Worksheet packet

A diagnosis in the record doesn't match what's in the room now

Supervisee training · Orchard Human Services, Inc.

These six worksheets accompany the six stages of the training module. Complete each one after reading its stage, before moving to the next. Bring the marked items to individual supervision.

What is in this packet

Worksheet	Title	Complete after
1	Syndrome or cause	Stage 1
2	Chronology mapping	Stage 2 · bring to Group A
3	Following the thread	Stage 3
4	The history structure	Stage 4 · bring to Group B
5	Prediction log	Stage 5 · four weeks
6	Consultation summary	Stage 6 · bring to Group C

> Scope reminder. Nothing in this packet asks you to make a diagnosis. Interns do not diagnose, and Associate Professional Counselors in Georgia do not diagnose independently. Every worksheet here builds a clinical picture and brings it to supervision, where the diagnostic conclusion is made.
>
> All vignettes are fictional and composite. Do not enter identifiable client information on any worksheet in this packet; use initials or a case code.

Worksheet 1 · Syndrome or cause

Complete after Stage 1 · about 20 minutes

Supervisee	Date

Instructions

Each statement below either describes what was observed, or claims an explanation for it. Mark each one S (describes the syndrome) or C (claims a cause). For every statement you mark C, write what evidence would be needed to support that claim.

Some are harder than they look. Statements that sound clinical and confident are often the ones making an unsupported causal claim.

Statements

S / C	Statement	If C — evidence needed
	1. The client reported sleeping about two hours a night for six days.	
	2. The client's mania was triggered by the divorce.	
	3. Speech was rapid and difficult to interrupt throughout the session.	
	4. She has bipolar disorder, which is why she overspent.	
	5. Collateral from the client's sister describes three days of increasing agitation.	
	6. The episode was clearly medication-induced.	
	7. Prednisone was started nine days before the behavioral change.	
	8. His paranoia is part of his bipolar illness.	
	9. The client denied feeling tired despite minimal sleep.	
	10. The UTI caused the confusion.	
	11. Urine culture was positive; no urinary or systemic symptoms were documented.	
	12. The client is manic.	
	13. Orientation to place fluctuated between the morning and afternoon assessments.	
	14. This presentation is trauma, not bipolar.	
	15. The client stopped taking clonazepam four days before admission.	

S / C	Statement	If C — evidence needed
	16. Improvement on olanzapine confirms the diagnosis.	
	17. Functioning returned to the client's pre-episode baseline within three weeks.	
	18. The antidepressant unmasked an underlying bipolar disorder.	
	19. The client described the sleeplessness as distressing and unwanted.	
	20. Her symptoms are just her personality.	

Bring to supervision

The two statements you were least certain about, and why:

> Check your reasoning: a statement can be entirely accurate and still be a cause-claim. The question is not whether you believe it, but whether the statement asserts why something happened.

Worksheet 2 · Chronology mapping

Complete after Stage 2 · about 45 minutes · bring to Group Session A

Supervisee	Date

Instructions

For each vignette: build the timeline, establish the direction of the sleep arrow, and mark what you would need to know that the vignette does not tell you. Then name which explanations remain open.

You are not being asked to reach a diagnosis. You are being asked to establish sequence.

Vignette A

R.M., 34, referred after a three-day inpatient stay

Presented to the emergency department agitated, speaking rapidly, convinced colleagues were monitoring her email. Discharged with a diagnosis of bipolar I disorder, single manic episode.

She had been prescribed clonazepam for two years for panic disorder. Her prescriber retired in March; she was unable to get a refill and her last dose was approximately five days before presentation.

Her partner reports she was “normal, maybe a little wound up” until roughly two days after the last dose, then stopped sleeping, became irritable, and by day four was pacing at night and “talking in circles.”

She describes the sleeplessness as “the worst part — I was desperate to sleep and couldn’t.”

Discharge summary notes “reduced need for sleep” and “no prior psychiatric history.” Toxicology was negative. No collateral was obtained during admission.

Timeline

Date / day	What happened	Source	Confirmed or reported?

The sleep arrow

Which came first — activation, or sleep loss? What in the vignette establishes it, and what only suggests it?

