

Centene Commercial Chart Examples

Published September 2023



Example 1

Example 1



Patient Name & Identifier

01/03/2022

Provider Name

Current Medications

Taking

- Meclizine HCl 25 MG Tablet 1 tab Orally twice a day
- Levothyroxine Sodium 25 MCG Tablet 1 tablet in the morning on an empty stomach Orally Once a day
- Pantoprazole Sodium 40 MG Tablet Delayed Release 1 tablet Orally Once a day
- chlorthalidone HCl 10 MG Capsule 1 capsule Orally Twice a day
- Zinc 50 MG Tablet 1 tablet Orally Once a day
- Vitamin C 1000 MG Tablet 1 tablet Orally Once a day
- Cholecalciferol 125 MCG (5000 UT) Capsule 1 tablet Orally Once a day, stop date 01/09/2022
- Famotidine 20 MG Tablet 1 tablet at bedtime as needed Orally Once a day

Discontinued

- Montelukast Sodium 10 MG Tablet 1 tablet at night Orally Once a day
 - benzonatate 200 MG Capsule 1 capsule as needed for cough Orally Three times a day, stop date 01/06/2022
- Medication List reviewed and reconciled with the patient

Past Medical History

Asthma.

Allergies

Analgesic: rash
iodine

Review of Systems

Review of Systems:

Constitutional Denies, Fever, Chills, Loss of appetite, Weight loss, Weight gain. Eyes Denies, Loss of vision, Double vision or change in visual acuity, Discharge, Pain.

Reason for Appointment

1. Telemed covid evaluation, cough

Assessments

1. 2019 novel coronavirus detected - U07.1 (Primary)
2. Mitral valve prolapse - I34.1
3. Anxiety - F41.9
4. Hypothyroidism, unspecified type - E03.9
5. Gastric reflux - K21.9
6. Cervicalgia - M54.2

Treatment

1. 2019 novel coronavirus detected

Continue Zinc Tablet, 50 MG, 1 tablet, Orally, Once a day
Continue Vitamin C Tablet, 1000 MG, 1 tablet, Orally, Once a day
Continue Cholecalciferol Capsule, 125 MCG (5000 UT), 1 tablet, Orally, Once a day

2. Anxiety

Continue chlorthalidone HCl Capsule, 10 MG, 1 capsule, Orally, Twice a day

3. Hypothyroidism, unspecified type

Continue Levothyroxine Sodium Tablet, 25 MCG, 1 tablet in the morning on an empty stomach, Orally, Once a day

4. Gastric reflux

Continue Pantoprazole Sodium Tablet Delayed Release, 40 MG, 1 tablet, Orally, Once a day
Continue Famotidine Tablet, 20 MG, 1 tablet at bedtime as needed, Orally, Once a day

5. Cervicalgia

Continue Meclizine HCl Tablet, 25 MG, 1 tab, Orally, twice a day

Procedures

The patient is aware that due to the Coronavirus Pandemic throughout our country, in-person, in-office visits, and elective procedures may increase the risk of exposure to infection and illness. To help reduce the risk of infection to patients and staff, telehealth and telephone visits will continue

Example 1

Patient Name

Otolaryngologic Denies, Hearing loss, Nasal congestion, Sore throat, Postnasal drip.
Cardiovascular Denies, Chest pain, Palpitations, Syncope, Leg swelling. Respiratory Reports, dry cough, Denies, Wheezing, Hemoptysis, Sputum production, Shortness of breath.
Gastrointestinal Denies, Nausea, Vomiting, Constipation, Diarrhea, Abdominal pain, Hematemesis, Hematochezia, Melena.
Genitourinary Denies, dysuria, polyuria, hematuria, change in urine color, change in urine odor.
Musculoskeletal Denies, Arthralgias, Joint swelling, Stiffness.
Neurological Denies, Headache, Dizziness, Confusion, Tremors.
Endocrine Denies, Polyphasia, Polydipsia, Polyuria.
Breast Denies, Lump or mass, Nipple discharge, Skin changes.
Psychiatry Denies, Depressed mood, Anxiety, Suicidal ideation, Homicidal ideation. Skin Denies, Rash, Discoloration, Nodule(s), Lesions, Sores. Female
Gu/Gyn Denies, Vaginal bleeding.

to be offered during this crisis and we will continue to offer in-person visits predominantly as a mean to address non COVID related illnesses or those with significant suffering and other significant medical needs. We will continue to follow the current CDC and national/state guidelines including, but not limited to (and subject to local/State/Federal updates), proper hand hygiene, social distancing, screening patients for symptoms and restricting access if necessary. We provide home services via our Cano at Home Urgency 24/7 telephone system and the Urgency phone number has been provided to the patient to call as needed.

Following patient's verbal consent, this Tele Medicine Visit was initiated with audio/visual communications and HIPAA confidentiality laws will followed with best intention. Patient understood there are alternatives and limitations to this type of care and that the Health-Care Provider, or the patient can discontinue telemedicine consultation/visit if it is left that the video or telephone conferencing connections are not adequate. Standard deductible and Coinsurances amounts apply to this "virtual visit" and are the responsibility of the patient/surrogate.

I have reviewed the medical history, the COVID-19 HPI Questions and Answers with the patient, along with their COVID-19 Risks Assessment Responses. I have discussed the treatment options and my recommendations with the patient. Based on my review and shared decision reached between myself and the patient, we have determined a mutual treatment plan. All significant risks related to treatment were discussed with the patient, including but not limited to cardiac death.

Follow Up

2 Weeks

History of Present Illness

TeleVideo Visit:

Televisit Video Platform

I certify that I conducted this virtual visit via both audio and visual telecommunication by using one of the following platforms: *Facetime*
The duration of this appointed was approximately *30-35 minutes*.

History of Present Illness:

Patient diagnosed with covid 19 last week that refers feeling better. She denies SOB, nausea, vomiting or chest pain. She only complaints of occasional Dry cough.

Examination

-Exam:

GENERAL APPEARANCE pleasant, well nourished, well developed, in no acute distress.

PSYCH cooperative with exam, good eye contact, judgement and insight good, speech clear.

Example 2

Example 2



Patient Name & Identifier

05/16/2022

Provider Name

Current Medications

Taking
Inhalers

Medication List reviewed and
reconciled with the patient

Past Medical History

Asthma Yes, .

Surgical History

Denies Past Surgical History

Family History

Father: cancer
Mother: arthritis

Social History

General:

Patient Smokes: No. Smoking Are
you a: Non Smoker. Advance
Directive: No. Consumes alcohol
regularly: No. Participates in
sports/recreational activities: No.
Exercise regularly: No.

Allergies

N.K.D.A.

Reason for Appointment

1. Bilateral knee pains

History of Present Illness

Knee pain:

45 year old female presents with c/o pain to bilateral knees. The pain is located medially, diffusely. Radiation of the pain does not occur. The character of the pain is sharp, severe. Symptoms occur with walking, bending, twisting, going up and down stairs, after sitting for prolonged periods, upon getting up after sitting for prolonged periods. Swelling has been intermittent. Catching/popping occurs intermittently to the knees and they will occasionally lock up. Motion has decreased secondary to the pain. Strength is not affected by the pain. Instability occurs intermittently. Numbness and tingling are not present to the lower extremities. Symptoms have been present for 12 years. Treatment to date has included nothing as of late. She saw a doctor in Iran who told her she may have a meniscus tear and recommended surgery 12 years ago, but she did not proceed. Previous imaging has not been done. The knee has no history of prior injuries. The pain started spontaneously.

