Center for Advanced Simulation in Healthcare/ Department of Healthcare Simulation Case Template (Short Form - diagnostic case)	
Case Name: Daniel Sodo	**Complaint: Chronic pain s/p Syme's amputation, difficulty tolerating the prosthesis**

Administrative Information

Presenting Situation: Patient is 38 year old caucasian male with a history of right foot amputation, chronic pain and PTSD.	**Diagnosis: Phantom limb pain** **DDx: Residual limb pain, neuroma, neural tethering, infection, skin breakdown, heterogenic ossification, osteomyelitis or foreign body reaction**

Learning Objectives:	**Activities:**
1. Understand how different healthcare professionals would diagnose and treat a patient with complex medical issues. 2. Recognize the communication requirements for an effective handoff between practitioners. (How is the patient involved and communicated with?) 3. Identify the social determinants of health related to a specific patient case presentation. 4. Analyze how social determinants of health might impact management of a specific patient. 5. Develop a treatment plan that involves an Interprofessional Healthcare team and addresses the Social Determinants of Health impacting a specific patient's care.	**First session** 1. View videos PT/POD or PA/Pharm 2. Review EHR 3. Small group discussion - IP care plan **Second session** 4. Large group student IP team meeting - IP care plan, handoff **Third session** 5. View video Faculty IP team care conference. 6. Faculty debrief **All sessions** 7. Reflections 8. pre/post surveys

Intended case purpose:

Formative Assessment	Comments: IP Care plans, student reflections

Program Case designed for:

_**X**_Physical Therapy __Path Assist __ Nursing __ Medicine __Nurse Anesthesia _**X**_Physician Assistant _**X**_Podiatry _**X**_Pharmacy __Dietician__ Health Administration __Lifestyle Medicine _**X**_Clin Psych _**X**_Interprofessonal focus _**X**_ Other - Social Work

Modality:

_X_ Standardized Patient **_X_**Virtual - Recorded video interviews	Comments: Male 35-45 years old, caucasian

Supporting Files (addendums):

_X_SP Case Script/Storyboard **_X_**EHR **_X_** SOAP-VS	

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Clinical Dashboard - Pertinent history and physical

HPI: Patient is 38 year old caucasian male with a history of right foot amputation, chronic pain and PTSD. He is presenting to the physical therapy department at the Marietta VA hospital because he is having trouble wearing his prosthesis due worsening pain where his right foot used to be and in the distal residual limb. He works 8 hours a day on his feet at the local Kroegers as a stocker. The pain is making it difficult to finish his shift without taking frequent breaks to rest his distal residual limb. His employer has given him a warning that if he is unable to comply with the physical requirements of his job, he will be terminated. He and his family cannot afford the loss of his income.

Onset: Pain present since he had his foot amputated 4 years ago.
Location: right distal residual limb and where his right foot used to be
Duration: 4 years, more severe pain over the past 3 months
Character: varies in nature, can be burning, crushing, shocking. He can't explain it, but he also feels like his toes are twisting and cramping, even though they are not there anymore. It is very unsettling and uncomfortable.
Aggravating factors: pressure on the distal residual limb from standing at work, fatigue, cold temperatures and stress. It makes no sense to him; but it is worse when he has intercourse, urinates or defecates.
Alleviating factors: He tried "a few" of his wife's oxycodone pills (prescribed after her C-section). That is the only medicine that has helped. Marajuana and alcohol help a little too.
Radiation: the electric shock type pain radiates to his toes
Timing: continuous, except for the shocks which are intermittent and occur several times a day
Severity: over the past three months, he rates his pain 8-10, with 10 being the worst possible pain. Prior to that his chronic pain was 6 or 7.

PMHx:
PTSD (served in Afghanistan, discharged with a purple heart 4 years ago after sustaining crush injury to right foot).

