

**Substance Use Disorder Patient Case Summary**

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| **Name**: Aaron Fadel **Age**: 32  **DOB**: 4/8/1989  **MRN:** 0336688 **Heigh**t: 5ft 10in.  **Admitting Weight:** 115 lbs  **BMI:** 16.5  **Healthcare Proxy:** Yes  **DNR:** No  **Admitting Diagnosis:** s/p Fall with T10 & T11 vertebral compression fractures (VCFs)Intractable pain, ETOH & Substance Use disorder | **Demographics**  **Gender Identity:** Male **Religion:** No **Household members:** wife and 2 children  **Occupation:**  **Marital status:** Married  **Race Ethnicity:** Caucasian  **Language:** English  **Postal Code:** 11566  **Other:** Veteran. Prior occupation construction worker and injured on the job due to fall; smokes 1 pack per day cigarettes. | **Allergies: None**  **Current Medications:**  Lopressor (Metoprolol) 100 mg by mouth daily  Duragesic (Fentanyl) transdermal patch 75mcg/hr every 72 hours  Ibuprofen 200mg every 4 hours by mouth as needed for breakthrough pain  Colace 100 mg 3 x daily as needed for constipation  Xanax 0.25mg every 6 hours by mouth as needed for anxiety  Ambien 10 mg by mouth at bedtime as needed.  **Immunization History:**  COVID-19  Seasonal flu  Tdap  Hepatitis B  BCG (TB) vaccine (since he was in Afghanistan five years ago) |
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| **HISTORY OF PRESENT ILLNESS:**  Aaron is a 32-year-old Caucasian male admitted to a rehabilitation facility one week ago due to a fall that occurred while he was working at a site as a construction worker. EMTs reported smelling alcohol on patient’s breath during transport to the hospital. Aaron subsequently injured his lower back with MRI results identifying vertebral compression fractures (VCF) of lower thoracic spine (T10-T11). Patient self- reports “heavily” drinking wine and starting opioid use after his return home from Afghanistan five years ago due to PTSD. Approximately three years ago, Aaron reports two suicide attempts after which he was admitted for mental health care at the VA hospital. Aaron has not been receiving any mental health services for the past 16 months, stating “A bottle of wine every night, my 8 oxycontin and my cigarettes have been doing the trick.” He currently reports pain 12/10 on a scale of 0-10 in his lower back, paresis of his lower extremities and requires assistance with ambulating and all ADLs. He also suffers insomnia, anxiety, and loss of interest in activities. His condition has worsened during the COVID-19 pandemic due mostly to the social isolation, restriction in his lifestyle (travel, entertainment, and recreation) and uncertainty of the future and his financial stability. He has increased his drinking, smoking and drug use since pandemic started.  Sarah has ordered the interprofessional healthcare team to meet to discuss the contributing factors of Aaron’s situation and develop a plan of care for him as he is will need to be discharged home in a few days. Evidence-based practice (SBIRT— Screening, Brief Intervention, and Referral to Treatment) should be emphasized. | | |
| **PAST MEDICAL HISTORY:** s/p Fall with T10 & T11 vertebral compression fractures (VCFs)**;** ETOH &Substance Use**;** Intractable pain, anxiety, depression, insomnia; hypertension; PTSD; vocal cord nodules; dysphagia | | |
| **SOCIAL HISTORY**: Lives with wife and two sons who are in elementary school. Fell during his work as a construction worker where his work schedule was erratic. Currently unemployed with disability application in the process. Wife works full time as a teacher. History of alcohol and opioid abuse. Wife states she is aware of patient’s substance use and that “Aaron has been through a great deal of emotional pain and needed help getting through it. He will need help even more now with his physical pain. I’m not sure how I can handle all of this. My boys are now being affected and acting out.” | | |
| **Medical Clinical Progress Report**   |  | | --- | | **Subjective:** Patient reports pain to be uncontrolled: “12/10” level. Also reports dysphagia  **Objective:**  VS: HR 80, BP 120/80, RR 15, O2 Sat 95%.  Gen: Patient awake and alert; appears mildly uncomfortable at times secondary to pain  HEENT: poor dentition  CV: Normal S1, S2 no murmurs/rubs/gallops  Chest: clear to ausculatation b/l  Abdomen: +normoactive bowel sounds, soft, nontender, non-distended  Musculoskeletal: +tenderness to palpation over T10-11  Neuro: A and O x 3; CN II-XII intact; 5/5 strength and sensation in upper extremities; 4/5 strength in proximal and distal lower extremities b/l. 5/5 sensation throughout lower extremities. No tremor noted    **Assessment/Plan**: Patient is 40-year old male with history of alcohol and opioid use disorder, chronic pain, PTSD and prior suicide attempts, admitted s/p fall resulting in T10, T11 vertebral compression fractures.   