



Fax Cover Letter

From: IBH **To:** Warhawk Health

Date: 05/01/2025 **Attention:** Lindsey Barton, CRNP

Pages (excluding cover pages): 7 **Fax #:** 334-244-3396

Message: re: Ashley D'elia 05/04/1984

☒ **Ph: 256-519-1088; Fax: 256-325-1890 Medical Records Department**

☐ **Ph: 256-975-4291; Fax: 256-325-1890 Credentialing Department**

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5/1/25, 12:17 PM

Print Preview

D'ELIA, Ashley DOB: 05/04/1984 (40 yo F) Acc No. 185880 DOS: 05/01/2025

**D'ELIA, Ashley**

40 Y old Female, DOB: 05/04/1984

Account Number: 185880

1048 BROOKWOOD DR, WETUMPKA, AL 36093-3379

Home: 334-235-7005

Guarantor: D'Elia, Ashley Insurance: AMERICAN BEHAVIORAL

BENEFITS MANAGERS Payer ID: 63103

Appointment Facility: IBH of Montgomery

05/01/2025

progress notes: SAVALLA N MCLEOD, APRN, PMHNP-BC

Current Medications**Taking**

- Airborne(Multiple Vitamins-Minerals) - Tablet Chewable as directed Orally
 - FLUoxetine HCl 20 MG Capsule 1 capsule Orally Once a day
 - Melatonin 5 MG Tablet 1 tablet in the evening Orally Once a day
 - Multi Complete(Multiple Vitamins-Minerals) - Capsule as directed Orally
 - Valtrex(valACYclovir HCl) 1 GM Tablet 1 tablet Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- No Reported Medical History.
- Medical History Verified.

Surgical History

- Tonsillectomy 3/30/03
- Bilateral Salpingectomy 5/30/2016
- Mastopexy 4/30/2017
- Partial Laparoscopic Hysterectomy 11/30/23

Family History

Granger Hammock: ADHD/
Anxiety/ Trauma.

Social History**NEW ADULT SOCIAL HISTORY:**

- Patient is from: Wetumpka, AL.
- Marital status: married.
- Describe your childhood: abusive, divorced.
- Describe current relationship: supportive and caring.
- Do you have any children?: yes, good relationship with children.
- Are you satisfied with your current support system?: yes.

Reason for Appointment

1. Initial visit for anxiety

History of Present Illness**Lab Results:**

- UDS negative.
- Urine temp: 94.

History of presenting illness:

The patient is a 40-year-old white female with a past psychiatric history of generalized anxiety disorder, presenting alone for an initial psychiatric evaluation. She appears visibly distressed but is a reliable historian.

She reports a significant worsening of anxiety over the past two weeks, rating her anxiety as 10/10 and her depression as 0/10. She describes severe worry, restlessness, crying spells, and poor concentration. Sleep is significantly impaired, limited to about 2 interrupted hours nightly, with frequent nightmares. Appetite is poor and she reports feeling sick to her stomach. She also reports a recent cold sore outbreak for the first time.

The acute exacerbation of symptoms was triggered by a traumatic event involving her 13-year-old son, who disclosed self-harming and a history of sexual assault by a 16-year-old peer. The situation has led to overwhelming emotional distress and a panic attack characterized by shortness of breath, a feeling of impending doom, and the urge to escape.

She is a nurse practitioner, college educator, and doctoral student. She values her role as a wife and mother and is highly motivated to be emotionally present for her children. She acknowledges unresolved childhood trauma but is not yet ready to process it. She reports increased hypervigilance, especially around her daughter, and feelings of parental guilt.

Psychiatric Review of Systems:

Depression: Denies classic depressive symptoms but reports situational sadness, guilt, and emotional overwhelm. **Anxiety:**

Reports excessive worry, irritability, muscle tension, shortness of breath, palpitations, and inability to relax. **Sleep:** Difficulty falling/staying asleep, averaging 2 hours/night with frequent nightmares. **Appetite:** Decreased; reports nausea and feeling unwell.

SI/HI: Denies any suicidal or homicidal ideation or intent.