Hospitalizations:
Extended hospital stay for management of crush injury with subsequent amputation or right foot

Surgical History:
Syme's amputation right foot

Immunizations:UTD

SHx:
_x_Tobacco: 1 pack per day
_x_Alcohol: whiskey on the rocks, 2 drinks/night

FHx:
M: (deceased) age 57 y/o ovarian cancer, dementia
F: (living) age 69 y/o , HTN, hyperlipidemia, AUD,

_x_Substances: marajuana nightly _x_Diet: fast food __ Exercise: sedentary, other on his feet all day at work _x_Sexual activity: married, but wife just had their 3rd child and is recovering from a C-section, so they have not been active for the past 4-5 months. _x_Home life/ safety: unreliable transportation, no childcare available _x_Mood: depressed, has flashbacks, chronic pain _x_Context (other elements that add to the patient's story) works stocking shelves at Kroger. Has struggled to keep up as his prosthetic foot has been very painful to wear.	depression B: (living) age 35 y/o HIV **Medications:** Was prescribed amitriptyline 25mg one tablet by mouth every night for chronic pain. Not taking because it "does nothing for his pain"	**Allergies:** SULFA
ROS (pertinent only) + "right foot" and distal residual limb pain, severe + depressed mood + anxiety + trouble sleeping due to pain + fatigue + cramping/twisting of "right toes" no fevers, chills, weakness, weight loss no HA or visual changes no N/V/D/constipation or blood in the stool no urinary symptoms no dizziness or syncope no CP, LE edema or palpitations no SOB, cough or hemoptysis no rashes or skin lesions no myalgias or joint pain no suicidal or homicidal ideation no slurred speech or balance issues		

Team 1: PT/POD. - Physical Therapy Clinic Marietta VA Hospital

Chief Complaint/Injury: Chronic pain s/p Syme's amputation, difficulty tolerating the prosthesis

Description of Circumstances Surrounding Injury/Compliant: Patient is 38 year old caucasian male with a history of right foot amputation, chronic pain and PTSD. He sustained a crush injury to his right foot when rubble fell on him as a building collapsed while he was serving in the Army in Afghanistan 4 years ago. Doctors were unable to save the foot and Daniel underwent a Syme's amputation. He was fitted with a total contact socket and a prosthetic foot and underwent physical and occupational therapy. He has suffered chronic pain where his foot used to be, since the surgery. He describes it as burning, shocking, crushing, twisting and cramping. The pain has increased to 8 -10 out of 10 over the past 3 months and it interferes with his health related quality of life. (HR-QOL)

Compounding/Contributing Factors: Daniel is married and has (3) young children; ages 5 years old, 3 years old and 6 weeks. His wife had a complicated delivery and his youngest son was born premature. He is under tremendous stress and they are struggling with medical bills from the hospitalization. He and his wife live paycheck to paycheck, have unreliable transportation and live 1.5 hours away from the VA hospital. They have no local support system and cannot afford daycare. Daniel has a physically demanding job stocking shelves at the local Kroeger grocery store. He needs to take frequent breaks to rest his distal residual limb due to the pain. His employer has given him a warning that if he is unable to comply with the physical

requirements of his job, he will be terminated. He is sleeping poorly, the pain is unbearable at night. He struggles with depression and flashbacks to his time in Afghanistan. They live in a ranch home with a one step entry. Daniel has no trouble navigating the step. He is able to drive (when the car is working), though he worries about doing so safely given all the pain he is struggling with in his right leg.

Pain assessment:
Onset: Pain present since he had his foot amputated 4 years ago.
Location: right distal residual limb and where his right foot used to be
Duration: 4 years, more severe pain over the past 3 months
Character: varies in nature, can be burning, crushing, shocking. He can't explain it, but he also feels like his toes are twisting and cramping, even though they are not there anymore. It is very unsettling and uncomfortable.
Radiation: the electric shock type pain radiates to his toes
Timing: continuous, except for the shocks which are intermittent and occur several times a day
Severity: over the past three months, he rates his pain 8-10, with 10 being the worst possible pain. Prior to that his chronic pain was 6 or 7.
Progression: getting worse
Aggravating factors: pressure on the distal residual limb from standing at work, fatigue, cold temperatures and stress. It makes no sense to him; but it is worse when he has intercourse, urinates or defecates.
Alleviating factors: Narcotics are the only thing that works. He was prescribed them after the surgery, but the doctor advised him he couldn't stay on them long term or he'd "get addicted". He has gotten more pain pills from friends and urgent care centers. Most recently, he tried "a few" of his wife's oxycodone pills (prescribed after her C-section). They are the only medicine that has ever helped. When he doesn't take them, he feels "awful" and the pain is worse than ever.

