Case Presentation Form

Presenting Provider Name: Dr. Abby Callis

Presentation Date: May 14th

Patient Biological Gender: M **Patient Age:** 8

Race:

❒ American Indian/Alaskan Native Asian
Black/African American
❒ Native Hawaiian/Pacific Islander
X White/Caucasian
❒ Multi-racial Other
❒ Prefer not to say

Ethnicity:

❒ Hispanic/Latino
X Not Hispanic/Latino
❒ Prefer not to say

Topics to discuss/areas of concern:

Client's presentation was such that they would normally be ruled out for evidence based outpatient anxiety treatment. Presentation was much more severe with a great deal of thought based and internal rituals plus self-harming/flagellation (for being bad or unforgivable) and the need for, but no ability to pay for, an inpatient treatment protocol. Some ability to do exposure work was present but hindered by families religious beliefs (primarily grandmother) and clients presentation with scrupulosity. Parents were psychologically minded though mother was prone to psychotic breaks and went through several rounds of ECT, and father had similar presentation of OCD and many years later completed suicide. Difficulty was providing treatment and maintaining the client in an outpatient CMHC setting with some sort of evidence based beneficial treatment when he needed inpatient evidence based anxiety treatment at a facility such as Rogers.

Pertinent Medical History:

Diagnosis:

OCD with scrupulosity and Tourette's

Psychiatric History: (Age of first mental health contact, Past Diagnoses, History of self-harming behaviors or suicide attempts, etc.)

Details:

Presented for treatment at age 5. No additional past diagnoses. Self-harming behaviors due to scrupulosity. No suicidal intent or behavior.

Medication summary:

Numerous medication combinations over time. At the time included Intuniv and Zoloft.

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Trauma History: (Age of significant traumas and brief summary)

Details: No known specific trauma though experienced several early in life separations from mother as she suffered from severe postpartum and would be removed from the home and hospitalized each time a child was born.

Social History: (Current living situation, employment status, pertinent legal history, level of education, relationship status, children, support system, etc.)

Details:
At the time client lived with his parents and three siblings. He was unemployed, had no legal history, was in the 1st grade and not involved with Department of Children and Families/foster care. He had very frequent contact with his paternal grandmother.

Pertinent Lab Work: N/A

Summary of recent Urine Toxicology (if applicable): N/A

Substance Use History, if applicable: (For each relevant substance include age at first use, age where use became problematic/regular, longest period of sobriety (Including what how patient maintained sobriety) and most recent pattern of use.)

N/A