Client Information Sheet for LUCY DUFAULT

Client Information

Name	Client Id		
LUCY DUFAULT	188525		
SSN	**DOB**	**Age**	**Gender**
474150273	06/05/2012	13	F
Street	**City**	**State**	**Zip**
361556 PINE ST	HILLIARD	FL	32046

Phone:

Allergies

Demographics

Race:

Religion: **Marital Status:**

Primary Language: **Disabilities:**

Program History

Program	Enrolled Date	Discharged Date	Assigned Staff
NORTH CCSU	11/27/2025		George Conner

Diagnoses

Dx Code	Description

Insurance

Insurance Name	Payer Seq	Effective Dates	Insured Id	Relationship	Insured Contact

Contacts

Contact Name	Relationship	Financially Responsible	Guardian	Emergency Contact
	Law Enforcement	N	N	N

Home Phone:

Lucy Dufault
188525

Admission Date: 11/27/25 Discharge Date: 11/30/25 Discharge GAF: _____

Discharge Diagnosis: Unspecified Anxiety Code: _____

Discharge Diagnosis (con't): _____ Code: _____

Referral	DISCHARGE REFERRALS AND APPOINTMENTS	Appt. Date / Time
☐	Psychiatrist/ APRN It is recommended that guardian schedule appointment within 7 days of discharge ☐ Child Guidance Center ☐ Northwest Behavioral ☐ Starting Point ☐ Clay Behavioral ☐ Helping Hands ☐ Stewart Marchman ☐ Daniel Memorial ☐ Right Path Behavioral ☐ Other	
☒	Primary Care Physician ☐ Medical Follow-Up ☐ Lab Tests PCP referral BMI ≥ 30	
☐	Therapist ☐ Starting Point ☐ Child Guidance Center ☐ Northwest Behavioral ☐ Clay Behavioral ☐ Stewart Marchman ☐ Daniel Memorial ☐ Right Path Behavioral ☐ Helping Hands ☐ Other	
☐	Case Management: ☐ Northwest BH ☐ Child Guidance Center ☐ Other	
☐	Substance Abuse Treatment AA/NA brochure provided ☐ Gateway ☐ Other	
☐	Legal	
☐	Other:	

Contact your local Mobile Response Team (MRT) for 24/7 mobile crisis assistance for any future mental health emergencies.
Duval County residents- Contact Child Guidance MRT - Phone (904) 982-4911
Nassau County residents- Contact Starting Point Behavioral MRT – Phone (904) 225-8280
Clay County residents- Contact Clay Behavioral MRT - Phone (904) 291-4357

Medications should be taken as prescribed. All medications should be safely stored up, away and out of child's reach

LIP Signature _____ Date 11/30/25

Departure Date 11/30/25 **Time** 1400 **Transportation:** ☑ Car ☐ Taxi ☐ Bus ☐ Ambulance ☐ Other

Destination: ☑ Home ☐ Group Home ☐ Foster Home ☐ Residential ☐ Jail ☐ Other

Name / Address 361556 Pine St, Hilliard, FL 32046

Discharge Planner: _____ Ext _____

Staff Escort: Stan Butler RN

☒ I have read and/or had the above explained to me. I understand the after-care plan and I received a Community Resource Guide

Parent/Guardian Signature Ei Sulil Patient Signature _____

Other _____ Relationship to Patient mother

***NOTE: 24 HOUR EMERGENCY SERVICES ARE AVAILABLE** - 904-695-9145*
***SUICIDE PREVENTION HOTLINE** – 988*

MENTAL HEALTH RESOURCE CENTER **CCSU DISCHARGE ORDERS / AFTER-CARE TREATMENT PLAN**	**NAME:** Lucy Dufault **CID #:** 188525

CONFIDENTIAL AND PRIVILEGED-PROFESSIONAL USE ONLY

PLEASE PRINT

ALLERGIES: (include medication, food, environmental)