Previous surgeries/treatments/therapies: (all 4 years ago)
Syme's amputation, right foot
Physical therapy - exercises, gait training, ice, compression, massage
Occupational therapy - worked on dressing, showering, employment evaluation
Prosthetist - fitted and adjusted prosthesis

Pertinent Exam Findings:
Vitals: BP: 132/82 HR: 90
Residual limb: Well healed residual limb with **hypertrophic scar 5mm thick**. **+ Callus formation medial** aspect of distal residual limb with surrounding **erythema**. No warmth, no discharge

Range of Motion:
LLE: AROM WNL hip, knee, ankle
RLE: AROM WNL hip, knee
Strength
LLE: 5/5 strength throughout
RLE: 5/5 strength throughout, **+ muscle knots in hip external rotator and ileal tibial band**
Sensation
LLE: intact to light touch and temperature throughout
RLE: **+ tenderness to palpation over scar. callus with surrounding erythema, + hyperesthesia along bottom and sides of distal residual limb**
Reflexes
LLE: intact 1+ DTR, achilles
RLE: intact 1+ DTR
Proprioception
LLE: intact throughout
RLE: intact to knee
Tinel's (residual limb): **+ Tinel's sign tibial nerve territory of residual limb**
Vascular

LLE: popliteal, posterior tibial and dorsalis pedis intact
RLE: popliteal intact. Skin on residual limb is warm and well perfused

Functional Mobility

Balance: fair
Bed Mobility: independent
Transfers: independent
Standing tolerance: fair
Gait: antalgic gait
Single leg stance left side 30 seconds
Single right stance right side 7 seconds due to pain

Treatment Goals:

1. Reduce Pain to 3-4/10
2. Adjust prosthesis fit so there is no skin irritation to reduce the risk of skin breakdown and pain during activities of daily living within 4 weeks.
3. Reduce scar thickness from 5mm to 3mm to improve the fit of the prosthesis and reduce pain within 8 weeks.
4. Improve balance from fair to good to reduce the risk of falling within 6 weeks.
5. Single leg stance on right side will improve to > 15 seconds and not limited by pain
6. Patient will be able to walk intermittently for 4 hours without being limited by pain in order to complete half of his work day without needing a break

Assessment: Daniel is a 38 year old patient with phantom limb pain, residual limb pain and suspected opioid use disorder, all of which are interfering with his function and quality of life. He is motivated to improve and has not received any treatment or therapy in 4 years.

Plan: Recommend 2-3 sessions per week

1. Limb massage/desensitization
2. Gait assessment/training
3. Application of compression
4. Scar management: compression, onion extract and heparin gel, silicone sheet application
5. Manual therapy in residual limb
6. Graded motor imagery
7. TENS unit
8. Education
9. Prosthetic review
10. Refer to podiatry (hand-off) for pain management and further assessment.

Team 1: PT/POD - Podiatry Clinic Marietta VA Hospital

Subjective/Chief Complaint: Requesting prescription for Oxycodone for chronic severe pain after Syme's amputation.

HPI: Daniel Sodo presents with chronic, debilitating pain of his right residual limb and where his right foot used to be after undergoing a Syme's amputation 4 years previously. He is having trouble tolerating his prosthesis and struggles to keep up at work. He was seen by Physical Therapy two weeks ago and the therapist called to discuss the case and sent his chart over for review.

Since his first Physical Therapy visit, he has not been able to make it to subsequent appointments, due to unreliable transportation, work hours and distance from the hospital. The therapist gave him some exercises to do and taught him how to massage his distal residual limb. She also ordered onion extract and heparin gel, as well as silicone sheets, but those items have not arrived yet. He is wearing a compression sleeve she gave him to use and that may be helping a little.

Daniel admits to taking his wife's oxycodone. He has been trying to cut down, because he is almost out. However, whenever he skips a dose, the pain flares up, he feels very irritable and gets a lot of stomach cramps. He is very nervous about what will happen if he runs out of the medication. Nothing else helps him with the pain, which he describes as "unbearable" and keeps him awake at night. It is getting to the point where sometimes he needs to take 2 pills because 1 is no longer relieving his pain.