Vital Signs

Ht 60, Wt 158, BMI 30.85.

Examination

General examination:

The patient appears to be well developed, well nourished, alert and oriented times 3, well developed, well nourished, alert and oriented times 3.

Right Knee:

Visual inspection shows neutral alignment.
Quadriceps atrophy not noted.
Erythema and warmth: not present.
Intra-articular effusion is not noted.
Extra-articular swelling is not noted.
Patellofemoral crepitation is present with active and passive ROM.

Example 2

ROM: 0 - 130.

Forced flexion does not produce pain.

McMurray's negative.

Reverse McMurray's negative.

Tenderness to palpation medial joint line, musculotendinous junction of medial hamstrings, pes region, distal IT band.

Lachman's examination is negative.

Valgus stress at 30 degrees shows no opening.

Varus stress at 30 degrees shows no opening.

Patellar mobilization produces no pain with mobilization in transverse and longitudinal planes.

Left Knee:

Visual inspection shows neutral alignment.

Quadriceps atrophy not noted.

Erythema and warmth not present.

Intra-articular effusion is not noted.

Extra-articular swelling is not noted.

Patellofemoral crepitation is present with active and passive ROM.

ROM: 0 - 130.

Forced flexion does not produce pain.

McMurray's negative.

Reverse McMurray's negative.

Tenderness to palpation medial joint line, lateral joint line, musculotendinous junction of medial hamstrings, pes region, medial retinaculum, lateral retinaculum.

Lachman's examination is negative.

Valgus stress at 30 degrees shows no opening.

Varus stress at 30 degrees shows no opening.

Patellar mobilization produces no pain with mobilization in transverse and longitudinal planes.

Lower Extremity Neurovascular Exam:

distal motor and sensory: intact.

Right Knee X-ray::

X-ray: Standing AP, 40 degree PA, lateral, and sunrise views taken today in the office show lateral PF joint space narrowing with spurring, but no medial or lateral joint space degeneration.

Left Knee X-ray::

X-ray: Standing AP, 40 degree PA, lateral, and sunrise views taken today in the office show lateral PF joint space narrowing with spurring, but no medial or lateral joint space degeneration.

Assessments

1. Pain in right knee - M25.561 (Primary)
2. Pain in left knee - M25.562

Treatment

1. Pain in right knee

Notes: The patient has chronic pain to both knees greatest to the medial side with intermittent locking and only mild, PF degenerative changes. Her exam is concerning for medial meniscus tears so we will obtain MRIs of the knees. She is also given a home therapy program. She will f/u after the MRIs are completed.

Example 2

Diagnostic Imaging

Imaging: Knee, Bilateral 4V (AP, Lat, 30 Deg PA Flexion, Sunrise)

Imaging: MRI : Knee, Left w/o Contrast (73721) (Ordered for 05/16/2022)

Imaging: MRI : Knee, Right w/o Contrast (Ordered for 05/16/2022)

Procedure Codes

73564 X-Ray Knee, 4 view complete, rt, Modifiers: RT

73564 X-Ray Knee, 4 view complete, lt, Modifiers: LT

G9903 Pt scrn tbco id as non user

Follow Up

After MRI with films

Provider Information

Example 3

Example 3

VISIT - DOS: 9/6/2022

Provider Information

Patient Name & Identifier

Patient Name

Ocular History

OU Epiphora

OS Onset: 9/6/2022

RT [RE] Eyelids-Chalazion

RT RESOLVED 05/16/2022

Onset: 8/23/2017

ICD9: 373.2 ICD10: H00.1

OD HSV

OU Presbyopia

OS Onset: 9/6/2022

Ocular Surgical History

None

Eye Medications

Valtrex 500 mg tablet

Sig: take 1 tablet 3x/day for one week then taper to 2x/day for one week then taper to 1x/day for one week then stop

Original Visit Date: 09/01/2022

Medical History

Asthma

ICD9: 493.90 ICD10: J45.909

Surgical History

Hysterectomy

Sx Date: 2014

Knee replacement

nasal sx

Tonsillectomy

Systemic Medications

Advair Diskus

Family History

Cancer

Cataracts

Diabetes

High Blood Pressure (hypertension)

Lazy Eye (strabismus)

Stroke

Allergies

No Known Allergies

Social History

Smoking Status: never smoked

Alcohol: Yes on occasion

Drugs: No

Chief Complaint

Patient presents with/for f/e HSV located right eye for several days. This condition requires taking Valtrex. Patient states that she is taking the Valtrex 500mg pills 3x/day for 1 week. She says that her right eye started to feel better by the 3rd day of taking the medication. Her vision isn't as fuzzy and her eye isn't as painful or light sensitive as it was.

Workup

Visual Acuity

	OD	OS	OU
CC	20/20	20/20	
SC			
PH			
Test Used: Sn Type: Spectacles			

Near Vision Test

	OD	OS	OU
CC			
SC			

Intraocular Pressure

Time		OD	OS	Notes
	IOP	11	11	ngd
	CC			

Tech Initials:

Psyc

Mood Appropriate

Orientation Normal

Provider Information

Exam

Slit Lamp Exam

OD		OS
lids normal	Lids	lids normal
lashes normal	Lashes	lashes normal
adnexa normal	Adnexa	adnexa normal
injection 2+	Conjunctiva	White and Quiet
White and Quiet	Sclera	White and Quiet

Example 3

dendrite nearly gone	Cornea	normal endothelium, epithelium, stroma, and tear film
Deep and Quiet	Anterior Chamber	Deep and Quiet
Flat and Round	Iris	Flat and Round
Clear lens capsule, cortex, and nucleus	Lens	Clear lens capsule, cortex, and nucleus

Refractions and Contacts

Refractions

Presently Wearing

	Sphere	Cylinder	Axis	ADD	Prism	Prism Type		Va D	Va I	Va N
OD	+0.50	+0.50	x 076	+2.25			OD			
OS	+0.75	+0.25	x 075	+2.25			OS			
							OU			

Assessment

Corneal-Keratitis-Dendritic, Herpes Simplex

ICD10: B00.52

environmental allergies

Location: OU
ICD10: Z91.09

Epiphora

Location: OU
ICD10: H04.203

Eyelids-Chalazion

Location: RT
ICD10: H00.11|H00.12

Other specified post procedure states

Location: RLL
ICD10: Z98.890

Presbyopia

Location: OU
ICD10: H52.4

Plan

Discussion

Corneal-Keratitis-Dendritic, Herpes Simplex: HSV right eye: Nearly Resolved. The nature of this viral infection was discussed including the potential for recurrent episodes and scarring which in some cases, necessitates corneal transplantation if visual function is affected. Discussed treatment options. Will continue but taper Valtrex 500mg tablets 1 tablet 3x/day for one week then taper to 2x/day for one week then taper to 1x/day for one week then stop. All questions were answered to the patient's satisfaction. Will continue to monitor.