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- Level of education: Advanced Degree.
- Job history: Yes: Graduate Professor & CRNP, able to maintain work/career.
- Alcohol use: social use only.
- Substance use: denies.
- Tobacco use: non smoker.
- Past mental health treatment/counseling: none.
- Past or pending legal issues: none.
- Religious affiliation: Christian.
- Current coping skills/stress relievers: exercise, reading, gardening, relaxation, massage, etc., art work, listening to music.

Allergies

- Naproxen: hives

**Hospitalization/Major
Diagnostic Procedure**

- Denies Past Hospitalization

Review of Systems***All Other Systems:**

Review of Systems (ROS) Scanned into chart, refer to PCP for follow up for medical concerns, Other than mentioned in HPI, all other 14 point review of systems are negative.

Psychosis: Denies hallucinations or delusions. **Mania:** Denies manic symptoms. **ADHD:** Denies inattentive or hyperactive symptoms. **PTSD:** History of childhood trauma; not yet ready to discuss. **Other:** Denies OCD, eating disorders, or conduct-related behaviors.

Medication Trials:

Bupirone (Buspar): Caused nausea; discontinued **Hydroxyzine (Vistaril):** Taken at night; caused excessive sedation and was ineffective for daytime anxiety **Fluoxetine (Prozac):** Long-term use, generally effective until recent situational stressor.

Vital Signs

Temp: **98.2 F**, HR: **79 /min**, BP: **120/81 mm Hg**, Wt: **134 lbs**, Pain scale: **0 1-10**, Oxygen sat %: **96 %**.

Examination***Mental Status Exam:**

- Musculoskeletal: gait and station Grossly normal.
- Musculoskeletal: strength and tone Grossly normal; no EPS, AIMs, or TD.
- Appearance Well-groomed, **Eye Contact:**, Good.
- Behavior Cooperative, anxious, fidgeting, shaking of hands/legs.
- Speech Normal volume, tone, and rate.
- Language Easily engages in conversation.
- Mood/Affect "Overwhelmed, panicky" , / , Full Range, Congruent .
- Perception Denies AVH and does not appear to be RIS.
- Thought Content Appropriate, Denies SI, HI, plan or intent, Denies AVH, Delusions.
- Thought Process Logical/coherent.
- Associations Intact.
- Insight Intact.
- Judgment Intact, Able to follow and understand directions.
- Orientation Oriented x 4.
- Attention/Concentration Alert, Good.
- Recent and remote memory Grossly intact.
- Fund of Knowledge Intact.
- Risk Assessment: **Suicidal ideations:**, Denies, **Homicidal ideations:**, Denies.
- Functional Status Independent with care needs.
- Support System Good support system.

Assessments

1. Post-traumatic stress disorder, chronic - F43.12
2. Generalized anxiety disorder - F41.1 (Primary)
3. Panic disorder [episodic paroxysmal anxiety] without agoraphobia - F41.0

Treatment

1. Generalized anxiety disorder

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Start Propranolol HCl Tablet, 10 MG, 1 tablet on an empty stomach, Orally, every 12 hrs, 30 days, 60 Tablet, Refills 1
Continue FLUoxetine HCl Capsule, 20 MG, 1 capsule, Orally, Once a day

2. Post-traumatic stress disorder, chronic

Start hydroXYZine Pamoate Capsule, 25 MG, 1 to 2 capsules at bedtime as needed, Orally, Once a day, 30 days, 60, Refills 1

3. Panic disorder [episodic paroxysmal anxiety] without agoraphobia

Start clonazepam Tablet, 0.5 MG, 1/2 tablet (0.25mg) to 1 tablet (0.5mg) as needed, Orally, Once a day, 30 days, 30

4. Others

Notes:

1. Others

Notes: It is the medical opinion of this provider that the patient is a good candidate for psychiatric treatment and medication management due to symptoms presented at initial evaluation and intake. Treatment plan from today will continue and be re-evaluated with each visit. At each visit, monitoring for efficacy and side effects of medication, including as applicable risk of falls, metabolic syndrome, and EPS/TD. Adjusting pt's medications as indicated and tolerated. Encouraging adherence to the treatment plan.

Risks/Benefits/Alternatives for treatment, including potentially rare but serious SE's and common but minor SE's, have been thoroughly discussed with pt, for which pt verbalized adequate understanding and consent. Monitoring pt's vital signs and weight at each visit. Will obtain/review routine blood work for pt as indicated at least annually. Will obtain other specific lab work tests as indicated.