1. Vertebral compression fractures: Patient reports severe pain; his pain control is complicated by underlying opioid use disorder. Given that pain is currently not controlled, will need to adjust patient’s pain medication regimen. Ibuprofen may be increased in dosage and changed to standing order, instead of PRN. Recommend consultation with pain management service, as patient’s current treatment with fentanyl patch is not sufficiently effective. Patient may need short-acting opioid therapy in acute setting for initial pain management. Would also consider additional non-opioid adjuvant therapy, such as SSRI. Continue with PT/OT to address mobility and functional status 2. Opioid use disorder: Patient is receptive to long-term treatment for opioid use disorder. After taper from opioid therapy, would recommend referral for methadone or buprenorphine therapy. 3. Alcohol use disorder: patient has not exhibited alcohol withdrawal symptoms. CIWA protocol has been completed. Continue with thiamine/folate/MVI. 4. Anxiety and Depression: patient to be referred to psychiatry for co-management of his underlying psychiatric conditions with substance use disorder. Ambien and Xanax should be tapered due to high risk for respiratory depression with concomitant opioid use. 5. Dysphagia; speech and swallow evaluation pending. 6. Oral lesion; Refer to oral surgery for evaluation of palatal lesion. Patient at risk for oral cancer due to history of alcohol use disorder 7. Prophylaxis: continue with bowel regimen; DVT prophylaxis, as patient is largely immobile. | | | |
| **Dental Clinical Progress Report as part of the VA system dental examinations are incorporated to all admitted patients. Nursing Requested Dental Consult. See images below**  **S: Patient interview,** “My teeth are broken but I do not have any pain”  Med Hx: (+) AUD; (+)PTSD ( + )depression ( + ) substance abuse ( oxycontin) (+) smoking / 10 cigarettes /day  **0**: Clinically, no extra-oral nor intra-oral swelling. H/N exam: evidence of xerostomia otherwise tissues-WNL  Multiple fracture teeth, several non-restorable, several teeth with lost restorations, severe attrition  suspect involuntary bruxism, mild supra-gingival calculus deposits.  Periodontal Status: generalized recession. Mild bleeding upon probing, pocket depths ranged  from 2mm to 6 mm.  **A: Periodontal:** Stage III/B with minimal deposits pending confirmation with radiographic findings.  **Caries risk :** High  **P:** When medically stable, send to dental clinic for detailed examination with radiographs,  dental prophylaxis and establish a dental treatment plan. | | |
| **Nursing Practitioner Clinical Progress Report**  **Objective:**  Aaron appears calm and engaged speaking in a hoarse voice and having difficulty swallowing meals and fluids. There are no visible signs of withdrawal, sweating, tremors, or agitation and client’s drug tests during the SUD treatment have been negative. He is still easily distracted and reports occasional anxiety, but his attention and concentration is improved, as evidenced by taking for 5 minutes about his wife and able to reflect about this prior employment and his service to the Armed Forces. His mood remains flat at times, but he laughs when speaking about his children and how much he misses being with his family. Overall, Aaron is slowly improving and his cravings for sleep, pain medications have been reduced to about 2x per day as compared to “all the time.”  Assessment: Drug addiction, alcohol dependency, PTSD, Depression, Functional dysphonia, impaired dentation  **Plan:** To engage Aaron in MAT which may assist John with goals for going back to work, stop drinking, etc  Will request additional 30-day extension of residential treatment to address ongoing cravings, and counseling  regarding PTSD and suicide ideations  Rehabilitation services for chronic pain  Referral to ENT and Dental Services  Plan to continue family sessions with wife, who is strongly supportive of recovery  Will continue to monitor John closely for depression, suicide ideations, and nightmare regarding his PTSD  Aaron’s Nurse Practitioner, Sarah, used the Drug Abuse Screening Test (DAST)and the Alcohol Use Disorders Identification Test (AUDIT) screens to confirm his alcohol and substance use. During his rehab stay, Aaron has newly complained of hoarseness when speaking and intermittent periods of difficulty swallowing. He is also exhibiting mild cognitive changes for which Sarah has ordered a neuropsych consult. Additionally, inspection of his oral mucosa has revealed poor dentition and an irregularly shaped lesion at the roof of John’s mouth | | |
