



Case Presentation Form

Presenting Provider Name: Jeremy Bauer

Presentation Date: 11/7/2019

Patient Biological Gender: F Patient Age: 14

Race:

- | | | |
|--|--|---|
| <input type="checkbox"/> American Indian/Alaskan
Native Asian | <input type="checkbox"/> Native Hawaiian/Pacific
Islander | <input type="checkbox"/> Multi-racial Other |
| <input type="checkbox"/> Black/African American | <input checked="" type="checkbox"/> White/Caucasian | <input type="checkbox"/> Prefer not to say |

Ethnicity:

- | | | |
|--|---|--|
| <input type="checkbox"/> Hispanic/Latino | <input checked="" type="checkbox"/> Not Hispanic/Latino | <input type="checkbox"/> Prefer not to say |
|--|---|--|

Topics to discuss/areas of concern:

Member's placements have frequently been disrupted, preventing long-term therapeutic relationships. Member's behavioral health has been unstable. Member has not been ready for trauma narrative. It appears that member either does not know of coping skills, or is resistant to using them. She appears to find identity in being a victim. She also appears to lack a connection to anyone she believes cares about her and can help her.



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Pertinent Medical History:

Diagnosis: F43.0 Posttraumatic Stress Disorder

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

Details: No current BH providers due to frequent and recent placement changes. Member currently placed in group home. Hospitalized 9/8/19 – 9/18/19, (readmitted 3 hours after discharge) 9/18/19 – 10/1/2019, and 10/12/2019 – current. Each hospitalization due to suicide attempt, suicidal ideation, and self-injurious behaviors.

Medication summary:

Desyrel 50mg QHS

Lamictal 25mg BID

Prazosin HCL 2mg QHS

Seroquel 25 mg QAM

50 mg QHS

Sertraline 100mg QAM

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

Details: Reports having no support system, that nobody wants her, nobody cares about her, and she just wants a home.

Reports biological father is dying (though plan is reunification, so this is likely inaccurate)

Reports father was physically abusive in the past.

Reports over 15 suicide attempts.

Reports being raped one year ago

Reports having herpes; denies being sexually active.

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

Details: Removed from home April 2019 due to allegations of abuse and neglect from parents. Returned home in May with family preservation services. Returned to care in August 2019 due to her behaviors. Currently residing in group home. Has been removed from previous group home for aggressive behaviors.



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Pertinent Lab Work: None known

Summary of recent Urine Toxicology (if applicable): None known

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.)

Reports history of alcohol abuse – states she was drunk daily for four months. Says she drank 4 beers and also liquors each morning.