0023

243-5816 REQUEST FOR PHYSICAL EXAMINATION

NOTE: Shaded Items not for rating board completion.

1. NAME	2. FILE NUMBER	3. YR. OF BIRTH	4. SEX	5. PERIOD OF SERVICE EOD	5. PERIOD OF SERVICE RAD	6. CONTROL DATE
	[redacted]	47	M	8/69	8/73	

7A. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN
George P. OJALA.

8. REGIONAL OFFICE
VARO Seattle

7B. ADDRESS OF VETERAN (Street, City, State and ZIP Code)
15458-42ND AV SO
Seattle, Wa 98188

9. RECEIVING STATION ONLY

A. DATE OF REQUEST	B. DATE SCHED. OR AUTH.	C. DATE COMPLETED
OCT 4 1977		NOV. 21 1977

10. PRIORITY OF EXAMINATION (Check appropriate boxes)

- ☐ TERMINAL
- ☐ ORIGINAL (S.C.)
- ☒ INCREASE OR REOPENED
- ☐ REVIEW
- ☐ POW
- ☐ ORIGINAL (N.S.C.)
- ☐ OTHER (Specify)

D. PLACE OF EXAMINATION
- ☒ CLINIC
- ☐ FEE
- ☐ OTHER STATION

E. NAME OF FEE EXAMINER OR OTHER STATION
OPC, Seattle

11. PLEASE CONDUCT:

- ☐ A. A COMPLETE GENERAL MEDICAL EXAMINATION WITH SPECIAL ATTENTION TO DISABILITIES LISTED IN ITEM 13.
- ☒ B. EXAMINATION LIMITED TO DISABILITIES CHECKED IN ITEM 12 AND/OR LISTED IN ITEM 13.

12. SERVICE-CONNECTED DISABILITIES

DIAG. CODE	(X)	CHECK DISABILITIES FOR WHICH EXAMINATION IS NEEDED
		Vein Anxiety Reaction

11-2-77 10 AM 9:00

13. OTHER DISABILITIES (List diagnoses or symptoms for which examination is requested.)

14. REQUIRE MEDICAL DETERMINATION OF
- ☐ COMPETENCY
- ☐ NEED FOR AID AND ATTENDANCE OR HOUSEBOUND (Provide VA Form 21-2connd)

15. SPECIALIST EXAMINATIONS
- ☒ (Check box if required, specify and give reasons for requests in Item 16, REMARKS)

16. REMARKS
NP- Make C File Available To Examiner — Note Report From DR G. Glenn Clemmitt Dated 9-22-77

17. CLAIMANT REPRESENTED BY
- ☐ AL
- ☒ [illegible]
- ☐ DAV
- ☐ ANC
- ☐ AMVETS
- ☐ OTHER (Specify)

18. DATE	19. SIGNATURE OF AUTHORIZING OFFICIAL	20. SYMBOL NUMBER AND RO NO.
10/3/77	SE Wheeler	3

VA Form 21-2507

11/07/77 dm

Special psychiatric examination.

Ojala, George P. 11/02/77

0023

This is a 30 year old veteran, whom I examined in January of 1977, and diagnosed as suffering from a chronic anxiety reaction. Since that time, there has been a psychiatric evaluation and a report by Dr. Glenn Clements, who documents a diagnosis of schizophrenia, latent type. I have reviewed that report, and essentially agree with it. This morning Mr. Ojala states that he is not good. His condition remains much the same as it was in January. He says he never really feels healthy. He either has the flue, or other body aches. He also complains of having a felt a good deal of depression, and several times has considered suicide. He has grave financial concerns, and says he does not have enough money to live on. He is in therapy with Dr. Clements, whom he sees twice a month, and he does take Haldol. He complains that his thoughts are pretty disjointed. He recently remembered an explosion in Viet Nam, in which he was blasted against a wall, and he got his back pain again.

He lives with a brother, but spends a week a month with his parents. His daily routine has very little structure. He does attend group therapy weekly, which he finds quite supportive. He feels unable to work, and uncoordinated muscularly. He is on public assistance.

Mental status examination: He is a rather good looking young man. He was alert, well oriented and cooperative. He is anxious. He, this time, admits to hearing voices. He also has ideas of reference. When walking down the street, he fears people will attack him. He has some difficulty with abstractions.

