Wing Memorial Hospital and

DATE/TTIME: 2/27/2013

TO: Bert Pimentel

ATTENTION

ADDRESS:

FAX NUMBER: 866-828-4150 # of PAGES (including cover): 109

MESSAGE: Sample Reports

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	Diagnostic Imaging (Radiology)	413/284-5241	413/284-
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	Rehab Services	413/284-5254	413/284-5
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Signed: Ann Bibert Shaw

ABDELKADER

Lungs show diminished air entry; no wheezes or crackles.

BP [], pulse []. HEENT: []. Neck supple. No JVD, carotid bruits, cervical adenopathy. Lungs clear to auscultation. Heart - S1, S2. No murmurs, rubs or gallops. Abdomen benign, nontender. No palpable masses. Audible bowel sounds. Extremities, no edema. Neuro exam was grossly nonfocal.

REVIEW OF SYSTEMS: Denies chest pain, cough, fever, chills, dysuria, hematuria, abdominal pain, nausea, vomiting, diarrhea, headaches or dizziness.

BLOMERTH

Patient has completed a pain drawing and analog scale in chart for review.

BLOMERTH CERVICAL SPINE EXAM
PHYSICAL EXAMINATION: On examination of the skin of the cervical spine, there are no scars, bruises or discolorations. There are no obvious deformities. Supraclavicular fossae are clear. There is no cervical lymphadenopathy. Thyroid gland is nonpalpable. Trachea is mobile and midline. Lungs are clear to A&P. There is no evidence of vertebrobasilar deficit. There is no tenderness to palpation throughout, and the cervical spine is supple. Romberg test is negative. There is no drift in the upper extremities. There is no past pointing with finger-to-nose testing. There is no evidence of dysdiadochokinesis. Upper and lower extremity reflexes are brisk, intact and symmetrical. Plantar responses downward. There is no clonus. Upper extremity myotomes are intact and symmetrical and graded 5/5. Valsalva test is nonpainful. There is no pain with cervical distraction. There is no pain with cervical compression. There is no pain with cervical compression in the extended and rotated positions bilaterally.

BLOMERTH-LUMBAR SPINE PE
PHYSICAL EXAMINATION: On examination of the skin of the lumbar spine, there are no scars, bruises or discolorations. There is no pain with percussion of the costophrenic angles. There is 90 degrees of lumbar flexion. There is 30 degrees of lumbar extension. Romberg test is negative. There is no drift in the upper extremities. There is no past pointing on finger-to-nose testing. There is no evidence of dysdiadochokinesis. Toe and heel walk is strong and adequate. Lower extremity myotomes are graded 5/5 and symmetrical. Lower extremity reflexes are brisk, intact and symmetrical. Plantar response is downward. Straight leg raising is 90 degrees bilaterally without low back or leg pain. Milgram's test is negative. Fabere test is negative. Sciatic nerves are nontender to palpation. There is no pain with deep springing of the lower lumbar spinous processes.

4

BLOMERTH CONTINUED

Patient's condition was explai
Patient's condition was explained as well as therapy options. Risks of procedure were reviewed. It was emphasized that no guaranty of cure could be made. The patient appeared to understand and elected to begin care.

BLOMERTH PHYSICAL EXAM
OBJECTIVE: [] is alert, cooperative and well oriented. [] stands [] tall and weighs [] lbs. Right arm BP is [], left arm BP is []. Resting pulse is [] beats per minute and regular. Respirations are []. Oral temperature is [].

On exam of the skin of the cervical spine there are no scars, bruises or discolorations. There are no obvious deformities. Supraclavicular fossae are clear. There is no cervical lymphadenopathy. Thyroid gland is nonpalpable. Trachea is mobile and midline. Lungs are clear to A&P. There is no evidence of vertebrobasilar deficit. There is no tenderness to palpation throughout, and the cervical spine is supple. Romberg test is negative. There is no drift in the upper extremities. There is no past pointing with finger-to-nose testing. There is no evidence of dysdiadochokinesis. Upper and lower extremity reflexes are brisk, intact and symmetrical. Plantar responses down. There is no clonus. Upper extremity myotomes are intact and symmetrical and graded 5/5. Valsalva test is nonpainful. There is no pain with cervical distraction. There is no pain to cervical compression. There is no pain with cervical compression in the extended or rotated positions bilaterally.

BLOMERTH-SUBJECTIVE
The patient's condition was reviewed with [] as well as [] therapeutic options. Risks and procedure were reviewed. In particular, the risk of CVA with cervical manipulation was explained to the patient. The patient appeared to understand and elected to begin care.

DZIALO

DZIALO-FINDINGS

My findings today are as follows:

1. Onychocryptoses right and left great toes.

2. There is clinical evidence of mycoses of nails. Pain is present, ambulation restricted.

DZIALO-INSPECTION OF BOTH FEET

Inspection of both feet shows no sign of bacterial infection or ulceration. There is no

evidence of any digital or plantar excrescences.

DZIALO-TREATMENT

Treatment today consisted of:

1. Inspection of both feet.
2. Debridement of all nails 1-5 bilateral.
3. All nails are filed smooth.

KERESHI

KERESHI PE

On neurologic examination patient was alert and friendly.

Cranial nerve examination was normal. On exam of motor systems, muscle tone, strength, reflexes and coordination were normal. Sensory exam was normal.

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

OOS #: [redacted]

DATE OF SERVICE: 01/15/13

PCP: KHALED ABDELKADER, MD

LOCATION: PMC
PHYSICIAN/PROVIDER: KHALED ABDELKADER, MD
DICTATING: KHALED ABDELKADER, MD

HISTORY OF PRESENT ILLNESS: A 65-year-old white male with a history of hypertension, hyperlipidemia, status post cardiomyopathy, coronary artery disease, chronic kidney disease, gouty arthritis who came today for continuing care. The patient had gained a couple of pounds, sore throat and cold symptoms. He received the flu shot. No nausea, vomiting or diarrhea. No abdominal pain. He had diarrhea for one day in the past but nothing now. He had a recent eye exam. He denies leg swelling. He is not active.

REVIEW OF SYSTEMS: No sore throat, cough symptoms. No fever or chills or rash. No paroxysmal nocturnal dyspnea or orthopnea. No cough or wheezing. No abdominal pain.

PHYSICAL EXAMINATION: Blood pressure today 136/46, pulse 62, temperature 96.1, weight 210. HEENT no erythema or exudate. Neck is supple. No JVD, carotid bruits, cervical abdominal pain. Lungs are clear to auscultation. Heart S1, S2. No murmurs, rubs or gallops. Abdomen is benign, obese, nontender, no palpable masses. Extremities no edema. The rest of the examination was nonfocal. He has multiple moles especially the face and the neck.

ASSESSMENT AND PLAN: Status post gouty arthritis stable, hypertension, hyperlipidemia, coronary artery disease. Advised to get PSA checked, try to lose weight, regular exercises. Follow up in three months, discussed shingles vaccine. The patient is going to think about it.

010 T:dmh DD:20130115 TD:1448 DT:20130117 TT:1021 JOB:08-03250292

ABDEK/STE
DL: 01/17/13

KHALED ABDELKADER, MD

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: PALMER

DATE OF SERVICE: [redacted]

OOS #: [redacted]

PCP: KHALED ABDELKADER, MD

LOCATION: PMC
PHYSICIAN/PROVIDER: KHALED ABDELKADER, MD
DICTATING: KHALED ABDELKADER, MD

HISTORY OF PRESENT ILLNESS: A 49-year-old white male with history of hypertension, hyperlipidemia, fatty liver, impaired glucose tolerance in the past, lumbosacral disc disease who came in today for continuing care. The patient has been trying to be active and weight-lifting, exercising regularly. His blood pressure has been up and down sometimes. Denies sore throat, cold symptoms. No chest pain. No nausea, vomiting, diarrhea. He is having an eye exam done in three weeks. Denies any dysuria or hematuria. The patient had a colonoscopy in the past. He does not take any medication. He was on hydrochlorothiazide in the past.

REVIEW OF SYSTEMS: No sore throat or cold symptoms. No headaches. No nausea, vomiting, or diarrhea. No abdominal pain. No dysuria or hematuria.

OBJECTIVE: Blood pressure was 160/102, pulse of 88, weight 170. When it was checked with his machine, it was 186/119. HEENT: Shows no erythema or exudate. Neck: Supple. No JVD, carotid bruits, cervical adenopathy. Lungs: Clear to auscultation. Heart: S1, S2, no murmurs, rubs, or gallops. Abdomen: Benign, nontender. No palpable masses. Extremities: No edema. Neurologic examination: Nonfocal.

ASSESSMENT AND PLAN: Hypertension, uncontrolled. Advised to restart hydrochlorothiazide, follow a diet, try to lose weight. Hyperlipidemia. Blood work will be done next May as well as PSA. The patient will be due for a colonoscopy. Advised to be active and lose weight. Follow up in three months. Check blood pressure in six weeks.

010 T:mj DD:20130114 TD:1431 DT:20130116 TT:0857 JOB:10-03014359

ABDEK/STE
DL: 01/16/13

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: PALMER

DATE OF SERVICE: [redacted]

OOS #: [redacted]

PCP: KHALED ABDELKADER, MD

LOCATION: PMC
PHYSICIAN/PROVIDER: KHALED ABDELKADER, MD
DICTATING: KHALED ABDELKADER, MD

HISTORY OF PRESENT ILLNESS: A 44-year-old white female with history of Crohn disease, GERD, status post Barrett esophagitis, depression, chronic back pain, status post ileostomy chronic resection. The patient came in today complaining of left-sided spasm and pain, especially in the left shoulder radiating to the left hand and left arm and left leg spasm at night with some left hand numbness and itching. The patient denied any injury. The spasm and the pain would be especially at night on the left side. Chronic lower back pain. She has been unable to sleep for the past four days. Walking with help if she gets up from bed. The patient has had these symptoms for about a month. She has history of left ovarian cyst. She is having pelvic pain of unclear etiology.

REVIEW OF SYSTEMS: No sore throat, cold symptoms. No cough. No nausea, vomiting, diarrhea. No dysuria or hematuria. No fever or chills. No neck pain.

OBJECTIVE: Blood pressure was 130/80, pulse 70, weight 182. HEENT showed postnasal drip, congested nasal mucosa. No cervical spine tenderness. Lungs clear to auscultation. Heart S1, S2. No murmurs, rubs or gallops. Abdomen benign, nontender. No palpable masses. Ileostomy bag. Extremities, no edema. There is decreased range of movement of the left shoulder, especially on abduction and external rotation. Right straight leg raising test is diminished because of back pain and lumbosacral tenderness. Left-sided straight leg raise test was normal. Normal range of movement of the hips. Deep tendon reflexes +2 and symmetrical.

ASSESSMENT AND PLAN: Left shoulder pain and left-sided spasm of unclear etiology. Advised moist heat and use Voltaren 75 mg twice a day. Chest x-ray will be obtained for the left shoulder. Advised to get blood work done including electrolytes and magnesium. The patient will be coming back in followup in two weeks. She already tried the tramadol; it did not help.

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NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: KHALED ABDELKADER, MD
DICTATING: KHALED ABDELKADER, MD

OFFICE VISIT CONTINUED:

010 T:bjh DD:20130116 TD:1537 DT:20130118 TT:1057 JOB:10-03017438

ABDEK/STE
DL: 01/18/13

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: PALMER

DATE OF SERVICE: 01/17/13

OOS #: [redacted]

PCP: KHALED ABDELKADER, MD

LOCATION: [redacted]
PHYSICIAN/PROVIDER: KHALED ABDELKADER, MD
DICTATING: KHALED ABDELKADER, MD

HISTORY OF PRESENT ILLNESS: A 47-year-old white male with history of hypertension, asthma, allergic rhinitis, status post right knee reconstructive surgery, left knee arthroscopic surgery for meniscal tear in the past. The patient had been having knee pain, especially on the left side, on and off. Been on etodolac by his orthopedic doctor, once a day. The patient's blood pressure is higher during the midafternoon usually. He gained seven pounds since last visit. He has been watching his salt intake. Denies any sore throat, cold symptoms. No chest pain or cough. No wheezing. No leg swelling. No numbness, tingling sensation. The patient denies fever or chills or cough.

REVIEW OF SYSTEMS: No sore throat, cold symptoms. No abdominal pain. No knee swelling. No fever or chills or rash. The patient is not active. Had a low vitamin D level.

OBJECTIVE: Blood pressure 148/94. Pulse of 84. Weight 181. HEENT showed postnasal drip. Ears normal. Neck supple. No JVD, carotid bruits, cervical adenopathy. Lungs clear to auscultation. Heart S1, S2; no murmurs, rubs or gallops. Abdomen benign, nontender, no palpable masses. Decreased range of movement of the left knee.

ASSESSMENT AND PLAN: Bilateral knee pain, left more than the right. Advised to follow up with his orthopedic doctor. Keep legs elevated. Use vitamin D supplements. Avoid salt in his diet. Keep checking blood pressure at home and get a followup in six weeks to recheck his blood pressure. If it is still high, we might need to increase his diltiazem or add hyddrochlorothiazide. Follow up in three months.

010 T:cmh DD:20130117 TD:1804 DT:20130121 TT:1013 JOB:10-03019299

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DL: 01/21/13

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

HISTORY & PHYSICAL EXAM

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

DATE OF ADMISSION: [redacted]

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF ADMISSION: 02/14/2013

DATE OF SERVICE: 02/14/2013

CHIEF COMPLAINT: Left-sided numbness.

HISTORY OF PRESENT ILLNESS: A 58-year-old white male with history of hypertension, hyperlipidemia, diabetes, GERD, diabetic neuropathy, patient of Dr. Dangman who is noncompliant and does not take his medicine regularly, who presented to the emergency room after he started having severe left foot sharp pains around 12:30 today and radiated to the left leg and numbness on the left side of his face and left side of the chest and arm. He had recurrent headaches on and off. The symptoms got worse until he went to the emergency room around 3:30. His usual neuropathy was in the form of bilateral feet numbness for the past two or three years, but these symptoms today are new, including the pain and the numbness on the left side of his face and the left arm with sudden onset associated with difficulty in concentration or remembering names at work. The patient, as mentioned, is noncompliant. He does not check his sugar regularly. Does not take his medications for blood pressure on a regular basis because of sometimes inability to afford the copayments. The patient denies blurry vision, double vision. No weakness. The pain is mostly at the plantar aspect of the left foot. No slurred speech. No abdominal pain. The patient denies chest pain or cough. No lightheadedness or dizziness. Occasional heartburn if he eats late.

PAST MEDICAL HISTORY: As mentioned, type 2 diabetes, hypertension, hyperlipidemia, GERD, dysphagia, diabetic neuropathy, foot pain in the past. Also noticed difficulty healing. Followed by Dr. Umanzor in the past. He is followed by podiatry clinic. History of left collarbone fracture, cleft palate and harelip surgery. Two trials of bone marrow transplantation for the cleft palate did not work.

SOCIAL HISTORY: He currently works with mentally challenged adults. The patient used to smoke. Quit 20 years ago. He used to smoke up to four packs per day for about 31 years. Occasional alcohol use.

ALLERGIES: _____ QUINAPRIL will give him cough.

Additional copy

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

FAMILY HISTORY: Brother with leukemia. Mother is diabetic.

CURRENT MEDICATIONS: Aspirin 81 mg p.o. once a day, metformin 500 mg three extended-release tablets once a day, omeprazole 20 mg p.o. once a day, simvastatin 40 mg p.o. once a day, valsartan 160 mg p.o. once a day.

REVIEW OF SYSTEMS: The patient is getting occasional headaches at least twice a week. No blurry vision, double vision. No fever. Denies sore throat or cold symptoms. No chest pain or palpitations. No shortness of breath. No cough or wheezing. Denies any nausea, vomiting, diarrhea, constipation. Occasional heartburn, especially if he eats at night. No dysuria or hematuria. No melena or bright red blood per rectum. No joint pains or aches. The patient had difficulty healing with scratches and abrasions. Denies any dizziness. No tremors. No heat or cold intolerances, easy bleeding or bruises. The rest of the review of systems was negative.

PHYSICAL EXAMINATION: VITAL SIGNS: On admission, the patient had blood pressure 157/88, pulse 88, temperature 98.7.

GENERAL: Well-developed, well-nourished male sitting in bed in no apparent distress.

HEENT: Postnasal drip. No icteric tinge.

NECK: Supple. No JVD, carotid bruits, cervical adenopathy.

LUNGS: Clear to auscultation.

HEART: S1, S2. No murmurs, rubs or gallops.

ABDOMEN: Obese, nontender. No palpable masses.

EXTREMITIES: No edema.

NEUROLOGIC: The patient with decreased sensation with the monofilament examination in the left leg in comparison with the right. No difference in sensation in the face or the arms. Cranial nerves II-XII within normal limits. No motor or sensory deficits. Deep tendon reflexes +2 and symmetrical. No slurred speech. The patient alert and oriented x3.

LABORATORY AND OTHER STUDIES: The patient had sodium 140, potassium 3.6, chloride 106, bicarb 28, BUN 13, creatinine 1.22, glucose 232. Troponin 0.03, INR 1. White count 10.5, H&H 10.3/32.4, platelet count 277. CT scan of the head showed no apparent disease. Chest x-ray showed no apparent disease. History of trace laryngeal penetration

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

with barium swallow in the past followed by Dr. Wexler. EKG showed normal sinus rhythm with LVH, Q-wave inversions in lead I, aVL and the anterolateral leads V3 through V6. No old EKG for comparison.

ASSESSMENT AND PLAN: Left foot pain and left-sided numbness. The patient to be admitted for neuro checks every two hours for 24 hours. Rule out transient ischemic attack. MRI will be done in the morning, including carotid ultrasound. Hyperglycemia. The patient will be started on his medication, and insulin sliding scale will be applied. Deep vein thrombosis prophylaxis with subcu Lovenox. History of anemia. Anemia workup will be done. EKG changes. Try to get old EKG for comparison. The patient will be admitted to observation. Left foot pain. Will be started on gabapentin and Vicodin as needed. Hypertension, uncontrolled. We will be adding a calcium channel-blocker to his ARB and increase Losartan to 100 mg a day. Duration of stay will depend on clinical course.

It took over an hour for the patient's evaluation including over 35 minutes of face-to-face evaluation.

010 T:trp DD:20130214 TD:2145 DT:20130215 TT:1123 JOB:08-03282751

KHALED ABDELKADER, MD

ABDEK/STE
D: 02/14/13
T: 02/15/13

Additional copy

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

HISTORY & PHYSICAL EXAM

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

DATE OF ADMISSION: 02/07/13

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF SERVICE: 02/07/13

DATE OF ADMISSION: 02/07/13

CHIEF COMPLAINT: Change in mental status.

