

Treatment of Common Conditions		
General Principles		
These are some of the common first line medications. They are not arranged in any particular order. qD=qDaily, HS=at bedtime In patients who are sensitive to medication side effects, lower starting doses and slower titrations can be helpful.		
SSRI/SNRI medications can cause hyponatremia especially in elderly patients. Elderly patients generally require lower doses and careful dosing based on renal and hepatic dysfunction.		
SSRI can be increased qWeekly or more quickly if pt tolerates it. SNRIs should be discontinued slowly over weeks to prevent withdrawal. SSRI can be discontinued somewhat quicker, but can still result in Antidepressant Discontinuation Syndrome .		
Anxiety disorders require higher SSRI/SNRI dosing. Response takes longer to achieve. Benzodiazepines can be helpful in the short term.		
Common 1st Line medications for MDD		
SSRI (mostly hepatic clearance)	Starting Dose	Dose Range
Sertraline	25mg-50mg qD	50-200mg
Escitalopram (qt prolongation)	5-10mg qD	10-20mg
Fluoxetine	10mg-20mg qD	20-60mg
SNRI (renal+hepatic dosing)		
Duloxetine	30mg qD	30-60mg
Venlafaxine (Can be activating)	37.5mg qD	75 -225mg
Others		
Mirtazapine (↑ Appetite + Sleep)	7.5-15mg HS	15-45mg HS
Bupropion (NDRI) Activating	150mg qAM	150-300mg qAM
ADJUNCTIVE MEDICATION FOR DEPRESSION		
To be added on vs changing the primary medication when: 2 or more antidepressant have been tried, partial response (25-50%↓Sx) with the initial tx, other side effects that can be targeted by the adjunctive medication		
Drug	Starting dose	Dose range
Aripiprazole (activating)	1mg qAM	2-15mg qAM
Quetiapine (sedating)	12.5-25mg qD/HS	150-300mg qD/HS
Risperidone	0.5-1mg qD/HS	1-3mg daily/HS
Common 1st line medications for GAD		
Drug	Starting dose	Dose range
SNRI (renal + hepatic dosing)		
Duloxetine	30mg qD	30-60mg qD
Venlafaxine XR	37.5mg qD	75 -225mg qD
SSRI		
Sertraline	25mg-50mg qD	50-200mg qD
Escitalopram (qt prolongation)	5-10mg qD	10-20mg qD
Paroxetine (anticholinergic)	10mg qD	10-50mg qD
Gabapentinoids (renal dosing)		
Pregabalin (can ↑ sleep/sedation)	25-75mg BID	25mg - 300mg BID
Common 1st line medications for Panic Disorder		
require higher dosing for panic disorder, AIM HIGH Pts		
Drug	Starting dose	Dose range
Citalopram	10mg qDaily	10-40mg qD
Escitalopram	5mg qDaily	10-20mg qD
Fluoxetine	5-10mg qDaily	20-60mg qD
Paroxetine	10mg qDaily	20-60mg qD
Sertraline	25mg qDaily	50-200mg qD
Venlafaxine XR	37.5mg qdaily	75-225mg qD
Fluvoxamine	25-50mg daily	100-200mg qD

GLOSSARY: **Apraxia:** Inability perform skilled movement. **Abulia:** Lack of will/drive for action/speech/thought. **Anhedonia:** Inability to experience/anticipate future pleasure. **Asociality:** Lack of motivation for social interactions **Avolition:** Inability to initiate goal directed activity. **Alogia:** Poverty of speech and thought. **Aphasia:** Acquired d/o of language. **Agnosia:** Inability to rec objects **Catalepsy:** Muscular rigidity, fixity of posture **Cataplexy:** Sudden loss of motor tone.