Conclusions: I will change my diagnostic impression from that of an anxiety reaction, to schizophrenic reaction, latent type. This does not represent a change in his basic condition, but only a change in diagnosis. He is competent.

DIAGNOSIS: Schizophrenic reaction, latent type.

C. Richard Johnson, M. D.

APPROVED

F. K. Curtis M.D.

REPORT OF ACTION TAKEN

TO:

DATE: December 7, 1979

VETERAN: OJALA, George P.
C or XC: [redacted]

The following action has been taken on a claim/inquiry submitted by you:

HR, Par. 29 eval .

The hospital did not certify that the vet was admitted and treated for his SC psychosis for a 21 day period. The evidence of record shows that he had unpaid bills and is in a financial dilemma. It is the opinion of this Board that the vet presented for admission and exaggerated his symptoms remaining hospitalized just long enough to create possible eligibility for a Par. 29 eval. The care provided this vet in the hospital could have been as easily provided on an OP basis. The HR is negative for psychosis. Entitlement is found not to exist for a 100% eva. under Par. 29.

Rating of 1/9/79 and 6/7/79 are confirmed.

V.F.W. Service Division
Dept. of Washington

The above statement was received from the VA Ajudication as to why I would not get an increase in disability benifets. The VFW in Seattle was representing me at that time.

Approved exception to SF 502

PATIENT'S NAME	AGE	SEX	RACE	SOCIAL SECURITY NO.	CLAIM NO.	NAME OF HOSPITAL
OJALA, George P.	33	M	Cau		c- SSN	VAMC, American Lake, WA

DIAGNOSES *(List in numerical order: first, the established clinical diagnosis responsible for the major part of patient's stay; then, in order of clinical importance, other established diagnoses for which treatment was given. Place letter "N" before diagnosis (es) responsible for Nursing Care placement. List Problem numbers after diagnosis.)*

ICDA CODE

1. Neurasthenic neurosis. 300.5
2. Immature personality. X Not service connected 301.89
3. Schizophrenia, paranoid type, by history; in good remission. 295.69
4. Drug dependence - psycho-stimulants (amphetamines).
5. History of drug dependence - opium and derivatives (hallucinogens).
6. ~~Post traumatic stress syndrome.~~

PERTINENT CLINICAL DIAGNOSES NOTED BUT NOT TREATED *(Include autopsy diagnoses not listed as clinical above)*

OPERATIONS/PROCEDURES PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION	DATE

MAY 30 1980

SUMMARY *(Brief statement should include, if applicable, history; pertinent physical findings; course in hospital; treatment given; condition at release; care patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at release; competency opinion when required; rehabilitation potential; and name of Nursing Home, if known.)*

The veteran was admitted to the American Lake VAMC with complaint of "extreme exhaustion," experiencing "everything as a stress" feeling, "headache all the time, uptight in the body." He feels distressed about the change in his disability status (75% to 40%) which was "unjust."

The history revealed that his present difficulties began, by his description, during the time when he was in Viet nam, as the result "of stress and exposure to stress suffered while in Viet nam." He felt that "sudden call of duty" to Viet nam was "unexpected stress after a long, pleasant experience in South America." He described in great details some of the "frightening experiences" while in Viet nam, adding later that "most of the living there was frightening." He felt that he was "beat ... , got himself hooked on any available drugs, living in constant fear of being attacked."

He was a part of the flight crew "concerned with saving the lives." He described his job as being extremely "dangerous; and many times flew stoned." On one such occasion, "he just cracked up, went crazy, and never recovered since." Since that time he feels that any change is "distress," any uncertain situation "distress" that leaves him "exhausted and helpless."

After the discharge from the service, he attempted to get a job, but has failed to stay with any, feeling "not able to meet the expectations or being physically exhausted." He feels distressed, "paranoid" about people "when walking through the supermarket, at times feels like exploding or attacking." Before entering the hospital, he was living with his parents. He had been asked by his father "an alcoholic" to "move out" although his mother did not feel the same way. He is continuing "to smoke grass but he has almost given up all other drugs." At this time he experiences considerable headache, that he implies is the result of the motorcycle accident that he suffered in 1973.