HISTORY OF PRESENT ILLNESS: An 89-year-old white female with history of hypertension, hypothyroidism, mild dementia, osteoarthritis, recurrent atrial fibrillation, chronic kidney disease, chronic headaches, history of congestive heart failure, TIA, aortic stenosis. Was on Coumadin which was stopped because of subdural hematoma after a fall. The patient was switched to aspirin. Has history of macular degeneration. Lives in assisted living for a couple of years. A patient of Dr. Kurella, who was noted by the staff and the son that she became unresponsive and closed her eyes. Was not talkative and not responding to outside stimuli for about an hour. Did not have any fever or seizures. No injuries or falls. No nausea, vomiting, diarrhea. She had chronic headaches. Takes tramadol twice a day, occasional ibuprofen around noontime. _____ problems. There were similar episodes in the past. The patient was admitted last month for shortness of breath, weakness, acute renal insufficiency, elevated troponin, chronic atrial fibrillation, history of peripheral vascular disease. The patient stayed in this condition for about an hour and by the time she came to the emergency room, she was back to her baseline according to her son and daughter who have been involved in her care. The patient had recurrent right little toe ulcer. No chest pain. No fever or chills. No dysuria or hematuria. No abdominal pain. The patient did not get evaluated for chronic headaches.

PAST MEDICAL HISTORY: Chronic headaches, chronic atrial fibrillation, status post subdural hematoma, TIA, macular degeneration, hypertension, hypothyroidism, DJD, dementia, chronic aortic stenosis, history of congestive heart failure.

PAST SURGICAL HISTORY: History of appendectomy, carpal tunnel syndrome surgery, cervical disc disease surgery in the past.

SOCIAL HISTORY: The patient does not smoke or drink.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted] MD
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

FAMILY HISTORY: Noncontributory.

ALLERGIES: TOBRAMYCIN EYE DROPS.

CURRENT MEDICATIONS: Aspirin 81 mg p.o. once a day, Levothroid 75 mcg p.o. once a day, Remeron 15 mg one-half tablet q.h.s., Toprol XL 25 mg p.o. once a day, tramadol 50 mg b.i.d.

REVIEW OF SYSTEMS: According to her daughter and son, the patient did not have any sore throat or chest pain. No cough or wheezing. No nausea, vomiting, diarrhea. No dysuria or hematuria. No melena or bright red blood per rectum. No dizziness or fever or chills. No rash. No easy bleeding or bruises. The rest of the review of systems was negative.

PHYSICAL EXAMINATION: The patient's blood pressure on admission 145/81, pulse 78, temperature 98.

GENERAL: Sitting in bed, frail patient, in no apparent distress.

HEENT: Dry mucous membranes. Showed no erythema or exudate.

NECK: Supple. No JVD, carotid bruits, cervical adenopathy.

LUNGS: Clear to auscultation.

HEART: S1, S2. No murmurs, rubs or gallops.

ABDOMEN: Benign, nontender, no palpable masses.

EXTREMITIES: No edema. The patient has a right little toe ulcer, some swelling. Deep peripheral pulses.

NEURO: The patient is alert. Cranial nerves II-XII within normal limits. No motor sensory deficits.

SKIN: Maculopapular rash on her legs.

LABORATORY AND OTHER STUDIES: Sodium of 140, potassium 5.1, chloride 103, bicarb 27, BUN 51, creatinine 1.91, troponin 0.06, BNP 1440. White count 4.4, H&H 11.2/35.8, platelet count 175. CAT scan of the head showed no apparent disease. Chest x-ray showed pulmonary vascular congestion unchanged.

ASSESSMENT AND PLAN: Change in mental status, chronic headaches, acute renal injury, right little toe ulcer, and dementia. The patient's code status is DNR/DNI. To be admitted for observation. Neuro checks every two hours for 24 hours. Fall risk. Neuro consult. Right little toe ulcer, consult Dr. Canto. Check UA. Acute renal injury, gentle

Additional copy

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

hydration with fluids. Chronic headaches, neuro consult. Duration of stay depending on clinical course.

It took over an hour for the patient's H&P preparation.

010 T:dea DD:20130207 TD:2249 DT:20130208 TT:1006 JOB:08-03275583

KHALED ABDELKADER, MD

ABDEK/STE
D: 02/07/13
T: 02/08/13

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

HISTORY & PHYSICAL EXAM

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

DATE OF ADMISSION: [redacted]

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DATE OF ADMISSION: 01/31/2013

DATE OF SERVICE: 02/01/2013

CHIEF COMPLAINT: Status post fall and right upper back pain.

HISTORY OF PRESENT ILLNESS: A 98-year-old white female with history of recent admission at the beginning of the month for a mechanical fall, left hip contusion, hypertension, hyperlipidemia, anxiety, osteoporosis, multiple back compression fractures, anxiety, chronic anemia, dyslipidemia who presented to the emergency room today after she fell at home. Fell in her room. She fell backwards, hurting her right upper back. Unable to tolerate the pain, the patient called the nurse who told her come to the emergency room. She tripped. Denied head injury, loss of consciousness. She had been having a problem with her balance. She lives alone. Feeling lightheaded. Denies chest pain or palpitation. She had difficulty with her vision. No blurry vision, double vision. No weakness. The patient denied any seizures. She had chronic shoulder pains and got prednisone injections in her shoulders in the past. She stated that she fell, actually, yesterday while ambulating. Did not hit any furniture. When the pain got worse, that was when she called the nurse today. She has been having occasional cough, dizziness. The pain was 10/10 in intensity. She has multiple allergies to pain medicines. The patient was able to open the door for the EMTs. The patient was short of breath. She was transported to the emergency room for evaluation.

PAST MEDICAL HISTORY: As mentioned, with osteoporosis and anxiety, back compression fractures, hypertension, hyperlipidemia, anemia, history of left shoulder rotator cuff tear, bilateral shoulder pains, status post bilateral cortisone injections in both shoulders, right knee fractures in the past.

SOCIAL HISTORY: The patient lives alone. Does not drink or smoke. Does not use a cane or walker currently.

FAMILY HISTORY: Noncontributory.

CURRENT MEDICATIONS: Ativan 0.25 mg every four hours p.r.n., Caltrate

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

600 mg p.o. b.i.d., Colace 100 mg p.o. b.i.d., natural tears two drops three times a day to both eyes, Norvasc 5 mg p.o. once a day, Ocuvite 2 mg b.i.d., senna two tablets q.h.s., tramadol 50 mg one tablet every six hours p.r.n., trazodone 50 mg q.h.s. one-half to one tablet as needed, Tylenol 650 mg q.4 hours p.r.n.

ALLERGIES: The patient had allergy to OXYCODONE, which gave her hallucinations; PERCOCET gave her hallucinations; VICODIN as well.

REVIEW OF SYSTEMS: The patient had been having a dry throat, but no cold symptoms. Occasional cough. No nausea, vomiting, diarrhea. No dysuria or hematuria. No fever or chills. Feeling lightheaded and dizzy sometimes. Leg cramps, imbalance, dizziness. No leg swelling.

PHYSICAL EXAMINATION: VITAL SIGNS: Blood pressure 125/56, pulse 89, temperature 99.

GENERAL: The patient is sitting in bed in mild distress.

HEENT: No erythema or exudate.

NECK: Supple. No JVD, carotid bruit, cervical adenopathy.

LUNGS: Diminished air entry. No wheezes or crackles.

HEART: S1, S2. Ejection systolic murmur 2/6 at the base.

ABDOMEN: Benign, nontender. No palpable masses.

MUSCULOSKELETAL: There is decreased range of motion of both shoulders. Pain in the right upper back, posterior shoulder blade. No knee swelling. Decreased range of motion of both ankles. No cervical spine or lumbosacral spine tenderness.

NEUROLOGIC: Grossly nonfocal.

LABORATORY AND OTHER STUDIES: The patient had an x-ray of the chest, ribcage. No rib fracture could be seen. Sodium 133, potassium 4.6, chloride 101, bicarb 28, BUN 20, creatinine 0.78, glucose 110, calcium 8.4. White count 15.8, platelet count 255, H&H 9.5/28.6 with 14 monocytes, 5 lymphs.

ASSESSMENT AND PLAN: Status post fall, severe right upper back pain. She will be admitted for observation, pain control and placement because of multiple falls in the same month. Continue the current medication. Leukocytosis. We will repeat CBC and get a urinalysis and chest x-ray in the morning. Hypertension. Continue the current medication. Duration of stay will depend on clinical course.

Additional copy

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: KHALED ABDELKADER, MD

HISTORY & PHYSICAL EXAM CONTINUED:

It took over an hour for the patient's admission including over 35 minutes face-to-face.

010 T:trp DD:20130201 TD:0035 DT:20130201 TT:1326 JOB:10-03033824

KHALED ABDELKADER, MD

ABDEK/STE
D: 02/01/13
T: 02/01/13

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

PCP: JOANNA PREIBISZ, MD

LOCATION: PMC
PHYSICIAN/PROVIDER: PAUL D.C. BLOMERTH
DICTATING: PAUL D.C. BLOMERTH

SUBJECTIVE: The patient tells us that she has noticed no major changes in her neck since the last time we saw her. She is a bit more stiff today with the cold, but this is within normal variation of the trouble that she has.

OBJECTIVE: Motion palpation reveals restricted right lateral bending at C2-3.

ASSESSMENT: The patient has cervical degenerative joint disease.

PLAN: Manipulation to above-mentioned areas of fixation with activator instrument. Ultrasound is used at 1 W/cm2 for five minutes for its analgesic and antiinflammatory properties. We will recommend that the patient see us again in three days. We will continue with our short trial of treatment.

054 T:laa DD:20130118 TD:1200 DT:20130121 TT:1741 JOB:10-03019859

BLOP /STE
DL: 01/21/13

_____
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MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #[redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: [redacted]
PHYSICIAN/PROVIDER: PAUL D.C. BLOMERTH
DICTATING: PAUL D.C. BLOMERTH

PCP: BART SOAR, MD

SUBJECTIVE: The patient states that he has zero pain today. Overall, he has been having some twinges occasionally, but at the moment, he has no trouble. He has been a lot better since his last visit to us. The pain on the dorsum of his left foot improved immediately after the last time we saw him.

OBJECTIVE: Motion palpation reveals some restriction at the left sacroiliac joint. There is restricted left rotation at L4-5.

ASSESSMENT: The patient is much better. He does have some segmental dysfunction on the lower lumbar spine, and leg length inequality.

PLAN: Manipulation of above-mentioned areas of fixation with activator instrument. Ultrasound was used at 1 W/cm2 for its analgesic and antiinflammatory properties. The patient is requested to follow up in a few days just to make sure he is good. Otherwise, we will see him on Friday, and that should be his last visit to us.

054 T:gia DD:20130116 TD:1041 DT:20130117 TT:1025 JOB:10-03016762

BLOP /STE
DL: 01/17/13

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: 02/04/13 OOS #: [redacted]

LOCATION: [redacted] PCP: BART SOAR, MD
PHYSICIAN/PROVIDER: PAUL D.C. BLOMERTH
DICTATING: PAUL D.C. BLOMERTH

HISTORY OF PRESENT ILLNESS: The patient tells us that she is still having some pain in her right lower back. Her 18-month-old and 4-year-old niece and nephew were visiting for the weekend and she did a lot of bending over the children. It has caused some setback, although her pain is really only about the same as the last time she was in. She has been utilizing the cat back exercises.

OBJECTIVE: Motion palpation reveals fixation at the right sacroiliac joint in extension.

ASSESSMENT: The patient has had a flareup of her back trouble.

PLAN: Manipulation to above-mentioned areas of fixation with activator instrument and pelvic blocking. Ultrasound is used at one watt per cm2 for five minutes for its analgesic and anti-inflammatory properties.

We will recommend that the patient see us again in about four days.

054 T:ar DD:20130204 TD:0919 DT:20130205 TT:1145 JOB:10-03035614

BLOP /STE
DL: 02/05/13

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MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: [redacted]
PHYSICIAN/PROVIDER: PAUL D.C. BLOMERTH
DICTATING: PAUL D.C. BLOMERTH

PCP: SARVALAKSHMI KURELLA, MD

HISTORY OF PRESENT ILLNESS: The patient tells us that she cannot remember having any arm symptoms lately. Her neck pain is down to a 2 on a scale of 0-10 and she continues to improve.

OBJECTIVE: Motion palpation reveals restricted right lateral bending at C5-6. There is tightness and tenderness in the right scalenes, particularly in the C5-6 area.

ASSESSMENT: The patient has cervical segmental dysfunction associated with intermittent radiculopathy and neck pain. This is complicated by cervical degenerative joint disease.

PLAN: Manipulation to above-mentioned areas of fixation with activator instrument. Ultrasound was used at one watt per cm2 for its analgesic and antiinflammatory properties. Active release procedure is used in the right scalene. Manual cervical traction was also utilized. Recommend the patient see us again in and around two weeks. We will taper off treatment. We plan to release the patient to an on-call or as-needed basis in the next few weeks.

054 T:cmh DD:20130213 TD:0911 DT:20130214 TT:1311 JOB:08-03279927

BLOP /STE
DL: 02/14/13

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB:

MR #: [redacted]
CHART LOC:

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: PMC
PHYSICIAN/PROVIDER: PAUL D.C. BLOMERTH
DICTATING: PAUL D.C. BLOMERTH

PCP: KHALED ABDELKADER, MD

HISTORY OF PRESENT ILLNESS: The patient is a 71-year-old, right-handed female who was in to see us today for lower back pain. She tells us her symptoms came on around one week ago without any particular incident or trauma. Her symptoms have been coming and going, but never fully resolving. This is the same problem that we have seen her for in the past. A review of our records reveals we have seen the patient in 2008, 2010, and 2011 for identical problems. She feels worse with sitting and a bit better with the use of cold, a pillow behind her back, and getting up and moving around. She describes a dull, achy pain in the right lower back that does not radiate into the lower extremities. She denies any changes in bowel or bladder. Her symptoms are worse first thing in the morning and at the end of the day, as well as varying with position. She denies any throbbing character to her pain. Her activities of daily living are not limited.

REVIEW OF SYSTEMS: On further review of systems, the patient is a nonsmoker. She currently takes omeprazole, lisinopril/HCTZ, and a daily baby aspirin. She denies any history of malignancy or inflammatory arthropathy.

OBJECTIVE: On examination, the patient is alert, cooperative, and well oriented. Her gait is slightly guarded. She stands 5 feet, 5 inches tall and weighs 131 pounds. The left arm blood pressure is 130/82. Resting pulse is 62 beats per minute and regular, respirations are 16. Oral temperature is 97.8 degrees Fahrenheit.

On examination of the skin over the lumbar spine, there are no scars, bruises, or discolorations. There does appear to be some flattening of the normal lumbar lordosis. There is no pain with percussion over the costophrenic angles. There is tenderness and fixation at the right sacroiliac joint. There is 70 degrees of lumbar flexion and 10 degrees of extension, both without pain. Romberg test is negative. There is no drift in the upper extremities. There is no past pointing with finger-to-nose testing. No evidence of dysdiadochokinesis. Toe and heel walk is strong and adequate. Lumbar myotomes are strong, intact, symmetrical, and greater than 5/5. Patellar reflexes are trace. Achilles reflexes are 0. There is no clonus. Straight leg raising is 70 degrees bilaterally without pain. Milgram test is negative. Fabere test is negative. The sciatic nerves are nontender to palpation.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: PAUL D.C. BLOMERTH

OFFICE VISIT CONTINUED:

RADIOGRAPHIC EXAMINATION: X-rays are deferred for the time being.

DIAGNOSIS: The patient has sacroiliac segmental dysfunction associated with lower back pain and complicated by lumbar disc degeneration.

The patient's condition is reviewed with her. We have treated her very effectively numerous times in the past. There is no reason to suspect that she will not benefit from our treatment today.

PLAN: Manipulation is performed at the right sacroiliac joint with activator instrument. Ultrasound is used at 1 W/cm2 for five minutes for its analgesic and antiinflammatory properties. We will recommend that the patient see us again in five days. We would see her on Friday; however, there is a fairly large snowstorm projected.

054 T:laa DD:20130206 TD:1124 DT:20130208 TT:1705 JOB:08-03273150

BLOP /STE
DL: 02/08/13

PAUL D.C. BLOMERTH

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: BMC
PHYSICIAN/PROVIDER: RICHARD DPM DZIALO
DICTATING: RICHARD DPM DZIALO

PCP: ELIZABETH RODGERS, MD

SUBJECTIVE: The patient is an 83-year-old diabetic female who presents here today for initial visit. The patient as a diabetic would be at risk doing her own nails. Care by a nonprofessional would pose as a health hazard for the patient. The patient's primary care physician is Dr. Rodgers. Date of last visit was on November 29, 2012. The patient has a complaint of pain. Nails are extremely long, some of them are ingrown.

PAST MEDICAL HISTORY: The patient's medical history includes diabetes, hypercholesterolemia, hypertension, degenerative joint disease.

MEDICATIONS: The patient has a complete medication list present in the hospital clinic chart.

ALLERGIES: PENICILLIN and SULFA.

OBJECTIVE: The patient's dorsalis pedis pulse is +2/+4 bilateral. Posterior tibial is 0/+4 bilateral. Capillary refilling time is +3 seconds bilateral. Hair growth is absent. Light touch is present. Babinski signs are noted. Muscle strength against resistance to dorsiflexion, plantarflexion, ankle joint is within normal limits. There is thinning of the skin. Dry skin present at the plantar aspect of both feet. The feet are cool to the touch from the tibial tubercle to the distal hallux.

ASSESSMENT: There are hypertrophic nails present right and left foot with incurvated nail margins of the right and left great toes. No signs of any bacterial infection. Diabetic foot exam was performed today. There were no signs of ulcers, lesions or open areas. The patient does not have complaint of numbness or tingling today. She is able to see the bottoms of both feet. There is a positive response to all 10 points when tested with a 10 gram monofilament testing. This is recorded and placed in her hospital clinic chart.

PLAN: Treatment today include,
1. Inspection of both feet.
2. Diabetic foot exam. We reviewed the patient's medical record. Lower extremity exam.
3. Trimming of all hypertrophic nails 1 to 5 bilateral. All nails are filed smooth. Diabetic foot care, proper foot hygiene was discussed

NAME: [redacted]M
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: RICHARD DPM DZIALO

OFFICE VISIT CONTINUED:

with the patient. A brochure on diabetes is provided to the patient for review.
4. She is given return appointment in two months.

552 T:bin DD:20130123 TD:1230 DT:20130124 TT:2201 JOB:10-03024148

DZIR /STE
DL: 01/24/13

RICHARD DPM DZIALO

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: 01/30/62

MR #: [redacted]
CHART LOC:

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: [redacted]
PHYSICIAN/PROVIDER: RICHARD DPM DZIALO
DICTATING: RICHARD DPM DZIALO

PCP: LANCE DAVID REYNOLDS, MD

HISTORY OF PRESENT ILLNESS: The patient is a diabetic male who presents here today for diabetic footcare visit. The patient's primary care physician is Dr. Lance Reynolds.

PAST MEDICAL HISTORY: The patient has a medical history of diabetes, hypertension, hypercholesterolemia.