He describes his pain as constant, crushing, burning, tingling, stabbing and shocking 8-10/10 pain in his right residual limb and where his right foot used to be. He also feels as if his right toes are cramping and twisting even though they are no longer there. His pain started 4 months ago and has been worsening over the past 3 months.

PMH: PTSD (served in Afghanistan, discharged with a purple heart 4 years ago after sustaining crush injury to right foot).

PSH: Syme's amputation right foot

Allergies: SULFA

Medications: Taking his wife's oxycodone 5mg 1-2 tabs by mouth every 6 hours.

Objective
Vitals: BP 145/90 HR 94 T 97.8° BMI 29.6
General: Alert, oriented x 3. Appears anxious and uncomfortable
Dermal: Well healed residual limb with hypertrophic scar 5mm thick. + Callus formation medial aspect of distal residual limb with surrounding erythema. No warmth, no discharge
Musculoskeletal:
Range of Motion:
LLE: AROM WNL hip, knee, ankle
RLE: AROM WNL hip, knee
Strength:
LLE: 5/5 strength throughout, left calf circumference 15.5 cm
RLE: 5/5 strength throughout, **right calf atrophied, circumference 13 cm**
Neurologic:
Sensation
LLE: intact to light touch and temperature throughout
RLE: **+ tenderness to palpation over scar, callus with surrounding erythema, + hyperesthesia along the bottom and sides of distal residual limb**.
Protective sensation intact with 5.07 Semmes Weinstein monofilament bilaterally
Reflexes
LLE: intact 1+ DTR, achilles
RLE: intact 1+ DTR
Proprioception
LLE: intact throughout

RLE: intact to knee
Tinel's (residual limb): **+ Tinel's sign in tibial nerve territory**

Vascular

LLE: popliteal, posterior tibial and dorsalis pedis intact
RLE: popliteal intact. Skin on residual limb is warm and well perfused

Assessment: Daniel is a 38 year old patient with phantom limb pain, residual limb pain, PTSD and suspected opioid use disorder; all of which are interfering with his function and quality of life. Exam findings significant for tenderness over scar, hyperesthesia of distal residual limb, right calf atrophy and +Tinel's sign in territory of his sural nerve (suspect neuroma). Callus formation with skin irritation indicates prosthesis may need adjustment.

Plan:

1. Phantom Limb Pain (PLP)
    a. Continue Physical Therapy 2-3 visits per week for gait training and non-pharmaceutical pain management
    b. Trial of gabapentin 600 mg 1 tablet by mouth every evening, will titrate up if patient tolerates the medication
    c. Referral to Clinical Psychology for CBT (hand off)
2. Residual Limb Pain (RLP) Suspect secondary to possible neuroma and skin irritation from poor fitting prosthesis. His RLP is likely exacerbating his PLP.
    a. Possible candidate for neurorrhaphy
    b. Nerve conduction study/EMG
    c. Ultrasound of residual limb to evaluate for possible neuroma
    d. Referral to Prosthetist to assess and adjust prosthesis
3. Opioid Use Disorder
    a. Referral to Substance Use Disorder Clinic (hand off)
4. Disposition
    a. Return to clinic for re-evaluation 2-4 weeks
    b. Consult Social Work to address transportation issues
    c. Schedule care team meeting in 2 weeks after patient is seen by Addiction Medicine and Clinical Psychology

Team 2: PA/Pharm - Substance Use Disorder Clinic Marietta V.A. Hospital

Reason for Consultation: Opioid Use Disorder

HPI: Daniel is a 38 year old male with a history of right Symes amputation and chronic severe pain is endorsed to our clinic by podiatry for suspected opioid use disorder. He was last seen by the podiatrist a month ago and has been unable to get to our clinic sooner because his youngest son (who was born prematurely) has been having recurring "chest colds". It is difficult for him and his wife to take off work, so they have been using their days off to care for their son and take him to his pediatrician appointments. Daniel is not sure why he has even been referred to Addiction Medicine as he does not think he has a problem. He uses oxycodone and sometimes dilaudid for pain management, not to "get high". The medication also calms his nerves and helps him get what little sleep he can.