	Agent	Reaction/Severity
☑ NKDA		☐ Rash ☐ N/V ☐ Flushing ☐ Anaphylaxis ☐ Other:
		☐ Rash ☐ N/V ☐ Flushing ☐ Anaphylaxis ☐ Other:
		☐ Rash ☐ N/V ☐ Flushing ☐ Anaphylaxis ☐ Other:
		☐ Rash ☐ N/V ☐ Flushing ☐ Anaphylaxis ☐ Other:

HOME MEDICATIONS (All prescribed meds, OTC, Herbal Products, Home Remedies, Vitamins, Supplements and Nutriceuticals)	STRENGTH	ROUTE	FREQUENCY	REASON FOR TAKING	LIP to Complete at Discharge(circle one) C - Continue D – Discontinue
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D
		☐ Oral ☐ Injection	☐ Daily ☐		C D

☑ No Current Medications ☐ Patient unable to provide medication history ☐ Transferred/Not Admitted

Signature of person taking history/Title [signature] Date/Time 11/28/25 @ 0010

LIP TO COMPLETE AT DISCHARGE (Include all physical & behavioral health medications patient taking at time of discharge)

MEDICATION (Print)	**STRENGTH**	**DOSE**	**ROUTE**	**FREQUENCY**	**TIME**
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
no meds			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm
			☐ Oral ☐ Injection	☐ Daily ☐	☐ 9 am ☐ 1 pm ☐ 5 pm ☐ 9 pm

Signature of discharging LIP [signature] Date/Time 11/30/25 1130

Reviewed with patient/guardian by (Staff Name/Title) [signature] Date/Time 11/30/25 1300

MENTAL HEALTH RESOURCE CENTER	**NAME:** Lucy Dufault
INPATIENT MEDICATION RECONCILIATION / ORDER	**CID #:** 188525

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RBHS PCR-1480 (9/2014; 8/2013; 2/2013; 11/08;11/07)

Chart Copy

Date: 11/30/2025
Time: 1115-1130
Duration: 15 minutes
Admission Date: 11/27/25
Discharge date: 11/30/2025

Identifying Information:
The patient was identified by name and DOB. The patient is a 13-year-old female who resides with her mother and two younger siblings. She attends Hilliard Middle Senior High School, where she is currently in the 8th grade.

Reason for Admission:
The patient presented for involuntary admission under the Baker Act after an incident on 11/27/25 in which she attempted to open a moving car door and struck her mother during an episode of emotional escalation. Her actions occurred in the context of family conflict, placing both herself and her mother at risk of harm. She has a history of obsessive-compulsive traits, emotional dysregulation, and escalating anxiety symptoms.

Legal Status
At Admission: Involuntary
At Discharge: Voluntary

Risk Status at Discharge:
Low Risk. The patient denied current or past suicidal or homicidal ideation. No self-injurious behaviors were observed or reported. She demonstrated insight into her condition and the use of coping strategies taught during admission.

Follow-up Care
Outpatient follow up: Family and patient were educated on the importance of continued therapy and outpatient follow-up. Patient will follow up with established Mental health provider at Breakthrough in Yulee, FL

Primary care follow-up to be scheduled with previously established provider post-discharge.

Discharge Diagnosis ICD-10:
Unspecified Anxiety Disorder (F41.9)
Obsessive-Compulsive Traits; Rule Out Obsessive-Compulsive Disorder (F42)

Medications at Discharge:
No medications at time of discharge.

Medication Allergies:
None

Weapons in the Home:
The patient denies any access to weapons or firearms in the home and reports feeling safe in her home environment.