PSYCHIATRIC SYNDROMES
NEUROLEPTIC MALIGNANT SYNDROME (NIMS)
Rare reaction to antipsychotic medication likely due to D2 blockade leading to impaired Ca2+ mobilization resulting in muscle rigidity, autonomic dysfunction, and sympathetic nervous system activation. dDx: Malignant catatonnia, Serotonin syndrome, ETOH /Bzd W/D, CNS infxn, DIMS. Presentation: Gradual onset vs serotonin syndrome. T>38C, muscle rigidity, confusion, agitation, tachycardia, tachypnea, hyper/hypotension, diaphoresis, sialorrhea, tremor, rhabdo, met acidosis. Tx: Stop offending agent , cooling, ICU/CTU level care, Dantrolene\benzos\amantadine\bromocriptine\levodopa med options. Labs: CBC, Lytes, CK, LDH, VBG, CRP, DIMS WORKUP!
SEROTONIN SYNDROME
Rare, lethal condition caused by initiation/dose ↑ of serotonergic med. Likely due to various mechanisms that increase qty/activity of serotonin through increased precursors, increased release of serotonin (MDMA), decreased metabolism (MAO inhibitors), reuptake inhibition, direct serotonin receptor agonism or other mechanisms Presentation: Acute onset confusion, agitation, coma, myoclonus, rigidity, tremors, shivering, hyperreflexia (lower-upper), ataxia, hyperthermia, nausea, diarrhea, mydriasis, tachycardia, hyper/hypotension, rhabdo. Tx: Stop offending agents, supportive care, likely ICU/CTU.
ANTICHOLINERGIC TOXIDROME
Mad as a hatter, hot as hell, red as a beet, dry as a bone, and blind as a bat. A delirium caused by anticholinergic drugs. Presentation: These patients can present with confusion, psychotic symptoms, dry skin, erythematous skin, fever, mydriasis, tachycardia, restlessness, and visual hallucinations. Treatment: General approach is stop the anticholinergic drugs, IV reversible cholinesterase inhibitors, benzos, and supportive care. CTU/ICU level care.
EXTRAPYRAMIDAL SYMPTOMS (EPS)
A group of conditions caused by excessive D2 blockade
ACUTE DYSTONIA
A neurologic hyperkinetic disorder characterized by repetitive/sustained muscular contractions. Most likely to occur in the first week of starting a D2 blocking drug or with a significant dose ↑. Can affect the head, neck, trunk, and limbs. Presentation: twisting, repetitive movements, and fixed postures. Most likely in head and neck. Can present with torticollis, trismus, tongue protrusion, jaw opening, blepharospasm, grimacing, opisthotonos. Treatment: IV anticholinergic drug such as benztropine 1-2mg IV/IM, Diphenhydramine 25-50mg IV/IM.
OCULOGYRIC CRISIS
A dystonic reaction that results in extreme upward deviation of the eyes. The eyes can also converge, deviate laterally, or downward. Treatment: IV anticholinergic drugs as above.
PSEUDOPARKINSONISM
Blockade of D2 receptors in the nigrostriatal dopamine pathway can mimic parkinsonism. Presentation: Can occur with acute or prolonged treatment resulting in masked faces, short shuffling gait, decreased arm swing, rigidity, bradykinesia, tremor, sialorrhea, etc. Treatment: Discontinue the higher potency antipsychotic and change to lower potency (less D2 antagonism). Parenteral anticholinergics useful.
TARDIVE DYSKINESIA
Occurs due to long term use of high potency antipsychotics, possibly due to ↑ dopaminergic transmission in the nigrostriatal pathway due to ↑ sensitivity to dopamine, ↑receptor count/sensitivity, striatal GABA hypofunction, and/or dopamine/cholinergic imbalance. Presentation: Peri-oral movements of the tongue lips and jaw are most common. Axial trunk twisting, torticollis, retrocollis and other forms of increased muscular contraction. Treatment: Do not stop the antipsychotic as this is a problem of ↑dopaminergic activity, therefore acute cessation of the agent could worsen symptoms. Anticholinergic drugs could worsen symptoms. Slow ↓ of the offending agent, and replacement with a low potency antipsychotic is preferred. TD is usually permanent, but can have some improvement with clozapine. Other agents that deplete monoamines such as tetrabenazine can be helpful. Benzodiazepines can help.
