

Justin Carlomusto Medical History

Detailed psychiatric course and major medical treatment

Prepared October 25, 2026 from the available medical records

The reviewed records document serious historical mood illness with suicidal thinking, self injury, reported repeated suicide attempts, and escalation to inpatient psychiatric care. Carrier Clinic diagnosed recurrent major depressive disorder, severe, without psychotic features in 2017. Monmouth Medical Center diagnosed a severe depressed episode of bipolar disorder without psychotic features in 2020. Another suicidal crisis in October 2021 led to a psychiatrist recommending voluntary inpatient treatment and an emergency department disposition of transfer to a psychiatric facility. These findings establish substantial severity during those episodes. They do not establish Justin's present symptoms, current diagnosis, or current suicide risk. [Carrier, pp. 1–3, 8–12; RWJ scan 072, pp. 1–7; scan 095, pp. 13–17; scan 018, p. 6; scan 006, p. 20]

This history gives particular attention to the psychiatric admissions, changes during treatment, functional effects, and differences between admission and discharge. It also includes a January 2023 outpatient withdrawal entry associated with Bright Harbor Healthcare, whose underlying records are unavailable. It also covers beta thalassemia intermedia, splenectomy, the 2013 matched sibling transplant, post transplant complications, kidney disease, medication reactions, and later emergency care. It is a synthesis of the records, rather than a new clinical evaluation or a certification that every lifetime encounter has been obtained.

Source references use original PDF page numbers or the numbered legacy scan and its page number. “CHOP” means the 1,013 page Children's Hospital of Philadelphia export; “Carrier” means the 24 page Carrier Clinic abstract; “RWJ summary” means the 149 page RWJBarnabas all visit export. “RWJ scan 095,” for example, identifies legacy document row 095 in the preserved source bundle. The source guide at the end explains the collection and remaining gaps.

Documented mental health severity

The strongest evidence of severity is the combination of suicidal symptoms and behavior, impaired insight or judgment during crises, repeated need for intensive treatment, and recorded effects on daily functioning. The word “severe” appears in the actual 2017 and 2020 mood disorder diagnoses. It is not a severity label added for this report. [Carrier, p. 3; RWJ scan 072, p. 5; scan 095, p. 17]

Episode	Acute findings	Level of care and outcome
February 25 to March 9, 2017	Depression, suicidal thinking, self injury history; a February 27 screen recorded thoughts about a method and intent without a specific plan. Poor impulse control, insight, and judgment were documented.	Carrier adolescent inpatient care; medications changed; mood improved; discharge home with High Focus partial hospital follow up.
November 21 to 27, 2020	Approximately five suicide attempts by medication overdose were reported for October and November. Depressed mood, poor sleep, and impaired insight or judgment were documented; a November 23 note still described risk despite no plan on the unit.	Voluntary adult inpatient admission at Monmouth Medical Center; medication changes and monitored treatment; improvement and denial of suicidal thoughts at discharge.

Episode	Acute findings	Level of care and outcome
October 8 to 9, 2021	Months of depression and suicidal thinking, worsening after a breakup, impaired work or school performance on the screening form, and a concerning collateral report. The narrative and plan checkbox were inconsistent.	Emergency psychiatric screening, 15 minute checks, psychiatrist agreement with voluntary inpatient treatment, and psychiatric facility transfer disposition. Subsequent inpatient course was not available.

The 2017 and 2020 admissions are supported by discharge summaries and treatment documentation. For October 2021, the available sources establish the crisis, observation, admission recommendation, and transfer disposition; they do not provide a complete receiving hospital admission and discharge chart. [Carrier, pp. 1–5, 8–12; RWJ scans 072, 095, 010, 017, 018, and 006]

Childhood mental health and the 2013 transplant admission

By 2013, CHOP psychiatry already recorded a history of attention deficit hyperactivity disorder, oppositional defiant disorder, anxiety, and depression. Educational documentation described special education and effects of ADHD or therapy needs on daily life. A later family account dated depressive difficulties to about 2014, but that cannot be treated as a precise onset because the 2013 consultation already mentioned depression. [CHOP, pp. 639, 954, 988; RWJ scan 095, pp. 13–17]

Anxiety was clinically significant during the medical transplant admission. On July 29, 2013, nursing recorded a possible anxiety attack with heart rate in the 150s and a complaint that breathing was harder. Oxygen saturation remained above 95 percent on room air, with a respiratory rate of 20; psychology was involved for similar concerns. Psychiatry later that day described him as calm, cooperative, cognitively intact, and without further panic, delusions, psychotic symptoms, or thoughts of harm to himself or others. Hydroxyzine, also called Atarax, was supported as needed for anxiety. These observations describe variation within the hospital course rather than continuous psychiatric instability. [CHOP, pp. 515–516]

On August 17, psychiatry described episodes of anxiety associated in part with preparation for discharge and particular worry about his heart. Some agitation persisted and was not always easy to deescalate verbally. Rapid eye blinking and other facial tics were observed. At the interview he had a content mood, appropriate affect, goal directed speech, intact orientation, memory and concentration, and fair insight and judgment. He denied hallucinations and thoughts of harming himself or another person. Clonidine was suggested for anxiety, agitation, ADHD or oppositional symptoms, and tics, beginning at a low bedtime dose with blood pressure monitoring. [CHOP, p. 639]

