AUSTIN MEDICAL EDUCATION PROGRAM

Consultation-Liaison Psychiatry Service

University Medical Center - Brackenridge

Austin, Texas

ORIENTATION PACKET

Lawrence A. Hauser, M.D.
Chief of Psychiatry - Brackenridge Hospital
Clinical Assistant Professor Department of Psychiatry and Behavioral Sciences
U.T.M.B. School of Medicine
Adjunct Clinical Faculty - Austin Psychiatric Residency Program

Mary Anderson, M.D.
Clinical Assistant Professor - Department of Psychiatry and Behavioral Sciences
U.T.M.B. School of Medicine
Adjunct Clinical Faculty - Austin Psychiatric Residency Program

William Streusand, M.D.
Clinical Assistant Professor - Department of Psychiatry and Behavioral Sciences
U.T.M.B. School of Medicine

Lowell McRoberts, M.D.
Clinical Faculty – Department of Psychiatry
Austin Medical Education Programs

Jack King, Ed.D.
Professor Emeritus - Department of Special Education - University of Texas at Austin

(Revised April 13, 2009)
I. Orientation Packet
   Weekly Schedule
   Staff
   Goals and Objectives
   Psychiatric evaluation
   AMSIT
   Neuro Exam

II. Consent for Emergency Care/ Medical treatment

III. Decision Making Capacity and Informed Consent

IV. Personality Types in Medical Management

V. Are Gender Disparities in Depressive Disorders Real?

VI. Anticholinergic Syndrome

VII. Serotonin Syndrome

VIII. Hydroxyzine / Opiate Withdrawal

IX. Delerium

X. Suicide
**WEEKLY SCHEDULE:**

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<tr>
<th>Day</th>
<th>Time</th>
<th>Activity</th>
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<td><strong>MONDAY:</strong></td>
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<td>7:30 – 12:00 PM</td>
<td>Psychiatry Rounds</td>
<td>Dr. Hauser</td>
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<td>12:00 - 5:00 PM</td>
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<td><strong>TUESDAY:</strong></td>
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<td>Psychiatry Rounds - residents</td>
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<td>Psychiatry Rounds – students</td>
<td>Dr. Streusand</td>
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<td><strong>FRIDAY:</strong></td>
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<td>8:00 – 9:00 AM</td>
<td>Psychology Rounds</td>
<td>Dr. King</td>
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<td>9:00-5:00 PM</td>
<td>Psychiatry Rounds</td>
<td>Dr. McRoberts</td>
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**HOW TO OPC THE FUN AND HAPPY WAY !!**
Original by Renu Anupindi MD typed up and adapted by Dale Hsieh MD

**OPC to Austin State Hospital**

1. Fill in the OPC application and turn it into Judy before 2:00 PM. Judy is in the surgery office located on the lower level of the CEC building. Try to get the application in as soon as possible, 2pm is really the final deadline.

2. Call PES at 440-4044 and get the letter of single portal of entry faxed to 324-7399. This letter sometimes gets forgotten by PES; make sure you follow-up with PES as well as with Judy. Judy is the one who gets the fax in her office.

3. Inform the social worker on the floor. The social worker’s primary job is to do the MOT. Make sure you sign the MOT form before you leave so you don’t have to come back.

4. Fax labs to Austin State Hospital at 419-2760. Just make sure labs are received. Call and follow-up; many times an OPC will get delayed because the labs were lost and the doctor will not be done.

5. Doctor to doctor transfer. The doctor will generally call you when everything else is done and he has received the labs. Again briefly know the patient’s information; make sure you get the name of the doctor you talk to. This name is important for the MOT.

6. Call the social worker. Call the social worker and give her the name of the doctor. She will take care of everything else. Congratulations, you’ve just OPCed a patient!

**OPC to Shoal Creek Hospital**

1. Verify the insurance and bed availability by calling 324-2029. Many times Shoal Creek will be full so always check. Sometimes they won’t take certain insurance, so make sure that the insurance is verified and that there are benefits. If Shoal Creek is full, you can OPC to ASH. Sometimes you can call back around 12:00 PM and 3:00 PM; they get bed updates around this time.