(Cont on SF 507)

ADMISSION DATE	DISCHARGE DATE	TYPE OF RELEASE	INPATIENT DAYS	ABSENCE DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
2/[illegible]/79	5/16/80	OPT/SC	161	11	GIC	See Page 3

Standard Form 507

c4S—16—81472-5 GPO

CLINICAL RECORD

Report on HOSPITAL SUMMARY Pg 2
or
Continuation of S. F. VA 10-1000
(Strike out one line) (Specify type of examination or data)

(Sign and date)

...ychiatric evaluation he was found to be a well-developed, white male, with no ...arent physical deficits, in good contact, oriented three times. He related, in ...ful and anxious manner, conveying the impression of urgency, and distress, that ...onded to reassurance and support, and he obviously needed a great deal of it. ...speech was somewhat accelerated, as if he was in a great hurry to communicate ...is preoccupation at once. Thought process was goal oriented, organized, ...ionally circumstantial and evasive, at times over-inclusive, but spontaneously ...ns to the original thought. The content conveyed distress about Viet nam, depri-...ion, and injustices suffered from the war, problems in adapting following the ...charge from the service, particularly sensitivity to stress, which seems to be ...ything and anything, regardless of circumstances. No frank delusions or halluci-...ons were elicited, but transient paranoid-like preoccupations are experienced. ...ffect reflected sudden shifts between extremes of sadness and anger, the changes ...ring in exaggerated fashion. The impulse control was tenuous, at best marginal. ...tellectual function appeared to be well preserved, though the concentration and ...tion fluctuated with the rise and fall of the experienced anxiety. The multiple ...s complaints of chronic weakness, fatigability, and exhaustion, headache, and ...ointestinal problems are experienced as genuine distressing difficulties, seem-... also relevant to the level of experienced anxiety.

...al examination by the admitting physician noted hyporeflexia and questionable ...ia, however subsequent observation did not substantiate the find. Laboratory data ...dmission indicated slight elevation of CPK of 88, otherwise laboratory work was ...mal. Chest x-ray revealed no active disease. Initial diagnostic evaluation was ...owed by psychological consult which essentially supported the impression of immature ...nality with narcissistic and hysterical features. Significant comments in the ...logical assessment were centered around underlying personality structure, and ...al interpretation that he is likely to report feelings of depression, and ...es multiple somatic complaints that will increase under stress. Under stress, ... felt he also may present psychotic experiences, delusions, hallucinations, ...ersonalization, etc. (For additional details, reader is advised to refer to ...ve psychological assessment). Due to a recurrent complaint of headaches, ...x-ray was obtained, which was normal. EEG also was normal.

...pitalization was initially characterized by the extreme flucuations between ...ive compliance and periodic escapades that, on occasion, were accompanied by ...d alcohol abuse, and fairly consistent demands that his discomfort be alleviated ...the drugs (the preference being Valium). The limits were set; this behavior ...ly subsided, but as the acting-out declined, a number of somatic complaints ...essive preoccupations with physical and emotional "inabilities" went up.

(Continue on reverse side)

(OVER)

PATIENT'S IDENTIFICATION (For typed or written entries give: name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
George P.		61C

...Jh, Wn D:5/21/80 T:5/23/80 kh

REPORT ON ______ or CONTINUATION OF 10-1000

STANDARD FORM 507
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.80 6-3
October 1975 507-106
GPO: 1975- 261-626/1195

In addition to Thorazine 600mg BID, and Benadryl 50mg PO for EPS QID, he was treated with individual and group therapy, (large and small group), milieu, and rehab-oriented activities, that were used as an extension of therapeutic endeavors initiated in individual and group psychotherapy, placing emphasis on resocialization and reality oriented activities.

Gradually he improved, and a review of the progress notes indicated that by the end of March he stabilized, but it was felt that the level of functioning was never close enough to guarantee self-sufficient existence, and the question was raised whether this can be achieved in the foreseeable future, or ever. The impression was that his overall immaturity, and his dependency needs will remain in conflict with the demands of reality, and the possibility of recurrent disintegration of psychotic proportion, or return to drugs, or whatever other means are available to avoid distress, are to be anticipated, if deprived of a reliable support system.

There is indeed a reality in his "complaint" that his difficulties can be related to the Viet nam war, the reality being that precipitating stresses contributed to the dissipation and disintegration of rather vulnerable psychic structures that could have possibly survived, or maintained more efficient equilibrium, without the exposure to the trauma of war. He, "this may be an assumption," could have gone through life remaining on the edge of the events as a contented observer, adequately equipped to survive as long as the door "to get away" from the stress, was open. The war, and the service, needed the participant, not the observer, and the role of participant was above his resources.