AKATHISIA
Inability to sit still/psychomotor restlessness. Intense unease/inner restlessness due to antipsychotic treatment, common with aripiprazole. Can occur with many drugs. Treatment: Reduce/stop offending agent, propranolol 20-40mg PO mg TID, benzodiazepines.

PSYCHIATRY INFORMATION CARD (PIC)
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GENERAL INFORMATION
Welcome to psychiatry at the UoF. As a clerkship student, you will learn how to diagnose, treat, and manage patients suffering from a wide range of medical and psychiatric illnesses.
EXPECTATIONS
PROFESSIONALISM: Be on time. Ask ahead to find out start times/expectations are for each component of your rotation Inpatients: Rounds start 9am 1/2nd floor Dube. OutPts: Varies ILLNESS/LEAVE: Communicate with the PGME/Clerkship coordinator/preceptors when you are ill/away ON CALL: Weekday call starts at 4:30pm. Handover occurs virtually, see rotation info for link. Weekend call starts at 8am with handover via virtual platform.
COMMON NOMENCLATURE USED IN PSYCHIATRY
CERTIFICATION: Involuntary admission to mental health facility under 1-2 medical certificates (FORM G). 1 Certificate = 72 hours, 2 Certs = 21 days from midnight of the 1st certification.
FORM G: Completed by physicians with admitting privileges to a mental health facility (usually a psychiatrist). One form may be completed by a resident in psychiatry. "Involuntary admission"
FORM G Timeline: Second form G must be completed by the end of the third day following the issuance of the first form G.
FORM A: Completed by physician (or prescribed health prof) if they feel the person should be examined by psychiatry for potential admission. A person may be examined at their residence, a doctor's office or, more usually, at a hospital ER by an ER doc/Family doc. Person must be taken to hospital within 7 days of initial examination (when doctor completed out form A). "mandated psychiatric assessment"
SECTION 20: A peace officer may apprehend a person without a warrant and convey that person as soon as is reasonably practicable to a place where they can be examined by a physician, if the peace officer has reasonable grounds to believe that the person is a suffering from a mental disorder AND b , likely to cause harm to himself or herself or to others or to suffer substantial mental/physical deterioration if not detained in a mental health center. Physician must examine within 24 hours or the order expires.
FORM H: H3.H4: 2 forms that your attendings' may complete (two psychiatrists). These forms allow for the issuance of a "Community Treatment Order" aka CTO . A pt under a CTO can be involuntarily taken to hospital for assessment with the issuance of a FORM H7 at the discretion of their primary community psychiatrist. CTO mandates treatment of some sort.
FORM C: Pt refuses voluntary exam. Family/person submits a form B on basis of sworn evidence to a judge. Judge can issue a form C/warrant which allows a peace officer to take the pt to be examined by a physician with admitting privileges to a mental health center.
Mental Health Approved Home: A home with not more than five people, where the operator + building have been licensed to provide care for a person with a mental illness.
LAJ: Long acting injectable medication
CMHN: Community Mental Health Nurse
EPS: Extrapyrmidal Symptoms. TD: Tardive Dyskinesia

PSYCHIATRIC HISTORY
ID: Name, gender, age, occupation/income sources/social services, living arrangements, marital status/past marriage/divorce, # children (age and custody), highest level of education, pronoun if applicable
Community contacts: Psychiatrist, Family Doctor, CMHN, therapist, CTO STATUS
Source of referral/mechanism: ER Doc? (who), H7? Section 20?
Chief Complaint: Helpful to use patients own words in quotes
HPI: Onset of symptoms, progression, number of episodes, TIMELINE!!