2. Call PES for the letter of single portal of entry faxed to 324-7399. See above.

3. Fill in the OPC Application and turn it into Judy before 2:00 PM. See above.

4. If the patient is a Travis County Healthcare District funded patient, indicated this information on #8 of the OPC form (for responsible party). If the patient is funded by the Travis County Healthcare District, a check for the filing fee is not needed.

5. If pt’s family is not able to pay the court fees; let Judy know that you need a check. If the patient is a Hospital District patient, they will not need a check for filing fees. Virtually no one pays for it on their own. Ask but don’t expect anyone to be able to afford it. If Judy or Brenda are out of the office for the day, call Crystal Castro (x77283) and request a check to file an OPC.

6. Doctor to doctor transfer. The doctor will generally call you when everything else is done and he has received the labs. Again briefly know the patient’s information; make sure you get the name of the doctor you talk to. This name is important for the MOT.

7. Letter of acceptance from Shoal Creek. Make sure it is faxed to 324-7399.

8. Call Judy. She needs the letter of acceptance from Shoal Creek, single portal of entry, and OPC before she can deliver the OPC to court. Remember that you have to get it to her by 2PM. Once all paperwork has been received by Judy, she will call “Congo Courier” to pick up and deliver to the courthouse. Congo’s # is 252-3400, should you ever need to call.

9. Call the social worker. Call the social worker and give her the name of the doctor. She will take care of everything else. Congratulations, you’ve just OPCed a patient!
The regular staff of the Psychiatry Education:

Lawrence A. Hauser, M.D.
Office Telephone #: 454-7741

Mary Anderson, M.D.
Office Telephone #: 451-8438

William Streusand, M.D.
Office Telephone #: 324-3315

Jack King, Ed.D
Office Telephone #: 454-7741

Judy Merten
GME Program Coordinator II
Office Telephone #: 324-7392
Office Location: Clinical Education Center (CEC) located on the Lower Level (Surgery Education Office)
Fax #: 324-7399

C & L Resident’s office
Telephone #: 324-7000
(ext. 72392 and 72394)
CONSULTATION – LIASION PSYCHIATRY
BRACKENRIDGE HOSPITAL ROTATION

I. Introduction

The principle objective of the C-L Psychiatry program is to optimize patient care by providing psychiatric assessment and recommendations for medical patients.

It is within this context that the residents are expected to gain valuable experience in dealing with medical patients experiencing emotional distress and psychiatric disorders.

The resident will be exposed to psychiatric principles of differential diagnosis, psychopharmacology, substance abuse, neurology, forensics, geriatric and child psychiatry, psychotherapy & psychological testing.

II. Facilities covered by Brackenridge C & L Service Resident

Brackenridge Hospital:
Inpatient services (24 hours/day-7 days/week
ER patients Monday – Friday, 8AM – 5 PM

Children
Patients under 18 years old are to be referred to the Child Psychiatry Service.

III. Expectations during C & L rotation

The resident will be expected to:
1. Attend scheduled morning rounds with C & L attendings.
2. Abide by work schedules and follow recommendations as provided by C&L attendings.
3. See assigned patients promptly and perform psychiatric evaluations with a written consult on the chart within 24 hours.
4. Write progress notes after each patient visit.
5. Communicate all urgent recommendations to the service requesting the consult by Doctor to Doctor contact (in addition to chart notes)
6. Keep accurate billing information (see Judy Merten for instructions)
7. Educate referring medical personnel on pertinent psychiatric issues.
8. See all patients on a regular basis according to the severity of the case. Gather current information from the chart so work rounds can be efficiently planned for the day.

9. Contact C&L attendings by telephone to present all new patients who will be discharged prior to the next scheduled attending rounds (includes weekends, holidays and evenings).

10. Make the psychiatry resident “on call” schedule in coordination with fellow C&L residents and submit to Judy Merten by the end of the day on the 1st day of rotation.

11. Respond to all requests for C&L services promptly and with an attitude of helpfulness and courtesy.

12. Interact with all patients and their families in a compassionate and respectful manner.

13. Present a didactic lecture at the end of the rotation.

III. Goals and Objectives

Upon completion of the C&L psychiatry rotation the resident should be able to:

1. Recognize, understand and differentiate the major DSMIV mental disorders.

2. Conduct an appropriate mental status examination.

3. Appropriately screen, diagnose and manage patients with mental disorders commonly encountered in a medical setting.

4. Communicate effectively and appropriately with patients with mental health problems.

5. Be familiar with the first-line treatment modalities for the major psychiatric categories of illness.

6. Recognize his/her level of competence in the diagnosis and treatment of psychiatric disorders and know when referral or consultation is necessary.