The transplant discharge summary documents a paradoxical reaction to lorazepam, also called Ativan: increased anxiety with delusions or hallucinations. Symptoms resolved without intervention, and lorazepam was subsequently avoided. Hydroxyzine did not help sufficiently, and nightly clonidine was introduced and increased for persistent anxiety. This medication associated event should be kept distinct from a primary psychotic disorder. The 2013 psychiatric consultations occurred during a medical transplant admission, not an admission to a psychiatric inpatient unit. [CHOP, pp. 463–465, 639]

Two inconsistencies limit exact reconstruction of the 2013 psychiatric medication timeline. The discharge summary mentions an August 27 psychiatry consultation despite an August 21 discharge; contemporaneous July 29 and August 17 notes are more reliable for those consultation dates. The discharge plan gives clonidine 0.1 mg at bedtime, while the printed medication table gives 0.05 mg at bedtime. The record supports clonidine

treatment but does not allow those conflicting discharge entries to be reconciled confidently. [CHOP, pp. 463–465, 515–516, 639]

Carrier Clinic inpatient treatment in 2017

Justin was admitted to Carrier Clinic's adolescent service on February 25, 2017, at age 14, and discharged March 9. Records describe two to three months of depression and approximately one week of suicidal thinking before admission. School distress, social isolation or few friends, ADHD, and anxiety were part of the context. He had already been attending High Focus partial hospital treatment. The assessment also recorded prior cutting or self injury and an attempt to scratch himself with a staple. These are reported or charted behaviors; the available abstract does not establish the medical extent of injury. [Carrier, pp. 1–5, 8–12, 18–21]

The admission suicide screens were not identical. On February 25, the Access assessment marked wishes to be dead and suicidal thoughts as present, while thoughts about a method, intent, a specific plan, and suicidal behavior within the preceding three months were marked absent. The assessment described depressed affect, fair impulse control, poor insight or judgment in the overall evaluation, and danger to self sufficient for inpatient care. It also recorded logical thought processes and no active homicidal ideation, delusions, or hallucinations. [Carrier, pp. 18–21]

The February 27 attending assessment recorded greater severity on several suicide items. It marked wishes to be dead, suicidal thoughts, thoughts about a method, and some intention to act as present; a specific plan was marked absent. The following page marked suicidal behavior in the preceding three months as present. That broad behavior item does not, by itself, establish a separately verified suicide attempt or its medical consequences. The difference from February 25 may reflect changing symptoms, additional disclosure, or differences in assessment; the abstract does not resolve why the responses changed. [Carrier, pp. 8–10]

The February 27 mental status examination described poor grooming, guarded and impulsive behavior, poor impulse control, restlessness, tense or depressed affect, and poor insight and judgment. Orientation, recall, concentration tasks, and estimated intellectual functioning were preserved. Thought processes were logical, with no active homicidal ideation, delusions, or auditory or visual hallucinations. The acute concern was therefore substantial depression and self directed risk, even though psychosis and gross cognitive impairment were not documented. [Carrier, pp. 9–10]

The final discharge diagnoses were major depressive disorder, recurrent, severe, without psychotic features; ADHD, combined type; and generalized anxiety disorder. “Rule out PDD NOS” appeared as a diagnostic consideration. A later printed problem list includes pervasive developmental disorder without that qualifier, but the abstract does not include a completed developmental evaluation establishing an autism spectrum diagnosis. The severe mood diagnosis is well supported as a diagnosis made during this stay; the developmental question remains unresolved in the reviewed material. [Carrier, pp. 3, 22–24]

During hospitalization, fluoxetine, also called Prozac, was changed to sertraline, also called Zoloft, and quetiapine, also called Seroquel, was added. The discharge summary reports gradual mood improvement, supportive family involvement, and a documented safety contract. A safety contract is a charted part of the discharge process, not proof that all risk had disappeared. The abstract does not supply a complete daily nursing record or establish every medication administration, observation interval, or therapeutic session. [Carrier, pp. 1–3]

The March 9 prescription list included guanfacine 2 mg at bedtime, lamotrigine 200 mg in the evening, quetiapine 25 mg twice daily, sertraline 50 mg each morning, and penicillin V 250 mg twice daily for the medical history. Hydroxyzine 25 mg twice daily appears in the printed prescription information, while the

instructions also say Vistaril was discontinued. Because hydroxyzine and Vistaril are the same medication, its discharge status is inconsistent. These are historical entries, not a current regimen. [Carrier, p. 3]

He was discharged home with a High Focus partial hospital appointment in Freehold the next morning, March 10 at 8:30. The school note confirms the hospitalization dates and anticipated school return after the partial hospital program. This sequence documents continuing need for structured treatment after inpatient stabilization. It does not establish uninterrupted severe symptoms throughout all subsequent years. [Carrier, pp. 1–5]

The Carrier medical history also matters to psychiatric care. A February 26 examination recorded thalassemia with past transfusions, bone marrow transplant in 2013, splenectomy, and vascular access placement and removal, despite “none” in another templated medical or surgical history field. The same examination described only a remote childhood febrile seizure, without recent seizures. The detailed medical history should take precedence over the blank or generic template entries. [Carrier, pp. 13–17]

Outpatient course and functioning from 2017 through 2018

Outpatient intake material from June 2017 records prior Carrier treatment and multiple intensive programs, including GenPsych and High Focus. Family accounts connected substantial school absence and repeating sixth grade with major medical treatment. The intake also describes fear of dying during transplant and past nightmares or flashbacks. Those symptoms are relevant to the emotional burden of medical illness, but the reviewed records do not establish a formal post traumatic stress disorder diagnosis. Developmental or autism testing was suggested; a completed diagnostic assessment was not found in the reviewed set. [RWJ scans 310, 323, and 324]