MEDICATIONS: The patient provides us with a complete medication list.

ALLERGIES: Has an allergy to LATEX.

Relates having gout in the left foot, has been present the last couple weeks. Last month had an attack in the right foot, and a couple months in the left foot as well. He will be seeing his primary care physician next week.

OBJECTIVE: A diabetic foot exam was performed today. There were no signs of ulcers, lesions, or open areas. The patient does have complaints of numbness and tingling in both feet. He is unable to see the bottoms of feet. A testing with 10-g monofilament was performed, positive response to all 10 points. This is recorded and placed in the patient's hospital clinic chart. The patient's dorsalis pedis pulse is +1/+4 bilaterally, posterior tibial pulse is +1/+4 bilaterally. Capillary filling time +3 seconds bilaterally. Hair growth is absent. Light touch is present. Babinski sign is not noted. Muscle strength against resistance to dorsiflexion and plantar flexion of the ankle joints is within normal limits. There is edema present, left foot, none right foot. The patient has good medial longitudinal arch off weightbearing. Vibratory sensation is intact, right and left foot. There is some erythema present at the dorsum of the left foot. The patient had stated that he had a similar redness present at the dorsum of the right foot in the areas of the second and third toes, and points to the area of the metatarsophalangeal joints and that had resolved. The patient's nails are within normal limits. He provides his own care. The right great toenail had been lost. He has received care for that over the years. For a fungus of right great toenail; had been on Lamisil and topical medications. There are only remnants of nail at the present time.

ASSESSMENT AND PLAN: The patient may be experiencing attack of gout at

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: RICHARD DPM DZIALO

OFFICE VISIT CONTINUED:

the present time, left foot. He is not interested in obtaining x-rays of his feet. We are going to do a uric acid test, and the findings will be forwarded to his primary care physician. We will see the patient in one year for a yearly diabetic foot exam, or if a problem arises he may call sooner.

552 T:mdv DD:20130123 TD:1015 DT:20130124 TT:1155 JOB:10-03023813

DZIR /STE
DL: 01/24/13

RICHARD DPM DZIALO

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: PMC
PHYSICIAN/PROVIDER: RICHARD DPM DZIALO
DICTATING: RICHARD DPM DZIALO

PCP: [redacted]

SUBJECTIVE: The patient is a 70-year-old diabetic female who presents here today for initial visit. The patient's primary care physician is Dr. Acquista. Date of last visit was on December 10, 2012. The patient has a complaint of ingrown left great toenail. It is discolored, blackened. This patient as a diabetic would be at risk doing her own nails. Care by a nonprofessional would pose as a health hazard for her.

PAST MEDICAL HISTORY: Medical history includes diabetes, morbid obesity, hypertension, hypothyroidism, hypercholesterolemia, peripheral neuropathy.

MEDICATIONS: The patient has a complete medication list present in the hospital clinic chart.

ALLERGIES: No known allergies.

OBJECTIVE: Inspection of right and left foot today show that there are no signs of bacterial infection or ulceration. There is no evidence of any digital or plantar excrescences. Both feet were examined dorsal, plantar, and rearfoot areas. Inspection of interdigital web spaces show no signs of tinea pedis, maceration, or fissuring. The patient's dorsalis pedis pulse is +1/+4 bilateral. Posterior tibial pulse, we could not elicit bilateral. There is absent hair growth. Feet are cool to the touch from the tibial tubercle to the distal hallux. Vibratory sensation is within normal limits of left foot, absent right foot. Testing with monofilament was performed today. There was a negative response to all the 10 points as recorded in our hospital clinic chart. There is no evidence of any ulcers, lesions, or open areas. The patient does have a complaint of numbness and tingling. She is unable to see the bottoms of both feet.

ASSESSMENT: My findings today are as follows: there is hypertrophic nails 1 to 5 right. Clinical evidence of mycosis of nails 1, 2, 3 left. There is a severely marked, overgrown, mycotic, onychogryphotic left great toenail creating pain for the patient especially with shoes on.

PLAN: Treatment today include the following:
1. Inspection of both feet.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]2
MR#: [redacted]
PCP: [redacted]
DICTATING: RICHARD DPM DZIALO

OFFICE VISIT CONTINUED:

2. Review of patient's medical record.
3. Manual debridement of the left great toenail, distal one third was able to be debrided back to the level where the patient may be able to maintain the nail. Bacitracin ointment and Band-Aid is applied to the left great toe. There was evidence of mycosis and she may use Vicks VapoRub daily to any involved nails. They are mycotic in nature. We would like the patient to soak this evening for 15 to 20 minute period in warm water and table salt. She will call as needed for return appointment. We will like her to have a yearly diabetic foot exam.

552 T:bin DD:20130131 TD:1204 DT:20130203 TT:2313 JOB:10-03032856

DZIR /STE
DL: 02/03/13

RICHARD DPM DZIALO

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40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: [redacted]
PHYSICIAN/PROVIDER: RICHARD DPM DZIALO
DICTATING: RICHARD DPM DZIALO

PCP: ELIZABETH RODGERS, MD

SUBJECTIVE: The patient is a 30-year-old female who presents here today accompanied by her mother for today's scheduled visit for ingrown nail procedure on her left great toe. Conservative care by the patient has not helped and this procedure is indicated today. The procedure a permanent surgical correction of the ingrown left great toenail lateral nail border was explained to the patient as well as risks and consequences such as pain, infection, regrowth of nail. The consent form was signed. The patient's vitals were within normal limits.

PREOPERATIVE DIAGNOSIS: Onychocryptosis, left great toenail lateral nail border.

POSTOPERATIVE DIAGNOSIS: Onychocryptosis, left great toenail lateral nail border.

PROCEDURE: The left foot was prepped and draped in usual aseptic manner. Inspection of the left great toe shows that there is no sign of bacterial infection. Injection with local anesthetic was performed to the left great toe. A local digital block with 3 cc of 1% Xylocaine plain with 1 cc of 0.25% Bupivacaine Plain. The effect of anesthesia was tested prior to start of the procedure. The lateral nail border of the left great toenail was freed from its underlying attachment to the nail bed with a periosteal elevator. A longitudinal incision was made running from distal to proximal and extended more proximal to the nail matrix area with a nail splitter blade. The lateral nail border was then excised three 30-second application with 89% phenol was applied to the nail matrix area of the lateral nail border of the left great toenail. The left great toe was then flushed with copious amounts of sterile water and the nail matrix area was inspected for any remnants of nail, none was noted. A Betadine solution and a gauze sterile dressing was applied to the left great toe. The patient tolerated the procedure well. Postoperative instructions were provided in writing and reviewed with the patient. Prescription is given for Tylenol with Codeine No. 3 quantity 12 one tablet every four to six hours as needed for pain, no refills.

Return appointment is given to the patient in one week at the Belchertown office. The patient has a ride home with her mother.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: BMC

DOB: [redacted]
MR#: [redacted]
PCP: ELIZABETH RODGERS, MD
DICTATING: RICHARD DPM DZIALO

OFFICE VISIT CONTINUED:

$52 T:bin DD:20120919 TD:1237 DT:20120920 TT:0635 JOB:10-02894670

DZIR /STE
DL: 09/20/12

RICHARD DPM DZIALO

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MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: [redacted]
PHYSICIAN/PROVIDER: RICHARD DPM DZIALO
DICTATING: RICHARD DPM DZIALO

PCP: LISA LEVHEIM, MD

SUBJECTIVE: The patient is an 84-year-old female who presents here today for a scheduled footcare visit. The patient's primary care physician is Dr. Levine. Date of last visit was on May 1, 2012. The patient has history of peripheral vascular disease and will be at risk doing her own nails. Care by a nonprofessional would pose as a health hazard for this patient. The patient has a complaint of pain. Nails are thick, yellow, hard. Pain is exacerbated with shoes on.

PAST MEDICAL HISTORY: The patient's medical history includes peripheral vascular disease, glaucoma, macular degeneration, diverticulosis, and hypertension.

MEDICATIONS: The patient has a complete medication list present in the hospital clinic chart.

OBJECTIVE: Inspection of right and left foot today show that there are no signs of bacterial infection or ulceration. There is no evidence of any digital or plantar excrescences. Both feet were examined dorsal, plantar and rearfoot areas. Inspection of interdigital webspaces shows no signs of tinea pedis, maceration or fissuring. The patient's pedal pulses are nonpalpable. There is absent hair growth. The feet are cool to touch. There is thinning of the skin. Slight edema present today. The patient does have significant systemic class findings for footcare to be considered medically necessary.

ASSESSMENT: There is clinical evidence of mycosis of nails. Nails are thick, yellow, and hard. Subungual debris. Marked limitation of motion. Pain.

PLAN: Treatment today include,
1. Inspection of both feet.
2. Review of patient's medical record.
3. Manual debridement of all diseased nails down to viable nail plate to tolerance of the patient. All nails are filed smooth with a rasp x10. Proper foot care and foot hygiene was discussed with the patient. She may use a skin lotion such as Advanced Therapy Lubriderm daily to bottoms of both feet.
4. She is given return appointment in two and a half months.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

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PCP: [redacted]
DICTATING: RICHARD DPM DZIALO

OFFICE VISIT CONTINUED:

552 T:bin DD:20120919 TD:1252 DT:20120920 TT:0757 JOB:08-03126229

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RICHARD DPM DZIALO

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MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: PMC PCP: LUIS SANTIAGO-CRUZ, MD
PHYSICIAN/PROVIDER: STJEPAN KERESHI, MD
DICTATING: STJEPAN KERESHI, MD

REFERRING PROVIDER: Jason Franconeri, P.A.

Thank you for referring the patient for neurologic consultation.

HISTORY OF PRESENT ILLNESS: The patient is a 45-year-old woman, married. She has no children. She is right handed. She works as assistant Vice-President for Hartford Financial Company.

Her chief concern is the memory.

According to the patient, for the last several months she was noted to have some difficulty with expression. The patient just misplaces words, and this happens on average once a week. However, the patient volunteers that there is lots of stress at work, and she is very busy.

This does not _____ activities at work, and nobody else notices except her husband.

However, the patient is concerned that she might have early-onset familial Alzheimer disease because her mother was diagnosed to have Alzheimer disease at age 58. Now she is 64 and she is very limited. However, she does not take medication.

The patient had an MRI of the brain four years ago. There was a question of lacunar infarct, but the patient reports history of migraines, which now occur twice a month, and before they were occurring more often, so this might be just a finding related to her migraines.

The patient is very active in her social life, as well as very busy at work.

PRESENT MEDICATIONS: Include sertraline, occasional lorazepam, Synthroid, Maxzide, Zocor and occasional ibuprofen.

SOCIAL HISTORY: The patient does not smoke, does not drink alcohol regularly.

ALLERGIES: PENICILLIN.

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PCP: [redacted]
DICTATING: [redacted]

OFFICE VISIT CONTINUED:

FAMILY HISTORY: Her mother has Alzheimer disease and father had cardiac artery disease.

LABORATORY STUDIES: The patient had some laboratory workup last July. CBC, chemistries, _____ profile was normal.

PHYSICAL EXAMINATION: On neurological examination, the patient is alert and oriented. Mini-Mental Status Examination was normal. She scored 30 on the scale from 0-30. She was oriented to time, place and person. Calculation was good. Immediate recall, retention. Repetition was good. She was able to spell "world" backwards, and she was able to copy design.

Her blood pressure was 122/64. Heart rate was 78. There was no bruit in the neck.

On cranial nerve examination, pupils are equal. They are normally reacting to light. There was no visual field deficit. No ophthalmoplegia. There is no facial asymmetry. Tongue and palate move symmetrically. There was no bruit in the neck.

On examination of the motor system, muscle tone, strength and reflexes are normal. Hand grips are equal. There is no arm lagging and no pronator drift.

Coordination was normal to finger-nose-finger test and fast alternating movements test.

Sensory examination was normal to light touch, pinprick and temperature.

Gait and standing are normal.

CONCLUSION: The patient presents with concern of her memory because she would misplace words. However, there is no evidence of any other cognitive impairment. Her mother was told that she might have vascular dementia, so it is unlikely that she has familial dementia. Generally, it is not recommended to do any additional workup, like genetic testing, since there are many other issues including social as well as ethical questions. Her mother probably does not have early familial dementia since her symptoms started at age 58, and she was found to have some vascular problem. There was a question if the patient had a lacunar infarct in test in 2008, but again my first impression is this is because of her migraines. For that reason, I reassured the patient there is nothing that we should do now, that probably there is no indication to go for any additional testing, which would require also a spinal tap, which she does not want to do anyway. There is nothing that can be done to prevent or delay onset of dementia, even if she has early familial dementia. My impression is that most of the problem is

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DICTATING: [redacted]

OFFICE VISIT CONTINUED:

because she is very busy and there is also stress at work.

No formal appointment was made, but the patient was advised to call me if she has any questions.

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MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC:

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: PMC
PHYSICIAN/PROVIDER: STJEPAN KERESHI, MD
DICTATING: STJEPAN KERESHI, MD

PCP: RONALD BEAUZILE, MD

REFERRING PHYSICIAN: Dr. Beauzile

Thank you for referring Mr. Guyott for neurologic consultation.

HISTORY OF PRESENT ILLNESS: The patient is a 23-year-old man, single. He has no children. He is right handed.

His chief problem is some numbness and tingling sensation and restlessness in the arms.

According to the patient, the first time when he was put on Abilify about three years ago, there was some reduced sensation. Then he was put on Inderal, which was helping.

However, one year ago he was put on Lamictal. Inderal did not help, and after discontinuation of Lamictal his symptoms persisted. He was tried on Requip which didn't help. Tylenol and Tylenol PM and Benadryl make it worse.

The patient reports that in the evening just before he goes to bed and ready to sleep he would have a feeling of numbness, tingling and restless in both arms. There is no problem in the legs.

The patient also described some other sensations, like in the middle of the night he would feel one-half awake/one-half asleep and that he would have a sensation like he cannot move his parts of the body.

PAST MEDICAL HISTORY: Significant for history of anxiety and depression.

PRESENT MEDICATIONS: Include Klonopin 0.5 mg one-half pill three times a day and Ritalin.

SOCIAL HISTORY: The patient does not smoke, does not drink alcohol.

FAMILY HISTORY: His mother has anxiety.

PHYSICAL EXAMINATION: On neurological examination, the patient is alert and in no acute distress. His speech was clear.

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PCP: R[redacted]
DICTATING: STJEPAN KERESHI, MD

OFFICE VISIT CONTINUED:

His blood pressure was 128/80. Heart rate was 78. There was no bruit in the neck.

On cranial nerve examination, pupils are equal. They are normally reacting to light. There is no visual field deficit. No ophthalmoplegia. There is no facial asymmetry. Tongue and palate move symmetrically.

On examination of the motor system, muscle tone, strength and reflexes are normal. Hand grips are equal. There is no arm lagging and no pronator drift.

Coordination was normal to finger-nose-finger test and fast alternating movements test.

Sensory examination was normal to light touch, pinprick and temperature.

CONCLUSION: The patient presents with some unusual sensation of numbness and restless in the arms. I am not sure how much this is psychogenic in origin. Neurological examination is nonfocal. He also has some difficulty sleeping with probably some change in his sleeping stages. I will start him on nortriptyline 25 mg for a week and then 50 mg - take all at once before he goes to sleep. Hopefully, this will help this sensation, too. I would be glad to evaluate him again in three months' time with consideration to switch to gabapentin depending on his progress.

Neurologic examination is otherwise nonfocal, so I do not see the need for any additional neurological workup.

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MEDICAL CENTER REPORT

NAME: [redacted]
DOB: [redacted]

MR #: [redacted]
CHART LOC: [redacted]

DATE OF SERVICE: [redacted]

OOS #: [redacted]

LOCATION: PMC
PHYSICIAN/PROVIDER: STJEPAN KERESHI, MD
DICTATING: STJEPAN KERESHI, MD

PCP: JOANNA PREIBISZ, MD

REFERRING PHYSICIAN: Joanna Preibisz, M.D.

Thank you for referring the patient for neurologic consultation.

HISTORY OF PRESENT ILLNESS: The patient is a 69-year-old woman, single. She has no children. She is right handed. She used to work as a machine operator.

Her chief complaint is headache. According to the patient, she has had them most of her life. They are just about the same now as before. She is not aware of triggering factors and they come almost daily. Once they come, they stay for the rest of the day. Headache usually starts in the forehead or back of the head. She also complains of some neck stiffness. There is no nausea. No photophobia. Headache, she describes as a deep ache. Average severity, she would grade 7 on the scale from 0-10.

The patient takes one Tylenol in a day, which usually helps some.

PAST MEDICAL HISTORY: Significant for history of a tonsillectomy, cholecystectomy, right hip fracture, surgery to the right wrist.

The patient has a history of vitamin D deficiency.

FAMILY HISTORY: Unremarkable.

The patient was seen by Dr. Kaye in 2006. She has some calcification in the frontal lobe and she had an MRI in August 2012, which was initially reported as normal but there was an addendum that there is some probable microvascular changes in the left posterior parietal region and there was a question if some of them might be small results of any hemorrhage.

PRESENT MEDICATIONS: Include multivitamin and calcium, Tylenol, Lotrisone vitamin D, Benadryl.

SOCIAL HISTORY: The patient does not smoke or drink alcohol. She lives with her sister.

PHYSICAL EXAMINATION: On neurological examination, the patient is

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CONSULTATION

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CHART LOC: **PCP:** [redacted]
DICTATING: STJEPAN KERESHI, MD

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DATE OF CONSULTATION: 06/25/2012

PRIMARY CARE PHYSICIAN: James Freeman, M.D.

Thank you for referring the patient for neurological consultation.

HISTORY OF PRESENT ILLNESS: The patient is an 83-year-old woman, widowed. She has four children. She lives alone.

The reason for admission and neurological consultation is weakness and dizziness.

The patient's records were reviewed, and history was obtained from the patient who was a good historian.

According to the patient, since 05/31, she has been treated for UTIs. Initially, she was on Cipro and, a few days after she finished the course, she developed, again, UTI. Then, she was put on Bactrim. Then, her symptoms recurred and she was put on Keflex for 21 days for which, now, she just finished treatment.

However, for the last several days, she has been complaining of feeling of lightheadedness and nausea. She had poor per-oral intake. On average, she tries to get up; she would feel lightheaded, just about to pass out, but there are no falls. Also, while walking, she was stumbling; had difficulty with balance. She feels a little stronger now, but still rather weak. She did not have any trouble with dizziness like this in the past.

PAST MEDICAL HISTORY: Significant for a history of thyroid problem, hypertension.

MEDICATIONS: Includes levothyroxine, trimethoprim, Premarin, lisinopril, sulfasalazine.

SOCIAL HISTORY: The patient does not smoke. Does not drink alcohol. She lives alone.

REVIEW OF SYSTEMS: The patient does not see on the left eye because

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CONSULTATION CONTINUED:

she had a central retinal artery thrombosis. Her hearing is also not so good. There is no chest pain. No palpitation. No difficulty swallowing.