COMMON CONDITIONS TO ALWAYS SCREEN FOR
Depression
2 wks persistently low mood OR anhedonia. Total of 5 symptoms of: low mood, anhedonia, +/- sleep, +/- appetite or wt gain/loss (5% Δ), psychomotor agitation/retardation, fatigue, worthlessness/inappropriate guilt, ↓concentration/++indecisiveness, ++ thoughts of death/suicide/any suicide attempt
Mania
7 days of persistently elevated/expansive/irritable mood and increased goal directed energy/activity. 3 SX of grandiosity/ ↑self esteem, ↓sleep, pressured speech, racing thoughts/flight of ideas, distractibility, ↑goal directed activity (work, school, sex) or psychomotor agitation, +++ involvement in activities with painful consequences. (4 SX if irritable mood).
Psychosis
Auditory , visual, tactile, gustatory, olfactory hallucinations, paranoia, delusions, thought insertion/withdrawal, ideas of reference, thought broadcasting, mind reading, abnormal abilities, religious ideation.
Generalized Anxiety
6 MO excessive worry in multiple domains of life (work, relationships, school, finances, etc) with difficulty controlling worry AND 3 SX: restless, easily fatigued, ↓conc/mind going blank, irritability, muscle tension, sleep disturbance (initiation, maintenance, restfulness)
Panic Disorder
Recurrent AND unexpected panic attacks defined by abrupt surge of intense fear/discomfort reaching peak within minutes with 4 sx: palpitations/++HR, diaphoresis, shaking, SOB, choking, CP/discomfort, nausea/GI sx, dizzy/presyncope, chills/heat, paresthesia's, derealization/depersonalization (feeling detached from ones body/self), fear of going crazy, fear of death
 OCD
The presence of obsessions, compulsions or both. OBSESSIONS: Recurrent + persistent thoughts, images, urges that are intrusive/unwanted = anxiety/distress AND attempts to ignore/suppress obsession/anxiety with thought/action or compulsion. COMPULSIONS: Repetitive behaviour or mental act pt is driven to perform rigidly to reduce anxiety/distress. e.g. hand washing, organizing, checking locks/stove, praying, repeating words/phrases, etc. Sx consume 1hr+/day
SUICIDE/HOMICIDE
Suicidality: thoughts (onset, intensity, frequency, distress), plans? Current suicidal actions? DID they take any suicidal action?! Overdose/self-harm. Homicidality: Thoughts, plans, ideas to harm others? DUTY TO WARN/Protect, firearms?
PAST PSYCHIATRIC HISTORY - Historical diagnoses, past suicide attempts, past psychiatrists, previous admissions, past certifications, previous ECT/TMS/KETAMINE, previous therapists/therapy (CBT/IPT/PD)
PAST MEDICAL HISTORY - All past medical history including: surgeries, DM, HTN, dyslipidemia, chronic kidney disease, ICU admissions, head injury, sz, cancer
MEDS - Current/past psychiatric medications and doses. Why were they changed?
ALLERGIES - Med allergies and reaction severity, EpiPen?
FAMILY HISTORY: Psychiatric diseases, suicide!!! , medical illness, addictions
SUBSTANCE USE Hx\FORENSIC\GAMBLING - Drug - AMOUNT, 1st use?, frequency, route (IV, insufflation, smoked, vaporized, oral). Past addictions treatment (rehab or detox stays). Nicotine, alcohol, psychedelics, cocaine, meth, cannabis, THC\concentrates. Include criminal charges/incarceration/gambling .
SOCIAL - Prenatal Hx\gestation time, developmental milestones, location of birth, location of childhood. School , academic achievement, bullying. Experience w/parents at different stages of development, parental occupation, physical/emotional/sexual abuse . Sexual/gender history

CONSULT STRUCTURE
1.HISTORY
2.MENTAL STATUS EXAM - ASEPTIC
A - APPERANCE
Race, gender, appear stated age?, cleanliness (well kempt, unkempt, disheveled), hair, clothes, malodorous, Behavior: agitation, cooperation, Eye contact Psychomotor agitation/retardation Gait (brisk, slow, ataxic, shuffling, etc)/Abnormal movements (tics, lip smacking, grimacing)
S - SPEECH
Rate of speech: Pressured, increased response latency, slowed Rhythm/Prosody : normal, stuttering, pitch/intonation Volume of speech, Articulation: accent, slurring, dysarthria
E-EMOTION
Mood: elevated, low, normal/good Affect: what you observe (flat, restricted, euphoric, euthymic)? Is their affect congruent or incongruent with their stated mood? Is their affect appropriate for the situation/questions/conversation? Is there excessive lability or a lack of affective variation?