| **Nursing Clinical Progress Report**  **Situation:** Patient is being scheduled for discharge to home in a few days. Patient’s pain is uncontrolled reporting 10/10 at rest and continues to require max assist with all mobility, transfers and ADLs. Patient is also exhibiting periods of forgetfulness and anxiety. This is day 7 without alcohol consumption and no further DTs noted. Nursing to join interprofessional team meeting to discuss plan of care for patient.  **Background:** Patient admitted to inpatient rehab facility due to vertebral compression fractures (VCF) of lower thoracic spine (T10-T11) resulting from fall at work. Patient unable to walk at that time but has professed with PT and OT. SW, ST, NP and Nutrition services provided during this admission. Patient revealing that he has a known history of ETOH and opioid dependency which he identifies he needs due to PTSD.  **Assessment:** Patient is alert and oriented x 3, however, is forgetful at times. BP 130/80, Heart Rate: 80 and regular. Respiratory rate: 22 and non-labored. No edema noted.Patient c/o of lower back pain 9/10 at rest radiating down legs. Current pain management orders include despite Fentanyl patch 75mcg/hr and Ibuprofen 200mg every 4 hours which patient is taking around the clock (ATC). Last bm this morning. Voiding 500 clear amber urine. Ambulating 10 feet with max assist and rolling walker. Transfers with max to mod assist to transfer bed to chair.  **Recommendations:** Pain management consult to address pain control needs. Will require home care referral and mental health follow up services. | | |
| **Physical Therapy Clinical Progress Report**  **Objective:**  Mr. Fadel is a 32-year-old male admitted with a primary diagnosis of a T10-T11 vertebral compression fracture following an accident at work. Past medical history includes HTN, anxiety, depression, insomnia, and PTSD (deployed in Afghanistan 2010). He is presently experiencing intractable low back pain and has a history of ETOH and substance abuse. He was most recently employed as a construction worker and lives with his wife and two sons. He lives in a private ranch style home with 4 steps to enter (railings on both sides) and all rooms situated on a single floor. He does not have any assistive devices or specialized bathroom equipment.    Orientation: A&O x 4  Patient goal: Mr. Fadel reports a desire to get his life back in order and to be able to move and function without pain  Pain: low back pain 9/10 at rest 10/10 with movement. Pain noted with paravertebral palpation in the lower thoracic and upper lumbar spine (R side > L side)  Baseline vitals: HR 82, BP 125/80, RR 15, O2 Sat 95%.  AROM WNLs distally in B LE’s / min limitations with active B hip ROM in all planes secondary to pain  Muscle strength: Bilat hip flexion 3-/5, hip and knee ext 3+/5, ankle motions 4/5  Posture: decreased lumbar lordosis with a posterior pelvic tilt noted in sitting and standing postures  Flexibility: decreased SLR hamstring flexibility (R to 45o and L to 50o)  Sensation: intact in bilateral LE’s, slightly diminished on the sole of the R foot  Balance: static sitting CS / dynamic sitting CG / static standing CG / dynamic standing min A  Functional Mobility:   * Bed mobility: supine to sit with mod to max A * Transfers: stand pivot transfer WC to bed and back with max A (mod A with sit to stand) * Ambulation: 10 ft in parallel bars with mod A. Decreased unilateral stance times with over dependence on upper extremities and lack of a heel to toe gait noted. * Elevations: activity not performed secondary to pain and anxiety at this time * WC mobility: 25 ft on level surfaces with min A   Assessment: Mr. Sullivan is a 40 y/o male with an admitting diagnosis of a T10-T11 compression fracture who presents with severe low back pain, bilateral LE weakness, and requires assistance with functional activities at the present time.    **Goals:**   1. Pt will perform bed mobility with min A within 1 week. 2. Pt will perform stand pivot transfers with CG within 1 week. 3. Pt will ambulate with a RW for 100 ft with CG within 1 week. 4. Pt will negotiate 4 six inch steps with B rails with min A within 1 week   **Plan:** Continue PT 5 d/wk  Pain management with thermal, electrical, and mechanical modalities and relaxation training  B LE and trunk strengthening exercises as tolerated  Sitting and standing endurance and balance activities  Bed mobility and transfer training  Ambulation and elevation training  Patient and family education  Ordering of required assistive devices and other equipment prior to D/C | | |
| **Occupational Therapy Evaluation**  **Occupational Profile:**  Aaron is a 32-year old male admitted to the rehabilitation facility after a fall at work. Admitting diagnosis includes vertebral compression fracture (T10-T11), intractable pain, ETOH and substance use disorder. Past medical history also includes anxiety, depression, insomnia, hypertension, and PTSD. John is a veteran and is currently unemployed. He most recently worked as a construction worker. He lives with his wife and two sons. He lives in a private ranch style home with 4 steps to enter (railings on both sides) and all rooms situated on a single floor. He does not have any assistive devices or specialized bathroom equipment.  **Analysis of Occupational Performance:**  **Subjective:** Aaron reports frustration and feelings of hopelessness.  **Objective:** Aaron participated in the OT evaluation at bedside in his hospital room. He was easily distracted and appeared restless throughout the session. He was AOx4. Vitals prior to start of the session: HR 80, BP 120/80, RR 15, O2 Sat 95%.  BUE AROM WFLs, MMT not tested,  BLE paresis noted throughout.  Pain reported at 12/10 on 0-10 analog pain scale.  Aaron required maximal assistance for bed mobility from supine to sit on edge of bed. He required maximal assistance to transfer from bed to chair. Seated at bedside chair, he was dependent (required total assistance) for lower body dressing due to limited trunk stability and pain. He declined to attempt to don a button-down shirt due to complaints of pain. Aaron was reluctant to participate in grooming activities. With verbal encouragement and minimal assistance, he was able to comb his hair and wash his face after set up, but he declined to participate in shaving his face. John declined further participation during the evaluation due to pain. He transferred from chair to bed with maximal assistance and required maximal assistance for bed mobility to return to supine.  **Assessment:** Aaron requires maximal to total assistance for ADLs and functional transfers. He has limited activity tolerance due to pain. He also demonstrates diminished energy and drive and presents with avolition towards daily activities. Aaron will require home safety check and further assessment of ADLs and IADLs prior to return home.  **Plan:** Aaron will participate in daily occupational therapy session to facilitate independence with ADLs, IADLs, functional mobility, pain management, and relaxation strategies. Recommend inpatient rehabilitation to address ADLs, IADLs, functional mobility, and pain management prior to return home. Recommend Recreational Therapy Consult for leisure exploration.  **Goals:**   1. Aaron will complete grooming activities independently with set up within 1 week. 2. Aaron will perform LE dressing with moderate assistance with adaptive equipment within 1 week. 3. Aaron will utilize compensatory strategies to don a button-down shirt with minimal assistance within 1 week. | | |
| **Nutrition Evaluation**  Admitting Dx: s/p Fall with T10 & Y 11 VCF, Intractable pain, ETOH and substance use d/o  PMH: Anxiety, Depression, Insomnia, HTN, PTSD, ETOH and substance use d/o  Meds: Lopressor, Fentanyl, Ibuprofen (prn), Colace, Xanax, Ambien  Diet: Regular  Height: 70 inches  Current Weight: 115 lb/ 52 kg  Weight Loss: N/A  BMI: 16.5 classified as underweight  Nutrient Needs:  Kcal: 1550 – 1800 (30 – 35 kcal/day)  Pro: 62 – 78 g/d (1.2 – 1.5 g/kg)  Fluid: 1550 - 1800 mL/d (1 mL/kcal)  Summary: 32 y/o male admitted to rehab facility s/p fall with multiple VCF and ETOH/substance use d/o. Pt with h/o drinking “heavily” (bottle wine/night) and taking opioids (8 oxycontin/day) along with smoking. Pt seen by SLP and noted with oral lesions, poor dentition and difficulty swallowing 2/2 acid reflux. Pt with decreased intake 2/2 ETOH/substance abuse and is at risk for malnutrition. Pt noted with cognitive changes, likely with micronutrient deficiency 2/2 ETOH intake, especially thiamin (Wernicke’s Encephalopathy) which may be contributing.  PES: Excessive alcohol intake related to h/o ETOH and substance abuse as evidenced by report of drinking > 2 drinks/day (drinking “heavily”, one bottle wine/night)  Intervention: Continue current diet as tolerated.  Commercial beverage medical food supplement therapy. If pt cannot meet needs via regular diet will add supplemental beverage 1-2 x/day  MVI supplement.  Coordination of Care. Monitor SLP f/u for chewing/swallowing function changes.      **Social Work Clinical Progress Report**  Social work met with Aaron, a 32-year old who identifies as male and White, for an initial assessment and to provide individualized psychosocial support using a trauma-informed and healing centered approach. John lives with his wife and two sons. Aaron’s wife works as a full-time teacher. Aaron is employed as a construction worker, but states that his schedule has been unpredictable. John completed the Drug Abuse Screening Test (DAST)and the Alcohol Use Disorders Identification Test (AUDIT) screens, which suggest an increase risk of health problems, as well as current consequences related to substance that might suggest a substance use disorder.  