Daniel complains of 10/10 severe pain in his residual limb and where his foot used to be. He describes it as stabbing, shooting, shocking and tingling. He has tried physical therapy, but was only able to make the first appointment. His podiatrist prescribed gabapentin, but that does "absolutely nothing" for his pain. Oxycodone

has worked but the dilaudid seems to be a bit more helpful.He last took hydromorphone ~12 hours before coming to the clinic.

Signs of Substance Use Disorder Past 12 months:	
X	**Use in larger amounts or more frequently**
X	**Unsuccessful efforts to cut down or quit**
	Excessive time spent using the drug
X	**Craving the drug** He gets very irritable when he is due for his next dose. He is constantly thinking about how he will get the next bottle of pills, since he doesn't have a prescription. None of the local urgent care centers will prescribe them for him anymore and have labeled him a "drug seeker". He has to get the medication from friends, family or buy them on the street.
X	**Failure to fulfill major obligations** He fell asleep on the couch when he was supposed to be watching the kids while his wife was working. He had just finished his second whiskey after taking 3 oxycodone. When his wife came home from work, she found the 5 year old had turned the stove on to try to cook dinner for the kids. This caused Simone and Daniel to have a big argument. She threatened to throw away all his pain pills if he ever passed out like that again when watching the kids.
X	**Continued use despite social/interpersonal problems** One of his friends caught him stealing a bottle of dilaudid from his medicine cabinet and they got into a fight about it. They are not friends anymore. Additionally, His wife is concerned that he is dependent on medication. They have been getting into arguments about it. She wants him to help more around the house and with the kids. Daniel feels he is too tired and in too much pain to help more with chores. Especially since he is not really sleeping at night.
	Activities/hobbies reduced given use
X	**Recurrent use in physically hazardous situations** Drives to and from work on pain medications
X	**Recurrent use despite physical or psychological problem caused by/worsened by use**
X	**Tolerance** Needs at least 2-3 oxycodone tablets to help with the pain, it used to be only 1. He has been switching on and off with hydromorphone
X	**Withdrawal Symptoms** Rebound pain, anxiety, irritability, insomnia, stomach cramps and diarrhea Clinical Opioid Withdrawal Score (COWS) = 14

Other Substance Use History:	
X	**Tobacco** 1 pack per day
X	**Alcohol** 2 drinks a night, whiskey on the rocks
X	**Benzodiazepines** Alprazolam 0.5mg 1 by mouth at night for sleep

	Cocaine No
X	**Marajuana** smokes 1-2 joints a day
	Gambling No
X	**Family History:** M: (deceased) age 57 y/o ovarian cancer, dementia F: (living) age 69 y/o AUD, HTN, hyperlipidemia, depression B: (living) age 35 y/o HIV
	History of SUD treatment No
	DUI No
	Incarceration No
X	**Prescription Drug Monitoring Checked: (**6 month review, 5 different prescribers)

Medication	Fill Date	Quantity	Prescriber
Hydromorphone 4mg	1 month ago	30	Lisa Hartz, NP
Oxycodone 10mg	6 weeks ago	21	Bruce Levin, DO
Oxycodone 10mg	3 months ago	30	Nancy Lewis, MD
Vicodin 10/325mg	5 months ago	60	Melissa McHenry, PA
Oxycodone 5mg	6 months ago	30	Myles Deserow, MD
Alprazolam 0.5mg	6 months ago	30	Lina Matta, MD

Mental Health History: PTSD, anxiety, depression, marital discord

Trauma History: Daniel sustained a crush injury to his right foot when rubble fell on him in a building collapse while he was serving in the Army in Afghanistan 4 years ago. Doctors were unable to save the foot and he underwent a Syme's amputation.