PHYSICAL EXAMINATION: On neurological examination, the patient is alert, oriented. No acute distress. Blood pressure 140/08, heart rate 78. There was no bruit in the neck.

On cranial nerve examination, pupils are 3 mm. They were sluggishly reacting to light. She could not see on the left eye. There is no facial asymmetry. Tongue and palate move symmetrically.

On examination of motor systems, muscle tone, strength and reflexes are normal. Hand grips are equal. There is no arm lagging. No pronator drift.

Coordination was normal for finger-nose-finger test and fast alternating movements test.

Sensory examination was normal to light touch, pinprick and temperature. There was severely reduced vibration in booth feet when she felt it only for 3 seconds.

LABORATORY AND OTHER STUDIES: On laboratory evaluation, urinalysis showed increased red and white blood cells, and a urine culture is pending. WBC 8.2. Blood sugar 120. Estimated GFR 45. BUN and creatinine were normal. Sodium was 128, which is low. Liver functions are normal. CPK is normal. CAT scan of the brain did not show any acute changes, and she is having MRI and duplex today.

CONCLUSION: The patient presents with episodes of feeling of lightheadedness after she had a prolonged period of urinary tract infection. She spent lots of time in bed and, whenever she tried to get up, she would feel lightheaded and dizzy. Also, her per-oral intake was very poor since she felt nauseated. Neurological examination is nonfocal. This is probably orthostatically related, and there is also some peripheral neuropathy, probably contributing to sensory ataxia. I would just continue with present management. It is unlikely that she had cerebrovascular involvement, but MRI is scheduled for today, which would help us there. Probably, then, we should start also with rehab therapy since there was probably some deconditioning. She spent the last three weeks in bed. For now, I advised her just to avoid any sudden change and not to get up too quick.

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PCP: J[redacted]D

CONSULTATION CONTINUED:

129 T:trp DD:20120625 TD:1146 DT:20120626 TT:0922 JOB:08-03036172

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STJEPAN KERESHI, MD

cc: JAMES FREEMAN, MD

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Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: STJEPAN KERESHI, MD

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DATE OF CONSULTATION: 08/07/2012

REFERRING PHYSICIAN: Linda Schoonover, M.D.

Thank you for referring the patient for consultation.

HISTORY OF PRESENT ILLNESS: The patient is 52-year-old male, single. He has no children. He is right handed. He is on disability because of history of heart attacks, CVA and neuropathy.

The patient is known to me. I have been seeing him for peripheral neuropathy. He also has a history of seizure. He has history of severe diffuse pain which is nonspecific and he complains of some burning feeling in the feet, generalized weakness and history of falls. He fell in the middle of July, sustained some rib fracture, was seen in the emergency room, prescribed Percocet for five days.

He is also taking Vicodin one pill four times a day. For his neuropathy, the patient was taking Neurontin 800 mg three times a day as well as Tofranil 25 mg three times a day. In the past he was on tramadol but it did not help.

Lately, however, his symptoms seem to be getting somewhat worse. There is more increased pain, especially while breathing and this might be because of his recent fracture. However, there is also some diffuse pains in the legs. He also has some difficulty walking and his legs just give out. He has a history of recent falls.

PAST MEDICAL HISTORY: Significant for history of CVA, history of MI, seizure, rotator cuff repair in April. History of alcohol abuse and narcotic dependence.

SOCIAL HISTORY: The patient reports he smokes 6-8 cigarettes a day and he admits to drinking two or three shots of whiskey 3-4 times in a week.

MEDICATIONS ON ADMISSION: Include baby aspirin, Plavix, Neurontin 800 three times a day, imipramine 25 mg three times a day, Dilantin 200 mg three times a day, lisinopril, nitroglycerin. He was taking oxycodone

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PCP: KHALED ABDELKADER, MD

CONSULTATION CONTINUED:

after he hurt his chest. He is also on simvastatin, Spiriva, Symbicort, B-complex vitamin, vitamin D.

LABORATORIES AND OTHER STUDIES. While he was in the emergency room, he had a CAT scan of the brain which was negative. On laboratory evaluation, CBC was normal. Electrolytes were normal. Potassium was normal. BUN and creatinine were normal. Blood sugar was also normal.

PHYSICAL EXAMINATION: On neurological evaluation, the patient is alert and in no acute distress. His speech was now clear, but when he was in the emergency room he had some slurred speech. His blood pressure was 145/85, heart rate 72, respirations 20, temperature 96.5.

On cranial nerve examination, pupils are equal. They are normally reacting to light. There is no visual field deficit, no ophthalmalgia. There is no facial asymmetry. Tongue and palate move symmetrically.

On examination of the motor system, reflexes are brisk except for reduced ankle jerks. Plantar is downgoing.

Coordination was normal for finger-to-nose-finger test.

On sensory examination, he appreciated vibration for three seconds on both sides.

CONCLUSION: The patient presents with increasing weakness, some falls, diffuse aches. It is not clear the amount of alcohol that he drinks. In view of his history of seizure and taking Dilantin, I would just obtain Dilantin level as this can produce some difficulty with balance too. I would also check B12 level and serum magnesium. While he is in the hospital, probably is reason to give him some opiate medication to break the cycle of pain; but as the outpatient, it is not productive to do that especially in view of history of abnormal pain behavior including continuous drinking, smoking and history of excessive prescription medication use. He was evaluated by physical therapy so outpatient rehabilitation for deconditioning would probably also be helpful. Otherwise, I would just continue his present management.

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HOSP#: [redacted] MR#: [redacted]
CHART LOC: [redacted] PCP: KHALED ABDELKADER, MD

CONSULTATION CONTINUED:

129 T:chb DD:20120807 TD:1739 DT:20120807 TT:2013 JOB:08-03082317

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D: 08/07/12
T: 08/07/12

STJEPAN KERESHI, MD

cc: KHALED ABDELKADER, MD

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Palmer, Massachusetts

CONSULTATION

NAME: [redacted] **DOB:** [redacted]
HOSPITAL #: [redacted] **MR #:** [redacted]
CHART LOC: [redacted] **PCP:**
DICTATING: STJEPAN KERESHI, MD

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DATE OF CONSULTATION: 02/21/2012

REFERRING PHYSICIAN: Nicholas Fay, M.D.

Thank you for referring the patient for neurological consultation.

HISTORY OF PRESENT ILLNESS: The patient is a 64-year-old man, single. He is right-handed. He has no children. He is temporarily unemployed, and he is getting Social Security. He used to work in a casino.

The reason for admission and neurological consultation is left-sided weakness and difficulty with ambulation.

History was obtained from the patient, who was a good historian. Also, his friend was present and I talked to the nurse.

According to the patient, yesterday morning, he woke up at around 5:30 a.m. and then, he could not support himself. He fell down. He had to prop himself up to be able to get up. He reports that he tried to touch his right arm with the left arm. He had no feeling on the left side. There was also some left arm heaviness and some facial droop. His friend also noted that his speech was somewhat garbled and incoherent. Since admission, his symptoms improved to a degree, but he still has some heaviness in the left side. He never had any trouble like this before.

The patient had a CAT scan of the brain, which showed probable acute right hemispheric infarct.

PAST MEDICAL HISTORY: Significant for a history of HIV, appendectomy and elevated cholesterol.

MEDICATIONS ON ADMISSION: Included Lyrica 75 mg three times a day for postherpetic pain in the right hand, Niaspan 1000 mg a day for elevated cholesterol and Atripla for HIV.

ALLERGIES: The patient is allergic to TETANUS SHOT.

NAME: [redacted]
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PCP:

CONSULTATION CONTINUED:

FAMILY HISTORY: His mother had rheumatic heart disease. There is no history of CVA or heart attack.

SOCIAL HISTORY: The patient smokes one pack of cigarettes daily. He denies alcohol or drugs.

LABORATORY AND OTHER STUDIES: The patient had some laboratory evaluation, and chemistry profile and CBC were negative.

REVIEW OF SYSTEMS: On review of systems, the patient denies any headache. He complained of some left visual field deficit. There is no chest pain or palpitations.

PHYSICAL EXAMINATION: On neurological examination, the patient is alert and oriented. His speech was clear. His blood pressure was 130/75, pulse 69, respirations 18, temperature 97.6.

On cranial nerve examination, pupils are equal. They are normally reacting to light. There was no nystagmus. He had a moderately severe left visual field deficit on confrontation. There is no facial asymmetry. Tongue and palate move symmetrically.

On examination of motor systems, muscle tone and reflexes are normal. Hand grips are equal, but there was moderately severe left arm lagging and pronator drift. Strength in the legs was normal.

On testing coordination, he had mild dysmetria on finger-nose-finger test on the left side.

On sensory examination, the patient appreciates light touch and pinprick on both sides, but there was evidence of left hemisensory neglect when double point simultaneous stimulation was applied. He would neglect the left side.

CONCLUSION: The patient presents with probable right hemispheric infarct. He is already placed on aspirin, which is appropriate. I discussed the importance of stopping smoking. He will be evaluated by physical therapy, and he will have physical therapy at home for strengthening. He is going to have MRI of the brain tomorrow. Duplex of the carotids did not show significant carotid stenosis. Nicotine patch is already applied. He probably would benefit from some statin treatment since he has a history of elevated cholesterol and it was found that statins have an anti-inflammatory effect and beneficial effect on recurrence of stroke.

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PCP:

CONSULTATION CONTINUED:

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T: 02/21/12

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Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: [redacted] MD

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NEPHROLOGY CONSULTATION

DATE OF CONSULTATION: 11/04/2012

REASON FOR CONSULTATION: Consult is requested by Dr. Hope to evaluate and help in management of the patient with severe renal insufficiency.

HISTORY OF PRESENT ILLNESS: The patient is an 80-year-old male who is a poor historian with past medical history of longstanding diabetes mellitus, hypertension followed by Dr. Kimberly Browne-Martin as an outpatient who presented to the emergency room with complaints of lower abdominal pain that began a day before his admission to the hospital. He had increasing lower abdominal pain and was unable to urinate. He did not have any history of urinary retention or prostate problems in the past, although the history is very unreliable at this juncture. He has had normal bowel movements. There was no fever, chills. There was no nausea, vomiting, or diarrhea.

The patient was seen in the emergency room, and a postvoid residual showed large volume of urine. He had a straight cath done with about 1500 cc of urine output. A Foley was placed. A CAT scan of the abdomen showed constipation with fecal impaction. He also had atrophic kidney with chronic scarring and perinephric stranding. There was no hydronephrosis based on the information available to me. He was admitted to the hospital and started on intravenous fluids. Renal consultation has been requested as BUN and creatinine are elevated with a creatinine of around 2.1. I do not have any basic creatinine levels on this patient at this juncture. He denies using any nonsteroidal anti-inflammatory agents.

PAST MEDICAL HISTORY: Significant for poorly controlled diabetes, longstanding hypertension, hypercholesterolemia, and hernia issues in the past.

PAST SURGICAL HISTORY: There is no history of surgery in the past.

ALLERGIES: The patient has no known drug allergies.

MEDICATIONS: As an outpatient include Actos, hydrochlorothiazide, levothyroxine, glyburide, Crestor, and Colace.

NAME: [redacted]
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PCP: [redacted] M

CONSULTATION CONTINUED:

SOCIAL HISTORY: The patient lives alone. He is able to follow all his day-to-day activities of living. Denies alcohol or tobacco use.

FAMILY HISTORY: History of hypertension.

REVIEW OF SYSTEMS: The patient denies any fever, chills, denies any chest pain, shortness of breath, nausea, vomiting. He did have constipation and abdominal pain. He did have urinary retention as mentioned before. Other systems were reviewed and negative.

PHYSICAL EXAMINATION: The patient was seen in the bed, awake, alert, oriented x3. Blood pressure was 149/67, pulse 68, afebrile. HEENT exam shows pupils equal bilaterally. Neck, no jugular venous distention was noted. Neck was supple. No thyromegaly was noted. Mucosa moist. There was no scleral icterus or conjunctival congestion. Cardiovascular system, S1, S2 without rub. Respiratory system, air entry decreased in the base. No crepitation or rhonchi heard. Abdomen was obese, soft with lower abdominal/suprapubic tenderness. There was no guarding, no _rigidity. Bowel sounds normal. Extremities showed no edema. There was no peripheral cyanosis or clubbing.

LABORATORY AND OTHER STUDIES: Done on admission: Sodium is 134, potassium 4.4, chloride 99, CO2 24, BUN 25, creatinine 2.2. WBC is 19.8. Hemoglobin 13, hematocrit 47.9. Labs done today: Sodium 136, potassium 4.6, chloride 105, CO2 24, calcium 8.9, BUN 30, creatinine 1.64, estimated GFR of 41.

IMPRESSION:
1. Elderly male with acute kidney injury versus acute-on-chronic kidney disease. Acute kidney injury in this patient is likely secondary to obstructive uropathy/possibility of bladder outlet obstruction as he had significant amount of urine output after placement of the Foley. He could also be slightly prerenal. He was not on any nephrotoxic agents. I doubt the patient has acute interstitial nephritis/acute _____ based on the presentation and the improvement of his creatinine with fluids.
2. Possibility of chronic kidney disease at baseline. I do not have a baseline creatinine on this patient at this juncture, and we will try to get his baseline creatinine from his primary care physician.
3. Leukocytosis. The exact reason was unclear at this juncture.
4. Diabetes mellitus.
5. Hypertension. Blood pressure is acceptable.

RECOMMENDATION: I recommend following the full complete results of the CAT scan and the renal ultrasound. I will keep the Foley catheter and recommend getting a urology evaluation on this patient. I recommend initiating Flomax 0.4 mg on this patient to help with his urine flow. We will also continue with IV hydration as the patient might have post-

NAME: [redacted]
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PCP: [redacted]

CONSULTATION CONTINUED:

obstructive diuresis. I recommend following his renal function, electrolytes, and divalence closely.

Thank you for allowing me to participate in the medical management of the patient. He needs followup with us as an outpatient after discharge.

cc: Kimberly Browne-Martin, M.D.
2 Medical Center Drive
Springfield, MA 01107

698 T:1hr DD:20121104 TD:1116 DT:20121105 TT:0838 JOB:10-02944262

BABK /STE
D: 11/04/12
T: 11/05/12

KIRSHNAN BABU, MD

cc: KIMBERLY BROWNE-MARTIN, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted] DOB: [redacted]
HOSPITAL #: [redacted] MR #: [redacted]
CHART LOC: [redacted] PCP: [redacted]
DICTATING: KIRSHNAN BABU, MD

REASON FOR CONSULTATION: Consult requested by Dr. Maguire to evaluate and help in management of the patient with end-stage renal disease who is presented to the hospital with complaints of not feeling well.

The patient is a 52-year-old female with past medical history of end-stage renal disease on hemodialysis, history of bipolar disorder, history of hypertension who presented to the hospital with complaints of generalized abdominal pain for about one-day duration, not feeling well with nausea and vomiting. There was no diarrhea. She complains of feeling lightheaded. She was noted to have high temperature (with a temperature of around 101 to 102 degrees Fahrenheit at the emergency room). Her blood pressure is also on the low side at 94/61. She was evaluated in the emergency room and was noted to have elevated white cell count of 15.8 with bandemia. Her urinalysis showed no major features of UTI. She did have a chest x-ray and a CAT scan in the emergency room. She has been admitted to the hospital with a diagnosis of pneumonia. Renal consult has been requested for evaluation and management of her end-stage renal disease.

REVIEW OF SYSTEMS: The patient is presently resting in the bed and has shaking chills. She is also tachycardic. She denies having any fever at home, though has not been feeling well for the last couple of days. She missed going to dialysis today. There was no diarrhea or constipation. As mentioned before, x-rays showed left lower lobe infiltrate. A CAT scan of the abdomen which was noncontrast showed adrenal nodule, but no abscess. She does not have any urinary symptoms and states that she passes some urine. There was no headache or neck stiffness.

PAST MEDICAL HISTORY: History of hypertension, history of end-stage renal disease on hemodialysis, hyperlipidemia, history of hypothyroidism, bipolar disorder, schizoaffective disorder and vitamin D deficiency.

PAST SURGICAL HISTORY: Good AV access placement.

ALLERGIES: Include allergies to AMBIEN and HALDOL.

MEDICATIONS: As an outpatient and inpatient reviewed.

FAMILY HISTORY: Significant for osteoporosis in the mother and history of hypertension and hypercholesterolemia in the mother.

SOCIAL HISTORY: The patient is a smoker for many years. She denies alcohol use or drug abuse.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: KHALED ABDELKADER, MD

CONSULTATION CONTINUED:

PHYSICAL EXAMINATION: The patient is resting in the bed, awake, alert and oriented. Blood pressure was 94/61, pulse 127, temperature 101.3 degrees Fahrenheit. HEENT examination shows pupils equal bilaterally with no jugular venous distention noted. Mucosae were dry. There is no scleral icterus or conjunctival congestion currently. There was no neck stiffness. Cardiovascular System: S1 and S2 without rub _____ decreased in the bases with left lower basal crepitation. No rhonchi. Abdomen was obese, soft, minimal epigastric tenderness. No guarding and no rigidity. Bowel sounds normal. Extremities showed trace edema. There was no peripheral cyanosis or clubbing. Upper extremity AV fistula with good bruit _____ noted. The puncture site on the AV access has some tenderness, but there is no discharge or pus.

LABORATORY DATA: Labs done today; sodium 132, potassium 4.2, chloride 91, CO2 25.2, BUN 47, creatinine 7.53, estimated GFR 6, calcium 9.2, albumin 3.2, CPK 558, troponin 0.06. Urinalysis: Yellow urine with specific gravity of 1.005, rbc's 3-4, wbc's 5-6.

IMPERSSION:
1. A 51-year-old female with end-stage renal disease on hemodialysis, admitted with fever and chills with likely left lower lobe pneumonia.
2. Bipolar disorder.
3. Hypertension.
4. Anemia.

RECOMMENDATIONS:
1. I agree with antibiotics Zithromax and ceftriaxone as ordered.
2. Gentle hydration x1 liter.
3. I do not think the patient needs immediate hemodialysis, and I will arrange for hemodialysis on Monday (her potassium is normal, and she seems to be on the dry side). I will recommend a low-potassium diet on this patient. I will also give her subcutaneous Epogen 5000 units x1 dose in the a.m.

Given severity of her illness and bandemia, I would like to give her one dose of vancomycin 1.5 g.

Thank you for allowing me to participate in the medical management of this patient.

cc: Palmer Dialysis Unit

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: KHALED ABDELKADER, MD

CONSULTATION CONTINUED:

698 T:hkr DD:20111022 TD:1602 DT:20111023 TT:2252 JOB:10-02532721

BABK /STE
D: 10/22/11
T: 10/23/11

KIRSHNAN BABU, MD

cc: KHALED ABDELKADER, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP:
DICTATING: KIRSHNAN BABU, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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NEPHROLOGY CONSULTATION

DATE OF CONSULTATION: 09/23/2012

REASON FOR CONSULTATION: Consult requested by the medical team to evaluate and help in management of patient with severe renal insufficiency.