By the June 22, 2018 physician visit, irritability, concentration difficulty, and arguments were still concerns, while his mother felt his mood was better. The note also described passed classes, plans for summer work or training, and camp participation. He reported eating and sleeping well and denied suicidal or homicidal thoughts, hallucinations, and delusions. These details demonstrate periods of functioning and improvement alongside a history of serious episodes. [RWJ scan 215, pp. 1–3]

The 2018 medication list included guanfacine extended release 4 mg daily, lamotrigine 200 mg at bedtime, quetiapine extended release 300 mg daily, sertraline 50 mg daily, and penicillin V 250 mg twice daily. The treatment plan continued psychiatric medication and therapy and supplied local psychiatric follow up options. The physician's symptom template labeled severity “severe” and duration “chronic,” even while the narrative described improvement and denied current suicidal thoughts. Separately, the outpatient diagnostic listing included recurrent major depressive disorder, moderate; generalized anxiety disorder; and ADHD, combined type. The differing fields should remain visible rather than be collapsed into a single severity rating. [RWJ scan 215, pp. 1–3; RWJ summary, p. 137]

An administrative outpatient closure signed June 22, 2021 described loss of contact and an unknown treatment outcome. Its imported header and portal dates are inconsistent with the narrative program dates. The narrative describes admission to the outpatient program in June 2017 and discharge or closure in June 2021. It should not be read as a continuous psychiatric hospitalization from 2018 through 2021, nor as evidence of either recovery or deterioration during the period of lost contact. [RWJ scan 202, pp. 1–2]

Monmouth Medical Center inpatient treatment in November 2020

Justin presented to Monmouth Medical Center Southern Campus for psychiatric emergency evaluation on November 21, 2020, at age 18, after family concerns about depression and suicidal behavior. Screening documentation supports voluntary inpatient admission. Bed availability was explored, and he ultimately agreed

to admission to Monmouth Medical Center's adult psychiatric unit, AP3. The inpatient stay ran from November 21 through November 27. [RWJ scan 107, pp. 1–15; scan 072, pp. 1–3]

The admission history described approximately two months of depression and approximately five suicide attempts by medication overdose during October and November 2020, with the last reported episode on November 15. These attempts were reported by the patient and documented in clinical assessments, with family information contributing to the presentation. The available records do not independently verify the exact amount taken or medical toxicity of each episode. The repetition, expressed wish for life to end, and resulting inpatient treatment are the central severity findings. [RWJ scan 072, pp. 1–3; scan 095, pp. 13–17]

Additional context included medication changes before admission, bereavement involving a brother, and a long history of depression and anxiety. Lamotrigine had reportedly been stopped about four months earlier because of concern about hair thinning; the patient reported no improvement in hair after stopping it. This is a reported reason for discontinuation, not proof that lamotrigine caused hair loss or that stopping it caused the crisis. Fluoxetine was recalled as worsening depression, whereas sertraline had previously been helpful. [RWJ scan 095, pp. 13–17]

On the November 22 psychiatric evaluation, mood was dysphoric, affect constricted, and insight and judgment impaired. Orientation and memory were preserved. He denied current suicidal or homicidal thoughts at that interview and had no documented hallucinations or delusions. That interview occurred after the recently reported attempts and within a supervised setting. The denial describes that moment; it does not negate the preceding behavior or the reason for admission. [RWJ scan 095, pp. 13–17]

The inpatient final diagnosis was bipolar disorder, current episode depressed, severe, without psychotic features, coded F31.4. Some notes also considered major depressive disorder or questioned borderline personality traits. Those are differential or tentative observations. The reviewed chart does not provide enough longitudinal evidence to independently settle bipolar disorder versus recurrent major depression, and it does not establish a definitive borderline personality disorder diagnosis. The accurate history is that the treating inpatient team diagnosed a severe bipolar depressive episode in 2020 after the earlier severe recurrent major depression diagnosis in 2017. [RWJ scan 072, p. 5; scan 095, pp. 13–17]

The treatment plan changed medication partly because quetiapine had been involved in the reported overdoses. Clinicians used olanzapine rather than simply restoring the previous quetiapine regimen. Olanzapine 5 mg at bedtime was started; lamotrigine was restarted at a low dose and increased during the stay; sertraline was introduced at 25 mg daily and increased to 50 mg; and trazodone was available for insomnia, reaching 100 mg at bedtime as needed. Guanfacine extended release 4 mg at bedtime appears on inpatient lists. Penicillin prophylaxis and the transplant or splenectomy history were addressed medically. [RWJ scans 072 and 095]

The November 22 plan includes “DC 1:1” and “SRO due to being medically compromised.” That wording documents a change in an observation or room plan, but the abstract does not establish the entire duration of one to one observation or explain every abbreviation. Medical room precautions should not be treated as a measure of psychiatric dangerousness. Similarly, PRN orders for agents such as haloperidol or diphenhydramine do not prove that they were administered, that restraints were used, or that psychosis was present. [RWJ scan 095, p. 17; scan 072, pp. 6–7]

Changes during the 2020 inpatient stay

On November 23, the physician wrote that Justin had not slept well and was still depressed and at risk, although there was no plan on the unit. Examination described a sad mood, constricted affect, impaired insight, and fair judgment. The same note's review of systems denied current suicidality, delusions, and hallucinations.