Withdrawal Symptoms: irritability, stomach cramps, insomnia, increased right residual limb pain,chills, tremor

Medications: Gabapentin 600mg tab by mouth at night
Oxycodone 5mg tab, 2 tabs by mouth every 6 hours or hydromorphone 4mg, 2 tabs by mouth every 6 hours while awake

Social History:
Married to Simone. They have 3 young children; ages 5 years old, 3 years old and 6 weeks old.
Works full time stocking shelves at Kroeger's. Daniel and his family live paycheck to paycheck. Their car is very unreliable and broke down again last week, causing Simone to miss her shift at work.

Physical Exam:
Vitals: BP 138/79 HR 90 T 98.8° BMI 29.6
General: Alert and oriented X 3, somewhat defensive and irritable, restlessness during interview with frequent shifting of legs and arms, yawning twice during interview
HEENT: **Pupils dilated,** reactive to light, no scleral icterus, **mucus membranes dry**

Neck: no lymphadenopathy, no thyromegaly
CVS regular rate and rhythm, no murmurs
Lungs: clear to auscultation bilaterally
Abdomen: soft, non-tender, no distended. liver not enlarged
Extremities: no clubbing, cyanosis or edema. atrophy of calf on residual limb
Skin: Well healed residual limb with hypertrophic scar 5mm thick. + Callus formation medial aspect of distal residual limb with surrounding erythema. No warmth, no discharge
Neuro: **+ hyperesthesia along the bottom and sides of distal residual limb**. Otherwise, nonfocal

Impression: Daniel Sodo is a 38 year old caucasian male with severe chronic pain s/p Syme's amputation 4 years ago, PTSD, marital discord and opioid use disorder.

Recommendations:

1. Opioid overdose education and intranasal naloxone education and distribution
2. Order urine drug screen, HIV, Hepatitis C, RPR and LFTs.
3. Information given for the SMART Recovery program
4. Encouraged patient to schedule his appointment with the clinical psychologist
5. Current signs and symptoms of withdrawal; patient is candidate and agreeable to initiate medication for opioid use disorder (MOUD)
6. Consult pharmacy for induction in clinic today with Suboxone
7. Initiate Suboxone (buprenorphine 4 mg/naloxone 1mg) in the clinic today. Will observe for 1-2 hours and reassess for signs and symptoms of withdrawal. If symptoms are relieved, will send home with an extra dose if needed before tomorrow morning.
8. Tele-health tomorrow. Reassess COWS score, Suboxone titration if needed. If treatment goals achieved, will provide 1 week maintenance prescription
9. Tele-health visit in 5-7 days, discuss symptoms, SOWS and monitor progress using the Brief Addiction Monitor-Revised (BAM-R)
10. Discussed risks and benefits of the buprenorphine/naloxone and objective signs and symptoms of withdrawal (tremor, piloerection, sweating). Instructed the patient on how to use Subjective Opioid Withdrawal Scale (SOWS) and to call the clinic if acute or disabling symptoms
11. Encouraged patient taper off alcohol use
12. Social work consultation

1 day tele-health visit follow up:
Pharmacist can do a video visit.

Team 2: PT/Pharm - Mental Health Services Marietta V.A. Hospital

Patient Name: Daniel Sodo	**Age:** 38 **Gender:** Male
Relationship Status: Married	**Reason for Visit:** anxiety, insomnia, marital discord, nightmares, chronic pain, opioid usage
Referred by: Podiatrist for CBT	**Support System:** Wife, Simone

HPI: Daniel is a 38 year old male with a history of right Symes amputation, with chronic severe pain, substance use disorder, depression, anxiety and PTSD. He is endorsed to our clinic by podiatry and the

substance use disorder clinic for evaluation, counseling and cognitive behavioral therapy.