Course of Stay:
UDS negative and HCG negative. The patient participated appropriately in milieu therapy, completed trauma assessment, and attended two family visits, which she reported went well. She met with the therapist and engaged in discussions about triggers including family conflict, emotional overwhelm, and compulsive urges. She reported improvement in obsessive thoughts and compulsions since admission and described decreased intrusive thoughts and greater ability to use coping strategies such as breathing techniques and drawing. She endorsed that her compulsive behaviors have "lessened" during her stay. She expressed that journaling or drawing could help her manage urges in the future, especially in moments when she feels overwhelmed. The patient acknowledged ongoing family stress and identified that emotional reactivity contributed to the incident leading to admission. She reported that the visit with her father went well and that she feels safe returning to her mother's home. She expressed willingness to participate in family therapy and continue outpatient sessions with her established therapist at Breakthrough Health in Yulee, FL. She denied suicidal or homicidal thoughts throughout her stay and had no behavioral issues on the unit. She slept adequately, ate normally, and maintained appropriate interactions with staff. she reported feeling "pretty good," denied SI/HI, denied hallucinations, and acknowledged moderate OCD symptoms (Y-BOCS = 23). Staff observed no aggression or agitation, and she completed ADLs with prompting. She remains psychiatrically stable and is requesting discharge.
Her mother will be contacted with aftercare appointments, and she is anticipated to return to school following discharge.

Stephanie Stephens, DNP, APRN, PMHNP-BC

11/30/25 1130
Date

Date: 11/29/2025
Time: 1145-1200

Duration: 15 minutes

Identifying Data:
The patient was identified by name and date of birth. She is a 13-year-old female who resides with her mother and two younger siblings and attends the 8th grade at Hilliard Middle Senior High School. She alternates supervised visitation with her father under recent legal arrangements.

SUBJECTIVE: The patient was evaluated today and reported she is "pretty good." She stated she slept adequately and is eating well. She did not identify any new stressors and denied suicidal or homicidal ideation, denying intent to harm herself or others. She reported that she met with the therapist today and felt the session went "pretty good." She noted her father visited today, describing the interaction as positive. She denied hallucinations but endorsed obsessive-compulsive symptoms consistent with her Y-BOCS checklist, including fears of harming herself or others, contamination concerns, excessive washing, checking behaviors, needing items placed "just right," and ritualized cleaning or arranging. Her Y-BOCS score of 23 places her in the moderate range. She verbalized that some behaviors arise from feeling overwhelmed or needing control in response to stress. She denied experiencing medication side effects as she is not currently on psychotropic medication. She stated she prefers therapy-based approaches but is open to further assessment. She acknowledged having difficulty managing emotional responses at home, including during the recent incident in which she attempted to open a car door and struck her mother, noting she was overwhelmed and trying to get her mother's attention. She stated she is hopeful for discharge tomorrow pending therapist recommendations and outpatient follow-up plans.

OBJECTIVE: Vitals remain stable. No adverse effects or medical concerns have been reported. She slept through the night, is eating normally, and denies pain. She remains behaviorally appropriate on the unit without agitation or aggression. The patient is completing ADLs with prompting and presents with improving engagement.

MENTAL STATUS EXAMINATION:
Appearance: Appropriate for stated age; clean and well-groomed.
Motor Behavior: Calm; no abnormal movements or agitation.
General Attitude and Behavior: Cooperative and respectful; more engaged during the interview.
Mood and Affect: Mood described as "pretty good"; affect mildly constricted but appropriate.
Anxiety: stated as mild, underlying anxiety traits remain evident through history.
Quality and Content of Speech and Thought: Speech limited and hesitant but coherent and goal-directed; no delusions observed.
Perception: No hallucinations or perceptual disturbances reported; no response to internal stimuli

noted.
Sensorium: Alert and oriented to person, place, time, and situation.
Cognitive Functions: Attention and concentration improving; engaged
Potential for Suicide, Homicide, and Violence: Denies current or past thoughts of self-harm or harm to others.
Dominant Character Structure: Rigid cognitive style with obsessive-compulsive traits and emotional reactivity under stress; limited insight and difficulty with impulse control.