Reading both portions is important: the physician still judged risk clinically relevant despite the immediate denial. Lamotrigine was listed at 25 mg twice daily by this point. [RWJ scan 095, pp. 1–3]

On November 24, he continued to describe anxiety and depression, with sad or anxious mood and impaired insight. He was tolerating medication without reported side effects and denied suicidal thoughts. The medication list had lamotrigine 50 mg twice daily and sertraline 50 mg daily. These notes support gradual treatment response rather than immediate resolution on admission. [RWJ scan 095, pp. 4–6]

On November 25, the physician described improved sleep, fair spirits, and slow improvement. Mood was anxious or neutral, affect remained constricted, and insight was still impaired; suicidal thoughts were denied. On November 26, he reported improving mood, denied thoughts of self harm, and felt ready to return home. Hallucinations and delusions continued to be absent in the detailed examinations. [RWJ scan 095, pp. 7–12]

The November 27 discharge summary described improved mood, a neutral presentation with a fuller range of affect, fair insight and judgment, medication adherence, group participation, and future orientation. He denied suicidal or homicidal thoughts and was discharged home with family. These findings support improvement sufficient for the treating team's discharge decision. They do not erase the severity of the admission or establish that there was no later recurrence. [RWJ scan 072, pp. 5–7]

The take home list was lamotrigine 50 mg twice daily, olanzapine 5 mg at bedtime, sertraline 50 mg daily, trazodone 100 mg at bedtime as needed for insomnia, and penicillin V 250 mg every 12 hours. Guanfacine appeared during the stay but is not clearly included in that take home list. An Ocean Mental Health telehealth appointment was scheduled for December 9, 2020 at 2:30 PM. These are discharge records, not verification of medication use or appointment attendance afterward. [RWJ scan 072, pp. 7, 10–11]

The 2020 psychiatric evaluation gives incorrect historical years for major medical procedures, stating transplant in 2011 and splenectomy in 2009. CHOP's detailed records support transplant on July 31, 2013 and splenectomy in October 2011. The psychiatric note remains important for its contemporaneous mental state findings, but its recalled surgical dates should not replace the primary medical chronology. [RWJ scan 095, p. 17; CHOP, pp. 462, 928]

Suicidal crisis and psychiatric transfer in October 2021

On October 8 and 9, 2021, at age 19, Justin underwent another psychiatric emergency screening at Monmouth Medical Center Southern Campus. He described months of depression and suicidal thinking, including wishes to die on approximately alternate days. Symptoms became more acute after a relationship breakup the preceding day. The longer history means the episode cannot accurately be reduced to a reaction beginning only with the breakup. [RWJ scan 010, pp. 1–2, 5]

The screening record described irritability, becoming upset more easily, inconsistent sleep and appetite, anxious restlessness or shaking, and reduced performance in a work or school functioning field. The employment portion recorded part time work and high school completion rather than current school enrollment. He was calm and cooperative during assessment while also reporting a wish to kill himself. Calm behavior did not lead the evaluating team to treat the episode as resolved. [RWJ scan 010, pp. 1–2, 5]

Justin reported that he was not taking psychiatric medication at the time and was willing to restart treatment. His mother reported that he had stopped after the prior hospitalization and had been moody, agitated, and unhappy over the preceding months. He was linked with outpatient therapy but had not disclosed his suicidal thinking to the therapist. These details show a gap between the existence of outpatient contact and the information available to that provider; they do not establish a single cause of the crisis. [RWJ scan 010, pp. 1–2]

The record contains an important conflict about a plan. The narrative says he denied a specific plan and feared developing one, while collateral information included a warning that he should not be trusted with his car. The structured screen marked current wish to die and current suicidal thoughts “Yes,” current intent “No,” and current plan “Yes.” It also marked no recent attempt and no current self injurious behavior. The record therefore supports an acute suicidal crisis with concern about access to means, but it does not clearly establish a fully specified plan or a new attempt during this visit. [RWJ scan 010, pp. 1, 5]

Past overdose information in this 2021 form refers back to the 2020 episode. It should not be counted as five additional attempts in 2021. The same screening denied homicidal thinking, hallucinations, and danger to others or property. The psychiatric severity documented here concerns mood symptoms and self directed risk. [RWJ scan 010, pp. 1, 5]

Observation sheets show checks at 15 minute intervals during the emergency stay. At about 2:35 AM on October 9, a note records that Dr. Santos agreed with voluntary inpatient psychiatric admission, was informed of a locally recorded C SSRS score of 28, and agreed to continued 15 minute checks. The charted number is reported here without assigning a standardized severity category or percentile, because the scoring implementation is not supplied. The clinician's documented response and recommended level of care are clearer evidence of the decision made. [RWJ scan 017, pp. 1–3; scan 018, p. 6]

Placement notes describe a bed search and insurance authorization delays. The emergency departure documentation lists transfer to a psychiatric facility on October 9. The preserved material does not provide the receiving hospital's complete admission, medication administration record, daily course, or final discharge summary. A subsequent inpatient diagnosis, duration of stay, and outcome cannot be reconstructed from the available transfer paperwork alone. [RWJ scan 018, pp. 1, 6–10; scan 006, p. 20]

Outpatient withdrawal in January 2023

On January 9, 2023, Justin withdrew from outpatient care against professional recommendation. The decision was abrupt and made in response to a screening for borderline personality disorder at Bright Harbor Healthcare. This event is included as supplemental history; the underlying Bright Harbor clinical records are unavailable. [Bright Harbor Healthcare — records unavailable; supplemental history]

The supplemental history describes personal requests to erase the Bright Harbor file as the reason the records are unavailable. A request for erasure does not establish that the provider completed deletion. No contemporaneous screening, treatment recommendation, discharge note, screening result, or confirmed borderline personality disorder diagnosis has been reviewed. [Bright Harbor Healthcare — records unavailable; supplemental history]