Medical History: Symes amputation right foot Severe chronic pain in residual limb	**Current Medications:** Gabapentin (600 mg) 1 tab by mouth every evening at bedtime Suboxone (Buprenorphine 4 mg/naloxone 1mg) 1 strip sublingually daily
Mental Health History: PTSD, anxiety, depression	**Substance Use History:** Tobacco**:** 1 pack per day Alcohol: 1-2 drinks a night, whiskey on the rocks (trying to cut down) Benzodiazepines: (previously taking alprazolam at night 0.5mg - stopped 2 weeks ago after Substance Use Disorder Clinic) Marajuana: smokes 1-2 joints a day Opioids: (previously taking Oxycodone 5mg tab, 2 tabs by mouth or hydromorphone 4mg, 2 tabs by mouth every 6 hours - stopped 2 weeks ago after Substance Use Disorder Clinic) Denies Cocaine or IV drug use
Employment: Works full time stocking shelves at Kroegers **Home Life:** Married to Simone. They have 3 young children; ages 5 years old, 3 years old and 6 weeks old.	**Trauma History:** Daniel sustained a crush injury to his right foot when rubble fell on him in a building collapse while he was serving in the Army in Afghanistan 4 years ago. Doctors were unable to save the foot and he underwent a Syme's amputation.
Education: High School Graduate	**Family History:** M: (deceased) age 57 y/o ovarian cancer, dementia F: (living) age 69 y/o AUD, HTN, hyperlipidemia, depression B: (living) age 35 y/o HIV
Cultural Background: Caucasian of Italian and Polish descent. Baptized as a catholic, however, the family never attended church.	**Legal History:** No incarcerations or DUI
Adverse Childhood Experiences: ● Bullied as a child in school ● Lived in an unsafe neighborhood, building was dilapidated and their apartment had cockroaches ● Father was unemployed and drank alcohol everyday ● Mother had to work to support the family and therefore was not home much to take care of Daniel and his brother ● Daniel and his brother Sam were very close. However, when Sam told their father he was	**Stressors:** Physical: Home is cluttered and crowded. They only have 2 bedrooms, so the 3 kids have to share a bedroom. Daniel and Simone cannot always afford utility bills, so they limit how much they use the heat in the winter. Social/Relationship: Simone and Daniel have been arguing. She is upset that he is using their very limited financial resources to obtain pain medication. She also feels he is unsafe supervising their children. Simone accuses him of not being supportive or doing

gay, his father kicked him out of the house.	his share of taking care of their home and family. Daniel is frustrated because he feels like she has no idea how much pain he has and feels she is blaming him for their financial struggles. Financial: Simone and Daniel are hourly workers and live paycheck to paycheck. They have trouble covering their rent every month and are struggling with medical bills from Simone's hospitalization and surgery. Life Events: Wife, Simone, had a seizure and required ambulance transportation to the hospital She underwent an emergency C-section and was hospitalized for 4 days. His youngest son, who is 6 weeks old now, was born prematurely and is having recurrent respiratory problems. His mother, Evelyn, died of Ovarian cancer last year. He served in the army and saw active combat in Afghanistan. Sustained a crush injury to his right foot when a building collapsed during bombing 4 years ago. He required an amputation of the right foot. He also saw his friend, Peter, die in the same building collapse. Peter was a fellow soldier on his team. Physiologic:Chronic severe pain right lower residual limb. Fatigue due to poor sleep. Feels sluggish and bloated from poor diet and alcohol use.

Mental Status Exam:

Appearance: Daniel is somewhat disheveled. He is sitting with shoulders slumped and looking down at the floor.

General behavior: He is cooperative, but has poor eye contact.

Speech: Daniel speaks slowly and softly. At times he mumbles and is hard to understand.

Emotions: He states he feels "depressed and anxious." He feels resigned. He is tired of going to appointments and doesn't feel like he will ever get better. His pain is awful and he feels panicked that there is nothing anyone can do for him. His employer and his wife do not understand how bad it is and how hard everything is for him. He feels resigned and like giving up. He sometimes thinks that his family would be better off without him. He has thought about "ending it all" but does not have a plan in mind. Doesn't enjoy things that used to make him happy (anhedonia).

Thinking process: His processes are coherent and organized, but tend to be fatalistic and negative.

Cognition: Daniel is alert but distracted. He scored below average on the Working Memory Questionnaire.

Insight: He demonstrates poor insight into his condition and behaviors. Daniel feels he is "doing the best that he can" and wishes that everyone would understand that he is in severe, unrelenting pain. He needs the pain medications to "just get by" and cannot help anymore than he is with taking care of the household or his children.

Judgment: Daniel shows poor judgment. His wife reports that he often drives under the influence of drugs and/or alcohol. Sometimes with the kids in the car. He drinks and uses opioids when he is supposed to be watching his children and has actually passed out on the couch as a result, leaving the children unsupervised.