Orders

Complete

When/For: next May as scheduled

Provider Information

Example 4

Example 4

Patient Name & Identifier

Office Visit

Start Date: 08/29/2022

Provider Information

Notes

Subjective:

HPI

Patient is a 48 y.o. female here for urgent care follow up. She was seen by urgent care on 8/25/22 for a syncopal episode. Urgent care work up (CBC, BMP, U/A, Head CT, CXR, EKG, and orthostatic Bps) unremarkable. Normal stress test last year.

Today, she reports that she "just does not feel well". She reports fatigue, cough, congestion, and postnasal drainage x 2 weeks. She took a covid test at onset of sx and it was negative. She has allergies and takes her meds regularly. has asthma but has not felt the need to use her albuterol inhaler.

No chest pain, palpitations, SOB, DOE, back pain, abd pain, rashes, fever, chills, sweats, body aches, numbness, tingling, or weakness. No recurrent syncope or lightheadedness. No headache. No dizziness.

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

REVIEW OF SYSTEMS

Review of Systems

Constitutional: Positive for fatigue. Negative for chills, fever and unexpected weight change.

HENT: Positive for congestion and postnasal drip. Negative for ear pain, rhinorrhea, sinus pressure, sinus pain, sneezing, sore throat, trouble swallowing and voice change.

Eyes: Negative for pain, discharge, redness and visual disturbance.

Respiratory: Positive for cough. Negative for chest tightness, shortness of breath and wheezing.

Cardiovascular: Negative for chest pain, palpitations and leg swelling.

Gastrointestinal: Negative for abdominal pain, nausea and vomiting.

Musculoskeletal: Negative for arthralgias, back pain and myalgias.

Skin: Negative for pallor and rash.

Allergic/Immunologic: Positive for environmental allergies.

Neurological: Negative for dizziness, facial asymmetry, speech difficulty, weakness, numbness and headaches.

Hematological: Negative for adenopathy. Does not bruise/bleed easily.

Psychiatric/Behavioral: Negative for dysphoric mood, self-injury, sleep disturbance and suicidal ideas. The patient is not nervous/anxious.

Objective:

Vitals:

08/29/22 0819
BP: 136/90
Pulse: 71
Temp: 98.1 °F (36.7 °C)
SpO2: 97%

Body mass index is 39.15 kg/m².

No LMP recorded. Patient is perimenopausal.

Physical Exam

Vitals reviewed.

Example 4

Constitutional:

General: She is not in acute distress.

Appearance: Normal appearance. She is **obese**. She is not ill-appearing or toxic-appearing.

HEENT:

Head: Normocephalic and atraumatic.

Right Ear: Tympanic membrane, ear canal and external ear normal.

Left Ear: Tympanic membrane, ear canal and external ear normal.

Nose: **Mucosal edema, congestion and rhinorrhea** present. No nasal deformity. Rhinorrhea is **clear**.

Right Turbinates: **Swollen**. Not pale.

Left Turbinates: **Swollen**. Not pale.

Right Sinus: **Maxillary sinus tenderness** present. No frontal sinus tenderness.

Left Sinus: **Maxillary sinus tenderness** present. No frontal sinus tenderness.

Mouth/Throat:

Lips: Pink.

Mouth: Mucous membranes are moist.

Pharynx: Oropharynx is clear. Uvula midline. No oropharyngeal exudate or posterior oropharyngeal erythema.

Tonsils: No tonsillar exudate or tonsillar abscesses. **2+** on the right. **1+** on the left.

Eyes:

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Neck:

Thyroid: No thyromegaly.

Vascular: No carotid bruit.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulses: Normal pulses.

Carotid pulses are **2+** on the right side and **2+** on the left side.

Radial pulses are **2+** on the right side and **2+** on the left side.

Heart sounds: Normal heart sounds. No murmur heard.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No stridor. No wheezing, rhonchi or rales.

Musculoskeletal:

General: No swelling or deformity. Normal range of motion.

Cervical back: Normal range of motion and neck supple.

Right lower leg: No edema.

Left lower leg: No edema.

Skin:

General: Skin is warm and dry.

Capillary Refill: Capillary refill takes less than 2 seconds.

Coloration: Skin is not pale.

Findings: No rash.

Neurological:

General: No focal deficit present.

Mental Status: She is alert.

Cranial Nerves: No cranial nerve deficit.

Gait: Gait normal.

Psychiatric:

Mood and Affect: Mood normal.

Thought Content: Thought content normal.

Assessment:

(R55) **Syncope, unspecified syncope type**

(J01.00) Acute non-recurrent maxillary sinusitis - Plan: amoxicillin-clavulanate (AUGMENTIN) 875-125 mg per tablet

Plan:

Urgent care work up reviewed. Unremarkable.

Will treat current symptoms / acute sinusitis with augmentin. Continue to eat yogurt (probiotics).

If any new symptoms, recurrent syncope/fainting, seek care urgently. We discussed getting labs and an echocardiogram today, but will defer at this time.

PEX w/ on 9/29/22.

Pt agrees w/ plan.

Example 5

Example 5

Discharge Instructions Provider Information

Author:

Service:

Author Type:

Filed: 01/28/2022 09:16 PM

Encounter Date: 01/28/2022

Status: Signed

Provider Information

Follow-up with your PCP in 2 days
Return to the Emergency Department if any symptoms change or worsen.
Follow-up with specialist if listed on discharge paperwork.
Any X-rays done after hours will be over read in the am by staff and you will be notified of any changes.

Service: Author Type:
Filed: 01/28/2022 08:39 PM Encounter Date: 01/28/2022 Status: Signed
Editor:

Bed: 23
Expected date:
Expected time:
Means of arrival:
Comments:
Long

Service: Author Type:
Filed: 01/28/2022 08:20 PM Encounter Date: 01/28/2022 Status: Signed
Editor:

History

Chief Complaint

Patient presents with

- Shortness of Breath

Patient is a 21 y.o. male with a history of asthma who presents with shortness of breath. The patient reports for the past 2 to 3 days he has been experiencing sore throat, cough, rhinorrhea, diffuse myalgias, and a fever up to 103F at home. He tested positive for COVID-19 on 01/25. He has been taking Tylenol and ibuprofen for his symptoms. Today he had an episode of shortness of breath that lasted for a couple of hours while he was resting. He was concerned that it felt like an asthma attack. He states he has not used an inhaler in over a year and does not even own one. No chest pain. No abdominal pain. No nausea or vomiting. No leg swelling.

The history is provided by the patient.

Shortness of Breath
Severity: Moderate
Onset quality: Sudden
Duration: 2 hours
Timing: Constant
Progression: Resolved
Chronicity: New
Context: URI

Patient Name & Identifier

Admit Date/Date of Service: 01/28/2022

Discharge Date: 01/28/2022

HAR:

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Example 5

Relieved by: **Nothing**
Worsened by: **Nothing**
Ineffective treatments: **None tried**
Associated symptoms: **cough, fever and sore throat**
Associated symptoms: **no abdominal pain, no chest pain, no headaches, no rash and no vomiting**
CURB 65 Score: **0**
Risk factors: **no recent surgery**

Past Medical History:

Diagnosis	Date
<ul style="list-style-type: none">Asthma	

History reviewed. No pertinent surgical history.

