐ YES	☐ NO

a	If material, are claimant's skills transferable?	☐ YES	☐ NO

To what occupation(s) can claimant's skills be transferred?

Explain

b	What is the vocational rule to be used?	

What jobs can claimant do if the claimant's vocational factors do not coincide with a vocational rule and if a determination is being made that claimant is not disabled?

Explain

If a person cannot do past relevant work, it will be determined whether he/she can do "other" work (work that exists in significant numbers in the person's region or several other regions in the country) To make this decision, the hearing officer considers the person's residual functional capacity, occupational base, age, education, and work experience (classified as unskilled, semi-skilled and skilled) If the person's work experience indicates that the work was semi-skilled or skilled, the hearing officer will identify the acquired work skills and, if necessary, specify the occupations to which the acquired work skills are transferable In deciding this review step, the hearing officer will refer to the medical/vocational guidelines (Appendix 2) of the Social Security regulations If all the person's vocational factors do not coincide with a particular rule in the guidelines, the hearing officer will use these rules as a framework for deciding this step If a person has the capacity to adjust to work other than what he/she has done in the past, the person will be found not disabled (20 CFR 404 1560-1569, 20 CFR 416 960-969)

Explain

Are there other issues relating to this determination?	☐ YES	☒ NO

Explain

CONCLUSION

The CLAIMANT is found to be

☐ **DISABLED**

☐ **DISABLED**, but with a new period of disability The earlier determination that claimant's disability has ceased is correct A new period of disability began as of ____

☒ **NOT DISABLED**

☐ **NOT DISABLED**, but with a later cessation date The claimant's disability ceased as of ____

Other conclusion

N/A

Disability Hearing Officer's Signature — Date

9/7/11

Salvatore P. Agro, DHO

Disability Hearing Officer's Name

Social Security Administration
Supplemental Security Income
Notice of Reconsideration

[redacted]

Date: 9/7/11

Claim Number: [redacted]

Local Social Security Office. 108
Telephone: (585) 232-6738
Address: 100 Chestnut St.
HSBC Building 14th Floor
Rochester, NY 14604

We're writing to let you know that we have made a disability hearing decision on your case.

Our Decision

We find that you are no longer eligible for payments.

The hearing decision is attached to this letter. Our decision deals only with whether you are disabled.

If you agree with our decision, you don't have to do anything.

If You Disagree With The Decision

If you disagree with the decision, you have the right to ask for a hearing. At the hearing, a person who has not seen your case before will look at it. That person is an Administrative Law Judge (ALJ). The ALJ will review your case and consider any new facts you have.

- You have 60 days to ask for a hearing.
- The 60 days start the day after you receive this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.

Enclosures:
Disability Hearing Officer's Decision
SSA Pub. No. 70-10281

See Next Page

- You must have a good reason for waiting more than 60 days to ask for a hearing.
- You have to ask for a hearing in writing. We'll ask you to sign a Form SSA-501-U5, called "Request for Hearing." Contact one of our offices if you want help.

Appeal in 10 Days To Keep Getting Your Check

You have 10 days to ask us to keep paying you. You must also ask for an appeal.

- The 10 days start the day after you get this letter.
- If you lose your appeal, you might have to pay back some or all of this money.

How The Hearing Process Works

The ALJ will mail you a letter at least 20 days before the hearing to tell you its date, time and place. The letter will explain the law in your case and tell you what has to be decided. Since the ALJ will review all the facts in your case, it is important that you give us any new facts as soon as you can.

The hearing is your chance to tell the ALJ why you disagree with the decision in your case. You can give the ALJ new evidence and bring people to testify for you. The ALJ also can require people to bring important papers to your hearing and give facts about your case. You can question these people at your hearing.

Please read the enclosed pamphlet "Your Right To An Administrative Law Judge Hearing And Appeals Council Review of Your Social Security Case." It has more information about the hearing.

It Is Important To Go To The Hearing

It is very important that you go to the hearing. If for any reason you can't go, contact the ALJ as soon as possible before the hearing and explain why. The ALJ will reschedule the hearing if you have a good reason.

If you don't go to the hearing and you don't have a good reason for not going, the ALJ may dismiss your request for a hearing.