Reliability: His reliability is fair. He has poor insight and did not relate some significant lapses in Judgment. However, what he has shared seems accurate and truthful.

Patient's Goals

1. Improved sleep
2. Pain control
3. Work on his relationship with Simone
4. Stop having nightmares
5. Less nervousness
6. No panic attacks
7. Improved self esteem and confidence
8. Cut down on alcohol, marajuana and tobacco
9. Get off of pain medications if possible

Assessment: This is a 38 year old caucasian male with PTSD, phantom limb pain, OUD, depression, anxiety and marital discord. He struggles with low self esteem and impaired cognitive processing. Daniel does not have much insight into his behaviors and does not really acknowledge that he has a substance use disorder or how this is affecting his health and the wellbeing of his family.

Plan:

1. Couples counseling
2. Cognitive Behavioral Therapy for pain management, flashbacks and insomnia
3. Cognitive Processing Therapy
4. Prolonged Exposure Therapy - Imaginal Exposure
5. Eye Movement Desensitization and Reprocessing (EMDR) Therapy
6. Social work/case management consultation
7. Follow up with Substance Use Disorder Clinic as scheduled tomorrow.

Team 2: PT/Pharm - Pharmacy Telehealth Visit Marietta V.A. Hospital

Name: Daniel Sodo	**VA Identification Card:** #3618402947	**Age:** 38 years old
Visit type: Pharmacy Telehealth	**Reason for visit:** 24 hour follow up after initiation of Suboxone (buprenorphine 4 mg/naloxone 1mg) at the Substance Use Disorder	

<table>
<tr><td></td><td>Clinic.</td></tr>
<tr><td>Drug:
buprenorphine/naloxone (Suboxone)
Current dose:
4mg/1mg sublingual tablet once daily</td><td rowspan="2">Indication: Opioid Use Disorder

Dosing: Patient took an induction dose in the clinic yesterday. He did not take any additional doses at home because he didn’t want to “replace one medication with another” despite ongoing withdrawal symptoms.

Any prior dose modifications: N/A

Food requirements: none

Monitoring: Patient is encouraged to track his withdrawal symptoms and suboxone usage in a symptom and dosing diary

Warnings: Keep medication out of reach from children. Rinse mouth out with water after taking the medication. Brush teeth 1 hour after medication dissolves

Withdrawal symptoms: Mr. Sodo complained of GI cramping, diarrhea, muscle aches, restlessness, anxiety, worsening limb pain and insomnia.</td></tr>
<tr><td>Available dosage forms:
2mg/0.5mg
4mg/1mg
8mg/2mg
12mg/3mg</td></tr>
<tr><td>Assessment:</td><td>Efficacy: The single induction dose of 4mg/1mg SL was insufficient to control the patient’s withdrawal symptoms.

Adverse effects: Patient did not report adverse effects after the induction dose. He was provided a complete list of potential adverse reactions to the medication.

Medication list:
Gabapentin 600 mg by mouth once daily.
Narcan nasal 1 spray nasally prn respiratory depression

Drug Interactions: gabapentin may enhance the CNS depressant effect of buprenorphine.. Patient has been informed to monitor for this closely; we will continue to monitor and discuss it in follow-up visits. For now, the risks of untreated opioid dependence are higher than this drug-drug interaction with low dose gabapentin</td></tr>
<tr><td>Plan:</td><td>1. Symptom and dosing diary provided
2. Patient education
a. mechanism of benefit/anticipated effect
b. clarification that suboxone is not “trading one medication for another”, rather is treatment for SUD
c. signs of withdrawal
d. potential adverse reactions
e. reviewed how to take medication and warnings.
f. educated on narcan indications and usage
3. Increase dose to 8mg/2mg once daily (will instruct patient to take first dose now)
4. Follow-up
a. Pharmacy telehealth visit in 24 hours for symptom monitoring; call clinic VA pharmacist if there are any</td></tr>
</table>

	pharmacy-related questions; will continue to titrate dose to suppress opioid withdrawal symptoms b. In-person follow up at SUD clinic in 5-7 days c. Dental follow up in 1 month