7. Prescribe psychotropic medications safely, appropriately and effectively.

8. Clearly formulate decision making rational for ethical / legal issues involved in psychiatric disorders.


10. Use self-observation and self-awareness to strengthen his/her abilities as a practitioner.

11. Formulate treatment plans that are realistic and practical for medical patients using a Bio-Psycho-Social model.
12. Perform short – term counseling and recognize and refer patients in need of long-term psychotherapy.
13. Be aware of available community mental health resources and how to access them.
14. Be able to write a cogent psychiatric consultation and present cases in an organized concise manner including a differential diagnosis and treatment plan.
15. Master an appropriate neurological examination.
16. Master the process of involuntary commitment procedures.
FORMAT FOR THE PSYCHIATRIC EVALUATION AND CONSULT NOTE

1. **Identifying Data:**
   Age, race, sex, occupation, marital status, where they live, date of admission, date of consult.

2. **Reason for Referral:**
   What generated the referral?
   What is the question being asked?
   Name of physician requesting the consult.

3. **Chief Complaint:**
   In the patient’s words, what is the problem?

4. **History of Present Illness:**
   How did they come to be hospitalized (brief) and the background of the psychiatric problem being evaluated with a current review of psychiatric symptoms ex. sleep, appetite, energy, delusions, hallucinations, mood etc.
   For suicide evaluations include method, history of prior attempts, how long they considered it, what was “the last straw”?, suicide note?, circumstances of attempt (location, alone or with others in house?, did they come to hospital on their own or were they found by someone else?
   Do they still want to die?
   
   Include relevant data from chart such as Etoh and tox screen results,
   head CT / MRI / EEG.

5. **Past Psychiatric History:**
   Current psychiatrist or psychotherapist, hospitalizations, medications, past therapy – what type, how long, any history of suicide attempts or violence.

6. **Medical History:**
   Medical problems
   Hospitalizations, surgeries
   Allergies / adverse reactions
   Head injuries
   Medications and doses
7. **Substance Use:**
Etoh – Amt., Type, History of DT's, Withdrawal, Etoh related medical problems.
- Drugs – Amt., Type, Route
- CIGG – PPD
- Caffeine – Cups per day
- Rehabilitation efforts

8. **Legal:**
- Arrests, Charges pending, Court Dates,
- Is patient on police hold?, Probation?, Parole?

9. **Social History:**
- Hobbies
- Education
- Vocation
- Religion
- Abuse, domestic violence
- Cultural background

10. **Family History:**
- Marriages - divorce
- Children – ages, Medical or Psychiatric history / are children of patient at risk for abuse or neglect?
- Parents – age, type of work, Medical and Psychiatric history
- Siblings – ages, type of work, Medical and Psychiatric history
- Relatives – history of suicide, substance abuse, psychiatric disorders

11. **Developmental History:**
- Where was patient raised
- Relationship with parents, growing up
- Any history of learning disabilities, school problems, or abnormal developmental milestones
- Brief description of experience in elementary, Jr. High, High School, College, Graduate schools

12. **Mental Status Exam and Pertinent Neurological Exam**
(See handouts)

13. **Impression:**
- Brief summary of the problem and its causes (include social and biological contributing factors)
- Risk of violence or suicide
- Psychodynamic Formulation (Stressors, immature defenses,
abnormal illness behavior if pertinent)

14. **Differential Diagnosis:**
   - **Axis I:** Biological Disorders
     - ex. Mood Disorders
     - Psychotic Disorders
     - Delirium, (list causes)
     - Dementia (list causes)
     - Substance Abuse
   - **Axis II:** Personality Disorders
     - ex. Personality disorders
     - Mental Retardation
   - **Axis III:** Medical conditions contributing to Psychiatric Disorder
   - **Axis IV:** Psychosocial stressers
   - **Axis V:** GAF Scale (Global assessment of functioning)

15. **Recommendations:**
   - Biological: ex. meds, doses, rationale, labs, CT, Neuro consult
   - Psychological: ex. Psychotherapy, Behavioral strategies
   - Social: ex. Housing, Social work consult, Nursing Home, Guardianship, 24 hour sitter?