HISTORY OF PRESENT ILLNESS: The patient is a 67-year-old male with past medical history of longtime diabetes mellitus, history of hypertension, history of CVA with right-sided weakness, hyperlipidemia, who presented to the hospital with complaints of generalized weakness. The patient apparently was noted to have uncontrolled hypertension with systolic blood pressure about 200s. He was also noted to have acute kidney injury with a BUN of 42 and creatinine of 0.9 (**). Renal consultation has been requested for evaluation and management of his renal insufficiency. The patient said that he has not been taking an adequate amount of p.o. fluids and had GI fluid losses. He denied using any nonsteroidal anti-inflammatory agents. He does have BPH and has mild prostate symptoms. He was apparently recently admitted to Harrington Hospital. His baseline creatinine from the past has been ranging around 1.2-2.6. He has been seen by my partner, Dr. Fares, in the past. The patient was treated with antihypertensive agents and has been admitted to the medical floor.

PAST MEDICAL HISTORY: History of longstanding diabetes mellitus, hypertension, history of CVA with right-sided weakness, and hyperlipidemia.

PAST SURGICAL HISTORY: Includes back surgery.

SOCIAL HISTORY: The patient has no history of alcohol abuse or illicit drug use.

FAMILY HISTORY: There is family history of hypertension and diabetes.

ALLERGIES: Include PENICILLIN.

MEDICATIONS: The patient states that he has been taking medication but does not remember the names.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP:

CONSULTATION CONTINUED:

REVIEW OF SYSTEMS: The patient denies any chest pain, shortness of breath. He does have lower extremity edema. No major urinary complaints. There is no fever or chills. He did have GI issues, as mentioned before. All other system reviewed were negative.

PHYSICAL EXAMINATION: The patient was resting in the bed, awake, alert, oriented x3. Blood pressure 173/93, pulse 68, afebrile. HEENT exam showed pupils equal bilaterally to light. No jugular venous distention noted. Neck supple. Mucosa was dry. There was no scleral icterus or conjunctival congestion. Cardiovascular system, S1, S2, without rub or murmur. Respiratory system, air entry decreased in the bases. Abdomen was soft, nontender, no guarding, no rebound, bowel sounds normal. Extremities showed no edema. There was no peripheral cyanosis or clubbing. Neuro exam was essentially nonfocal.

LABORATORIES: Done on 09/23/2012: Sodium 139, potassium 4.9, chloride 103, CO2 28, BUN 42, creatinine 3.09(**), calcium 8.6, estimated GFR 20, magnesium 1.9, albumin 3.5. Troponin 0.06. TSH 4.92.

IMPRESSION:
1. A 67-year-old white male with acute kidney injury superimposed on baseline stage 4 chronic kidney disease with progressive chronic kidney disease. Likely since the patient has acute kidney injury, he has prerenal azotemia in the setting of decreased p.o. intake. I would certainly rule out obstruction.
2. Chronic kidney disease stage 4. The creatinine at baseline ranging around 2-2.5, likely secondary to longstanding hypertension and diabetes.
3. Uncontrolled hypertension. The patient likely at baseline essential hypertension with possible renal parenchymal hypertension. Possibility of noncompliance should also be considered in this patient.

RECOMMENDATIONS:
1. Check spot urine for electrolytes, protein and creatinine.
2. Check a renal ultrasound to assess the size of the kidney and to rule out obstruction.
3. Hold all nephrotoxins and avoid ACE inhibitor and angiotensin receptor blocker.
4. I agree with intravenous hydration.
5. Would use clonidine 0.4 or 1 mg p.o. q.4 hours p.r.n. for blood pressure control in addition to all of the regular blood pressure medications.
6. I would also check a urine drug screen.
7. Noncompliance issues should also be discussed with this patient in detail at a later date.

Thank you for allowing me to participate in medical management of the patient. [redacted].

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP:

CONSULTATION CONTINUED:

698 T:rhs DD:20120924 TD:2200 DT:20120925 TT:0559 JOB:08-03131840

BABK /STE
D: 09/24/12
T: 09/25/12

KIRSHNAN BABU, MD

cc:

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: KIRSHNAN BABU, MD

DATE OF SURGERY: 11/14/11

REASON FOR CONSULTATION: Consult requested by Dr. Abdelkader to evaluate and help in management of the patient with end-stage renal disease who presented to the hospital with complaints of right lower extremity pain, back pain and some cough. The patient also had chest pain.

HISTORY OF PRESENT ILLNESS: The patient is a 61-year-old female known to our service. Past medical history of ESRD, history of diabetes mellitus, diabetic retinopathy, neuropathy and nephropathy who presented to the hospital with complaints of chest pain/back pain. She was seen by paramedics and brought into the hospital. She had pressure-like sensation in the retrosternal area and back pain. She had this pain for a few days. The chest pain was poorly characterized; it did not radiate, did not increase with movement. There was no shortness of breath, but she did have cough with whitish sputum. She had some nausea and vomiting. There has also been some palpitations. She also complains of pain in the right lower extremity. The patient was seen in the ER, and she was hemodynamically stable with a blood pressure of 124/53, pulse 100 and respiratory rate of 16. She had a chest x-ray which showed a question of pneumonia and was treated with ceftriaxone and Zithromax. She has been admitted to the hospital and renal consult has been requested for evaluation and management of her renal insufficiency.

PAST MEDICAL HISTORY: History of type 2 diabetes with retinopathy, neuropathy and nephropathy and is on hemodialysis, hypotension during dialysis, peripheral vascular disease, atrial fibrillation with permanent pacemaker; history of congestive heart failure, MI; history of mild-to-moderate mitral regurgitation; history of MRSA infection in the past; history of peptic ulcer disease; history of upper GI bleed.

ALLERGIES: The patient is allergic to **FLU SHOTS AND AMBIEN.** She is also allergic to **VANCOMYCIN.**

MEDICATIONS AS AN OUTPATIENT: _____.

FAMILY HISTORY: There is no family history of kidney disease.

REVIEW OF SYSTEMS: Patient did have chest pain as mentioned before. No significant shortness of breath. Complains of dry mouth, back pain and right lower extremity pain. There was also some fever and chills. Her appetite has been on the low side. She did have cough with whitish sputum. There was no diarrhea. All systems reviewed negative.

PHYSICAL EXAMINATION: The patient is resting in the bed, awake, alert. Blood pressure was 115/69, pulse 67, afebrile. HEENT shows pupils equal bilaterally.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: KHALED ABDELKADER, MD

CONSULTATION CONTINUED:

Neck: No jugular venous distention noted. Mucosa was dry. There was no scleral icterus or conjunctival congestion. Cardiac system: S1, S2 without rub. Respiratory system: Air decreased in the bases, no crepitation or rhonchi heard. Abdomen: Obese, soft, nontender, no guarding, bowel sounds normal. Left upper extremity AV fistula with good bruit anteriorly was noted. Extremities showed redness extending from the thighs to the toes. There was some heat. There was no peripheral cyanosis or clubbing. There was trace edema.

LABORATORY DATA: Labs done today: sodium 128, potassium 4.5, chloride 85, C02 28.2, BUN 44, creatinine 6.81, hemoglobin 10.9, hematocrit 33, WBC 19.2, platelets 166; polys 55, bands 38; CPK 61, calcium 7.1.

IMPRESSION:
1. 61-year-old white female with end-stage renal disease admitted with pneumonia.
2. Right lower extremity cellulitis.
3. Coumadin toxicity/supratherapeutic INR.
4. Hyponatremia.
5. Hypocalcemia.
6. Type 2 diabetes mellitus.

RECOMMENDATION:
1. I will arrange for hemodialysis for the patient at the inpatient dialysis unit.
2. In regards to her low sodium, I would recommend placing the patient on 1500 cc fluid restriction and the sodium should get corrected with dialysis.
3. Antibiotics as per medical team.

Thank you for allowing me to participate in the medical management of the patient.

BABK /PNG
D: 11/14/11
T: 11/14/11

KIRSHNAN BABU, MD

cc: KHALED ABDELKADER, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: BMC

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: KIRSHNAN BABU, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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NEPHROLOGY CONSULTATION

DATE OF CONSULTATION: 09/23/2012

REQUESTING PHYSICIAN: Todd Hope, M.D.

REASON FOR CONSULTATION: Evaluate and help with management of the patient with renal insufficiency.

HISTORY OF PRESENT ILLNESS: The patient is an 86-year-old Caucasian male who is a poor historian (history obtained from the patient's medical records) who presented with complaints of fever and altered mental status. He has longstanding history of atrial fibrillation, history of coronary artery disease on Coumadin, chronic renal insufficiency with baseline creatinine around 1.5-1.8 followed up by Dr. Slater, history of recurrent UTI, chronic obstruction with indwelling catheter, essential tremor and dementia, was brought here by family with the above complaints. He has had a UTI about three days ago. He also had cough with some expectoration. There was no nausea, vomiting, diarrhea. He had decreased energy level and has had increased fatigue, malaise. He has been sleepy.

The patient was evaluated by his visiting nurse on the day of admission who noticed that the patient had temperature 101.6 degrees Fahrenheit with decreased breath sounds at the bases with increasing confusion. The patient was brought into the ER and was noted to have temperature of 101.2 degrees Fahrenheit. He had a pulse rate of 103 and respiratory rate of 19. His blood pressure was 132/63 with an oxygen saturation 98% on room air.

The patient has had a sick contact (the patient's daughter was having upper respiratory tract symptoms).

In the workup in the emergency room, the patient had increased WBC count. His urinalysis showed large amount of leukocyte esterase and increased WBCs. His renal function was also worse with a creatinine of 1.8. A chest x-ray showed bilateral haziness with chronic changes. He was admitted to the hospital, diagnosed with UTI/sepsis and acute kidney injury.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: BART SOAR, MD

CONSULTATION CONTINUED:

REVIEW OF SYSTEMS: As noted above. Other systems reviewed and were negative.

PAST MEDICAL HISTORY: History of coronary artery disease, history of mitral regurgitation, essential tremor, pancreatitis, chronic atrial fibrillation, BPH. Previous history of pneumonia requiring intubation, chronic indwelling Foley catheter, recurrent UTIs, chronic renal insufficiency followed up by Dr. Slater, (stage 3 at baseline), dementia, history of left lower extremity DVT, hypertension, hypercholesterolemia.

PAST SURGICAL HISTORY: Singular IVC filter placement and bilateral elbow surgery.

SOCIAL HISTORY: The patient lives at his home. During the daytime hours has friends and family who take care of him during the day. At night he resides with his daughter, and has a healthcare proxy. He does not drink and does not smoke.

FAMILY HISTORY: Noncontributory.

ALLERGIES: LEVAQUIN, causes confusion. PENICILLIN, ATIVAN and VERSED.

MEDICATIONS: As an outpatient, inpatient reviewed in detail.

PHYSICAL EXAMINATION: The patient is resting in the bed, sleepy, but fully arousable, able to follow simple commands. Blood pressure 110/58, pulse 82, afebrile. HEENT exam shows pupils equal and bilaterally react. No jugular venous distention noted. Mucosa is dry. There is no scleral icterus or conjunctival congestion. Cardiovascular system, S1, S2 which is irregularly irregular with a systolic murmur. Respiratory system, decreased in the bases with a few basilar crepitations. Abdomen is soft, nontender. No guarding, no rigidity. Bowel sounds normal. He does have a lower abdominal hernia. There is an indwelling catheter in place. Extremities showed no edema. There is no peripheral cyanosis or clubbing. Neuro exam is essentially nonfocal.

LABORATORIES DONE TODAY: Sodium 137, potassium 4.2, chloride 102, CO2 26, BUN 26, creatinine 1.53. Admission creatinine was 1.8. Hemoglobin 13.7, hematocrit 39.2, WBC 11.2, platelets 131.

IMPRESSION:
1. Elderly male with acute kidney injury. Acute kidney injury in this patient likely secondary to renal hypoperfusion in the setting of prerenal state and urinary tract infection. He does have a Foley catheter which is draining adequate amount of urine. I doubt the patient has obstructive uropathy. He was also on Lasix which could

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]

CONSULTATION CONTINUED:

have caused the prerenal azotemia in the setting of decreased p.o. intake.
2. Stage 3 chronic kidney disease at baseline, followed by Dr. Slater.
3. Urinary tract infection in the setting of indwelling Foley catheter.
4. History of obstructive uropathy.
5. Question of pneumonia.

RECOMMENDATION:
1. I recommend continuing the antibiotic therapy and would recommend following the vanco level and the dosing to be based on those levels.
2. I do not think the patient requires intravenous fluids at this juncture. (The patient has already received fluids since admission and his renal function has improved.) Will continue the present antihypertensive regimen. I recommend following his input/output chart closely.
3. After discharge he needs to be followed up by Dr. Slater in his office.

I had a lengthy discussion with the patient and wife at the bedside.

Thank you for allowing me to participate in the medical management of the patient.

cc: Jonathon Slater, M.D.
Bart Soar, M.D.

698 T:rhs DD:20120923 TD:1712 DT:20120923 TT:1724 JOB:10-02898586

08

BABK /STE
D: 09/23/12
T: 09/23/12

KIRSHNAN BABU, MD

cc: BART SOAR, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: GEORGE-ELIE FARES, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF CONSULTATION: 10/31/12

REASON FOR CONSULTATION: I was asked to assist in the management of this 90-year-old patient who has a history of peripheral vascular disease who presented to the hospital with chills and chest pain and was noted to have an elevated serum creatinine.

HISTORY OF PRESENT ILLNESS: In summary, the patient, who has not been seen by doctors recently, has had an elevated serum creatinine since at least 2011 with serum creatinine in the range of 1.3 mg/dl. He is a smoker and has smoked for several years. He has a history of peripheral vascular disease and underwent, in the past, a left carotid endarterectomy. He was noted to have elevated blood pressure while in the hospital. Currently he denies any chest pain, shortness of breath, nausea, vomiting, diarrhea. Blood pressure has been elevated with systolic blood pressure up to the 160s and he was started on amlodipine. He denies any family history of kidney disease. No prior history of acute kidney injury. Ho history of kidney stones.

PAST MEDICAL HISTORY: His past medical history is notable for chronic kidney disease, dyslipidemia, peripheral vascular disease, macular degeneration, BPH.

PAST SURGICAL HISTORY: Notable for left carotid endarterectomy.

CURRENT MEDICATIONS: As an outpatient, none. Currently the patient is on amlodipine.

ALLERGIES: He is allergic to **PENICILLIN AND ASPIRIN.**

SOCIAL HISTORY: He is a smoker. He drinks alcohol on a daily basis.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As mentioned in the HPI. Remaining review of systems essentially negative.

PHYSICAL EXAMINATION: On physical examination, blood pressure is 145/87, heart rate 56, respiratory rate 16, temperature 97.5. He looks his stated age. Patient in no acute distress. He is awake, alert. Head NCAT, pink conjunctivae, anicteric sclerae. Throat clear. Septum midline. Neck supple. Lungs, good air entry bilaterally. Cardiovascular, S1, S2, regular rate and rhythm. Abdomen is soft, obese, nontender, positive bowel sounds.

NAME: [redacted] DOB: [redacted]
HOSP#: [redacted] MR#: [redacted]
CHART LOC: [redacted] PCP: [redacted]

CONSULTATION CONTINUED:

Extremities, no peripheral edema.

LABORATORY DATA: White count of 5.9, hemoglobin 11.6, platelet count 157, sodium 141, potassium 3.9, chloride 105, C02 30, BUN 26, creatinine 1.34, estimated GFR 50.

IMPRESSION:
1. CKD stage 3 which is moderate with stable kidney function over the course of the last several months which I believe is secondary to age-related glomerulosclerosis and hypertensive kidney disease. The patient has benign urine sediment which makes an interstitial or glomerular type of etiology very unlikely. He does have a history of BPH which can also cause fluctuation of serum creatinine. Given his underlying history of peripheral vascular disease, I could not rule out the possibility of ischemic nephropathy. Overall his kidney function is stable and appears to be at baseline.
2. Mild anemia which does not have any indication for erythropheresis stimulating agents.
3. Hypertension.
4. History of renal cysts.
5. BHH.

PLAN:
1. Suggest conservative management.
2. I agree with amlodipine.
3. Would avoid the use of ACE inhibitor or ARBs, because of the possibility of underlying renovascular disease.
4. There is no indication for Procrit.
5. May need bladder scan to rule out postvoid residual.
6. _____on the patient.

Thank you for allowing me to participate in the care of your patient.

FARG /PNG
D: 10/31/12
T: 10/31/12

Date: Time:

cc: AMELIA JAWOREK, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: GEORGE-ELIE FARES, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF CONSULTATION: 01/28/2013

HISTORY OF PRESENT ILLNESS: I was asked to assist in the management of this 91-year-old patient who has a history of chronic kidney disease stage 4, well known to me, who is being treated for community-acquired pneumonia and is noted to have mild elevation of serum creatinine. The patient was admitted initially with pneumonia. Was started on Zithromax and ceftriaxone and apparently had MRSA in his sputum and was subsequently switched to Tygacil. He has been complaining of nausea. According to him, he lost some weight due to decreased oral intake over the last few weeks and month. He denies any chest pain. There is no report of vomiting or diarrhea, but has been complaining of nausea. The patient known to have a history of left nephrectomy with a single functional kidney. Recent blood culture was essentially negative. He had a chest x-ray a few days ago that was improved.

PAST MEDICAL HISTORY: Notable for chronic kidney disease stage 4, hypertension, COPD, recurrent urinary tract infection, history of pacemaker malfunction, spinal stenosis, peripheral neuropathy, gout, sick sinus syndrome, atrial fibrillation, blindness due to a macular degeneration, hypothyroidism, history of DVT.

PAST SURGICAL HISTORY: Notable for pacemaker, nephrectomy, cataract surgery.

MEDICATIONS: As in inpatient were reviewed and include furosemide and potassium chloride.

ALLERGIES: IODINE, MORPHINE, IV CONTRAST.

SOCIAL HISTORY: Does not smoke or drink alcohol.

FAMILY HISTORY: Negative for kidney disease.

REVIEW OF SYSTEMS: A 12-point review of systems negative except as mentioned in History of Present Illness.

PHYSICAL EXAMINATION: Blood pressure 136/72. Heart rate is 60. Respiratory rate is 16. Temperature 97.5. Constitutionally, he looks

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted] MD

CONSULTATION CONTINUED:

his stated age. He is sitting out of bed. Not in acute distress. Neurologic, he is alert, awake. Head, atraumatic, normocephalic. Eyes, no scleral icterus. Neck supple. Lungs, decreased breath sounds. Cardiovascular, S1, S2. No rub. Abdomen soft, obese, nontender, present bowel sounds. Extremities with trace peripheral edema.

LABORATORY AND OTHER STUDIES: White count 11.7. Hemoglobin is 13.2. Platelet count 102. Sodium 143. Potassium 4.3. Chloride 107. CO2 is 27. Calcium 7.5. BUN 104. Creatinine 2.7.