What is missing

Explanations still open

Vignette B

> **T.W., 71, referred by his daughter three months after hospitalization**
>
> Underwent hip replacement in January. On the second post-operative day he became agitated, pulled at his IV line, and told staff that the nurses were replacing his medications with poison.
>
> Psychiatry was consulted; he was started on an antipsychotic and discharged with “bipolar disorder with psychotic features, late onset.”
>
> Nursing notes record that he was oriented and conversational each morning and confused by evening. He had a fever of 100.9°F on the second day. He had not previously received any psychiatric diagnosis in 71 years.
>
> His daughter reports he was fully himself within about ten days of going home, and has remained so for three months. He is still taking the antipsychotic.
>
> He now presents for counseling because, in his words, “they say I have a mental illness and I don’t know what to do with that.”

Timeline

Date / day	What happened	Source	Confirmed or reported?

Which delirium features are present, and which are absent from the record?

What is missing

Explanations still open

Vignette C

> **J.A., 26, self-referred, carrying a bipolar II diagnosis from two years ago**
>
> Two years ago, six weeks after starting sertraline for depression, he had a period of about ten days in which he slept three to four hours nightly, felt “better than I have ever felt,” started three businesses, and spent roughly $9,000. He describes not wanting or needing more sleep during that period.
>
> Sertraline was stopped. The elevated period continued for a further three weeks, with the same reduced need for sleep and clear functional change, before resolving.
>
> He has had two subsequent depressive episodes and one four-day period last spring of reduced sleep, elevated mood and increased activity, with no medication change and no identifiable trigger.
>
> His mother had “nerves” and was hospitalized twice in her thirties; records are not available.
>
> He tells you he has read that bipolar is overdiagnosed and wants your opinion on whether his diagnosis is real.

Timeline

Date / day	What happened	Source	Confirmed or reported?

The sleep arrow

What does the persistence after sertraline was stopped tell you? What does it not tell you?

He asks for your opinion. What do you say, and why?

> Vignette C is included deliberately. Not every mismatch resolves toward a non-bipolar explanation, and a

clinician who cannot recognise a well-supported bipolar picture is as unsafe as one who accepts every diagnosis uncritically. Bring your answer to the last question to Group Session A.

Worksheet 3 · Following the thread

Complete after Stage 3 · about 30 minutes

Supervisee	Date

Instructions

Read the five notes in sequence. Then answer the questions beneath them. These are abbreviated for the exercise; real notes carry more detail, but the pattern is the one you will actually encounter.

> **Note 1 — ED admission, 03/14**
>
> Pt brought by police, agitated, disorganized speech, reports not sleeping. Hx unavailable. Started on antipsychotic for safety. Impression: acute manic vs psychotic episode, etiology unclear. Labs pending. Collateral to be obtained.

> **Note 2 — Inpatient day 2, 03/16**
>
> Calmer on medication, sleeping. Still guarded. Impression: bipolar I disorder, current episode manic with psychotic features. Labs reviewed — unremarkable except mild leukocytosis. Collateral not yet obtained. Discharge planning initiated.

> **Note 3 — Discharge summary, 03/18**
>
> Dx: Bipolar I disorder, current episode manic with psychotic features. Improved on medication. Follow up outpatient in 2 weeks. Recommend continued mood stabilizer and antipsychotic.

> **Note 4 — Outpatient psychiatry intake, 04/02**
>
> New pt, hx of bipolar I per recent hospitalization. Currently stable, denies symptoms. Continue current regimen. Discussed importance of medication adherence given diagnosis.

> **Note 5 — Primary care annual, 09/21**
>
> PMH significant for bipolar I disorder. Reports fatigue, weight gain 24 lbs since spring, feeling “flat.” Likely related to psychiatric illness and medication. Continue current management, follow with psychiatry.

Questions

1. At which note did new evidence stop being added and repetition take over? What is the specific sentence that marks the shift?

2. Name the mechanism at work in Note 4, and the one at work in Note 5.

3. What could the clinician writing Note 2 reasonably have done differently, given what was in front of them?

4. What could they not reasonably have done, given the setting and the information available?

5. Note 5 attributes fatigue and weight gain to psychiatric illness and medication. What else could explain them, and what would you want checked?

> Question 4 matters as much as question 3. If your answers describe a clinician who should simply have been more careful, reread Stage 3. The point of this worksheet is to see the structure, not to assign blame — and a supervisee who arrives at a placement believing hospital clinicians are careless will not be able to work with them.

Worksheet 4 · The history structure

Complete after Stage 4 · about 45 minutes · use on a live case, bring to Group Session B

Supervisee	Date

Instructions

This is a reusable framework, not a one-time exercise. Use it on a current case this week. Where you do not have the information, write what you do not have and where it would come from — the gaps are as informative as the content.

Use initials or a case code. Do not enter identifiable information.