ASSESSMENT: The patient continues to display symptoms consistent with anxiety, obsessive-compulsive traits, and emotional dysregulation. Her Y-BOCS score of 23 indicates moderate OCD-range symptoms, consistent with her reported checking behaviors, contamination fears, ordering rituals, reassurance seeking, and intrusive thoughts. She remains psychiatrically stable, denying SI/HI, and shows improved behavioral control compared to admission. Collateral history indicates significant family conflict, rigid thinking patterns, and distress related to disruptions in routine and perceived violations of personal boundaries. Her impulsive behaviors, including opening a moving car door and striking her mother during an episode of emotional dysregulation, reflect impaired judgment and difficulty tolerating stress. Given her limited treatment history, unclear diagnostic boundaries, and ongoing compulsive and emotional symptoms, continued inpatient treatment remains appropriate for stabilization, diagnostic clarification, and the development of coping strategies. Additional evaluation is needed to determine whether OCD may be contributing to her presentation.

DIAGNOSIS:
Unspecified Anxiety Disorder
Obsessive-Compulsive Traits (Y-BOCS = 23; further evaluation required)
Rule Out Obsessive-Compulsive Disorder

Recommended Treatment Plan:

1. Continue to monitor mood symptoms and thoughts of self-harm.
2. The patient will continue on observation only; no psychotropic medications initiated at this time.
3. Discharge planner to continue to set up outpatient services upon discharge, including therapy referrals.
4. Social Services to ensure safe discharge planning, identifying barriers to outpatient treatment and providing resources to caregivers as needed.
5. Continue attending therapy groups and unit activities to support emotional regulation and skill development.
6. Risks, benefits, side effects, alternatives, and consequences of non-treatment versus compliance were discussed with the patient, who verbalized understanding.

Stephanie Stephens DNP, APRN, PMHNP-BC

11/29/25 12/16
Date

Date: 11/28/2025

Time: 1045-1130

Duration: 45 minutes

Identifying Information:
The patient is a 13-year-old female who resides with her mother and two younger siblings. She attends Hilliard Middle Senior High School, where she is currently in the 8th grade. She alternates visitation with her father under recently updated supervised visitation arrangements.

History of Present Illness:
History was obtained from emergency services personnel, chart review, and a one-to-one interview with the patient. The patient presented for involuntary admission to MHRC under the Baker Act after an incident on 11/27/25 in which she attempted to open a car door while the vehicle was in motion and then struck her mother during the same episode. According to the Baker Act, her actions occurred in the context of escalating conflict, placing her and her mother at risk of harm. During interview, the patient explained that the event began when her mother touched items she perceives as personal and "contaminated," which triggered significant distress. She reported attempting to get her mother's attention by hitting her and opening the car door to force her mother to pull over, insisting she "never intended to hurt her." She described the episode as fueled by anxiety, loss of control, and overwhelming frustration. The patient reported having an anxiety attack during the incident and stated that her mother's recording of her behavior increased her distress. She later calmed and attended Thanksgiving dinner but was brought to MHRC that evening after her mother contacted police regarding worsening emotional dysregulation at home. She endorsed intermittent obsessive and rigid patterns related to contamination, order, and control but has never received a formal diagnosis. She denied suicidal ideation, homicidal ideation, hallucinations, or intent to harm others.

Psychiatric Review of Systems:
The patient denied suicidal or homicidal ideation, auditory or visual hallucinations, paranoia, or delusions. She endorsed escalating anxiety and distress related to perceived loss of control, interpersonal conflict, and disruptions to established routines. She described ritualistic behaviors including excessive handwashing and difficulty tolerating others touching her belongings. She denied sleep or appetite disturbance other than episodic stress-related changes.

Past Psychiatric History:
The patient has a prior voluntary admission to Wolfson's Children's Hospital lasting approximately three days for threats of self-harm when overwhelmed by school demands. She

reported that she received an unspecified psychiatric medication during that stay but found it unhelpful and discontinued it. She reported no other psychiatric hospitalizations and has not been engaged in consistent outpatient psychiatric treatment.