Family History

Problem	Relation	Age of Onset
<ul style="list-style-type: none">None	Mother	
<ul style="list-style-type: none">None	Father	

Social History

Tobacco Use

<ul style="list-style-type: none">Smoking status:	Never Smoker
<ul style="list-style-type: none">Smokeless tobacco:	Current User
Types:	Snuff

Substance Use Topics

<ul style="list-style-type: none">Alcohol use:	Yes
<ul style="list-style-type: none">Drug use:	Never

Review of Systems

Constitutional: Positive for fever. Negative for chills.
HEENT: Positive for rhinorrhea and sore throat. Negative for congestion.
Eyes: Negative for visual disturbance.

Respiratory: Positive for cough and shortness of breath.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.

Endocrine: Negative for polyuria.

Genitourinary: Negative for dysuria, flank pain and hematuria.

Musculoskeletal: Positive for myalgias. Negative for back pain.

Skin: Negative for rash.

Allergic/Immunologic: Negative for immunocompromised state.

Neurological: Negative for dizziness, speech difficulty, light-headedness and headaches.

Psychiatric/Behavioral: Negative for behavioral problems and confusion.

All other systems reviewed and are negative.

Physical Exam

First Vitals Checked [01/26/22 2020]

BP	Heart Rate	Resp	Temp	SpO2
116/77	109	20	99.6 °F (37.6 °C)	98 %

Patient Name & Identifier

Discharge Date: 01/26/2022

HAP:

Example 5

Clinical Impressions as of 01/29/22 0740

COVID-19 virus infection

History of asthma

Short of breath on exertion

MDM

Number of Diagnoses or Management Options

COVID-19 virus infection: new and does not require workup

History of asthma: minor

Short of breath on exertion: new and does not require workup

Amount and/or Complexity of Data Reviewed

Tests in the radiology section of CPT®: reviewed and ordered

Review and summarize past medical records: yes

Independent visualization of images, tracings, or specimens: yes

Risk of Complications, Morbidity, and/or Mortality

Presenting problems: high

Diagnostic procedures: high

Management options: low

Patient Progress

Patient progress: stable

Assessment / Plan

Patient is a 21 y.o. male with a history of asthma who presents with shortness of breath for 2 hours that has resolved. He reports testing positive for COVID-19 2 days ago. He has URI symptoms as well as diffuse myalgias. Initial vital signs were notable for tachycardia, was WNL. Patient is saturating appropriately on room air. Exam was unremarkable. Lung sounds were clear to auscultation, no wheezing, RRR with no MRG. No unilateral leg swelling. Repeat vitals showed improvement of HR with no intervention. CXR was performed that showed no acute cardiopulmonary process. At this point, presentation is consistent with COVID-19 URI. Shortness of breath has resolved. Patient is given a prescription for inhaler. He is comfortable was discharged home with his mother.

I have personally seen and examined this patient and have participated in the care of this patient. I have reviewed and discussed with the resident all pertinent clinical information including history, physical exam and treatment plan.

The examiner was fully protected in appropriate PPE gear during the entirety of this exam.

Patient is a 21 y.o. male diagnosed today with

Final diagnoses:

COVID-19 virus infection

History of asthma

Short of breath on exertion

Patient presents emergency department history of asthma complaining of shortness of breath that has improved and is worse with exertion and tested positive for COVID-19 2 days ago.

Patient reports myalgias and is mildly tachycardic otherwise stable vital signs.

Patient has no other acute concerns or findings on exam and is required no intervention with a benign chest x-ray.

Patient's work-up is consistent with COVID-19 infection and he is stable for discharge home on albuterol as needed and follow-up information was given to discharge for PCP.

Patient was told to rapidly follow up with their primary care physician.

Patient Name & Identifier

Admit Date/Date of Service: 01/28/2022

Discharge Date: 01/28/2022

HAR:

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Example 5

Physical Exam

Vitals and nursing note reviewed.

Constitutional:

General: He is not in acute distress.

Appearance: Normal appearance. He is not ill-appearing.

HEENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Mouth/Throat:

Mouth: Mucous membranes are moist.

Eyes:

General: No scleral icterus.

Extraocular Movements: Extraocular movements intact.

Conjunctiva/sclera: Conjunctivae normal.

Cardiovascular:

Rate and Rhythm: Regular rhythm. Tachycardia present.

Pulses: Normal pulses.

Heart sounds: Normal heart sounds.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing.

Abdominal:

General: Abdomen is flat. Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness.

Musculoskeletal:

General: No swelling or tenderness. Normal range of motion.

Cervical back: Normal range of motion and neck supple.

Right lower leg: No edema.

Left lower leg: No edema.

Skin:

General: Skin is warm and dry.

Capillary Refill: Capillary refill takes less than 2 seconds.

Neurological:

General: No focal deficit present.

Mental Status: He is alert and oriented to person, place, and time.

Sensory: Sensation is intact.

Psychiatric:

Mood and Affect: Mood normal.

Behavior: Behavior normal.

Thought Content: Thought content normal.

ED Course

XR Chest I Vw Portable AP (Results Pending)

Stable

No results found for this visit on 01/28/22.

Procedures

ED Medication Orders (From admission, onward)

None

Example 6

Example 6

History of Present illness Narrative 10-10-2022

Note Date & Type	Note	Facility
10-10-2022 History of Present	Patient Name & Identifier	Baptist Health Medical Center - Arkansas
	<p>Gynecologic Exam</p> <p>HPI</p> <p>Patient is a 54 y.o. No obstetric history on file. female here for ANNUAL exam w/ no new medical or surgical illnesses. She is not taking HRT. This patient has had a hysterectomy.</p> <p>She is having vasomotor symptoms. At night. She reports no gynecologic symptoms.</p> <p>PAP was 1 year ago. Results: nl</p> <p>Mammo: denies breast symptoms. The pt does perform breast self-exams monthly. Her most recent mammogram was 1 year ago and was Normal. Had today.</p> <p>Patient's last menstrual period was 09/01/2015.</p> <p>Past Medical History:</p> <p>Diagnosis Date</p> <p>Anemia</p> <p>Anesthesia complication</p> <p>Possible vomiting with intubation/anesthesia with cholecystectomy. Gown had to be changed during recovery due to soiling.</p> <p>Asthma 07-2015</p> <p>Allergy to dust mites</p> <p>Past Surgical History:</p> <p>Procedure Laterality Date</p> <p>CHOLECYSTECTOMY</p> <p>GALLBLADDER SURGERY</p> <p>HYSTERECTOMY</p> <p>TVH</p> <p>MOUTH SURGERY</p> <p>Family History</p> <p>Problem Relation Age of Onset</p> <p>Diabetes Mother</p> <p>Arthritis Father</p> <p>Heart disease Father</p> <p>CHF</p> <p>Diabetes Brother</p> <p>Asthma Maternal Uncle</p> <p>Social History:</p> <p>Social History</p> <p>Tobacco Use</p> <p>Smoking status: Never Smoker</p> <p>Smokeless tobacco: Never Used</p> <p>Vaping Use</p> <p>Vaping Use: Never used</p> <p>Substance Use Topics</p> <p>Alcohol use: No</p>	

Example 6

Drug use: No

Current Outpatient Medications

Medication Sig Dispense Refill

albuterol (PROVENTIL HFA; VENTOLIN HFA) 90 mcg/actuation
inhaler Inhale 2 puffs into the lungs every 6 (six) hours as
needed for Wheezing.