See Next Page

If You Want Help With Your Hearing

You can have a friend, lawyer, or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are also lawyers who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your hearing.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

If You Have Any Questions

If you have any questions, call us toll-free at 1-800-772-1213. We can answer most questions over the phone. You can also write or visit any Social Security office. The address and telephone number of the office that serves your area is shown on page 1.

If you do call or visit an office, please have this letter with you. It will help us answer your questions.

Beatrice M. Disman
Regional Commissioner

Appendix 4

Horse-shedding, Lecturing and Legal Ethics

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Horse-shedding, Lecturing and Legal Ethics

By Edward Carter[1]

It is the rare witness who testifies without having been prepared to testify by the lawyer calling him. Normally a substantial amount of time passes (usually at least a year if not several years) between the event about which a witness will testify and the date of his testimony and because of that if the witness testifies "cold," that is without preparation, the witness often will not have thought about the event about which he will testify since it occurred and as a result he may have difficulty both remembering the details of the events and describing them coherently. Putting an unprepared witness on the witness stand can result in exchanges on the witness stand such as the following:

Attorney: "Please don't shake your head. All your answers must be oral. Did you travel to London?"

Witness: "Oral."[2]

Sometimes referred to as horse-shedding, a term coined by James Fenimore Cooper in the era when horse sheds were close to every rural courthouse and attorneys who rode circuit used them as a place to talk to witnesses before trial, witness preparation is not only ethical when properly done, but is part of what every diligent lawyer must do to prepare for trial. When improperly done it can lead to perjury and professional discipline against the attorney. For that reason it is critically important for attorneys to understand the ethics of witness preparation.

When preparing a witness for trial a lawyer can meet with the witness to discuss the witness's role in the trial as well as explain what constitutes effective courtroom demeanor. During the meeting with the witness the lawyer can also discuss what the witness remembers, reveal the expected testimony of other witnesses, and review with the witness the questions that the lawyer will ask at trial. The witness can also be shown any physical evidence such as documents that will be introduced and about which the witness will be questioned and the witness can be told about the expected lines of cross-examination. As part of the process of witness preparation the lawyer can also rehearse the witness's actual testimony and suggest a choice of words.[3] If the witness had previously made a statement and a memorandum of that statement was made, for the purpose of refreshing the witness's recollection the lawyer can show the memorandum to the witness.

There are a number of witness preparation practices that are controversial and in some cases that violate the law or the rules of professional responsibility, or both. Some of those practices are discussed below.

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[1]Edward Carter is the Supervisor of Financial Crimes Prosecution for the Attorney General of Illinois and adjunct professor of law and Chicago-Kent College of Law.

[2]Gary Slapper. *The Law Explored: preparing witnesses.* TIMESONLINE, April 25, 2007. http://business.timesonline.co.uk/tol/business/law/columnists/gary slapper/article1700573. Site last visited March 30, 2008.

[3]*Restatement of the Law Third, The Law Governing Lawyers*, §116, Comment (b).

1. The Lecture

One of the oldest witness preparation practices is called the lecture. While frequently used in connection with the initial interview of a defendant-client, it is also sometimes used when interviewing witnesses. As practiced, before hearing the client or witness's version of what occurred, the lawyer explains the law relating to the charged offense or the law relating to a possible defense and frequently the law relating to both and then asks the client or witness to tell him her version of the events. The lecture is frequently criticized by legal academics as violating Model Rule of Professional Conduct 3.4(b) which prohibits a lawyer from falsifying evidence or counseling or assisting a witness to testify falsely[4] or at least as bordering on such a violation[5] because, it is argued, it encourages a defendant or witness to falsely tailor her testimony to the applicable law. Despite those criticisms, the practice of explaining the law before hearing the client or witness's version of the events has been approved by courts[6] and ethics committees of bar associations.[7]

2. Simultaneous Interviews

Simultaneous interviews of potential witnesses do not violate any rule of professional responsibility, but as a practical matter they should be avoided. A simultaneous interview of witnesses may be an efficient use of time, but if opposing counsel brings it out during trial, such an interview can give the appearance of collusion, can weaken the strength of the witness' testimony in the eyes of the trier of fact, and sometimes so weaken the witness's testimony as to render it worthless. Simultaneous witness interviews also can make it difficult to learn exactly what happened because the witnesses may try to align their testimony instead of openly relating what they believe they saw or heard.