What the psychiatric history establishes

The record supports a recurrent pattern of clinically serious depressive and suicidal episodes from adolescence into young adulthood, with at least two fully documented psychiatric hospitalizations, intensive partial hospital treatment, and a later crisis requiring inpatient escalation. Specific indicators include suicidal intent on a 2017 screen, poor impulse control and judgment during that admission, approximately five reported attempts preceding the 2020 admission, continued inpatient risk noted on November 23, 2020, and the 2021 need for observation and transfer. This is a substantial historical burden even though some interviews documented calm behavior or denied immediate intent. [Carrier, pp. 1–12; RWJ scans 072, 095, 010, 017, and 018]

Functional effects appear across settings: school difficulties and social isolation in adolescence, medical treatment related school absence, irritability and concentration problems during outpatient care, and impaired

work or school functioning recorded during the 2021 crisis. The sources also describe passed classes, work or training plans, family support, willingness to engage with treatment, group participation, and improvement before discharge. Both impairment and periods of functioning belong in an accurate history. The records do not independently establish permanent inability to work or a continuous level of severity between encounters.

[Carrier, pp. 8–12; RWJ scans 310, 323, 324, 215, 072, and 010]

The available evidence does not establish a primary psychotic illness. The main 2017 and 2020 final mood diagnoses explicitly say without psychotic features, and detailed examinations repeatedly deny delusions or hallucinations. The 2013 lorazepam reaction is separately documented as medication associated. A templated 2020 phrase about affective flattening should not outweigh the detailed examinations and final diagnosis. Lack of psychosis does not make suicidal depression mild. [CHOP, p. 463; Carrier, pp. 3, 10; RWJ scan 095, pp. 1–17]

Diagnostic uncertainty remains clinically relevant. Historical ADHD and generalized anxiety are repeatedly recorded; oppositional defiant disorder appears in the childhood history. Major depression and bipolar depression were diagnosed at different encounters. Pervasive developmental disorder, autism evaluation, borderline traits, and trauma related symptoms were considered or mentioned without enough reviewed documentation to establish a definitive diagnosis in each category. Medication use alone cannot resolve those questions: lamotrigine does not establish epilepsy, and antipsychotic medication does not establish psychosis.

[CHOP, pp. 639, 926; Carrier, pp. 3, 15, 22–24; RWJ scans 323, 324, and 095]

No reviewed psychiatric assessment after the October 2021 crisis establishes Justin's current mood, current suicidal thinking, current functional capacity, or present medication adherence. A medication list printed in 2025 may carry forward older prescriptions. This history can support a clinician's review of past severity; present status requires a current assessment rather than inference from older admissions. [CHOP, pp. 21, 917–918; RWJ scan 010; source coverage described below]

Historical psychiatric medication course

The following dated entries distinguish documented treatment decisions from a current medication list. They are not prescribing instructions. Brand names are included where they help match the original records.

Record date	Documented psychiatric medication information
2013 transplant admission	Hydroxyzine as needed; clonidine introduced for anxiety, agitation, and tics. Lorazepam avoided after a paradoxical reaction. Clonidine discharge entries conflict at 0.05 versus 0.1 mg at bedtime.
March 2017 Carrier discharge	Guanfacine 2 mg at bedtime; lamotrigine 200 mg in the evening; quetiapine 25 mg twice daily; sertraline 50 mg in the morning. Hydroxyzine status is inconsistent. Fluoxetine had been changed to sertraline during the stay.
June 2018 outpatient visit	Guanfacine ER 4 mg daily; lamotrigine 200 mg at bedtime; quetiapine XR 300 mg daily; sertraline 50 mg daily.
November 2020 admission and discharge	Lamotrigine restarted and increased to 50 mg twice daily; olanzapine 5 mg at bedtime; sertraline increased to 50 mg daily; trazodone 100 mg at bedtime as needed at discharge. Guanfacine ER appears during admission but is not clear on the take home list.
October 2021 crisis	Patient reported no current psychiatric medication use and willingness to restart. The receiving inpatient regimen is unavailable.

Record date	Documented psychiatric medication information
CHOP list printed August 2025	Risperidone 0.25 mg daily, lamotrigine 200 mg at bedtime, and guanfacine ER 3 mg daily appear on a list with older start dates. This is not verification of use in 2025 or 2026.

Sources for the medication chronology are CHOP pages 21, 463–465, 639, and 917–918; Carrier page 3; RWJ scan 215 pages 1–3; scan 095; scan 072 pages 7 and 11; and scan 010 pages 1–2. Medication orders, historical reconciliation lists, prescriptions at discharge, and confirmed administrations are different types of evidence and should not be treated as interchangeable.