Aaron self-reported that he had been drinking at the construction site prior to his fall. He stated he has been drinking 4-5 drinks each day, drinking between 28 and 35 drinks per week. The maximum amount of drinks he reported having on any one day in the past month is 10 drinks. He reports exceeding the recommended dosage of oxycontin (up to 8 pills) as well as increased tobacco consumption. John reported that his increased drinking and opioid use occurred after his return home from Afghanistan five years ago due to PTSD. Aaron has a history of two previous suicide attempts for which he was admitted and treated for mental health care at the VA hospital. The first suicide attempt occurred three years ago and the second attempt occurred approximately 2 years ago. John has not been receiving any mental health services for the past 16 months, saying that drinking and opioids help him cope with feelings of sadness, isolation, and loneliness, which were exacerbated due to COVID-19. Additionally, he stated that the “buzz and numbness” that alcohol and opioids provide helps to decrease his intrusive thoughts and to calm him down. He expressed an aversion to post-use headaches and hangover symptoms. He reported increased instances of blacking out and drinking after he passes out or vomits. John admitted that his alcohol use led to his fall-related injuries. He reports that his use of alcohol and opioids has been a source of tension between him and his wife. His wife states she is aware Aaron’s alcohol and opioid use. She mentioned that “Aaron has been through a great deal of emotional pain and needed help getting through it. He will need help even more now with his physical pain. I’m not sure how I can handle all of this. My boys are now being affected and acting out.”  The social worker administered the 7-item Generalized Anxiety Disorder (GAD-7), PC-PTSD-5 scale, and the 9-item Patient Health Questionnaire (PHQ-9). He fell within the severe range on both the GAD-7 (anxiety) and the PHQ-9 (depression). Aaron scored a 5 out 5 positive responses on the PC-PTSD-5 scale, which measures how traumatic events were affected over the past month. Some of the responses could be related to the significant loss of mobility and independence. John explained that his nightmares seemed to be worsening prior to admission to the hospital and the rehab center. Additionally, he reported increased rumination and intrusive thoughts. John reported that he did not have any current suicidal ideations, intentions, or plans. Due to Aaron’s difficulty swallowing and cognitive changes, these measures should be readministered upon discharge.  Aaron describes his family with pride and expressed that he enjoys spending time with his family and friends. His interactions with friends often includes drinking wine as one of their main activities. He has tried to quit once before, but it made him feel extremely agitated and he had to leave work because he felt sick. Furthermore, he was unsure how to get help for his condition and did not want others to find out about it, lest he be labeled as an addict. He is especially worried and ashamed about how this has impacted his children. He acknowledged that he spends a significant amount of money on alcohol that could be used for bills and necessities, which add to his anxieties related to uncertainty of the future and his financial stability. Recently, he has become more concerned with sending his sons to college. Also, he does not like upsetting his wife and he knows that she is concerned for his health.  He expressed that he would like to get his life back to the way it was and stop living in shame.  Social work discussed short-term goals with John, which include returning home, regaining his independence, and functional mobility. He reported that his long-term goals are to enjoy life with and help provide for his family. John reported a 5 out of 10 on the on his readiness for change related to his alcohol and opioid use behaviors. He attributes this ambivalence to the need to control his increased nightmares and intrusive thoughts.  It is recommended that Aaron receive treatment for substance use and individual and family therapy to address, loss, depression, traumatic stress and anxiety. Due to mobility limitations and COVID-19, many services are restricted. John stated that he was not willing to be transferred to inpatient dual diagnosis treatment at this time. However, he seemed more amenable to intensive outpatient treatment combined with participation in remote twelve-step, and/or mutual support meetings. In addition, he stated that he would be open to speaking to a therapist remotely upon discharge and has internet access and video capabilities at home. Family sessions are recommended to discuss the John’s needs and how they can all work together to support each other and maintain family functionality. Social work will also speak with Aaron’s wife about emotional support resources (i.e., therapy provides, Al-Anon) for her and their sons in addition to the recommended family sessions.  Social work is working with Aaron to complete and submit his disability application and will make additional referrals for vocational training. Additional financial resources will be explored. Due to his status as a Veteran, Aaron’s primary insurance is Tricare, which includes substance use and mental health treatment. He is also eligible for health insurance through his wife’s employer and EAP.  Transportation resources will be identified to help Aaron get to appointments and other activities. Social work will continue to provide emotional support throughout the remainder of his inpatient rehabilitation stay. Social work, in consultation with the entire medical team, will continue to work with the patient and family to ensure referrals to appropriate resources, durable medical equipment vendors, and to services that can provide ongoing emotional and psychological support. | | |