IMPRESSION:
1. Acute kidney injury.
2. Chronic kidney disease stage 4.
3. Single functional kidney.

PLAN: I suspect that his kidney function is slightly worse in the setting of intravascular depletion resulting in renal hypoperfusion. On physical examination, he does not appear to be volume overloaded and I will therefore suggest to hold his loop diuretics for the time being. I will also hold potassium supplement for as long as his furosemide is on hold. We will continue to follow closely his kidney function and electrolytes. There is no indication to obtain a renal imaging study unless his kidney function does not improve with supportive management described previously. I will continue to follow closely his kidney function and electrolytes.

Thank you for allowing me to participate in the care of your patient.

888 T:scb DD:20130128 TD:0953 DT:20130128 TT:1125 JOB:13-00684058

FARG /STE
D: 01/28/13
T: 01/28/13

GEORGE-ELIE FARES, MD

cc: ANTHONY ACQUISTA, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: GEORGE-ELIE FARES, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF CONSULTATION: 04/23/2012

HISTORY OF PRESENT ILLNESS: I was asked to assist in the management of this 67-year-old patient who has a history of chronic kidney disease, stage 3, followed by Dr. Slater, who presented to the hospital with diarrhea and was noted to have an elevated serum creatinine. The patient recently underwent a right carotid endarterectomy at UMass; has been complaining of diarrhea for at least three days. She has been complaining of nausea and mild abdominal pain. She tells me that she started having diarrhea after she took colchicine because of an episode of gout. The patient denies any chest pain or shortness of breath. She denies being started on any new medication recently. She denies the use of non-steroidal anti-inflammatory drugs.

PAST MEDICAL HISTORY: Notable for chronic kidney disease, stage 3; diabetes mellitus; hypertension; dyslipidemia; peripheral vascular disease.

PAST SURGICAL HISTORY: Notable for carotid endarterectomy, tubal ligation, carpal tunnel surgery.

MEDICATIONS: Current medications as an outpatient were reviewed.

ALLERGIES: She is allergic to IV DYE.

SOCIAL HISTORY: Does not smoke or drink alcohol.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As mentioned in history of present illness.

PHYSICAL EXAMINATION: The blood pressure is 152/55, heart rate 68, respiratory rate 14, temperature 97.5. Constitutional, the patient looks her stated age. She is in no acute distress. Neurologically, she is alert and oriented to time, place and person. Head atraumatic, normocephalic. Neck supple. Lungs clear to auscultation. Cardiovascular, S1, S2, regular rate and rhythm. Abdomen soft, nontender, positive bowel sounds. Extremity with no peripheral edema.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: EDWARD RYTER, MD

CONSULTATION CONTINUED:

LABORATORY AND OTHER STUDIES: White count 13.3, hemoglobin 10.2, platelet count 282. Sodium 137, potassium 4, chloride 110, CO2 at 14, BUN 96, creatinine 2.63.

IMPRESSION AND PLAN: A 67-year-old patient with acute kidney injury superimposed on chronic kidney disease, stage 3. The clinical history is consistent with volume depletion, resulting in renal hypoperfusion and prerenal state. She has a non-anion gap metabolic acidosis due to gastrointestinal losses of bicarbonate. Her baseline creatinine is in the range of 1.5-1.7 mg/dL. My suggestion would be to proceed with vigorous hydration. I would add bicarbonate to her intravenous fluid, as she has a low bicarbonate level. I would obtain spot urine electrolytes. I would hold off renal imaging study unless her kidney function does not improve with volume expansion. I would hold her angiotensin-converting enzyme inhibitor and diuretics for the time being.

Thank you for allowing me to participate in the care of your patient.

888 T:trp DD:20120423 TD:1705 DT:20120424 TT:1207 JOB:12-00594126

FARG /STE
D: 04/23/12
T: 04/24/12

GEORGE-ELIE FARES, MD

cc: EDWARD RYTER, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: GEORGE-ELIE FARES, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF CONSULTATION: May 23, 2012

HISTORY OF PRESENT ILLNESS: I was asked to assist in the management of this 92-year-old patient who presented to the hospital after a mechanical fall and who was noted to have an elevation of calcium on arrival and currently being evaluated for a finding of bilateral hydroureters. The patient was noted to have lytic bone lesions as well on a CAT scan, which is concerning for metastatic disease of unknown primary. She is currently being evaluated also be oncology. She denies any nausea or vomiting, diarrhea. Her appetite seems to be preserved. She denies any weight loss. There is no history or report of chest pain or shortness of breath. She did have an ultrasound of the abdomen, which showed, yesterday, a right hydronephrosis. Preliminary workup showed a normal intact PTH and negative serum immunofixation and a slightly low vitamin D-25 level.

PAST MEDICAL HISTORY: Notable for diabetes mellitus, hypertension, history of CVA, hypothyroidism, impaired vision.

CURRENT MEDICATIONS: As an outpatient were reviewed and include a calcium supplement.

ALLERGIES: ASPIRIN and PENICILLIN.

SOCIAL HISTORY: There is no history of alcohol or smoking.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As mentioned in History of Present Illness. The remainder of the review of systems is essentially negative.

PHYSICAL EXAMINATION: The blood pressure is 160/79, heart rate is 83, respiratory rate 20, temperature 96.9. Constitutional, she looks her stated age. She is in no acute distress. Neurologic, she moved all four extremities. Head atraumatic, normocephalic. Eyes, pupils equal, conjunctivae anicteric. Throat clear. Ear, no discharge. Septum midline. Neck no JVD. Lungs clear to auscultation. Cardiovascular, S1, S2, regular rate. Abdomen soft, obese, nontender, bowel sounds present. Extremity with trace peripheral edema.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC:

DOB: [redacted]
MR#: [redacted]
PCP: ANTONE CRUZ, MD

CONSULTATION CONTINUED:

LABORATORY AND OTHER STUDIES: Showed a urine protein of 13.7, a urine creatinine of 32, sodium 139, potassium 4.4, chloride 104, CO2 28. BUN is 25, creatinine 0.99, calcium 10.3, albumin 3.2.

IMPRESSION AND PLAN:
1. Right hydronephrosis with questionable underlying metastatic cancer of unknown primary. The patient will likely need a dedicated study to evaluate obstructive uropathy. The ultrasound of the abdomen did not visualize the left kidney, which needs to be also assessed.
2. Hypercalcemia, in the setting of her metastatic disease aggravated by calcium supplements. Her calcium level has actually returned to normal.
3. Hypertension.

PLAN:
1. Await a PTHrP.
2. I would hold ACE inhibitor if serum creatinine worsened.
3. I would order a CT scan of the abdomen to assess both kidneys.

Thank you for allowing me to participate in the care of your patient.

888 T:cah DD:20120523 TD:0826 DT:20120523 TT:1003 JOB:12-00611704

FARG /STE
D: 05/23/12
T: 05/23/12

GEORGE-ELIE FARES, MD

cc: ANTONE CRUZ, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

ADDITIONAL COPY

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #[redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: GEORGE-ELIE FARES, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF CONSULTATION: 06/20/12

REASON FOR CONSULTATION: I was asked to assist in the management of this 80-year-old patient with no prior history of hyponatremia who presented to the hospital with shortness of breath and was noted to have a low serum sodium.

HISTORY OF PRESENT ILLNESS: In summary, the patient was treated in the outpatient setting for a bronchitis with antibiotics. He reports worsening shortness of breath which prompted his presentation to the hospital for further evaluation. He did have a chest CT which showed extensive mediastinal and hilar adenopathy with prominent hilar consolidation and nodules consistent with malignancy, in addition to a small right pleural effusion and suspicious lytic bone lesions and liver masses. The patient denies any nausea, vomiting or diarrhea prior to presentation. He tells me that he lost more than 20 pounds in the course of the last few months. He did have some reduction in his appetite. He has been told recently to increase his fluid intake and he has been drinking more than usual water. No chest pain, pleuritic type. Of note, he had been on Dilantin because of underlying seizure disorder.

PAST MEDICAL HISTORY: Notable for seizure disorder.

PAST SURGICAL HISTORY: Notable for hernia repair and prostate surgery.

MEDICATIONS: Dilantin, aspirin.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: He has a history of smoking, does not drink alcohol.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As mentioned in the HPI, the remainder essentially negative.

PHYSICAL EXAMINATION: The blood pressure is 126/62, heart rate 80, respiratory rate 18, temperature 98.4. Constitutional: He looks his stated age. He is in no acute distress. Neurologic: He is alert, oriented to time, place and person. Head NCAT. Pink conjunctivae, anicteric sclerae. Throat clear. External ears no discharge. Septum midline. Neck no JVD. Lungs, good air entry bilaterally. Cardiovascular: S1, S2, regular. Abdomen soft, nontender, present bowel sounds. Extremities with no peripheral edema. Musculoskeletal,

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]

CONSULTATION CONTINUED:

grossly normal range of motion.

LABORATORY DATA: Labs showed a urine sodium of 53, urine osmolality 240. Labs on admission showed a serum sodium of 120, BUN 26, creatinine 0.94, potassium 5.2, chloride 90, C02 25, urine osmolality 267, TSH 1.97.

IMPRESSION: In summary, this is an 80-year-old patient with hyponatremia which appears to be hypotonic in a setting of probably metastatic cancer with significant lung involvement. The hyponatremia is multifactorial in part due to excessive free water intake which, in combination with underlying SIADH which could be preneoplastic, could have compounded his hyponatremia. In addition to that, he is on Dilantin, which can contribute as well to hyponatremia. There is a history of weight loss, and there is a component also of hypovolemia, although the urine sodium was 53 this morning. He does have an elevated serum potassium on admission and although he is not hypotensive, it would be reasonable to rule out hypoadrenalism. There is no evidence for hypothyroidism.

PLAN:
1. Restrict free water intake.
2. A sodium chloride tablet for a total of four doses.
3. I agree with a random cortisol level.
4. Follow sodium.

Thank you for allowing me to participate in the care of your patient.

FARG /PNG
D: 06/20/12
T: 06/20/12

GEORGE-ELIE FARES, MD

cc: STEPHEN HOLUK, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]A
HOSPITAL #: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF CONSULTATION: 02/05/13

REASON FOR CONSULTATION: I was called to see this patient by the hospitalist to assist in the management of patient's dialysis requirements.

HISTORY OF PRESENT ILLNESS: To summarize, June is a 77-year-old woman with a history of ESRD on hemodialysis. She had dialysis yesterday. She comes in with shortness of breath and today she is found to have fluid overload and hence this consultation.

Recently she was treated with azithromycin for bronchitis during dialysis. During dialysis she has been getting Midodrine 5 mg before and during dialysis for low blood pressure. She was on metoprolol succinate which has been changed to metoprolol tartrate q.p.m. for control of AFib.

PAST MEDICAL HISTORY: Other medical problems include history of ESRD, obesity, gout, chronic kidney disease, chronic atrial fibrillation, ovarian cancer.

PAST SURGICAL HISTORY: Bilateral hip replacements, hysterectomy and partial colectomy.

SOCIAL HISTORY: No smoking or alcohol abuse. She is divorced.

FAMILY HISTORY: Not significant for any kidney disease.

ALLERGIES: BACTRIM, ZESTRIL, NOVOCAINE.

REVIEW OF SYSTEMS: Positive for shortness of breath. No chest pain, nausea, vomiting. No abdominal pain.

PHYSICAL EXAMINATION: On examination, the patient is an elderly woman. She is obese. She is comfortable, arousable. Blood pressure 110/50, pulse 90, temperature 98.6. Neck supple, no JVD. Lungs with bilateral crackles. Heart S1, S2, regular, no gallop or rub. Abdomen soft, nontender, obese. Neurologic: She is arousable. No asterixis. Nonfocal. Extremities: No rash, no clubbing. No joint swelling or deformities.

All of the medications were reviewed.

LABORATORY DATA: Potassium 5, calcium 9.1, sodium 138, hemoglobin 10.8.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: [redacted], MD

CONSULTATION CONTINUED:

IMPRESSION: 77-year-old woman with ESRD and chronic atrial fibrillation comes in with mild fluid overload.

I will proceed with _____ultrafiltration to try to remove fluid as tolerated. In the meantime, we will use Midodrine 10 mg before and 10 mg during dialysis. I will dialize her again today, and we will try to lower her dry weight by 1-2 kilos over the next couple of days. I have discussed with with Dr. Laliberte and Dr. Todd. We will be happy to follow with the team.

PADB /PNG
D: 02/05/13
T: 02/06/13

BALAJI ATHREYA, MD

cc: RICHARD SHUMAN, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]23
MR #: [redacted]0
PCP:
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF CONSULTATION: 02/07/13

REASON FOR CONSULTATION: I was called to see this patient by the ER physician last night because of acute kidney injury.

HISTORY OF PRESENT ILLNESS: Irene is a nursing home resident. She was brought in because of altered mentation. At the time of admission, in the ER, she was found to have a low blood pressure with the systolic in the 80s. However, she was able to answer questions and she was awake when the ER physician examined her. Lab work was done and she was found to have a BUN of 57, creatinine 12.4, and Dr. Hanson called me to discuss the case. We agreed to proceed with the usual workup and started her on IV fluids and inserted a Foley catheter and a sonogram was ordered. Subsequently, I spoke to Dr. Tangban and the BUN and creatinine were already slowly decreasing but she was having significant acidosis; therefore, we changed IV fluids to D5W with 3 gm of sodium bicarbonate.

I had the opportunity to see this patient this morning in the ICU. Chart was reviewed.

PAST MEDICAL HISTORY: Ongoing medical problems include history of hypertension. No known renal issues in the past and has not seen any nephrologist in the past. History of anxiety, GERD, and UTI.

PAST SURGICAL HISTORY: No significant past surgical history.

SOCIAL HISTORY: No smoking or drug abuse.

FAMILY HISTORY: There is no family history significant for renal disease.

REVIEW OF SYSTEMS: Patient was unable to give a good review of systems. They were obtained from the chart.

PHYSICAL EXAMINATION: On examination, the patient is an elderly woman who is awake. She is comfortable, not in any distress. Mucosa is dry. Neck supple. No JVD. Lungs equal to percussion. No significant rales. Heart S1, normotensive, no rub. Abdomen soft, nontender, bowel sounds heard. Neuro: Alert and awake, able to answer simple questions. She had no _____edema, no rash, no clubbing, no joint swelling or deformities.

CURRENT MEDICATIONS: All the current medications were reviewed.

NAME: [redacted]
HOSP#:
CHART LOC:

DOB: [redacted]
MR#:
PCP:

CONSULTATION CONTINUED:

LABORATORY DATA: BUN 30, creatinine 10.25, sodium 136, potassium 4.4, C02 9.5, calcium 7, phosphorus 7.8. Hemoglobin was 13.2, WBC count 11.7, platelets 112. Urinalysis showed specific gravity more than 1.030 with a large amount of blood and protein; however, the gross appearance is normal.

IMPRESSION: 89-year-old woman with acute kidney injury most likely due to dehydration. She admits that she might have sustained acute tubular necrosis. Further clinical course will determine this. We will certainly rule out glomerulonephritis in this elderly lady, especially since she had some blood and protein in the urine.

She has severe acidosis again due to renal failure.

Hypotension, most likely due to volume depletion.

RECOMMENDATION: Continue with aggressive IV hydration. We will continue D5W and bicarbonate to replace the bicarb. We will watch the potassium and the sodium as well. We will watch intake and output closely, keeping the input more than the output, and maintaining the systolic blood pressure at more than 100 mmHg to maintain adequate renal perfusion.

I ordered a urine for protein-creatinine ratio as well. I will be happy to follow as needed.

PADB /PNG
D: 02/07/13
T: 02/07/13

BALAJI ATHREYA, MD

cc:

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted] MD
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF CONSULTATION: 02/05/13

REASON FOR CONSULTATION: I was called to see this patient by the hospitalist to assist in the management of patient's dialysis requirements.

HISTORY OF PRESENT ILLNESS: To summarize, June is a 77-year-old woman with a history of ESRD on hemodialysis. She had dialysis yesterday. She comes in with shortness of breath and today she is found to have fluid overload and hence this consultation.

Recently she was treated with azithromycin for bronchitis during dialysis. During dialysis she has been getting Midodrine 5 mg before and during dialysis for low blood pressure. She was on metoprolol succinate which has been changed to metoprolol tartrate q.p.m. for control of AFib.

PAST MEDICAL HISTORY: Other medical problems include history of ESRD, obesity, gout, chronic kidney disease, chronic atrial fibrillation, ovarian cancer.

PAST SURGICAL HISTORY: Bilateral hip replacements, hysterectomy and partial colectomy.

SOCIAL HISTORY: No smoking or alcohol abuse. She is divorced.

FAMILY HISTORY: Not significant for any kidney disease.

ALLERGIES: BACTRIM, ZESTRIL, NOVOCAINE.

REVIEW OF SYSTEMS: Positive for shortness of breath. No chest pain, nausea, vomiting. No abdominal pain.

PHYSICAL EXAMINATION: On examination, the patient is an elderly woman. She is obese. She is comfortable, arousable. Blood pressure 110/50, pulse 90, temperature 98.6. Neck supple, no JVD. Lungs with bilateral crackles. Heart S1, S2, regular, no gallop or rub. Abdomen soft, nontender, obese. Neurologic: She is arousable. No asterixis. Nonfocal. Extremities: No rash, no clubbing. No joint swelling or deformities.

All of the medications were reviewed.

LABORATORY DATA: Potassium 5, calcium 9.1, sodium 138, hemoglobin 10.8.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]MD

CONSULTATION CONTINUED:

IMPRESSION: 77-year-old woman with ESRD and chronic atrial fibrillation comes in with mild fluid overload.

I will proceed with _____ultrafiltration to try to remove fluid as tolerated. In the meantime, we will use Midodrine 10 mg before and 10 mg during dialysis. I will dialize her again today, and we will try to lower her dry weight by 1-2 kilos over the next couple of days. I have discussed with with Dr. Laliberte and Dr. Todd. We will be happy to follow with the team.

PADB /PNG
D: 02/05/13
T: 02/06/13

_____
BALAJI ATHREYA, MD

cc: RICHARD SHUMAN, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: MMC

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF CONSULTATION: 09/02/12

REASON FOR CONSULTATION: I was called to see this patient by Dr. Hope for assessment of acute kidney disease and acidosis.

HISTORY OF PRESENT ILLNESS: The patient is well known to me. He sees my partner, Dr. Slater, in the outpatient setting. He is a 74-year-old man with a history of stage 2 chronic kidney disease with a baseline creatinine normal at 1.4 mg/dL. He had a foot infection, and he was started on Bactrim one tablet twice a day on August 8. He took that for 10 days and subsequently developed diarrhea and he had diarrhea for almost two weeks, which was watery, and he lost about 10-15 pounds. He came into the hospital yesterday with a creatinine of 3.58 with a bicarb of 10 and he was given IV fluids. Subsequently, creatinine has decreased to around 2.5 and bicarb is around 13 and hence this consultation. His ongoing medical problems include history of longstanding hypertension, anemia, recently started on Procrit; history of gout, chronic kidney disease stage 2 with a baseline creatinine 1.3 mg/dL, GERD, anxiety.