Beta thalassemia and splenectomy

CHOP describes beta thalassemia intermedia with increasing transfusion requirements, subsequent transfusion dependence, and iron overload. Deferasirox, also called Exjade, was used for iron chelation before transplant. These are the documented hematologic reasons for the transplant pathway. A later psychiatric collateral description of a history of cancer should not replace the CHOP diagnosis: the reviewed transplant records identify thalassemia, not malignancy, as the indication. [CHOP, pp. 462, 928; RWJ scan 018]

Multiple CHOP surgical histories give laparoscopic splenectomy in October 2011, when Justin was nine. The original 2011 operative report is not in the reviewed collection. Consequently, the exact operative indication, spleen size, blood loss, pathology, and immediate postoperative course cannot be stated from these records. The procedure and resulting asplenia are well documented, while those surgical specifics remain unavailable. [CHOP, pp. 362, 462, 928]

By July 2013, penicillin prophylaxis was being continued because of asplenia. The CHOP conditioning summary also states that aspirin had previously been used under an outside hospital protocol for post splenectomy thrombocytosis and was stopped on that admission. Penicillin was restarted before transplant discharge and appears repeatedly in later psychiatric and medical medication records, commonly 250 mg twice daily. The repeated entries establish a longstanding prophylaxis history, not independently verified current adherence. [CHOP, pp. 463, 928; Carrier, p. 3; RWJ scan 215; scan 072, p. 11]

Conditioning and matched sibling transplant in 2013

The first conditioning admission ran July 8 through July 13, 2013. Justin received four days of alemtuzumab, also called Campath, from July 9 through July 12 in preparation for a reduced intensity matched sibling transplant. Premedication included methylprednisolone, acetaminophen, and diphenhydramine. The admission diagnosis combined beta thalassemia intermedia with increasing transfusion requirement and asplenia. [CHOP, pp. 928–929]

Campath caused several recorded reactions. After the first infusion, he developed fever to 38.8 degrees Celsius and received vancomycin and aztreonam for 24 hours while blood culture showed no growth to date. Fever recurred after the second dose within the same interval. A cough after the third dose was thought related to infusion. Hives developed with about 10 percent of the fourth infusion remaining; additional diphenhydramine and then hydroxyzine resolved them, and the remaining portion was not given. There were no documented respiratory, circulatory, or gastrointestinal features accompanying the hives. [CHOP, p. 928]

He was discharged on a prednisone taper with plans for acyclovir and fluconazole prophylaxis. Inhaled pentamidine was given July 12 in the setting of the Bactrim allergy; G6PD activity was recorded as normal at

18.8. Exjade was continued temporarily with a plan to stop before the next admission. Aspirin was stopped, and penicillin prophylaxis continued until readmission. [CHOP, pp. 928–929]

The main transplant admission ran July 23 through August 21, 2013. Conditioning included fludarabine and melphalan after the earlier Campath, under the reduced intensity CHP 894 protocol. On July 31, at age 11, Justin received matched sibling donor cord blood plus matched sibling bone marrow. This was an allogeneic transplant from a sibling donor; the records describe both graft sources on the same transplant date. [CHOP, pp. 462, 518]

Central access required additional procedures. The discharge summary lists Broviac placement July 24, while its narrative refers to line placement July 25. During that period, an existing right internal jugular port was found to terminate in the right ventricle. On July 25 the port catheter was revised and shortened by 4.5 cm, with the tip repositioned to the junction of the superior vena cava and right atrium; the operative account describes no complication. The date disagreement for Broviac placement is retained rather than silently resolved. [CHOP, pp. 462–463, 843–844]

Graft versus host disease prophylaxis began with cyclosporine on day minus one and mycophenolate mofetil on day plus one. The summary records transition to oral tacrolimus on August 13 and oral mycophenolate on August 15. Blood counts were monitored for pancytopenia and blood products were supplied as needed. G CSF was used August 7 through August 17, stopping after three days with an absolute neutrophil count above 2,000. [CHOP, p. 462]

The hospital course required infection prophylaxis and management of fever. Immunoglobulin was given every two weeks beginning August 1, with antiviral, antifungal, and Pneumocystis prophylaxis. A fever on July 30 prompted cultures and vancomycin and aztreonam, with gentamicin added for persistent fever and tachycardia. He became afebrile with normalized heart rate within 24 hours. Vancomycin and gentamicin were stopped, and clindamycin with aztreonam continued through neutrophil engraftment. Penicillin was resumed for asplenia. [CHOP, pp. 462–463]

Poor oral intake required total parenteral nutrition from July 31 through August 16. Nausea was treated with antiemetic medication. Exjade was held before and during the transplant admission. The Broviac was removed August 19. The previously revised port was left in place at that time and removed during the March 2014 procedure admission. [CHOP, pp. 40, 463]

At August 21 discharge, the summary listed white blood cells 2.9, hemoglobin 10.3, platelets 49, absolute neutrophil count 566, and creatinine 0.5 in the source laboratory units. These were dated post transplant values, not current blood counts or kidney function. Engraftment results in August were recorded as 100 percent, and a November note states 100 percent donor as of September 30, 2013. A March 18, 2014 nonenriched engraftment specimen, resulted March 26, again showed 100 percent. The sources support successful donor engraftment at those times, without establishing present chimerism or a complete lifelong transplant outcome. [CHOP, pp. 41, 255, 463, 837–838]

The psychiatric effects during this admission are detailed earlier: panic or anxiety episodes, agitation, fear concerning the heart, a paradoxical lorazepam reaction, and psychiatry involvement. They are important parts of the transplant experience, but the record does not establish that the transplant itself caused the later mood disorder. [CHOP, pp. 463, 515–516, 639]

Post transplant infections and medication complications

From August 30 through September 1, 2013, Justin was admitted for abdominal pain and painful urination. Blood and urine cultures were negative, while BK virus testing was positive without documented hematuria.