This impression, at the time of his discharge, was consistent with the impression obtained earlier that "recovery" that will ascertain a full self-reliable existence is remote, and probably unrealistic. He hasn't worked since 1975, existing by relying on "service connected disability" which insured the survival, but reinforced the dependency . At this point the most that one can hope for is that he would learn to use the remaining resources in more prudent and economical fashion that would lead towards some degree of rehabilitation, probably always remaining dependent on "service-connected disability" as the source that will guarantee basic survival.

In addition to the above described therapy, he was also referred to the behavioral training clinic, receiving twice-weekly biofeedback, helping cope with tensions, and various complaints of "pain, depression, feeling of being-dejointed, etc." He responded to this with some alleviation of symptoms as he did to any form of therapy he was offered support and reassurance. He also was evaluated by the Podiatrist, who noted that he has third and fourth toenail deformity on the right foot, in addition to having fungal infection, and suggested excision for permanent removal. The planned surgical procedure was not done due to his failure to return from the pass on time, to obtain the necessary preliminary laboratory work. In case of additional difficulties, the procedure can be done on the outpatient basis.

On 5/15/80 he was given an OPT/SC discharge, with one month's supply of medication, consisting of Thorazine 500mg BID; Diocytl Sodium Sulfosuccinate 240mg Q. HS; and Benadryl 50mg PO for EPS, QID. He is considered competent for VA purposes. The veteran will be living with his parents in Port Angeles. His next follow-up outpatient appointment was arranged for 6/5/80 at 1 PM; our Outpatient facility,

M. R. YOKAN, M.D. 5/21/80

Approved exception to SF 502

PATIENT'S NAME	AGE	SEX	RACE	SOCIAL SECURITY NO.	CLAIM NO.	NAME OF HOSPITAL
OJALA, GEORGE P.	32	M	C		C-551()	VAMC SEATTLE WA

DIAGNOSES *(List in numerical order: first, the established clinical diagnosis responsible for the major part of patient's stay; then, in order of clinical importance, other established diagnoses for which treatment was given. Place letter "N" before diagnosis (es) responsible for Nursing Care placement. List Problem numbers after diagnosis.)*

ICDA CODE

1. Adjustive reaction with anxiety and depression
2. Chronic drug abuse
3. Headaches

PERTINENT CLINICAL DIAGNOSES NOTED BUT NOT TREATED *(Include autopsy diagnoses not listed as clinical above)*

OPERATIONS/PROCEDURES PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION — DATE

SUMMARY *(Brief statement should include, if applicable, history; pertinent physical findings; course in hospital; treatment given; condition at release; date patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at release; competency opinion when required; rehabilitation potential; and name of Nursing Home, if known.)*

HISTORY: The patient is a 32 y/o Caucasian male who is admitted with vague complaints of depressed mood, sleep disturbance and decreased energy with fleeting thoughts of suicide. He claims to have had these symptoms for 10 years but is most concerned about having tried many different psychotropic drugs without relief. He has been in outpatient therapy for at least the past year with some minimal response. Patient states he believes he has post-traumatic stress syndrome and needs evaluation for this. He does, however, give a history of drug abuse prior to his Vietnam experiences and interpersonal problems dating to this time also. He also has a history of paranoid schizophrenia in the past which has poor substantiation. He has also carried the diagnosis of drug abuse, post-traumatic stress syndrome, neuresthenic neurosis, and immature personality. He states that no medications, either neuroleptics or antidepressants have helped him in the past. He states the best he has done is with Lithium. Right now he feels there is a "short circuit" in his head and a feeling of pressure or vise around his head recently. He has had chronic headaches for many years without any exacerbation. Patient has been unemployed for most of his life, has no real interest in working but has made various attempts at vocational training without follow through in the past. Patient is currently living with his mother in a retirement home trailer court in Port Angeles area. He is 100% service connected until recently when his benefits were cut to 50%. This appeared to be somehow related to his recent admissions to this hospital.