Case code

The structure

Domain	What you are establishing	What you have / what is missing
Episode chronology	Dated sequence of the presenting episode and any prior ones. What happened, in what order.	
The sleep arrow	Decreased need for sleep, or distressing inability to sleep? Which came first — activation or sleep loss?	
Duration and pattern	How long did the disturbance last? Present most of the day, nearly every day? Or shifting within a day?	
Functional baseline	What is this person like when well? Work, school, relationships, self-care. Source of that picture.	
Current function	Measured against that baseline, not against a general standard.	
Prior episodes	Manic, hypomanic, depressive, postpartum, psychotic, mixed. Complete return to baseline between them?	
Family history	Psychiatric history in first-degree relatives, including undiagnosed or historical descriptions.	
Trauma and triggers	Trauma history and the chronology of	

Domain	What you are establishing	What you have / what is missing
	triggers, reminders, anniversaries, and interpersonal context.	
Medication timeline	Every start, stop, missed dose, dose change, injection, anaesthesia exposure. What was taken, not what was prescribed.	
Substance and withdrawal	Including prescribed medications the client may not think of as substances.	
Medical and neurological	Recent illness, infection, surgery, injury, seizure, stroke. Current medical conditions and providers.	
Cognition	Attention, orientation, fluctuation. Any period of confusion, disorientation, or lost time.	
Collateral	Who knew this person before the episode? What do they describe? Consent status for contacting them.	
Course after the precipitant	What happened once any identified cause was corrected or resolved?	
The record itself	What does the prior documentation establish, and what does it assert without establishing?	

Which kind of mismatch is this?

Mark one, and say what led you there.

- The diagnosis was accurate and the client is well-managed and between episodes
- The diagnosis was accurate and current medication is doing the work
- A different condition shares surface features with what was diagnosed
- The original conclusion was reached under conditions that could not support it, or the record is too thin to verify

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Bring to supervision

The single most consequential thing you do not know about this case, and how you would find it out:

Worksheet 5 · Prediction log

Complete after Stage 5 · one live case, four weeks

Supervisee	Date

Instructions

Write your formulation. Then write what you expect to see if it is right, and what would tell you it is wrong. Then check, weekly, and record what actually happened.

Start with one prediction per week. If this feels paralysing rather than clarifying, say so in supervision — that is useful information, not a failure.

Case code

Working formulation

If this formulation is right, I expect to see

What would tell me I am wrong

Be specific. "The client gets worse" is not a disconfirming observation — nearly every formulation survives it.

Weekly log

Week	What I predicted	What actually happened	Held / revised
1			

Week	What I predicted	What actually happened	Held / revised
2			
3			
4			

At four weeks

Did anything fail? What did you change as a result?

> Bring the entries where the prediction failed first. Those are the valuable ones. A log in which every prediction held is more likely to mean the predictions were too safe than that the formulation was perfect.

Worksheet 6 · Consultation summary

Complete after Stage 6 · about 40 minutes · bring to Group Session C

Supervisee	Date

> Before you begin: read the practice's Consent & Confidentiality policy. Consent status, and what the client knows is being sent, are settled before anything is drafted. For clients who are minors this involves the guardian and the young person's assent — check the policy rather than assuming.
>
> This worksheet is a drafting exercise. Nothing drafted here is sent without supervisory review.

Part one — draft

Using Vignette A or B from Worksheet 2, draft a consultation summary. Report observation. Leave inference to the reader.

Episode chronology, dated

Sleep: decreased need, or inability? Which came first?

Functional baseline and current function

Collateral obtained, and from whom

Course after the identified precipitant resolved

What has been tried, and what changed

Closing question

One real question that invites the prescriber's reasoning. Not a request for a verdict.

Part two — peer review

Swap with a peer. Mark every sentence in their draft that states a conclusion rather than an observation, then complete the checklist.

Check	Yes	No
Every clinical statement is something that was observed or reported, with its source named		
No sentence asserts what the prior episode was caused by		
No sentence characterises the original assessment or the clinician who made it		
The sleep direction is stated as evidence, not as a conclusion		
The functional baseline is sourced, not assumed		
The closing question could be answered more than one way		
Nothing in the draft would read as a request to change or stop medication		
The client knows what is being sent		
The timing is appropriate — the picture is currently stable		

Part three

The prescriber replies that the diagnosis stands, and gives a reason you had not considered. What is your next step with the client, and what changes in your treatment plan?

> If your draft required heavy softening to sound respectful, the problem is usually in the content rather than the tone. Rewrite it as observation and check whether the softening is still needed.