P-PERCEPTION
Are they responding to unseen stimuli? Evidence that they are hallucinating/psychotic? Auditory, visual, tactile, olfactory hallucinations
T-THOUGHT PROCESS
Linear: logical progression of thought without deviation from topic Circumstantial: Excessive/unnecessary detail provided in response with eventual return to the original inquiry Tangential: significant deviation from the topic discussed/asked with no return to topic and/or no response to original inquiry Loosening Associations: Unlike tangentiality, the ideas lack any reasonable connection Flight of ideas: Rapid shift in topics discussed Thought blocking: Sudden termination of speech for no apparent reason/explanation Perseveration: Repetition of phrase, words, or sentence
T -THOUGHT CONTENT
Poverty of thought: overall reduction of thoughts Overabundance of thought: Increased quantity of thoughts Delusions, obsessions, suicidal thoughts, homicidal thoughts
I-INSIGHT
Full/intact > partial > limited > absent - <i>Does the pt know they have a mental illness? How much understanding do they have? Do they feel they warrant hospitalization or treatment?</i>
C-COGNITION
Can be formally assessed using MMSE, Mini mental, MOCA or informal impression of cognition: "No obvious gross cognitive deficits". Comment on LOC/GCS/Orientation
3.DIFFERENTIAL DIAGNOSIS
List from most to least likely (DSM 5 Dx). Suicidal ideation/attempt is not a diagnosis. Historical diagnoses can be listed here as "historical diagnosis of:" If a Dx is of particular interest and requires further inquiry, a "rule out:" specifier can be added with explanation
4.IMPRESSION/FORMULATION
Imp/formulation can be written as a case summary with a biopsychosocial approach. <i>The biopsychosocial factors can be categorized into predisposing, precipitating, perpetuating, and protective factors that led to the development of the current presentation. Some factors can be included in multiple areas.</i>
Biological factors Age, FHx, med compliance, OPT F/U, duration of illness, substance use, med illness
Psychological factors Attachment style, personality disorders, temperament, trauma, childhood, bullying, factors affecting self esteem, gender identity
Social factors Relationships (loss or support), employment, education, immigration
PLAN
The plan can be structured using the "safety, biopsychosocial framework"
Safety: Discharge vs Admission. Voluntary vs involuntary. Safety can include, certification, nursing observation, ICR, restraints, vitals, neurovitals etc.
Bio: Medications, neurostim(ECT/TMS). BW (CBC, lytes, cr/urea, LE/LFTs,TSH, B12) Drug levels (lithium, epival, clozapine, etc). Lipids, HgbA1C. Prolactin if on D2 Antagonists, PREG TEST. Urinalysis/Utox Consider HIV, HEP C, Syphilis RPR, Chlamydia/Gonorrhea. Head imaging if applicable. Consider ECG.
Psycho: CBT, IPT, DBT, psychodynamic, group therapy, etc). Cognitive testing?
Social: Finances, housing, family interventions, educational supports, etc

ADMISSION PROCESS
1. Print Consult Note x2
2. Fill out fax cover sheet (include consulting + outpatient psychiatrist + Family Doctor). Check off adult department of psychiatry or child
3. Put consult note w/cover sheet in fax bin located behind psych nursing desk.
4. Call bed line and admit patient (8004)
5. Print admission order set -> FORMS ON DEMAND -> SEARCH PATIENT -> INPUT PT INFO -> ALL FORMS-> PK_Dube_ER_ADULT\CHILD_INPATIENT_ADMISSION
COMMON MEDICATIONS
ANTIPSYCHOTICS
Acutely agitated patients can be treated with any antipsychotic, however olanzapine or haloperidol are preferred agents at RUH for acute treatment.