   If you are recommending medications, psychotherapy or substance abuse rehab you must state where you have arranged outpatient follow-up (ie. MHMR or privately if the patient has insurance).

   **Note:** All suicidal patients get a 24 hour sitter until seen by the Psychiatry Attending on Rounds.
A BRIEF OUTLINE OF THE MENTAL STATUS EXAM

(“AMSIT” mnemonic)

I. Appearance, Behavior and Speech

A. Patient’s sex, apparent age, other identifying features, scars, tattoos
B. Dress and personal appearance (grooming, personal hygiene, obvious physical abnormality)
C. Do they appear physically ill or in distress?
D. Manner of relating to examiner (placating, negativistic, cooperative, seductive)
E. Increased or decreased psychomotor activity
   1. Rigidity
   2. Catatonia
   3. Stereotypics, picking at bed clothes
   4. Mannerisms, gestures, tremors, tics, gait
   5. Performance of (compulsive) acts repetitiously
F. Observable evidence of emotional state (faces of depression, anger, etc.; signs of anxiety)
G. Disturbance of attention: distractibility; self – absorbed
H. Speech: spontaneity, mute, rate, volume, accent, (language spoken if other than English)

II. Mood and Affect (emotional tone underlying all behaviors)

A. Quality of Mood – What you observe overall in the patient ex., Anger, sadness, happiness, anxiety, apathy; euphoria
B. Appropriateness of Mood – (is mood appropriate to content of thought or situation)
C. Range of Affect – expanded, normal, restricted, flat } change in emotion
D. Intensity of Affect – amplitude (mild to intense) } that is observed during the interview
E. Stability vs. Lability
F. Relatedness – ability of patient to express warmth and interact emotionally with examiner.

III. Sensorium

A. Orientation (time, place, person, reason for hospitalization)
B. Memory – immediate recall, short term, recent, long term
C. Concentration – repeat months of year backwards, serial 7’s, serial 3’s
IV. Intellectual Functioning (estimate of current functioning)

A. Vocabulary
B. Complexity of concepts
C. General fund of information
D. Education level

V. Thought Processes
(does patient speak in a logical, coherent, goal-directed manner?)

A. Formal thought disorder – disorder in form of thinking
B. Delusional thinking
C. Perceptual disturbances (Hallucinations)
D. Suicidal / homicidal ideation
E. Judgment
F. Insight
NEUROLOGICAL EXAM FOR PSYCHIATRIST

I. CRANIAL NERVES

I. Smell

II. Look at optic disc
    Check Vision

III, IV, XI. Pupils (pupils equally reactive to light and accommodation PERLA)

    Extraocular movements (extraocular movements intact EOMI)

    Nystagmus

V. Sensation on face

VII. Smile (orbicularis oralis)

    Squeeze eyes shut (orbicularis oculi)

    Lift eyebrows (temporalis)

VIII. Hearing

IX, X. Gag, uvula

XI. Shoulder shrug (trapezius, sternocleidomastoid)

XII. Stick out tongue (tremor, move side to side)

II. SCREENING TESTS

A. Drift – upward (cerebellar dysfunction – ipsilateral)
    downward (motor dysfunction – contralateral)

B. Fix – make a fist, roll hands around each other; reverse direction

C. Complex command (ie. Take right hand, touch left ear, stick out tongue)

III. GAIT
IV. SPEECH

V. CEREBELLUM
   A. FTN (finger to nose)
   B. RAM (rapid alternating movements)
   C. HTS (heel to shin)
   D. Tandem ataxia (walk “heel to toe”)

VI. PARIETAL
   A. Copying
   B. Stereognosis
   C. Graphasthesia

VII. PATHOLOGICAL REFLEXES
   A. Babinski
   B. Rhomberg
   C. Frontal release signs (palomental, globellar, snout)

VIII. REFLEXES
   A. Observe mainly for symmetry
   B. (biceps, triceps, brachioradialis, patellar, achilles)
   C. Ankle clonus

IX. SENSORY

X. MOTOR
   A. Involuntary movements
   1.  
   B. Muscle (strength, size, tone)