Psychiatric Medications (Prior/Current):
The patient is not currently taking psychotropic medication. She reported previously being prescribed medication during her Wolfson admission but could not recall the name. Records have been requested but may not arrive until after the holiday weekend. She has never maintained long-term psychiatric medication use and expresses hesitancy about medication, preferring therapy-based approaches.

Legal History:
The patient denied any legal involvement. Records confirm no juvenile charges or criminal history.

Substance Abuse History:
The patient denied any history of alcohol, tobacco, or illicit drug use. No evidence of substance use was noted in emergency documentation.

Psychosocial History:
The patient resides with her mother and siblings. Her parents divorced five years ago, and recent supervised visitation orders were established due to concerns regarding her father's disciplinary practices and emotional environment. The patient described escalating conflict with her father, including fear of retaliation when reaching out to her mother for support. She expressed frustration about her father's harsh punishments toward her siblings and believes she was punished for advocating for her brother. She reported moderate academic success, stable friendships, and no issues with peers at school. She endorsed increased stress around holidays and transitions between parental homes. She denied trauma history but described emotionally distressing experiences related to parenting dynamics.

Developmental History:
The patient met all developmental milestones on time. She reported no significant early developmental delays. She denies a history of bullying and reports moderate ease in forming friendships, although she tends to keep her social circle small. She has never been in special education or remedial programs. There is no documented history of autism evaluation, though her rigid thinking patterns and need for control warrant further assessment.

Past Medical History:
The patient denied any major medical illnesses, surgeries, head injuries, or seizures. She is lactose intolerant and allergic to amoxicillin. She takes no medical medications. Her last

menstrual period occurred at the beginning of the month, although she reports irregular cycles with long gaps between periods, which may be influenced by stress. She has never been hospitalized for medical reasons.

Admission Vital Signs:
Height: 62 inches
Weight: 169.4 lbs
BMI: 30.9
Blood Pressure: 117/79
Pulse: 75
Respiratory Rate: 17
Temperature: 98.2°F

Mental Status Exam:
Appearance: Age-appropriate, mildly unkempt.
Behavior: Calm but guarded; cooperative with prompting.
Speech: Normal rate and volume; coherent but occasionally hesitant when discussing sensitive topics.
Mood: Described as anxious and overwhelmed.
Affect: Congruent with mood, somewhat constricted.
Thought Process: Linear and goal-directed.
Thought Content: Denies current suicidal or homicidal ideation.
Perception: No hallucinations or perceptual disturbances reported or observed.
Cognition: Alert and oriented x4.
Insight: Poor; limited understanding of emotional triggers and behavioral escalation.
Judgment: Poor as evidenced by impulsive and unsafe behaviors.
Eye Contact: Fair; intermittent but appropriate.
Attention: Distracted but redirectable during interview.

Interpretive Summary:
The patient presents with emotional dysregulation, anxiety, rigid thinking patterns, and impaired impulse control leading to unsafe behaviors, including opening a car door while the vehicle was moving and physical aggression toward her mother. Her symptoms appear to be driven by underlying anxiety, difficulty tolerating loss of control, and possible obsessive-compulsive traits. She demonstrates poor insight and judgment, and her home environment is complicated by high-conflict parental dynamics, inconsistent discipline, and emotional distress surrounding visitation with her father. She has minimal treatment history, unclear diagnostic clarity, and has not engaged in medication or therapy consistently. The patient's symptoms and behaviors, combined with family conflict, safety concerns, and rigid cognitive patterns, support the need for inpatient

treatment for stabilization, diagnostic clarification, and initiation of structured therapeutic intervention.

Diagnoses:
Unspecified Anxiety Disorder
Obsessive-Compulsive Traits (Further evaluation required)
Rule out Autism Spectrum Disorder

Prognosis:
Fair, contingent upon engagement in treatment, completion of diagnostic clarification, and strong family involvement. Without intervention, the patient remains at risk for worsening emotional dysregulation and unsafe impulsive behaviors.