The March 2014 biopsy history later describes BK viremia as resolved. The reviewed record does not show that every episode of later renal dysfunction was caused by BK virus. [CHOP, pp. 41, 362–363]

The November 7 through November 11, 2013 admission involved fever and respiratory illness with adenovirus and rhinovirus, as well as dapsone induced methemoglobinemia. Dapsone was discontinued. Methemoglobin was recorded at 15.8 percent on November 10 and 10.2 percent on November 11. Chest imaging showed a small right and trace left pleural effusion with atelectatic change and no pneumonia on the referenced CT. The medication reaction belongs in the adverse reaction history even though dapsone had been used for infection prophylaxis. [CHOP, pp. 241–243, 279–280, 285, 287–288]

Further admissions occurred December 26 through December 28, 2013 and January 3 through January 4, 2014 for fever or viral upper respiratory symptoms, with negative bacterial cultures in the summaries. Rising creatinine was an additional concern; the January summary records a peak of 1.4. These encounters occurred during post transplant follow up and preceded the renal biopsy. [CHOP, pp. 112–113, 178–180]

January 2014 notes described itchy, flaking scalp as likely residual skin graft versus host disease, improving with lotion. The word “likely” is part of the source assessment. The reviewed documentation does not establish a broader chronic graft versus host disease stage, current activity, or current treatment requirement. [CHOP, pp. 102, 105, 109]

Kidney disease and March 2014 biopsy

Persistent elevation of creatinine after transplant, resolved prior BK viremia, and exposure to potentially nephrotoxic medicines were listed in the biopsy history. Justin underwent left renal biopsy and port removal on March 17, 2014, with observation through March 18. The discharge nursing note described stable vital signs, no bleeding or swelling at the biopsy site, and discharge home. Port removal reflected that the access was no longer needed in that episode. [CHOP, pp. 40–41]

The final pathology, resulted March 21, 2014, was diffuse mesangioproliferative glomerulonephritis with features suggestive of mesangiolysis. Microscopy described increased mesangial cells and matrix in most evaluable glomeruli, accentuated lobular architecture, and areas suggestive of mesangiolysis. The report found no crescent formation, and the tubulointerstitial compartments were unremarkable. [CHOP, pp. 40–41]

The pathologist stated that mesangiolysis raised the possibility of glomerular basement remodeling of the kind seen with thrombotic microangiopathies, but no acute arteriolar fibrinoid necrosis or microthrombi were identified. Clinical correlation was recommended. This is a qualified pathologic discussion; it should not be converted into an unqualified diagnosis of transplant associated thrombotic microangiopathy. [CHOP, pp. 40–41]

Hyperkalemia appears in the CHOP problem list. A December note mentions a prior potassium peak of 6.7 with an internal November 17 date, so that peak should not be relabeled as occurring during the December admission. On March 18, 2014, IgG 473, IgM 59, and IgA 27 were low in the reported units, while mitogen testing was described as normal. Those dated immune studies do not by themselves establish a new present day immunodeficiency diagnosis. [CHOP, pp. 31, 47–49, 187]

Later RWJ values include creatinine 1.00 on October 8, 2021; 1.19 on April 4, 2025; and 1.11 on April 28, 2025, with reported estimated filtration rates above 60. They provide later snapshots but do not substitute for a longitudinal nephrology assessment or prove that the biopsy defined kidney disease permanently resolved. [RWJ summary, dated laboratory sections for October 8, 2021 and April 2025]

Other childhood history and cardiac assessment

The CHOP history describes birth at 37 weeks by emergency cesarean delivery for fetal heart decelerations, followed by doing well, and a febrile seizure at about age three. The reviewed material does not establish recurrent epilepsy. Carrier's 2017 medical examination likewise described no recent seizures. [CHOP, pp. 925–926; Carrier, p. 15]

A two page pediatric echocardiogram dated September 26, 2016, obtained for an innocent murmur or chest pain, described normal chamber dimensions, valves, and biventricular function on two dimensional, pulse Doppler, and color flow assessment. It is reassuring historical testing, not a present cardiac clearance. [RWJ echocardiogram, September 26, 2016, pp. 1–2]

Adult medical findings and emergency visits

During the November 2020 hospitalization, recorded lipids included total cholesterol 290, LDL cholesterol 186, triglycerides 397, and HDL cholesterol 37 mg/dL. Fasting status is not established in the reviewed material. ALT 62, white blood cells 12.0, and platelets 461 were also flagged in the dated results. These values warrant accurate inclusion as historical abnormalities, without assigning a cause, familial lipid disorder, or present abnormality from a single admission. [RWJ summary, pp. 23–24, 56–57 and November 2020 laboratory results]

On April 4, 2025, Justin attended Community Medical Center's emergency department for nausea and an episode of vomiting blood after alcohol intake the prior evening. No ongoing bleeding was observed during the emergency evaluation. Hemoglobin was 16.2 and white blood cells 14.3 in the reported units. The plan included primary care or gastroenterology follow up and a short course of ondansetron. The encounter does not establish an alcohol use disorder or a confirmed source of gastrointestinal bleeding. [RWJ summary, April 4, 2025 emergency visit narrative and laboratory results]

On April 28, 2025, he returned for cough or congestion and chest pain worsened by breathing. Heart rate was 116 on recorded vital signs and 112 on ECG, with oxygen saturation 99 percent. Troponin was below 6, D dimer below 150, viral testing was negative, and chest radiography reported no acute cardiopulmonary process. Symptoms improved with fluids and ketorolac. The emergency diagnoses were chest wall or pleuritic pain, with primary care and cardiology follow up advised. [RWJ summary, April 28, 2025 emergency visit narrative, imaging, ECG, and laboratory results]

The formal ECG interpretation associated with that visit included sinus tachycardia, possible left atrial enlargement, and a septal infarct of undetermined age. The emergency clinician interpreted no acute ischemic ST or T changes, and the available troponin was negative. This documentation is insufficient to add a confirmed prior heart attack to the medical history. The qualified ECG wording and the clinical assessment should remain visible together. [RWJ summary, April 28–29, 2025 ECG and emergency assessment]

Allergies and adverse medication reactions

Medication	Recorded reaction and qualification
Lorazepam or Ativan	Hallucinations and increased anxiety during transplant care; described as a paradoxical reaction that resolved after the episode.
Dapsone	Methemoglobinemia during the November 2013 admission; drug discontinued.