| **Speech & Language Therapy Clinical Progress Report**  Patient is a 32-year-old man admitted s/p fall with T10 & T11vertebral compression fractures (VCFs). PMH includes intractable pain, anxiety, depression, insomnia, hypertension, PTSD, ETOH and substance use disorder. Per nursing report, patient has hoarse vocal quality and has been having difficulty swallowing during meals. He was receiving a regular texture diet with thin liquids. However, his diet was changed to NPO pending SLP evaluation.    **S:** Patient was awake, he was oriented to person and place but not to time. When asked “why he was in the hospital,” he stated he “didn’t know.” He reported that he has been having difficulty remembering things for the past year. He also complained of a scratchy throat, and he was observed to have a hoarse vocal quality.    **O:** Patient provided verbal consent to participate in bedside swallow evaluation, which was completed to screen for potential swallowing difficulties and possible need for a modified barium swallow. Oral motor exam revealed missing dentition and a small lesion on hard palate. Adequate strength and ROM were observed for all lingual and labial movements. Patient accepted trials of regular and soft solids, puree, and thin liquids. Adequate lip seal with no anterior loss of food or liquid was observed for all textures. Mastication and manipulation of regular solid was judged to be effortful, A-P transit slow and mild residue was observed in the buccal cavities following the swallow. Trials of soft solids and puree were tolerated, mastication/manipulation were judged to be adequate with mild presence of oral residue. Thin liquids were also tolerated with no overt s/s of aspiration or penetration, e.g., no coughing, choking or wet breath sounds following trials. Patient c/o a sensation of “something stuck in his throat”, and pointed to sternal notch region when asked to localize the sensation.    A cognitive screening was administered (MOCA 7.1), results indicated a possible moderate cognitive impairment, c/b difficulties in the areas of visuospatial skills, executive function, language (semantic fluency), delayed recall and orientation.      **A:** Patient presents with suspected mild – moderate oropharyngeal dysphagia, c/b oral residue and difficulty clearing residue with prompts and cues to use a tongue sweep to clear buccal cavities. He is judged to be safe for soft solids and thin liquids as there were no overt s/s of aspiration or penetration following trials. Vocal quality may be hoarse secondary to reflux as well as alcohol intake. The results of the cognitive screen indicated deficits that may impact the patient’s safety in his everyday activities.    **P:** Change diet to soft solids with thin liquids, follow up for safe tolerance with this diet consistency and to educate regarding safe swallow strategies. Consider VFSS and/or esophageal to assess swallow physiology of pharynx and esophagus due to patient report of globus sensation. Due to the globus sensation, a barium swallow/esophagram is recommended pending GI/primary physician approval to r/o possible GERD. Initiate speech therapy targeting cognitive deficits, including orientation, safety, and memory. Monitor vocal quality and consider ENT consult if it does not improve.   * Oral lesions and/or saliva gland stones (caused by dehydration due to the over use of pain medication and high amounts of alcohol- diuretic), and hoarse vocal quality (caused by 1/3 sized nodules/vocal cordpolyp and straining due to dehydration and excessive alcohol use) – Head and neck cancer? * Difficulty with swallowing (acid reflex), poor dentition (acid reflex and vomiting) and poor nutritional status (decrease in appetite due to over use of pain medication) * Cognitive changes – acute vs. progressive? Related to ETOH vs. neurological disorder * Ability to return to work due to cognitive/language changes, judgement/reasoning/safety awareness * Oral motor exam – other findings? * What is status of current diet textures? Need for nutritional supplements? * Consult – ENT, Nutrition, psychiatry, neurology, oral surgeon? * Willingness to participate in therapy * Family support/counseling * Referral for barium swallow to rule out problems with the pharynx and esophagus as well as cancer of the esophagus and neck | | |
| **Peer Support**  Access to internet  Social interaction with his veteran peer | | |
| **PHYSICIAN ASSISTANT ASSESSMENT** | | |