Plan:
Expected length of stay: 3–4 days
Schedule family session; obtain additional collateral on psychiatric and psychosocial history.
Medications: observation only, consider introduction of Luvox pending formal OCD assessment and patient/guardian consent.
Labs: Order standard admission labs.
Y-BOCS Assessment: The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) will be completed with the patient during this admission. Scoring and interpretation will be documented in the next clinical note to support diagnostic clarification.
Trauma assessment: Schedule with assigned therapist.
Admit for acute assessment, management, and stabilization.
Medical provider to address all medical needs during admission.
Social services to coordinate discharge planning.
Monitor closely for mood changes and self-harm ideation.
Engage patient in group therapy, milieu programming, and activity therapy sessions.

Stephanie Stephens DNP, APRN, PMHNP-BC

11/28/25 1130
Date

DATE:	TIME	ORDERS (Please Sign & note time)
[illegible]	[illegible]	PCP referral BMI ≥ 30
11/28/25	0920	
		Nathan Thilges, PA-C
11/28/25	1124	Order noted. — Myrna RN
11-29-25	0044	24° Chart Check, 2-Bailey Tech
11/30/25	0130	24° chart check — Jennifer Clark RN
11/30/25	1130	
		Discharge Patient to home
		No Medications
		Clara

ALLERGIES: NKA

MHRC NORTH (20TH St) CCSU PHYSICIAN/ARNP ORDERS	NAME: Lucy Dufault CID #: 188525

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RBHS PCR-1421 (1/2015)

To be initiated by Licensed Independent Practitioner

Diagnosis: Unspecified anxiety, R/O ~~OCD~~ OCD **ELOS:** 2-3

History and Physical exam / medical follow-up by ARNP/PA

Follow Nursing Protocols unless otherwise specified: _____

Develop Treatment Plan, Primary Problem:

☐ Thought Disorder ☒ Risk of Self Injury/ Neglect ☐ Substance Abuse/Dependency

☐ Depression ☐ Risk to Others ☐ Disruptive Behavior ☐ Disorientation

Schedule Family Session: ☐ NA ☒ Yes: with mom

Phone calls to legal guardian only unless authorized or otherwise specified by law.

Visiting by legal guardian only unless otherwise specified by law or authorized by Treatment Team.

Hold psychotropic medications for B/P < 90/50 ages > 14 years and B/P <80/50 ages < 14 years

Laboratory: _____

_____

Medication:

☐ Benadryl 25 mg. by mouth or I.M. if needed x1 for acute EPS

Other:

Observation only
- Y-BOCS screening
- Lil therapy
- TA -

☒ Medication Summary reviewed and reconciled

ALLERGIES/REACTIONS: ☒ NKA _____

LIP Signature: _____ APRN Date: 11/28/25 Time: 1348

Orders noted by **Nurse**: _____ RN Date: 11/28/25 Time: 1407

11-29-25, 0044, 24° Chart check, J. Baisden

MHRC INPATIENT CCSU INITIAL TREATMENT ORDERS	NAME: Lucy Dufault CID #: 188525

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PCR-1420 (2/2025)

To be Initiated under Protocol by Nursing Staff

Admit to CCSU. Obtain MHRC records of previous treatments.

☑ Consult with Emergency Services Evaluator on the results of patient's CSSR-S Recent with SAFE-T protocol assessment to determine proper observation precaution level. Document nursing rationale on Nursing Assessment.

Milieu therapy and programming to include activity/educational groups, fresh air breaks and individual/group sessions, as indicated

Clinical Care Precautions:

☐ Unpredictable Behavior ☐ Falls ☐ Green alert/Violence ☐ Substance Withdrawal

☐ Sexual/SIB ☐ Age ☐ Seizures ☐ Medical: _____ ☑ Other: Safety

Observation Level Monitoring:

☑ **Close Observation every 15 min** for: ☐ CSSR-S **Low** Risk of Suicide

OR

☐ **Constant Observation** for ☐ CSSR-S **Moderate** Risk of Suicide

OR

☐ **Contact LIP** for any individual at CSSR-S **High** Risk of Suicide to consult and obtain order(s) for proper observation precautions.