OLANZAPINE 2.5-10mg PO/IM BID PRN (MAX 20mg/24HR) <i>QT prolongation, cannot give IM preparation within 2 hours of parenteral benzo</i>
HALOPERIDOL 2-5mg PO/IM QID PRN. *IV dosing ↑ risk of arrhythmia/QTC↑ <i>Risk of acute dystonia/eps, can give w/bzd e.g. 5mg Haldol/2mg Ativan PO/IM</i>
RISPERIDONE 0.5-1mg PO qD/BID, ↑ 1-2mg/d q2-5d. Target range 2-6mg/day. <i>Risk of dystonia/eps, prolactinemia, full effect from dose Δ > 1 week.</i>
QUETIAPINE IR Initial: 25mg BID, ↑ 50mg/d q2-5d OR 300mg XR daily, ↑ q2-5d 100-300mg/d. Target 400-800mg/d for IR/XR in schizophrenia
ARIPIPRAZOLE: Initial 2-5mg qDaily. ↑ 5mg/d q1-3 weeks. Max 15-30mg/d. Risk of akathisia
ANTICHOLINERGICS
BENZTROPINE: 1-2mg IM/IV TID for acute dystonia <i>IV route preferred for acute dystonic crisis, transition to oral after resolution, taper slowly</i>
BENZODIAZEPINES Avoid in elderly, risk of delirium, ↑ risk resp dep w/OPIOIDS
LORAZEPAM: 0.5-2mg PO/IM/IV QID PRN: Renal excretion
CLONAZEPAM: 0.25-0.5mg PO BID: long acting, typically scheduled not prn
DIAZEPAM: Initial: 5-10mg PO/IV PRN. Hepatic metabolism, poor IM absorption, ++ active metabolites
MOOD STABILIZERS (ACUTE MANIA)
Always draw trough blood levels after start or dose change
LITHIUM: Initial 600mg-900mg DIV BID/TID: lower for geri. (Check AM Level 5 days after dose Δ). Target level 0.8-1.2, 0.4-0.8 geri, ↑ 300-600mg q5d
VALPROATE: Initial 250-500mg PO BID. ↑ 250-500/day q3-4d <i>Target level 350-875, lower for geri. (AM trough 3-4 days after dose Δ)</i>
ANALGESICS
ACETAMINOPHEN 500-1000mg TID PRN max 3g to 4g/24hr for adults <i>Peds 10-15mg/kg/dose, max <75/mg/kg/day & <3000mg/day. Adults: max 2g/day if liver dysfunction. Avoid if alcoholic hepatitis or actively drinking.</i>
IBUPROFEN 200-400mg QID PRN max 3200mg/24h <i>Avoid if on lithium, AKI, CKD, CVD/MI hx. 10mg/kg dose peds MAX 40/mg/kg/day or 2400mg whichever is lower.</i>
NAPROXEN 250-500mg BID PRN PO <i>Avoid if on lithium, AKI, CKD, CVD/MI hx, age>65</i>
ANTIEMETICS
DIMENHYDRINATE 25-50mg PO/IM/IV QID PRN <i>Avoid in elderly, delirium, restless legs</i>
ONDANSETRON 4-8mg PO/IV Q8-12H <i>QT prolongation, constipation risk</i>
METOCLOPRAMIDE 5-10mg PO/IV Q6H PRN <i>QT prolongation, EPS/DYSTONIA (use with caution if other D2 antagonists), TD</i>
ANTACIDS
RANITIDINE 150mg PO qD/BID PRN
ALMAGEL 10-20ml PO QID PRN
NRT-See preprinted order
DISCLAIMER: The medication doses/treatments listed here are a guide only. Please consult the relevant updated guidelines and product monographs for correct/updated dosing. Pharmacy can be consulted to ensure safety.