No current facility-administered medications for this visit.

Allergies:

Nitrous oxide

Review of Systems:

Review of Systems

Constitutional: Negative for activity change, appetite
change, fatigue and fever.

Eyes: Negative for photophobia and visual disturbance.

Respiratory: Negative for shortness of breath.

Cardiovascular: Negative for palpitations and leg swelling.

Gastrointestinal: Negative for abdominal distention,
abdominal pain, blood in stool, constipation, diarrhea,
nausea and vomiting.

Endocrine: Negative for cold intolerance, heat intolerance
and polyuria.

Genitourinary: Negative for difficulty urinating, dyspareunia,
dysuria, flank pain, frequency, genital sores, hematuria,
menstrual problem, pelvic pain, urgency, vaginal bleeding,
vaginal discharge and vaginal pain.

Musculoskeletal: Negative for arthralgias.

Neurological: Negative for light-headedness and headaches.

Exam:

Vitals:

10/10/22 1512

Weight: 268 lb (121.6 kg)

Height: 5' 1" (1.549 m)

Physical Exam

Constitutional:

Appearance: Normal appearance.

HENT:

Head: Normocephalic and atraumatic.

Nose: Nose normal.

Eyes:

Extraocular Movements: Extraocular movements intact.

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Pulmonary:

Effort: Pulmonary effort is normal.

Chest:

Breasts:

Right: Normal.

Left: Normal.

Example 6

Comments: No lad BILATERALLY

Abdominal:

General: Abdomen is flat. Bowel sounds are normal.

Palpations: Abdomen is soft.

Genitourinary:

General: Normal vulva.

Exam position: Lithotomy position.

Vagina: Normal.

Cervix: Normal.

Uterus: Normal.

Adnexa: Right adnexa normal and left adnexa normal.

Musculoskeletal:

Cervical back: Normal range of motion and neck supple.

Skin:

General: Skin is warm and dry.

Neurological:

General: No focal deficit present.

Mental Status: She is alert and oriented to person, place, and time.

Assessment/Plan:

WWE

-PAP

-Encourage SBE monthly

I have counseled patient on preventative health maintenance & lifestyle issues including but not limited to safe sex practices, contraception, and risk of STDs, all according to the patients clinical situation and risk factors as assessed at this visit. I discussed routine screening mammography, colon screening guidelines, and cervical cytology screening according to the patients history and risk factors.

Provider Name

Example 7

Example 7

Patient Name & Identifier

Encounter Date: 09/12/2022

Patient

Name

Appt. Date/Time

09/12/2022 04:00PM

DOB

11/18/2018

Service Dept.

Scottsdale Children's Group - Shea Office

Provider

Insurance

Provider Name

Chief Complaint

sc Sick Visit

cough x 1 week , runny nose, possible sore throat
here w/ mom

Patient's Care Team

Primary Care Provider:

Patient's Pharmacies

WALGREENS DRUG:

Vitals

09/12/2022 04:03 pm

WT: 35 lbs 8 oz With
clothes (16.1 kg; 55th
%)ile)

T: 97.6 F° temporal
artery (36.44 C)

Allergies

Reviewed Allergies

CEFDINIR: Hives (Mild to moderate)

EGG: Hives (Mild to moderate)

Medications

Example 7

Reviewed Medications (09/12/2022)

albuterol sulfate 0.63 mg/3 mL solution for nebulization USE AS DIRECTED	07/13/21	filled
albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization USE 1 VIAL VIA NEBULIZER EVERY 4 TO 6 HOURS	11/22/21	filled
albuterol sulfate HFA 90 mcg/actuation aerosol inhaler inhale ONE PUFF BY MOUTH as needed FOR cough/wheeze	06/14/22	filled
amoxicillin 400 mg-potassium clavulanate 57 mg/5 mL oral suspension SHAKE LIQUID AND GIVE 4 ML BY MOUTH TWICE DAILY FOR 10 DAYS	11/22/21	filled
amoxicillin 400 mg/5 mL oral suspension SHAKE LIQUID AND GIVE 8 ML BY MOUTH TWICE DAILY FOR 10 DAYS AS DIRECTED	01/19/22	filled
azithromycin 200 mg/5 mL oral suspension SHAKE LIQUID WELL AND GIVE 4 ML BY MOUTH ONCE ON DAY 1 THEN 2 ML ONCE DAILY FOR DAYS 2 THROUGH 5	09/12/22	prescribed
cefdinir 250 mg/5 mL oral suspension SHAKE LIQUID AND GIVE 2.5 ML BY MOUTH TWICE DAILY FOR 10 DAYS. DISCARD REMAINDER	02/08/22	filled
ciprofloxacin 0.3 % eye drops	03/27/22	filled
Comp-Air Nebulizer Compressor USE WITH ALBUTEROL EVERY 3-4 HOURS	07/15/21	filled
EPINEPHrine (Jr) 0.15 mg/0.3 mL injection,auto-injector	08/16/21	filled
montelukast 4 mg chewable tablet TAKE 1 TABLET BY MOUTH EVERY DAY	07/15/22	filled
prednisolONE 15 mg/5 mL oral solution Take 5 mL every day by oral route as directed for 5 days.	09/12/22	prescribed
triamcinolone acetonide 0.1 % topical ointment APPLY TOPICALLY TO THE AFFECTED AREA TWICE DAILY AS NEEDED	04/26/22	filled
ZyrTEC	11/03/21	entered

Vaccines

Vaccines not reviewed (last reviewed 03/31/2020)

Vaccine Type	Date	Age	Amt.	Route	Site	NDC	Lot #	Mfr.	Exp. Date	VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis												
DTaP-IPV	03/31/20	1 y 4 mo	0.5 mL	Intramuscular	Thigh, Left		UJ190AAA	Sanoft Pasteur	02/22/21	Hb: 10/30/2019	03/31/20	Martha Seavedra MA

Example 7

Problems

Reviewed Problems

- Acute sinusitis - Onset: 11/03/2021
- Eczema - Onset: 03/31/2020
- Allergy to edible egg - Onset: 09/19/2019

Family History

Family History not reviewed (last reviewed 03/21/2019)

Social History

Social History not reviewed (last reviewed 03/31/2020)

General Pediatric

Name of Mother: Caroline

Name of Father: (Notes: No Involved)

Home and Environment

Are you passively exposed to smoke?: No

Marriage and Sexuality

What is your parents' marital status?: Unmarried

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

What was the date of your most recent tobacco screening?: 06/18/2019

Surgical History

Surgical History not reviewed (last reviewed 11/22/2021)

Past Medical History

Past Medical History not reviewed (last reviewed 11/22/2021)

Musculoskeletal/Rheum problem: Y - Ehrlös Danlos syndrome

Screening

Example 7

None recorded.

HPI

SC Pediatric Sick HPI

Reported by parent.