Waived testing to include ✓ 12-panel UDS ✓ Urine HCG ___ Breath Alcohol Detection

Nurse initiating protocol D. Vrpe Date 11/28/25 Time 0100

Orders noted by **Nurse** D. Vrpe Date 11/28/25 Time 0100

LIP Signature [signature] Date 11/28/25 Time 1349

MHRC INPATIENT CCSU ADMISSION ORDERS	**NAME:** Lucy Dufault **CID #:** 188525

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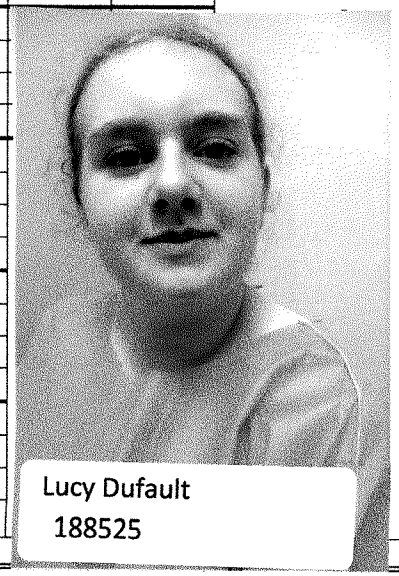
PCR-1419 (2/2025)

INITIALS	SIGNATURE	INITIALS	NATURE	INITIALS	SIGNATURE
		SV	A. Vigneau		

ORDER DATE	MEDICATION ORDER	CONSENT DATE	HOUR										



MENTAL HEALTH RESOURCE CENTER

MEDICATION ADMINISTRATION RECORD

DOB: 6/5/12

ALLERGIES: NKA/NKDA

NAME: Lucy Dufault

CID #: _ 188525

Chronological List/Current Medication Information

Include: ALL medications prescribed during the individual's stay. Indicate all date changes and medication deletions and additions.

Date	Medication	Dosage	Frequency	Date Discontinued	Staff Initials	At Discharge
						☐ Continue ☐ Discontinue
						☐ Continue ☐ Discontinue
						☐ Continue ☐ Discontinue
						☐ Continue ☐ Discontinue
						☐ Continue ☐ Discontinue
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						☐ Continue ☐ Discontinue
						☐ Continue ☐ Discontinue

No meds

LIP Signature _____ Date Reconciled 11/30/25

MENTAL HEALTH RESOURCE CENTER	NAME: Lucy Dufault
INPATIENT SUMMARY OF MEDICATIONS	**CID #:** 188525

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RBHS PCR-1485 (2/2013)

TEST DONE	RESULTS
URINE PREGNANCY	☑ Neg ☐ Pos ☐ N/A
Nurse's Signature: L. Vaughan	
Date / Time: 11/28/25 @ 2300	
COVID19 – ANTIGEN RAPID TEST	☐ Neg ☐ Pos
Nurse's Signature:	
Date / Time:	
MultiStix 10 SG URINALYSIS	
Positive Results (Specify):	
Nurse's Signature:	
Date / Time:	