Encouraging life style modifications including diet and exercise as indicated and tolerated to minimize metabolic risks. A psychiatric crisis plan of care has been discussed/formulated. Pt has been instructed to call crisis hotline or this clinic as options if in crisis, the telephone numbers for which has been provided to the pt. Pt has contracted for safety easily and convincingly in community treatment setting, citing multiple good reasons for safety, and agreeing to seek emergency medical help if in a psychiatric crisis.

Add On Psychotherapy**Therapy- Anxiety:**

- Plan/goal for treatment: Reduce overall frequency and intensity of the anxiety symptom so that daily functioning is improved, Decrease worry and fearful thoughts and increase positive, problem-solving thoughts.
- Interventions utilized: CBT/Solution Focused/Supportive, Validated patient's feelings.
- Patient response: Identified triggers for anxiety, Acknowledges limitations and discussed symptoms.

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- Patient progress and plan: Progress is guarded, Plan is to continue therapy to make significant progress and to maintain stability.

Therapy- Stress:

- Clinician met with patient: 10:00am to 10:40am - 40 minutes.
- Plan/goal for treatment: Patient will be able to cope with routine life stressors, Learn ways to manage frustrations in a positive manner.
- Interventions used: Reviewed coping skills to manage distress and anxiety, Discussed triggers for stress and ways to more effectively deal with triggers.
- Patient response: Discussed feelings related to stressors and frustrations, Reported sleep is being impacted by stressors and increased anxieties.
- Progress and plan: Patient making progress towards goals, Therapy will continue to help patient manage stressors and frustrations.

ATTESTATION: I hereby attest the note written for this patient encounter accurately reflects the assessment findings, decisions made, and services rendered by this provider, Savalla McLeod, PMHNP-BC. All interventions documented were rendered by this provider, who had a Face to Face visit with this patient, unless otherwise noted.

Visit Codes

- 99204 NEW PT OFFICE VISIT.

Procedure Codes

- 90836 INDIVIDUAL PSYCHOTHERAPY 38 TO 52 MIN
- 96127 BRIEF EMOTIONAL/BEHAV ASSMT, Modifiers: 59

Follow Up

Dr. Kwak (Reason: to monitor medication efficacy and emotional stabilization.)



Electronically signed by SAVALLA MCLEOD, PMHNP on 05/01/2025 at 11:55 AM EDT

Sign off status: Completed

IBH of Montgomery
1040 LONGFIELD CT

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*Reviewed
5/1/25
J. Branton
CLP*

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MONTGOMERY, AL 36117-8055
Tel: 334-288-9009
Fax: 334-288-9497

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Patient: D'ELIA, Ashley DOB: May 4, 1984



UDS SCREEN

Date Collected: 5/1 Time Collected: 9:32 Collected By: HOPatient Name: Ashley D'elia DOB: 5/4/84Insurance: ARB Physician: MCWODMedical Record _____ Sex: M/F: F

Positive	Negative	Internal Control Valid	Multi-Panel drug test cup
			AMPHETAMINES (AMP)
			BARBITURATES (BAR)
			BUPRENORPHINE (BUP)
			BENZODIAZEPINES (BZO)
			COCAINE (COC)
			METHAMPHETAMINE (MET)(mAMP)
			ECSTASY (MDMA)
			METHADONE (MTD)
			OPIATES/MORPHINE (MOP)or (OPI)
			OXYCODONE (OXY)
			PHENCYCLIDINE (PCP)
			THC (MARIJUANA)

COMMENTS: TEMP: 94 BA: _____

I authorize the above ordered lab test as deemed medically necessary by my provider. In an effort to improve the ability to make informed medical decisions, your provider has requested that a urine drug screen (UDS) be completed upon your initial visit and for follow-up visits. Although a valuable diagnostic tool, your insurance carrier may not cover associated costs. As a result, you may be charged a \$20.00 fee for each UDS to cover the cost of this important test. This fee must be paid, and test must be completed prior to seeing your provider.

*

Signature: _____

Date: 01 May 25

Revised 6 2024