3. Exclusion Orders and Revealing Testimony

At the start of any criminal trial the prosecutor and the defense attorney almost always make a joint motion to exclude witnesses from the courtroom. Courts routinely grant these motions. It is a violation of the exclusion order to provide a witness who has not yet testified with a transcript of another witness's testimony or to relate a summary of the witness's testimony to a witness who has not yet testified.

4. Obstructing Access to a Witness

The law recognizes that in a criminal case both the prosecution and the defense have an equal right to interview witnesses[8] and Model Rule of Professional Conduct 3.4(a) prohibits an attorney from obstructing another party's access to a witness. A witness has a right to refuse to talk to an attorney who is seeking to interview her and she may choose not to talk to the prosecutor or the defense attorney or both. It is improper for a lawyer who does not represent the witness to tell the witness not to speak to the attorney for the other

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[4] J. Alexander Tanford. *The Ethics of Evidence*, 25 AMERICAN JOURNAL OF TRIAL ADVOCACY 487 (Spring 2002).

[5] Lisa Salmi. *Don't Walk the Line: Ethical Considerations in Preparing Witnesses for Depositions and Trial*, 18 Rev. Litig. 135 (1999).

[6] *State v. McCormick*, 298 N.C. 788 (1979).

[7] *Nassau County Bar Op. No. 94-6* (1994).

[8] *Kines v. Butterworth*, 669 F.2d 6 (1st Cir. 1981)

side and it is improper for an attorney to insist that he be present when the witness meets with the opposing side.[9]

As important as it is to prepare witnesses for trial, as the following colloquy illustrates, the attorney preparing a witness must not lose sight of the fact that she, too, must be both prepared for and attuned to what she is saying and the questions she is asking:

Lawyer: "So, your baby was conceived on July 12?"

Witness: "Yes."

Lawyer: "And what were you doing at that time?"[10]

[9] *See, International Business Machines Corp. v. Edelstein*, 526 F.2d 37 (2nd Cir. 1975).

[10] *Gary Slapper at Note 2.*

Biographies

Lynda (L. J.) Fisher is a senior attorney in the Disability Advocacy Project (DAP) in the Rochester office of the Empire Justice Center, concentrating on Social Security and Supplemental Security Income disability issues, primarily administrative hearings and appeals. She is a graduate of the City University of New York School of Law. Before coming to Rochester in 2004, she was a staff attorney at Nassau Suffolk Law Services in Riverhead, Long Island, representing HIV positive clients in a variety of civil legal issues.

Jocelyne Martinez is a graduate of St. John's University and Georgetown Law Center. She is a supervising attorney in the Brooklyn Neighborhood Office of The Legal Aid Society in NYC. She has 24 years of experience as an attorney and has represented clients in housing, consumer law, family law and public assistance cases. For the past 14 years, Jocelyne has represented clients in disability cases. Jocelyne has represented applicants and claimants in all aspects of their disability cases, including young adults. She currently supervises public assistance and disability attorneys and paralegals. Jocelyne trains pro bono attorneys on how to interview potential clients, make meritorious representation determinations, research, gather evidence, prepare for hearings, write pre-hearing briefs, and conduct hearings.

Emilia Sicilia is the Director of Disability Benefits Advocacy at the Urban Justice Center's Mental Health Project. She represents individuals with mental illness in appealing the denial of disability benefits in their individual administrative and federal court claims, and in impact litigation against the Social Security Administration, including the class action lawsuits *Martinez v. Astrue*, which challenged SSA's policy of suspending and denying benefits based on an outstanding warrant, and *Padro v. Astrue*, which charges the denial of due process based on biased and hostile proceedings by five administrative law judges in SSA's Queens hearing office. Prior to joining the Urban Justice Center, Ms. Sicilia worked at Paul, Weiss, Rifkind, Wharton & Garrison. She is a graduate of the University of Wisconsin Law School and Wesleyan University.