Medication	Recorded reaction and qualification
Trimethoprim sulfamethoxazole or Bactrim	Rash, with a high dose qualifier in CHOP history.
Ceftriaxone	Hives in CHOP history. Some other records list a broader cephalosporin allergy without equivalent detail.
Levofloxacin	Hives or rash and eye swelling in the RWJ allergy record, attributed to an outside facility history.
Alemtuzumab or Campath	Infusion associated fever, cough, and hives during July 2013 conditioning. This is documented in the hospital course; its status as a current formal allergy entry is not established here.

The main sources are CHOP pages 463 and 928 and allergy sections throughout the export; Carrier pages 13–17; and RWJ allergy documentation including scan 015. A recorded drug reaction, a broader class entry, and an infusion reaction should not be silently merged. Lamotrigine related hair thinning was a patient reported concern, not an established allergy in the reviewed material. [RWJ scan 095, pp. 13–17]

Source coverage and unresolved details

The CHOP source contains 1,013 pages, with the major admission narratives spanning July 2013 through March 2014, later embedded flowsheet entries through December 2022, and a medication snapshot printed in August 2025. Print dates do not establish treatment dates. The Carrier source is a 24 page abstract of the February to March 2017 admission; a second filename obtained later was byte identical and represents the same records, not a second hospitalization. The RWJ collection includes a 149 page all visit export covering listed encounters from January 2010 through April 2025, plus 57 preserved legacy scan files totaling 288 pages and a separate two page 2016 echocardiogram.

The RWJ document inventory contained 326 items; 269 were not reviewed in the preserved scan set. Some preserved forms repeat the same screening or copy historical text, so copied material was not counted as a separate event. The collection does not include a complete Jersey Shore or Hackensack Meridian chart, the original 2011 splenectomy operative record, a complete receiving hospital chart after the October 2021 transfer, or a current psychiatric evaluation. The absence of a particular diagnosis from this report is therefore not proof that it never occurred.

Earlier searches of the extracted CHOP text and OCR supplements, the available RWJ summary and preserved scans, and the Carrier abstract did not identify a tailbone or coccygeal injury. No injury date, imaging result, diagnosis, or treatment can be documented for that concern from the reviewed sources. This is a limit of the available collection, including the unreviewed legacy items, rather than a conclusion about the entirety of Justin's life.

Several discrepancies deserve reconciliation when the original clinicians' records are available: the 2013 clonidine dose entries and consultation date; hydroxyzine's 2017 discharge status; major depression versus bipolar depression across episodes; the unresolved developmental evaluation; the conflicting 2021 plan checkbox and narrative; the receiving hospital's 2021 course; and the present psychiatric and medical medication list. The splenectomy and transplant dates should use the CHOP chronology unless the actual operative records establish otherwise.

Source guide

Bright Harbor Healthcare is the provider associated with the January 9, 2023 outpatient withdrawal entry. Its clinical records are unavailable; this entry is supplemental history rather than a reviewed clinical note. The history describes personal requests for file erasure, but completion of deletion has not been established.

CHOP refers to Justin_Carlomusto_CHOP_Records_2025-08-01.pdf, 1,013 pages. Original PDF page numbers are used throughout. Key psychiatric pages are 463–465, 515–516, and 639; major transplant pages are 462–465, 518, 837–844, and 928–929; kidney pathology is on pages 40–41.

Carrier refers to Medical Records - Justin C - Abs.pdf, 24 pages, also preserved under Carrier_Clinic_2017_Abstract.pdf. Discharge summary pages 1–3, school letter page 5, attending assessment pages 8–12, medical examination pages 13–17, and Access assessment pages 18–21 are the main references. Pages 22–24 are a later printed snapshot of the same historical episode.

RWJ summary refers to RWJBarnabas_All_Visit_Records_2026-10-24.pdf, 149 pages. It contains structured encounter information, laboratory results, and clinical narratives; empty structured history fields do not mean that the separate narrative and scanned medical history is absent.

RWJ legacy scan numbers identify the original document inventory rows and filenames in the preserved source bundle. The main 2020 references are 072_CERN_BEHAVIORAL_HEALTH_DISCHARGE_DOCUMENTATION.tiff, 095_CERN_BEHAVIORAL_HEALTH_PHYSICIAN_DOCUMENTATION.tiff, and 107_CLIN_DOC_BH_BH_CLINICAL_DOCUMENTATION.tiff. The main 2021 references are scan 010 behavioral health forms, scan 017 observation documentation, scan 018 placement and screening progress notes, and scan 006 emergency documentation. Outpatient references include scans 202, 215, 310, 323, and 324. Page counts in citations refer to pages within that scan, not to a combined PDF.

Original source collections are available as CHOP Records, Carrier Clinic Abstract, RWJBarnabas All Visit Records, and RWJBarnabas Records and Scans. The document index maps each numbered scan to its exact original filename. The present report paraphrases and organizes those sources; original signed clinical records remain the reference for clinical or administrative decisions.

[CHOP original records](#)

[Carrier Clinic original abstract](#)

[RWJBarnabas all visit export](#)

[RWJBarnabas records and legacy scans](#)

[RWJBarnabas numbered document index](#)