PAST SURGICAL HISTORY: Significant for right knee arthroscopy surgery and tonsillectomy.

SOCIAL HISTORY: No smoking or alcohol abuse is present.

FAMILY HISTORY: Noncontributory.

MEDICATIONS ON ADMISSION: Include Allegra, allopurinol, aspirin, Ativan, doxazosin 4 mg, iron sulfate, hydrochlorothiazide 12.5 mg, ibuprofen 200 mg q. day, omeprazole, Procrit 10,000 units once a month, Toprol XL, vitamin B12, vitamin B6, vitamin D, metoprolol 50 twice a day.

REVIEW OF SYSTEMS: Positive for diarrhea and abdominal pain. No melena. No cough. No shortness of breath. No chest pain. No fever. No rash. No joint swelling or deformity. No hematuria. No other urinary symptoms. All other systems reviewed and negative.

PHYSICAL EXAMINATION: The patient is a pleasant 74-year-old man who is

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: MMC

DOB: [redacted]
MR#: [redacted]
PCP: SARVALAKSHMI KURELLA, MD

CONSULTATION CONTINUED:

comfortable at rest. Neck supple. No JVD. He has mild pallor. The mucosa is moist. Lungs, air entry good, no rales. Heart sounds are normal. No gallop or rub. Abdomen distended, soft, nontender, bowel sounds heard. Neuro, he is alert and awake. No asterixis. No focal motor deficits are present. Extremities, no dependent edema, no rash, no clubbing. No joint swelling or deformity. No palpable lymphadenopathy. The blood pressure today was 136/53, pulse 82, temperature 97.

LABORATORY AND OTHER STUDIES: All the labs were reviewed. Back in May, iron stores were adequate. As of 09/02, BUN 68, creatinine 2.74, CO2 13, calcium was 11.6, magnesium 1.6, albumin 3.6 on admission. Hemoglobin was 7.9, WBC 5.5, platelets 133. Urinalysis in the past showed no significant protein or blood.

IMPRESSION AND PLAN: A 74-year-old man with acute kidney disease superimposed on chronic kidney disease with severe metabolic acidosis.
1. Acute kidney disease due to hypoperfusion from a combination of dehydration and the continued use of non-steroidal anti-inflammatories. With IV hydration, the renal function is improving and I expect the renal function to return to baseline with adequate hydration and optimizing the renal perfusion. We will watch intake and output and maintain systolic blood pressure at more than 100 mmHg and I will hold the hydrochlorothiazide and discontinue the NSAIDs.
2. Severe metabolic acidosis. He has hyperchloremic metabolic acidosis. We will check the urinary anion gap to differentiate RTA from GI loss of bicarbonate. He most likely has bicarbonate losses in the stools due to diarrhea. I will change the IV fluids to D5W with 3 amps sodium bicarbonate at 100 cc/hour x2 L and then switch him back to half normal saline.
3. The diarrhea was probably related to the use of Bactrim for 10 days. C. diff has been ordered and the results are pending. The diarrhea seems to be subsiding at the present time.
4. Severe anemia. His iron stores, vitamin B12, folate were all adequate. He is currently on Procrit injections for the last few months. He will need a blood transfusion if hemoglobin continues to decrease, and I agree with continuing with the Procrit for the time being.

I will be happy to follow him as needed. Thank you for the opportunity.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: MMC

DOB: [redacted]
MR#: [redacted]
PCP: SARVALAKSHMI KURELLA, MD

CONSULTATION CONTINUED:

6998 T:dea DD:20120902 TD:1145 DT:20120904 TT:0945 JOB:08-03109103

PADB /STE
D: 09/02/12
T: 09/04/12

BALAJI ATHREYA, MD

cc: SARVALAKSHMI KURELLA, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: PALMER P2-05

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF CONSULTATION: July 9, 2012

HISTORY OF PRESENT ILLNESS: I was called to see this patient by Dr. Cheryl Geoffrion for assessment of the patient's polycystic kidney disease. The patient is a 40-year-old man with a history of polycystic kidney disease. He was seen by Dr. Poppel about three or four years ago and subsequently the patient decided not to go back for followup. He is a patient of Dr. Booth and he is supposed to see my partner, Dr. Slater, in the outpatient setting. In the meantime, he came to the hospital because of flank pain, which started two days ago, on the left side, which was radiating to his groin. Since admission, he has been getting some narcotics and the pain is under control and he has undergone imaging studies and results are pending. His baseline creatinines have been around 1.3-1.4 mg/dL, but at the time of admission creatinine was 1.75 which has increased to 2.01 and hence this consultation.

PAST MEDICAL HISTORY: Other medical problems include history of polycystic kidney disease, hypertension, migraines, history of retinal tear, status post repair. In the past he has had a right bundle-branch block on EKG. History of seasonal allergies.

ALLERGIES: No known drug allergies.

MEDICATIONS AT HOME: Include Proscar 5 mg one-half tablet a day, Cozaar a small dose, although he does not remember the exact dose. He is also on vitamin D, Biotin and thiamine.

REVIEW OF SYSTEMS: Positive for left flank pain with radiation with nausea and vomiting. No diarrhea or constipation. No gross hematuria. No fever. He did have some sweating at home. No chest pain, cough expectoration. No headache. All other systems reviewed are negative.

PHYSICAL EXAMINATION: Blood pressure is 138/70, pulse is 78 per minute. The patient is a pleasant, middle-aged man who appears comfortable at rest. Neck supple, no JVD. Mucosa is dry. Pupils are equal. Lungs, air entry equal, no rales. Heart S1, S2 normal, no gallop or rub. Abdomen soft, nontender, bowel sounds heard. Neuro, he is alert and awake, no focal motor deficits. Extremities, no edema, no

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: GARY BOOTH, MD

CONSULTATION CONTINUED:

rash, no clubbing. No joint swelling or deformity. No palpable lymphadenopathy. The back was examined, no midline tenderness. There was mild tenderness along the left flank. No CVA tenderness.

LABORATORY AND OTHER STUDIES: BUN 20, creatinine 2.1, serum lipase normal, hemoglobin 30.7, WBC of 8.5. Urinalysis showed trace blood, no serum protein. The CAT scan done yesterday was reviewed. The kidney measured about 17 cm with multiple cysts, along with hepatic cysts. No mention about hydronephrosis. Ultrasound of the kidney has been ordered.

IMPRESSION: A 40-year-old man with polycystic kidney disease with left flank pain.

PLAN: The pain may be related to the polycystic kidney disease. However, a urinary tract infection should be ruled out. Bleeding into the cysts is a possibility as well. I will review the ultrasound results.

In the meantime, we will hydrate him, keep intake, monitor output and he needs adequate pain control. We will obtain _____ for sodium, creatinine and protein. Further workup will be determined by the outcome on the base investigations.

6998 T:cah DD:20120709 TD:1229 DT:20120710 TT:0646 JOB:08-03049848

PADB /STE
D: 07/09/12
T: 07/10/12

BALAJI ATHREYA, MD

cc: GARY BOOTH, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: BALAJI ATHREYA, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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NEPHROLOGY CONSULTATION

DATE OF CONSULTATION: March 31, 2012

REASON FOR CONSULTATION: I was called to see this patient by Dr. Cheryl Geoffrion for assessment of acute renal failure.

HISTORY OF PRESENT ILLNESS: The patient is a 74-year-old woman with a history of chronic kidney disease and she is being followed by my partner, Dr. Slater. She has been admitted because of low blood pressure and an episode of passing out. Prior to the admission, she was not feeling well for a couple of days and she had some nausea and poor p.o. intake. At the time of admission, she was hypotensive and she required pressors and she is currently being managed per sepsis protocol. Her baseline creatinine is usually around 1.1 and 1.2 mg/dL which has increased to 2.47 on admission. The LFTs are also elevated. At present, the blood pressure is acceptable and there has been a mild improvement in the serum creatinine. The urine output has improved.

PAST MEDICAL HISTORY: Her ongoing medical problems include a history of chronic kidney disease, morbid obesity, hypertension, diabetes mellitus, history of peripheral neuropathy, urine incontinence, osteoarthritis, lower extremity stasis ulcers.

ALLERGIES: She is allergic to ZESTRIL, which causes cough.

MEDICATIONS ON ADMISSION: Lasix 40. It was just increased to 40 b.i.d., but she did not take it twice a day. Spironolactone 50 mg, doxazosin 4 mg, Starlix one tablet t.i.d., which has been held for the last week or so; Detrol LA, calcium, metoprolol 150 b.i.d., metformin 1 g b.i.d., lovastatin 20 mg, aspirin, Diovan 160 b.i.d., Osteo Bi-Flex p.r.n.

FAMILY HISTORY: Noncontributory to this admission.

SOCIAL HISTORY: She is married, lives with her husband. Has a son. No history of smoking or alcohol abuse.

REVIEW OF SYSTEMS: Poor p.o. intake. She had cough with dizziness and nausea. No urine symptoms. No fever. No rash. All other systems reviewed and

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: VICTORIA NOBLE, MD

CONSULTATION CONTINUED:

negative.

PHYSICAL EXAMINATION: The patient is a pleasant woman who is comfortable. She is obese. Neck supple, no JVD. Lungs, air entry equal, no significant rales. Heart S1, S2, normal. There is no gallop or rub. Abdomen is obese, soft, nontender. Extremities, no significant dependent edema, no rash, no clubbing. All the blood pressure readings were reviewed.

LABORATORY AND OTHER STUDIES: BUN 43, creatinine 2.32, sodium 139, potassium 4.2, CO2 22.5. Hemoglobin 11, WBC 10.3, which was 13.1 on admission.

ASSESSMENT AND PLAN: A 74-year-old woman with acute kidney disease superimposed on chronic kidney disease.

Acute kidney disease due to hypoperfusion from low blood pressure. Volume depletion might be playing a role as well.

She has underlying chronic kidney disease with a baseline creatinine 1.2 mg/dL due to hypertensive diabetic kidney disease.
My recommendation, at this point, is to hold the diuretics and the Diovan. We will avoid hypotension and maintain the systolic blood pressure at more than 100 mmHg. She is nonoliguric at present. The renal function should improve with IV hydration. I will be happy to follow as needed.

cc: Victoria Noble, M.D.

6998 T:cah DD:20120331 TD:1414 DT:20120402 TT:1131 JOB:10-02709050

PADB /STE
D: 03/31/12
T: 04/02/12

BALAJI ATHREYA, MD

cc: VICTORIA NOBLE, MD

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: PMC PCP: [redacted]
PHYSICIAN/PROVIDER: SIVAKUMAR PADMANABHAN, MD
DICTATING: SIVAKUMAR PADMANABHAN, MD

PRIMARY CARE PHYSICIAN: Jeremy Golding, M.D.

ONCOLOGY: Ahmad Daniyal Siddiqui, M.D.

SUBJECTIVE: The patient was seen in Wing Memorial ICU during November 2012 hospitalization. At that time, he had acute hypoxic respiratory failure. He was requiring nonrebreather mask for a few days and then his oxygenation was quite poor. I was called in to give further evaluation and recommendations at that time. He had bilateral ground glass infiltration on CAT scan. There was acute pneumonitis on a background of chronic lung disease pattern. He was a nonsmoker. He had pancytopenia. He had history of CML. Since he was immunocompromised, he underwent flexible fiberoptic bronchoscopy with transbronchial lung biopsy and the bronchial cultures were negative, bronchial washings were negative for Pneumocystis organisms. He was given broad-spectrum antibiotics. Echocardiogram showed a normal LV function. Bronchoscopy revealed normal endobronchial tree. No mucus plugs or lesions. Transbronchial biopsy showed organizing pneumonia. There was no growth of AFB or fungus. The patient was given a protracted course of steroids for organizing pneumonitis. Since starting the steroids, he made a significant recovery with improvement in his oxygenation. Subsequently, he was discharged as an outpatient. He has not been on oxygen. Steroids have been tapered off currently. He does not report any chest symptoms.

CURRENT MEDICATIONS: Have been reviewed. Allopurinol, Simvastatin, multivitamins, acyclovir, Protonix, Lasix, and currently MAR is showing prednisone 20 mg by mouth daily but for the pneumonitis part, it was told that he can be weaned off the steroids.

SOCIAL HISTORY: The patient got pneumonia vaccine in the last five years and flu vaccine in October 2012. The patient does not smoke.

CLINICAL EXAM: The patient is not ill. Temperature 98 Fahrenheit, pulse rate of 80 and respirations of 18, blood pressure 120/52, BMI 23, height 5 feet 7 inches. On examination, the patient is not acutely ill. He looks pale in the conjunctiva. Oral mucosa is clear. Heart sounds are normal. Breath sounds are equal and clear. Abdomen is soft, nontender. No edema.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: SIVAKUMAR PADMANABHAN, MD

OFFICE VISIT CONTINUED:

DIAGNOSTIC STUDIES: The recent CBC shows severe pancytopenia, under the care of hematology/oncology, Dr. Siddiqui. Recent chest x-rays December 6, 2012, post hospitalization shows significant improvement in organizing pneumonitis and there are some residual chronic changes. mediport is in place.

ASSESSMENT AND PLAN: A 73-year-old male with history of CML, pancytopenia, recent acute and chronic lung disease, severe hypoxemia and respiratory failure from organizing pneumonitis. Clinically and radiographically, the patient has significantly improved. The plan is to taper off the steroids, observe, and watch for any recurrence of infection or inflammation. If there are any new pulmonary problems, I will be glad to follow up. At this time, I will follow up in the office as needed.

d/w Dr Siddiqui--steroids can be tapered off over 1-2 week period.

cc: Ahmad Daniyal Siddiqui, M.D.

Jeremy Golding, M.D.
279 Lincoln Street
Hahnemann Family Health Center
Worcester, MA 01605

9979 T:dtm DD:20130118 TD:1129 DT:20130122 TT:0000 JOB:08-03254229

PADS /STE
D: 01/18/13
T: 01/22/13

SIVAKUMAR PADMANABHAN, MD
Report ESigned in PCI
Date:01/22/13 Time:1225

COPY SENT TO _____ DATE _____

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

Additional copy

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: PMC PCP: BART SOAR, MD
PHYSICIAN/PROVIDER: SIVAKUMAR PADMANABHAN, MD
DICTATING: SIVAKUMAR PADMANABHAN, MD

SUBJECTIVE: The patient feels better compared to two months ago. At that time, when he was in Florida, he had lot of symptoms of exacerbation with shortness of breath and wheezing. Now, his shortness of breath and wheezing are improved. He has a dry cough. No fever. His sleep is mostly disturbed because of cough. He is compliant to ProAir and Advair Diskus. Advair Diskus is 250/50 mcg b.i.d. He also takes Flonase nasal spray. He has quit smoking many years ago. He is up to date with the vaccines for pneumonia and flu.

OBJECTIVE: The patient does not appear ill. He is afebrile. Pulse rate of 61 and regular. Blood pressure 144/76 mmHg. Oxygen saturation 97%. Pupils are equal. Oral cavity, no thrush. No JVD. Tracheostomy scar in place. Heart sounds normal intensity. No murmur. Breath sounds are equal, distant, clear. Abdomen soft and nontender. No calf tenderness.

Chest x-ray had been in 2008. It was reportedly clear. His PFTs are from 2008 as well. He has evidence of obstructive airway disease and lung volumes have been elevated. The DLCO was also low.

ASSESSMENT, PLAN AND RECOMMENDATIONS: History of asthmatic bronchitis, history of tracheostomy 18 years ago for traumatic injury to the chest. At this time, he does have trouble swallowing, which has been evaluated with swallow study in the past. He has a modified diet in place. Clinically, asthma appears to be stable. My recommendations will be to continue Advair 250/50 mcg b.i.d. and use ProAir 2-3 times a day. We will get an updated chest x-ray. We also update pulmonary function test. The patient was counseled. We will follow up in two months with all those studies.

cc: Bart Soar, M.D.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: SIVAKUMAR PADMANABHAN, MD

OFFICE VISIT CONTINUED:

9979 T:rjk DD:20120523 TD:1456 DT:20120525 TT:0622 JOB:10-02769495

PADS /STE
D: 05/23/12
T: 05/25/12

SIVAKUMAR PADMANABHAN, MD
Report ESigned in PCI
Date:05/25/12 Time:1200

COPY SENT TO _____ DATE _____

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Additional copy

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: [redacted] PCP: SARVALAKSHMI KURELLA, MD
PHYSICIAN/PROVIDER: SIVAKUMAR PADMANABHAN, MD
DICTATING: SIVAKUMAR PADMANABHAN, MD

SUBJECTIVE: Patient is doing fairly well. I think she has a history of bronchial asthma well controlled with Flovent 220 mcg 2 puffs twice a day, Ventolin inhaler q.6h. and Singulair 10 mg once a day. She thinks that her asthma is fairly well controlled. No recent exacerbating symptoms in her chest. No cough, sputum, wheezing, pain or shortness of breath. She is up to date with her pneumonia and flu vaccines. She has not had any recent chest x-ray although in the past she has had two PFTs that had shown normal spirometry, normal lung volumes and normal DLCO. She had normal PFTs in 2010 and she had a normal spirometry in April 2011.

OBJECTIVE: Patient is clinically doing well, afebrile, pulse rate of 62, regular blood pressure 118/62, saturation 96%. Pupils are equal. No oral thrush. Heart sounds are normal. Breath sounds are equal and clear. Abdomen is soft and nontender. No calf swelling. No calf tenderness.

DIAGNOSTIC STUDIES: Chest x-ray in the past has been clear.

ASSESSMENT, PLAN AND RECOMMENDATIONS: History of bronchial asthma, hypertension, gastroesophageal reflux disease. She can continue Singulair, Flovent as well as albuterol. We will get updated chest x-ray as well as full pulmonary function testing. We will follow up in two months.

cc: Sarvalaskhmi Kurella, M.D.

Additional copy

NAME: [redacted]
HOSP#: V[redacted]
CHART LOC: [redacted]

DOB: 1[redacted]0
MR#: M[redacted]
PCP: SARVALAKSHMI KURELLA, MD
DICTATING: SIVAKUMAR PADMANABHAN, MD

OFFICE VISIT CONTINUED:

9979 T:msr DD:20120523 TD:1545 DT:20120525 TT:0901 JOB:08-03001512

PADS /STE
D: 05/23/12
T: 05/25/12

SIVAKUMAR PADMANABHAN, MD
Report ESigned in PCI
Date:06/13/12 Time:1742

COPY SENT TO _____ DATE _____

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

OPERATIVE REPORT

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: BMC BP-01

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: SIVAKUMAR PADMANABHAN, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF PROCEDURE: 01/28/2013

DIAGNOSIS: Fevers, left lower lobe pneumonia. The patient is on a ventilator to look for endobronchial mucus plugging.