TEST DONE		RESULTS
iScreen DRUG SCREEN SQUARE CUP 12:	*Test Strip Color*	***Negative Result = Normal***
Amphetamine (AMP)	*Light Blue*	☑ Neg ☐ Pos
Barbiturates (BAR)	*Royal Blue*	☑ Neg ☐ Pos
Buprenorphine (BUP)	*Pink*	☑ Neg ☐ Pos
Benzodiazepines (BZO)	*Green*	☑ Neg ☐ Pos
Cocaine (COC)	*Red*	☑ Neg ☐ Pos
Ecstasy (MDMA)	*Brown*	☑ Neg ☐ Pos
Methamphetamine (MET)	*Purple*	☑ Neg ☐ Pos
Morphine (MOP)	*Fuchsia*	☑ Neg ☐ Pos
Methadone (MTD)	*Orange*	☑ Neg ☐ Pos
Oxycodone (OXY)	*Dark Green*	☑ Neg ☐ Pos
PCP (PCP)	*Grey*	☑ Neg ☐ Pos
Marijuana (THC)	*Dark Blue*	☑ Neg ☐ Pos
Nurses' Signature		
Date / Time:		

☑ Urine cup provided to patient Signature: L. Vaughan Date/Time 11/28/25 @ 0400

☐ Urine cup provided to patient Signature: _____ Date/Time _____

COMMENTS: _____

11/28/25 0900

MENTAL HEALTH RESOURCE CENTER	**NAME:** Lucy Dufault
INPATIENT INHOUSE LABORATORY TESTS	**CID #:** 188525

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RBHS PCR-1300 (11/2024; 01/2015)

DATE: 12/1/25

Lucy Claire DuFault (Individual who received services) | 6/5/2012 (DOB) | 9778 (SSN – last 4 digits only)

I hereby authorize

Mental Health Resource Center South
P. O. Box 19249 (11820 Beach Blvd 32246)
Jacksonville, FL 32245-9249
(904) 642-9100 Fax (904) 493-4309

Mental Health Resource Center North
P. O. Box 19249 (3333 W 20th Street 32254)
Jacksonville, FL 32245-9249
(904) 695-9145 Fax (904) 493-4472

to ☐ Receive records from ■ Release records to ☐ Communicate verbally with

Dustin DuFault (Name/Organization)
815 Stanley Drive (Address)
Fernandina Beach, FL, 32034 (City, State, Zip)
410.982.9607 (Telephone and/or Fax Number)

I understand the information being disclosed references psychiatric and/or alcohol or substance abuse treatment. Consent is given to disclose the following: (check all that apply)

■ Discharge Summary ■ Psychiatric evaluation ■ BioPsychosocial Assessment
■ Progress Notes ■ Medication Record/Prescriptions ■ Laboratory Results (excluding HIV)
■ HIV Test Results ■ Sexually Transmitted Diseases ☐ Photograph(s)
■ Verbal Exchange of information ■ Other: Communication logs with parents if they exist

Reason for request: ■ Continuity of Care ☐ Other _____

I authorize the disclosure of information for:

☐ One time for specific dates _____ ■ 1 year from date of this authorization

- I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and do not need to sign this form in order to receive treatment, payment, or to enroll or be eligible for benefits.
- I acknowledge that I have had access to, read, and accept the Joint Notice of Privacy Practices. I give consent to this disclosure as described above.
- I understand that I have the right to revoke this authorization at any time in writing. I understand that revoking this authorization will not affect any actions already taken on it.
- I understand that I am entitled to receive a copy of this authorization upon request.
- Each disclosure requires an additional signed authorization. If not previously revoked, this consent will expire 90 days after the date of my signing this consent unless otherwise indicated.
- I hereby agree to hold the center harmless from any liability that may result directly or indirectly from the records released in accordance with this consent. I understand that any disclosure of the information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Dustin DuFault — Signature of Individual/Patient's Personal Representative
12/1/25 — Date
Father, Legal Custodian — Authority to act as representative (Relationship to pt)

Mary Rapp — Witness
12/1/25 — Date

Prohibition of Redisclosure: This information is being disclosed to you from records whose confidentiality is protected by state laws specifically Florida Statutes 394.4615, 455.667 and 394.45 and federal laws including HIPAA and 42 CFR Part 2. State Laws prohibit you from any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by State Regulations.

MENTAL HEALTH RESOURCE CENTER **CONSENT TO DISCLOSE INFORMATION**	**NAME:** _____ **CID#:** _____