Notes:

cough x 1 week, runny nose, possible sore throat

h/o eczema, allergies, asthma, food allergies

takes benadryl and zyrtec, breathing treatments (svn) this am, inhaler with spacer/mask not working well

nasal congestion- croupy cough, montelukast q pm

no ear pain, no HA, no abd pain, no V/D, no new rashes

good appetite, good energy, working harder to breathe

no motrin or tylenol, no known sick exposures but goes to school, family with sore throat as well

ROS

ROS as noted in the HPI

Physical Exam

General Appearance: General Appearance: mildly ill appearing. Level of Distress: uncomfortable. Attentiveness: attentive.

HEENT: Eyes: PERRLA, EOMI, non-injected, and no exudates. Ears: right canal normal and TM normal, left TM normal and canal normal, and no pain with ear movement. Nose: rhinorrhea and nasal congestion. Oropharynx no erythema or exudate and moist mucous membranes and tonsils not enlarged; +PND, tongue coated.

Cardiovascular System: Heart Sounds: regular rate and rhythm and no murmur.

Lungs/Chest: Lungs/Chest no tachypnea or retractions and rhonchi.

Abdomen: Auscultation: normal bowel sounds. Palpation: not tender or distended and (normal) soft.

Skin: General: generalized warmth.

Assessment / Plan

1. Persistent cough -

Patient with cough. Supportive care with elevating the head of the bed, a humidifier at night, and frequent liquids. Return for tachypnea, retractions, shortness of breath, increasing/new fevers, chest pain, or not improved in 1 week. Rx azithromycin and prednisolone. Strep negative. Declined culture.

R05.3: Chronic cough

- azithromycin 200 mg/5 mL oral suspension - SHAKE LIQUID WELL AND GIVE 4 ML BY MOUTH ONCE ON DAY 1 THEN 2 ML ONCE DAILY FOR DAYS 2 THROUGH 5 Qty: (15) mL Refills: 0 Pharmacy: WALGREENS DRUG STORE #03215
- prednisolone 15 mg/5 mL oral solution - Take 5 mL every day by oral route as directed for 5 days. Qty: (25) mL Refills: 0 Pharmacy: WALGREENS DRUG STORE #03215
- RAPID STREP GROUP A, THROAT

RAPID STREP GROUP A, THROAT

- Result:
 - Rapid Strep: negative

Return to Office

Patient will return to the office as needed.

Encounter Sign-Off

Provider Name

Example 8

Example 8

Patient Name & Identifier

Provider Name

CC Chief Complaint

Joint pain

HPI

The patient is a Very pleasant 52-year-old male presenting for evaluation for joint pain. He reports the pain started suddenly approximately 5 years ago which is diffuse joint and muscles without any other associated symptoms except for fatigue, headache and insomnia. He has seen rheumatologist and has tried multiple treatments for presumed fibromyalgia including Cymbalta, Gabapentin and Lyrica which were ineffective. Flexeril was ineffective. He is seeing urologist and had brain MRI. He recently had cervical spine MRI results are pending. This has affected his life. He denies any photosensitive rash, oral ulcers, sicca symptoms, hair loss, pleurisy, neuropathy, fever or any weight loss. He is not able to exercise as much because of the myalgia.

AVISE test 12/2021 positive ANA titer 1:80 speckled pattern otherwise negative. Antihistone antibodies negative.

RS Rheumatic Review of Systems

12 point review of system was completed which was negative except for what was mentioned in the HPI (Subjective)

Constitutional: no recent weight loss; no recent weight gain; no fever; no chills; not sweating heavily at night;

Eye: no eye symptoms; not occurring briefly; no blurry vision; no gritty eyes; no pain in or around eyes; no red eyes;

ENT: no mouth sores; no nosebleeds; no hoarseness; no hearing loss; no mouth dryness; no sore throat; no ringing in ears;

Cardiovascular: no chest pain; no palpitations;

Pulmonary: no difficulty breathing; no cough; no wheezing;

GI: no abdominal pain; no constipation; no heartburn; no diarrhea; no black or tarry stools; no nausea; no vomiting; no bloating;

GU: no urinary urgency; not at night while asleep; no pain during urination; no hematuria; no burning sensation during urination;

Endocrine: no increased thirst; no heat intolerance; no cold intolerance; no hot flashes;

Hematologic Symptoms: no easy bleeding;

Neurological: no lightheadedness; no tremor; no difficulty with balance; no numbness; no dizziness; no fainting; no memory loss;

Muskuloskeletal Symptoms: no shoulder joint pain; **back pain; muscle aches; joint stiffness generalized;**

Psychological: no anxiety; no emotional lability; not depressed; **Initial;**

Skin: rash; itching;

Example 8

Problem List

Problems

ANA positive R76.8 (795.79): Onset Date: 08/10/2022

Allergies

Allergies

Eggs (edible):

Numb Nuts:

Medications

Medications

Dupixent 300 mg/2 mL subcutaneous syringe:

Medication Compliance

Medications Source: source of patient information was medication list ; source of patient information was patient's own medications;

Treatment Status: medication compliance reported;

- **Non-compliance:** no coffee consumption; no tea consumption; no cola consumption; not a current moderate tobacco smoker; not a light cigarette smoker; not a heavy cigarette smoker (20-39 / day); not a former smoker; **never smoked**;

Past Medical History

Status: past medical history reviewed; **asthma**; no diagnosis of hematologic disorder;

Past Surgical History

Status: surgical history reviewed;

Social History

Status: social history reviewed;

Diet: no vegetarian diet; no gluten-free diet;

Alcohol Use: not a social drinker; not drinking in moderation (2 drinks/day or fewer); no heavy alcohol consumption; not using alcohol; has not stopped drinking alcohol;

Exercise Habits: physical activity level appropriate for age;

Work History: working full time;

Marital History **single**; not currently married; not divorced; not widowed;

Family History

Status: family history reviewed;

Mother: age of mother 52 years; no diagnosis of heart disease; no diagnosis of obesity; no diagnosis of osteoporosis; no

Example 8

diagnosis of diabetes mellitus; no diagnosis of rheumatologic disorder; no diagnosis of osteoarthritis; no diagnosis of rheumatoid arthritis; no systemic lupus erythematosus; no diagnosis of fibromyalgia;

Father: no diagnosis of systemic HTN; no diagnosis of heart disease; no diagnosis of obesity; no diagnosis of osteoporosis; no diagnosis of diabetes mellitus; no diagnosis of rheumatologic disorder; no diagnosis of osteoarthritis; no diagnosis of rheumatoid arthritis; no systemic lupus erythematosus; no diagnosis of fibromyalgia;

Sister: no diagnosis of heart disease; no diagnosis of obesity; no diagnosis of osteoporosis; no diagnosis of diabetes mellitus; no diagnosis of rheumatologic disorder; no diagnosis of osteoarthritis; no diagnosis of rheumatoid arthritis; no systemic lupus erythematosus; no diagnosis of fibromyalgia;

Brother: no diagnosis of heart disease; no diagnosis of obesity; no diagnosis of osteoporosis; no diagnosis of diabetes mellitus; no diagnosis of rheumatologic disorder; no diagnosis of osteoarthritis; no diagnosis of rheumatoid arthritis; no systemic lupus erythematosus; no diagnosis of fibromyalgia;