DESCRIPTION OF PROCEDURE: Informed consent obtained from the patient's wife. The patient was placed on 100% FIO2 on ventilator. Flexible fiberoptic video bronchoscope was passed via the endotracheal tube. Subcutaneous mucosa was anesthetized with 1% lidocaine. The patient was on fentanyl and Versed drip. The bronchoscope was passed, and the full tracheobronchial tree was inspected. Tip of the endotracheal tube was above the carina. Carina was sharp. The tracheobronchial tree appeared inflamed. There was no gross mucus plugging. There was mild inflammation, mild mucosal bleeding seen in the lingula and the right middle lobe entrance. All the bronchial openings were patent in the left upper lobe lingula, left lower lobe, right upper lobe, right middle lobe and right lower lobe. Bronchial washings were collected to send for cultures. Bronchoalveolar lavage was done in the lingula that is also being sent for cultures. Scope was removed. The patient tolerated the procedure well. No complications.

9979 T:trp DD:20130128 TD:1626 DT:20130129 TT:1036 JOB:10-03029151

PADS /STE
D: 01/28/13
T: 01/29/13

Date: Time:

Additional copy

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: SIVAKUMAR PADMANABHAN, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF CONSULTATION: January 29, 2013

PRIMARY CARE PHYSICIAN: Shabnam Cherylath, MD

HOSPITALIST: Dr. Jill Levin

REASON FOR CONSULTATION: Left lower lobe pneumonia.

CHIEF COMPLAINT: The patient was admitted with cough and congestion and found to have pneumonia, left lower lobe, five days ago.

HISTORY OF PRESENT ILLNESS: An 81-year-old male with history of Parkinson disease, hyperlipidemia, dementia. He is admitted for the past five days. He was found to have a left lower lobe pneumonic infiltrate on the initial chest x-ray. He is being treated with vancomycin as well as Zosyn. He seems to be improving. He is coughing, scanty sputum, it is clear. No history of hemoptysis. No chest pain on breathing. No shortness of breath normally. He is not on oxygen at home.

REVIEW OF SYSTEMS: No upper respiratory symptoms. No abdominal pain, vomiting or diarrhea. No leg pain or swelling. He has no trouble swallowing. He is retired. He has been having Parkinson's for over two years.

PAST MEDICAL HISTORY: Hyperlipidemia and Parkinson disease.

ALLERGIES: No known drug allergies.

MEDICATIONS: Reviewed. Currently he is on DVT prophylaxis with heparin and other medications were also reviewed. He is on Levaquin 750 mg IV daily and vancomycin 1 gram IV q.12.

SOCIAL HISTORY: He used to work for _____business. He has no history of alcohol or tobacco use. No birds, no pets, no travel.

FAMILY HISTORY: Noncontributory for Parkinson disease.

He has had his flu vaccine. He got the pneumonia vaccine during this

NAME: [redacted]
HOSP#:
CHART LOC:

DOB:
MR#:
PCP:

CONSULTATION CONTINUED:

hospitalization.

PHYSICAL EXAMINATION: An elderly male in no acute distress. Saturation 99% on 2 liters. Pulse rate of 80, respiratory 20, blood pressure 150/70, temperature 98.5. No pallor, no icterus. Oral mucosa is moist. No neck vein distention. Heart sounds are normal. Breath sounds are equal. A few crackles in the left base. No egophony, no rhonchi. Abdomen firm, nontender. Bowel sounds heard. No calf swelling. No calf tenderness. Neurologically there is rigidity, slowness of speech, and he is alert and oriented.

Chest x-ray shows improving left lower lobe atelectasis/consolidation. Much better than five days ago. ECG sinus rhythm, no acute changes.

LABORATORY DATA: Cultures have all been negative. Flu test has been negative. There was no leukocytosis since admission. White count 6, hemoglobin 11.2, platelet count 235. No eosinophilia. D-dimer of 624, probably due to inflammatory process. Glucose 113. BUN 24, creatinine 0.9, sodium 140, potassium 4.4, CO2 31, calcium 9.4, magnesium 1.9.

ASSESSMENT AND PLAN: An 81-year-old male with history of Parkinson disease, hyperlipidemia admitted for left lower lobe bronchopneumonia. This could have been viral and could have been a component of atelectasis. Overall the patient is improving. Clinically he does not appear toxic. There is no leukocytosis. The left lower lobe process seems to be resolving radiographically. At this time I do not see any "indication for bronchoscopy." Will complete a course of antibiotics for a total of 14 days. We can switch the patient to oral Levaquin and if the cultures remain negative, vancomycin can be stopped. Encourage mucolysis, decongestants, as well as incentive spirometry. Follow-up chest x-ray in 1-2 weeks. A D-dimer could be high due to an inflammatory process, however, since he has been mostly bedridden in the hospital for the last five days, I would be inclined to check bilateral venous leg Doppler. There are no other signs to suspect pulmonary embolism at this time.

Thank you for this consultation.

cc: Shabnam Cherlyath, MD
Jill Levin, M.D.

NAME: [redacted]
HOSP#:
CHART LOC:

DOB:
MR#:
PCP:

CONSULTATION CONTINUED:

9979 T:dlp DD:20130129 TD:1847 DT:20130130 TT:0739 JOB:10-03030838

PADS /STE
D: 01/29/13
T: 01/30/13

Date: Time:

cc: SHABNAM CHERIYATH, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

CONSULTATION

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC:

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: SIVAKUMAR PADMANABHAN, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF CONSULTATION: February 7, 2013

PRIMARY CARE PHYSICIAN: Dr. Shaukat Matin

PULMONOLOGIST: Dr. Shamim Najeebi

REASON FOR CONSULTATION: Hospitalist, Dr. Jill Levin, called pulmonary consult because of right lung mass.

CHIEF COMPLAINT: Shortness of breath for two days.

HISTORY OF PRESENT ILLNESS: An elderly 85-year-old male with severe COPD, emphysema is admitted to the hospital because of COPD exacerbation. For the last two days he had increasing shortness of breath. He had no cough, sputum, hemoptysis, chest pain.

REVIEW OF SYSTEMS: No upper respiratory symptoms, sick contacts, nausea, vomiting, diarrhea, sleep problems.

PAST MEDICAL HISTORY: Atrial fibrillation, COPD, emphysema, spot in the lung. The patient says he was told about a spot in the lung and he has had a bronchoscopy in the past, but we are awaiting medical records from Dr. Najeebi's office. Other past history, chronic kidney disease, COPD, congestive heart failure, hypothyroidism, hypertension, gouty arthritis, bladder tumor.

PAST SURGICAL HISTORY: Include laparotomy, appendectomy, cataracts.

ALLERGIES: MORPHINE.

MEDICATIONS: Home medications reviewed. Currently he is getting steroids, Lopressor, Clozaril, Synthroid, vitamin D, Vicodin, Advair Diskus 500/50 mcg b.i.d., DuoNeb one q.6 hours while awake, Solu-Medrol 80 mg IV q.8 hourly.

SOCIAL HISTORY: He has been in construction and electrician. He has been a smoker until recently. He has had recent pneumonia vaccine and flu vaccine in the past.

FAMILY HISTORY: Negative for lung cancer or emphysema. He is on home oxygen.

NAME: [redacted]
HOSP#:
CHART LOC:

DOB:
MR#:
PCP:

CONSULTATION CONTINUED:

PHYSICAL EXAMINATION: The patient is an elderly man in no acute distress. Temperature 97.5, pulse rate of 80, respirations of 20, blood pressure 183/94, saturation 98%. No pallor, no icterus. Oral cavity is clear. No JVD. Heart sounds are normal. Irregular rhythm. Breath sounds are equal, symmetrical, diminished. Abdomen soft, nontender. No testicular swelling. No pedal edema. No calf tenderness. Neurologically alert and oriented. No clubbing, no edema.

Chest x-ray and CAT scan of the chest revealed there is a large 6 cm mass in the right upper lobe that is extending into the endobronchial tree. There is no mediastinal lymphadenopathy.

LABORATORY DATA: Glucose 135, BUN 24, creatinine 1.4, sodium 137, potassium 4.6, calcium 9.4, troponin 0.06. White count 12.7, hemoglobin 15.1, platelet count 249.

ASSESSMENT AND PLAN: This is an 85-year-old male with history of CHF, hypertension, gout, atrial fibrillation, hypothyroidism, severe chronic obstructive pulmonary disease, emphysema on home oxygen known to have a lung mass. The right upper lobe mass is very significant and highly suspicious for a malignancy, but old records from primary care physician mentioned about a lung mass. At this point, I would recommend obtaining old records from Dr. Najeebi's office although I would like to get the old record from Dr. Najeebi's office if he has had any prior CT chest, PFTs, bronchoscopy report and the last progress note. When I mentioned to the patient about the possible bronchoscopy, he says that he has had it in the past so until we know the old records in the intermission, I will abate and then plan accordingly and give recommendations. At this time, I have been giving him steroids and bronchodilators. He is DNR.

cc: Martin Shaukat, M.D., 185 West Ave, Ste 201, Ludlow, MA 01056
Shamim Najeebi, M.D., 99 Shaker Rd, East Longmeadow, MA 01028

9979 T:dlp DD:20130207 TD:1824 DT:20130208 TT:0921 JOB:10-03041137

PADS /STE
D: 02/07/13
T: 02/08/13

Date: Time:

cc: SHAUKAT MATIN, MD

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ADDITIONAL COPY

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

OPERATIVE REPORT

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: WMC

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: BERNARD CLIFFORD, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

DATE OF PROCEDURE: 2-26-13

SURGEON: Bernard Clifford, MD.

PROCEDURE: Colonoscopy to the terminal ileum with biopsy.

INDICATIONS: Colon cancer screening.

MEDICATIONS: Versed 4 mg IV, Demerol 75 mg IV.

DESCRIPTION: A history and physical were performed. The risks and benefits of the procedure were explained to the patient and informed consent was obtained. The patient was placed in the left lateral decubitus position. A digital rectal exam was performed and was found to be normal. The Pentax pediatric video colonoscope was introduced into the rectum and advanced to the cecum with the assistance of abdominal wall pressure. The cecum was identified by transillumination, palpation and identification of the ileocecal valve. Examination was performed and the scope was removed. She tolerated the procedure well and was returned to the recovery area in stable condition.

FINDINGS: The terminal ileum was examined and appeared normal. The visualized colonic mucosa was within normal limits. In the cecum was a less than 5 mm polyp which was removed with the biopsy forceps. There was some liquid stool which limited the sensitivity of the examination for detection of small polyps. This was washed and suctioned as best possible. Moderate diverticulosis of the sigmoid was noted with scattered diverticula throughout the remainder of the colon. Retroflexed examination showed some small internal hemorrhoids.

IMPRESSION: Colon polyp.

RECOMMENDATION: Follow up the biopsy results.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: BERNARD CLIFFORD, MD

OPERATIVE REPORT CONTINUED:

cc: Meme Orquiola, MD

CLIB /CB
D: 02/26/13
T: 02/26/13

BERNARD CLIFFORD, MD

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: PMC PCP: AMELIA JAWOREK, MD
PHYSICIAN/PROVIDER: ARTURO AGUILLON-BOUCHE, MD
DICTATING: ARTURO AGUILLON-BOUCHE, MD

NAME: MARTIN, BARBARA MR #: 063056

The patient has two lesions on the right cheek area. There is a small possibility that these represent basal cell carcinoma. If they are basal cell carcinomas we will have to re-excise. I am going to do minimal margins of resection so if they are cancer I may get positive margins and have to re-excise. There is also a little vein in the lower eyelid that will be cauterized with the Telangitron from the other office.

Electronically signed by Arturo Aguillon on 03/21/12 at 13:45 hrs

_____
ARTURO AGUILLON-BOUCHE MD

AA/JMB
DD: 03/08/2012
DT: 03/10/2012

AGUA /CB
DL: 03/27/12

COPY SENT TO _____ DATE _____

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted]2 OOS #: [redacted]

LOCATION: PMC PCP: LUIS SANTIAGO-CRUZ, MD
PHYSICIAN/PROVIDER: ARTURO AGUILLON-BOUCHE, MD
DICTATING: ARTURO AGUILLON-BOUCHE, MD

NAME: LAGACE, JASON MR #: 178880

The patient is sent to this office in consultation because of carpal tunnel syndrome.

The patient has carpal tunnel syndrome and pain in both hands. The symptoms have been present for two months. Nerve conduction studies showed moderate carpal tunnel syndrome on the right, none on the left. He has pain in both hands and triggering of both rings and right small finger.

I discussed the physiopathology of carpal tunnel syndrome and trigger finger. After discussion we talked about the possibility of observation, injection of steroids or surgery. The advantages and disadvantages of the different options were given. After this we agreed on injection of steroids. Consent was obtained. Injection of left ring finger, right ring finger and right small finger was performed. After this, the symptomatology completely disappeared.

Follow up in three weeks or p.r.n.

Electronically signed by Arturo Aguillon on 03/21/12 at 13:45 hrs

ARTURO AGUILLON-BOUCHE MD

AA/JMB

Additional copy

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: ARTURO AGUILLON-BOUCHE, M

OFFICE VISIT CONTINUED:

DD: 03/08/2012
DT: 03/10/2012

AGUA /CB
DL: 03/27/12

COPY SENT TO _____ DATE _____

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WING MEMORIAL HOSPITAL & MEDICAL CENTERS
40 Wright Street, Palmer, MA 01069

MEDICAL CENTER REPORT

NAME: [redacted] MR #: [redacted]
DOB: [redacted] CHART LOC: [redacted]

DATE OF SERVICE: [redacted] OOS #: [redacted]

LOCATION: [redacted] PCP: VICTORIA NOBLE, MD
PHYSICIAN/PROVIDER: ARTURO AGUILLON-BOUCHE, MD
DICTATING: ARTURO AGUILLON-BOUCHE, MD

NAME: COLLINS, KATHRYN MR #: 054428

The patient is sent to this office in consultation today by Dr. Ratner because of a basal cell carcinoma on the left ala nasi.

The patient has a basal cell carcinoma on the left ala nasi very close to the outer rim. Unfortunately I will have to do a skin graft in this area that will be very noticeable. She understands.

Excision of the lesion will be performed with full thickness skin graft. She thought Dr Ratner offered some sort of local therapy. If indeed this could be managed with some local therapy; either freezing or cautery that would probably leave a smaller scar than my full thickness skin graft. She is going to think about it. If she decides to have surgery with us she will call Beth. She will stop aspirin for ten days prior to the procedure. I will obtain consent today.

Electronically signed by Arturo Aguillon on 03/21/12 at 13:45 hrs

ARTURO AGUILLON-BOUCHE MD

AA/JMB
DD: 02/23/2012
DT: 02/27/2012

AGUA /CB
DL: 03/27/12

COPY SENT TO _____ DATE _____

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

OPERATIVE REPORT

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: ARTURO AGUILLON [redacted]

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

****

DATE OF SURGERY: 03/21/12

SURGEON: Arturo Aguillon-Bouche, M.D.

INDICATIONS: The patient is here for multiple lesions.

DESCRIPTION OF PROCEDURE: He has multiple skin tags, four skin tags in both axillas. Under local anesthesia, lesions were shaved, sent to pathology department.

There are multiple actinic keratoses, three in the forearms and one in the left upper back. The one in the left upper back is the one that I am more concerned about. It is around T4 and 12 cm from the midline. All these lesions were frozen. I asked the patient to see Dr. Ratner in three months, especially to check the lesion on the left upper back and the rest of the body because he also has basal cell carcinoma of the face. All lesions were frozen. The patient tolerated well.

There is another lesion on the left cheek area, lower eyelid. Lidocaine 1% with epinephrine was used to infiltrate the area. The lesion plus margins 1.5 cm; the scar 3.5. With 3.5-loupe magnification, the lesion completely excised, sent to pathology department. Undermining of the wound was performed to try to avoid scleral show. This was achieved. Some deformity of the lower eyelid was identified. The wound closed in three layers with 5-0 Vicryl, 5-0 Vicryl, and 6-0 plain catgut. Adequate closure was obtained.

PLAN: The wound sheet discussed with the patient. Follow up in two weeks with me. Follow up in three months with Dr. Ratner.

cc: Bart Soar, M.D.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: BMC

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: ARTURO AGUILLON-BOUCHE, M

OPERATIVE REPORT CONTINUED:

243 T:dea DD:20120321 TD:1116 DT:20120322 TT:0823 JOB:08-02929438

AGUA /STE
D: 03/21/12
T: 03/22/12

Date: Time:

NOT FOR REDISCLOSURE WITHOUT PATIENT'S INFORMED CONSENT

WING MEMORIAL HOSPITAL & MEDICAL CENTERS
Palmer, Massachusetts

OPERATIVE REPORT

NAME: [redacted]
HOSPITAL #: [redacted]
CHART LOC: PALMER

DOB: [redacted]
MR #: [redacted]
PCP: [redacted]
DICTATING: ARTURO AGUILLON-BOUCHE, MD

FINAL SIGNED DOCUMENT IN HYLAND ONBASE

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DATE OF PROCEDURE: March 8, 2012

INDICATION FOR PROCEDURE: The patient is here for exchange of implants. I had done an implant and mastopexy a few weeks ago and she would like to have larger breasts. I have discussed with her in detail that I would prefer to do the procedure and wait another one or two weeks, but because of social circumstances she prefers to do the procedure right now. She understands there is a risk of infection. I had discussed this in my office and I had discussed with her again at the time. Today, her friend, Heather, was here with her.

DESCRIPTION OF PROCEDURE: The patient was pen marked. Brought to the operating room, general anesthesia administered. A vertical incision on the previous scar was performed. Dissection carried down until the implants were found and removed.

Slight mastopexy was performed on the left side to even the nipples and capsulotomy inferolateral was performed bilateral to try to drop the implants as much as possible. I was very concerned to continue the capsulotomy inferiorly, for concern that I will decrease the level of the implants significantly, and significant dissection medially inferior was performed until what I thought was adequate position of the implants.

The previous implants were removed and 500 cc round, smooth surface Mentor implants were performed. Unfortunately, they do not have the records of the implants at this point, so I do not know the serial number of the implants placed, but they were 500 cc round, smooth surface, Mentor gel implants.

The wound closed in three layers. Adequate closure was obtained.

The patient was concerned about doing another mastopexy and tightening the lower pole, but if I would do this it would push the implants cranially and I was concerned doing that; therefore, I decided not to do this part of the procedure. Sterile dressings were applied. The patient was awake and transferred to the recovery room in good condition.

NAME: [redacted]
HOSP#: [redacted]
CHART LOC: [redacted]

DOB: [redacted]
MR#: [redacted]
PCP: [redacted]
DICTATING: ARTURO AGUILLON-BOUCHE, M

OPERATIVE REPORT CONTINUED:

243 T:cah DD:20120321 TD:1112 DT:20120321 TT:1848 JOB:08-02929424

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D: 03/21/12
T: 03/21/12

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