MENTAL STATUS EXAM: Patient was casually dressed, somewhat disheveled young man in need of hygiene and grooming. He was generally cooperative and non-agitated but hunched in his chair and acting rather guarded and suspicious. His speech was normal rate without pressure, increased volume, or latency. He denied any hallucinations or delusions. He did have some preoccupation with feeling of injustice against him due to decrease of his service connected disability. His affect was somewhat constricted with subdued mood. He expressed some suicidal ideation with

ADMISSION DATE	DISCHARGE DATE	TYPE OF RELEASE	INPATIENT DAYS	ABSENCE DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
9/22/81	11/19/81	REGULAR	58	0	7W	/// ///

VA FORM 10-1000 MAR 1972 — EXISTING STOCK OF VA FORM 10-1000, JAN 1971 WILL BE USED.

HOSPITAL SUMMARY

D:11/13/81 T:11/25/81 pw 3

☆U.S. Government Printing Office: 1981—341-527/4139

(Sign and date)

no plans or commitment to this. There is no homicidal ideation. His intellectual status showed an average intelligence with clear sensorium.

PHYSICAL EXAMINATION except for obesity was essentially within normal limits.

LABORATORY: Screening laboratories were obtained: thyroid studies, CBC, SMA 12, Dexamethasone suppression test, urinalysis, chest x-ray which were all within normal limits.

PSYCHOLOGICAL TESTING: The patient showed average verbal and abstract problem solving skills on intellectual evaluation. There were no signs of organic impairment on this testing. He showed no interest in superficial social activities but does want close relationships and wants us to like him. He does value independence. He does not want others telling him what to do and has a great deal of difficulty with authority. He is likely to misinterpret other's intentions and expectations when he feels stressed. He showed considerable anger, especially with women. He did have symptoms of depression and disordered thinking on the MMPI and was evaluated as likely to experience physical symptoms related to his psychological distress. There was no indication of frank thought disorder or other endogenous depression.

HOSPITAL COURSE: The patient was admitted to the ward and observed for several days. He showed a superficial interaction with patients on the ward which generally increased to a productive interaction over the next several weeks. The patient generally took a very passive stand and showed no insight into his problems. He was virtually unwilling to approach problems from another point of view and was mostly interested in getting some sort of medication intervention. There was absolutely no sign of post-traumatic stress syndrome in this patient. He was not happy with this evaluation but took it fairly well. Patient was started on a trial of Nardil [illegible] mg qd and his Lithium carbonate was discontinued after the first week. Patient reported no improvement fmom the Nardil and wanted to stop it and stated he would do so. He was encouraged to continue this for at least a two month trial. During the course of his one month hospitalization no significant improvements were made which could be attributed to the Nardil.

The patient did make a good friend apparently with one other patient on the ward and made arrangements to take him back to his mother's retirement home with him.

During this hospitalization the patient was reviewed for his chronic headaches and hypoglycemia and no organic basis for either of these could be substantiated. It should be noted the patient has a long, long history of drug abuse, approximately 400-400 LSD dosages in the past. He denies current significant use of drugs and was

(Continue on reverse side)

(Sign and date)

not interested in further treatment for this. Patient was rather manipulative and negative throughout his hospital stay but with no significant behavioral or ward problem.

DISPOSITION: Patient discharged after six weeks of hospitalization to his mother's retirement home in Port Angeles. He was encouraged to remain in the Seattle area and to seek appropriate treatment for his ongoing problems. However, the patient seemed unable to separate from his mother at this time.

MEDICATIONS ON DISCHARGE: Nardil 50 mg qd.

Patient will be followed by Dr. Norman in the Port Angeles area.

The patient may return to his prehospital activities immediately.

The patient is competent for VA purposes and was not suicidal or homicidal at the time of discharge.

KATHLEEN MYERS, MD
Resident in Psychiatry

Dr. Norman Peterson
932 Caroline
Port Angeles WA 98362

(Continue on reverse side)

STANDARD FORM 507
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.8D 4-8
October 1975 507-105
☆ U.S. Government Printing Office: 1981—341-468/4281

copy 1 to medical file
1 to UFW-al 19 NOV 81

Nelsons came into hospital

nightmares - flash backs
depression dulling - no joy in life
anxiety
trouble getting motivated
fatigue
isolation from others - alienation
chronic headache
sleep disturbance
difficulty in concentrating
despair - am I ever going to be well
lack of interest in everything
Suicidal thoughts
fantasies of retaliation
memory impairment
hopelessness
TM syndrom

TO AL Nelson