Intake

Vital Signs

Date	Pulse	SpO2	FI02	BP	Resp	Temp	Height	Weight	Pain	BMI	Head Cir.
08/10/2022, 03:31 PM	65 beats/minute			106/77 mmHg		97.5 F	5 ft 9 in	134 lbs	2	19.8	

Physical Exam

General Appearance: well-appearing; well developed; well nourished;

Head Exam: ears normal; nose exam normal; no alopecia;

Neck Exam: no decrease in neck suppleness; salivary glands normal; cervical lymph nodes not enlarged;

Eye Exam: PERRLA; lacrimation not decreased; conjunctiva normal; sclera normal; no periorbital swelling; no redness; no jaundice;

Ear Exam: no inflammation of auricle; external auditory canal normal;

Nose: no nasal discharge; no sinus tenderness;

Oropharyngeal Exam: no mouth sores; buccal mucosa normal; not dry; floor of mouth not dry; no oral thrush; all teeth not absent; dentition not in poor repair; no gingival erythema; no ulceration of gums;

Cardiovascular Exam: heart rate and rhythm normal; heart sounds normal; no murmur; axillary lymph nodes not enlarged;

Lung Exam: no abnormal breath sounds; not wheezing; no rhonchi; no rales; respiratory excursion not diminished; no signs of hypoxia; no pleurisy; no oxygen via nasal cannula;

Abdominal Exam: abdomen soft; no abdominal distention; no abdominal tenderness; bowel sounds normal; no hepatomegaly; no splenomegaly;

Neurological Exam: oriented to time, place, and person; sensation intact for light touch; motor strength normal; normal muscle tone;

Psychiatric Exam: attitude normal; affect normal; not cooperative; pleasant;

Hands no pain elicited by motion of fingers of right hand; no pain elicited by motion of fingers of left hand; no swelling of DIP joints of right hand; no swelling of DIP joints of left hand; no tenderness on palpation of fingers; no Heberden's nodes; no Bouchard's nodes;

Wrists no pain elicited by motion of right wrist; no pain elicited by motion of left wrist; no swelling of tenosynovial compartments of wrist; no tenderness on palpation of dorsal aspect of right extensor pollicis brevis tendon; no tenderness on palpation of dorsal aspect of left extensor pollicis brevis tendon; no swelling along extensor pollicis brevis and abductor

Example 8

pollicis of right wrist; no swelling along extensor pollicis brevis and abductor pollicis of left wrist;

Elbows no range of motion evaluation; no pain elicited by motion of right elbow; no pain elicited by motion of left elbow; tenderness on palpation at lateral epicondyle of right elbow with negative tennis elbow test; tenderness on palpation at lateral epicondyle of left elbow with negative tennis elbow test;

Shoulders normal shoulder abduction; no pain of right shoulder elicited on motion; no pain of left shoulder elicited on motion; no tenderness on palpation at bicipital groove; no tenderness on palpation of acromioclavicular joint; no pain elicited during Hawkins-Kennedy impingement test of shoulder; no pain elicited during Jobe impingement test of shoulder;

Neck head is not tilted forward; normal active flexion of cervical spine; normal cervical spine extension; **abnormal cervical spine rotation to right; abnormal cervical spine rotation to left**; no muscle spasm at trigger point of cervical muscles;

Spine no thoracic spine dowager's hump; abnormal thoracolumbar spine kyphosis; full range of motion of thoracolumbar spine; no thoracolumbar spine pain elicited by flexion; no thoracolumbar spine pain elicited by extension; no tenderness on palpation of thoracolumbar spine;

Gait Exam: normal gait and stance; not antalgic; normal balance;

Hips no pain elicited by motion of right hip; no pain elicited by motion of left hip;

Knees no crepitus of patella; no pain elicited by motion of right knee; no pain elicited by motion of left knee; no erythema of right knee; no erythema of left knee; no prepatellar swelling of right knee; no prepatellar swelling of left knee; no tenderness of right insertion of sartorius, gracilis, and semitendinosus muscles; no tenderness of left insertion of sartorius, gracilis, and semitendinosus muscles; no tenderness on palpation of iliotibial tract of right knee; no tenderness on palpation of iliotibial tract of left knee;

Ankles no pain elicited in right ankle by motion; no pain elicited in left ankle by motion; no erythema of right ankle; no erythema of left ankle; no tenderness on palpation at Achilles tendon insertion of right foot; no tenderness on palpation at Achilles tendon insertion of left foot; plantar fascia of foot not thickened; no tenderness on palpation of plantar aspect of heel;

Feet no right foot pain elicited by motion; no left foot pain elicited by motion; no erythema of dorsal aspect of right foot; no erythema of dorsal aspect of left foot; no erythema of first right tarsometatarsal joint; no erythema of first left tarsometatarsal joint; no tenderness on palpation of tarsometatarsal joints; no tenderness of Achilles tendon on palpation;

Skin Exam: no skin malar erythema; no plaque with scales; no erythematous plaques; no scales of scalp; no Raynaud's phenomenon; skin not thickened; no nail dystrophy; no nail pitting;

✓ Assessment and Plan

1. **ANA positive R76.8 (795.79):**
08/10/2022
2. **Fatigue R53.83 (780.79):**
08/10/2022
3. **Pain in unspecified joint M25.50 (719.40):**
08/10/2022
4. **Cervicalgia M54.2 (723.1):**
08/10/2022

Assessment

The patient has chronic joint and muscle pain with associated is fatigue and headache. He was treated for presumed fibromyalgia without any improvement in symptoms. He has positive ANA but no other systemic symptoms of connective tissue disease. I feel his manifestations could be underlying connective tissue disease. Additional blood work was ordered to supplement the AVISE panel. We will obtain report of the recently completed cervical spine MRI.

Provider Name

Example 9

Example 9



Patient Name
& Identifier

no rapid heart beat with epinephrine, no blood thinners, no prosthetics, no allergy to latex, no allergy to epinephrine, no spinal cord stimulator, no brain stimulator, and no allergy to iodine.

ROS

Provider reviewed on Apr 08, 2022.

A focused review of systems was performed including integumentary and was notable for Rash.

No Problems With Healing And No Problems With Scarring (hypertrophic Or Keloid).

Overall Assessment: 4.0 - Severe
Itch Numeric Rating Scale (NRS): 7.0

Plan: Treatment Regimen.

Begin the following treatment(s): Would like to initiate Dupixent. Prescribed Elidel while we wait for Dupixent coverage.

Continue the following treatment(s): Triamcinolone ointment as needed for flares.

Recommend the following Over-The-Counter treatment(s): Probiotic/Prebiotic recommended La Roche Posay Thermal Spring Water.

Plan: Counseling.

I counseled the patient regarding the following:

Skin care: Patient should bathe using lukewarm water with a mild cleanser and moisturize immediately after.

Recommended Dove, unscented cleanser. Emollients should be applied at least 2-3 times daily. Avoid scented detergents or fabric softeners. Avoid excessive hand washing.

Expectations: The patient is aware that atopic dermatitis is chronic in nature and can improve with moisturizers and topical steroids and worsen with stress, scented soaps, detergents, scratching, dry skin, changes in weather and skin infections. Uncontrolled atopic dermatitis is associated with a negative quality of life and poor sleep.

Contact office if: Atopic Dermatitis worsens or fails to improve despite several weeks of treatment; patient develops skin infections (such as: yellow honey colored crusts or cold sores).

Eczema handout reviewed and provided.

I recommended the following:

Bleach Baths

Cleansers

Moisturizers

Plan: Additional Notes.

I gave patient: dupixent 200 mg samples per Lix. SC

Plan: Dupixent Initiation.

Indications:

Patient isn't a candidate for systemic therapy with methotrexate or cyclosporine.

Patient has been unresponsive to aggressive topical therapy.

Patient does not have access to phototherapy.

Failed Treatments: Topical Steroids and Topical Elidel

Treatment Protocol: 400mg on day one then 200mg every other week

Dupixent Counseling:

I discussed with the patient the risks of dupilumab including but not limited to eye infection and irritation, cold sores, injection site reactions, worsening of asthma, allergic reactions and increased risk of parasitic infection.

Live vaccines should be avoided while taking dupilumab. Dupilumab will also interact with certain medications such as warfarin and cyclosporine. The patient understands that monitoring is required and they must alert us or the primary physician if symptoms of infection or other concerning signs are noted.

Dupixent Monitoring:

There is no laboratory monitoring requirement with Dupixent.

2. MIPS

Plan: MIPS Quality.

Quality 226 (Tobacco Use Screening and Cessation Intervention): Patient screened for tobacco use and is an ex/non-smoker

Staff:

Provider Name

Example 10

Example 10



Piedmont

PHC Inpatient Record

Patient Name

Sex: F

Adm: 8/14/2022, D/C: 8/15/2022

All Notes (continued)

History

Chief Complaint

Patient presents with

- Flank Pain

Right. X this afternoon. Hx of kidney stones

The history is provided by the patient. No language interpreter was used.

55 y.o. female w/ a Hx of HTN and asthma presents to the ED via POV, c/o right flank pain which started this morning. Pt reports that she was having hematuria and flank pain earlier this week and thought that she was passing a kidney stone. Pt states that her pain had subsided, but returned today. Pt has a Hx of kidney stones and states that her pain feels similar to passing a stone. Pt has associated nausea. Pt denies vomiting. PSHx of cholecystectomy. There are no alleviating or exacerbating factors. No Tx has been tried to relieve the Sx.

Past Medical History:

Diagnosis

Date

- Allergic state

- Asthma

- History of hematuria
- Hypertension
- Kidney stone

Past Surgical History:

Procedure	Laterality	Date
• BREAST SURGERY Breast Reduction	Bilateral	2004
• LAPAROSCOPIC CHOLECYSTECTOMY		1995
• CESAREAN SECTION (SEE COMMENTS)		1992, 1999
• EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY		
• EYE SURGERY		
• TONSILLECTOMY childhood		
• TONSILLECTOMY		child

Family History

Adopted: Yes

Family history unknown: Yes

Example 10



PHC Inpatient Record

Patient Name

Sex: F

Adm: 8/14/2022, Dis: 8/15/2022

Additional Information

Social History

Tobacco Use

- Smoking status: Never
- Smokeless tobacco: Never

Vaping Use

- Vaping Use: Never used

Substance Use Topics

- Alcohol use: Yes
Alcohol/week: 0.0 standard drinks
Comment: only very occasionally - beer
- Drug use: No

Review of Systems

Constitutional: Negative for activity change, chills and fever.

HENT: Negative for rhinorrhea and sore throat.

Eyes: Negative for visual disturbance.

Respiratory: Negative for cough and shortness of breath.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.

Genitourinary: Positive for flank pain (right). Negative for dysuria and hematuria.

Musculoskeletal: Negative for arthralgias.

Skin: Negative for rash.

Neurological: Negative for weakness, numbness and headaches.

All other systems reviewed and are negative.

Physical Exam

BP 147/85 (BP Location: Right Upper Arm, Patient Position: Sitting, BP Cuff Size: Large) | Pulse 88 | Temp 97.9 °F (36.6 °C) (Temporal) | Resp 16 | SpO2 96%

Physical Exam

Vitals and nursing note reviewed.

Constitutional:

General: She is not in acute distress.

Appearance: She is well-developed. She is not ill-appearing, toxic-appearing or diaphoretic.

HENT:

Head: Normocephalic and atraumatic.

Eyes:

General: No scleral icterus.

Conjunctiva/sclera: Conjunctivae normal.

Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Pulses: Normal pulses.

Example 10



PHC Inpatient Record

Patient Name

Sex: F

Adm: 8/14/2022, D/C: 8/15/2022

Heart sounds: Normal heart sounds.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness. There is right CVA tenderness. There is no guarding or rebound.

Musculoskeletal:

Cervical back: Normal range of motion and neck supple.

Lymphadenopathy:

Cervical: No cervical adenopathy.

Skin:

General: Skin is warm.

Findings: No erythema or rash.

Neurological:

Mental Status: She is alert and oriented to person, place, and time.

Cranial Nerves: No cranial nerve deficit.

Psychiatric:

Speech: Speech normal.

ED Course

Alteplase Stroke Assessment

NIH Stroke Assessment Scale

MDM

Allergies:

Allergies

Allergen	Reactions
• House Dust Mite	
• Milk	

Vital Signs:

Reviewed the patient's vital signs.

Pulse oximetry interpretation: %

Old Medical Records:

There are no old records within Epic.

The patient's available past medical records and past encounters were reviewed.

Example 10

Medications given in the ED:

Current Outpatient Medications:

- cyclobenzaprine (FLEXERIL) 10 MG tablet, 2 (two) times daily as needed. , Disp: , Rfl:
- fluticasone propion-salmeteroL (ADVAIR) 100-50 mcg/dose diskus inhaler, Inhale 1 puff into the lungs every 12 (twelve) hours., Disp: , Rfl:
- hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet, Take 1 tablet (25 mg total) by mouth daily., Disp: 90 tablet, Rfl: 3
- loratadine (CLARITIN) 10 mg tablet, Take 10 mg by mouth daily., Disp: , Rfl:
- naproxen sodium/pseudoephedrin (SUDAFED 12 HR PRESSURE-PAIN ORAL), Take by mouth. The one that she has to purchased from behind pharmacy counter, Disp: , Rfl:
- potassium chloride (KLOR-CON) 10 MEQ CR tablet, Take 1 tablet (10 mEq total) by mouth daily., Disp: 90 tablet, Rfl: 3
- fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray, 1 spray by Nasal route daily., Disp: 3 each, Rfl: 3
- fluticasone-umeclidin-vilanter (TRELEGY ELLIPTA) 200-62.5-25 mcg DsDv, Inhale 1 puff into the lungs daily. (Patient not taking: Reported on 3/30/2022), Disp: 3 each, Rfl: 3

MEDICAL DECISION MAKING

Chief Medical Diagnosis: kidney stone

Differential Diagnosis include, but are not limited to:
UTI, pyelonephritis

Plan: CT, blood work, pain medication, UA.

Nursing Notes: Reviewed and utilized the nursing notes.

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