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Control No: 22-554-9

Medical Record Excerpt & Outline

Patient Name	:	Alan Washington
WCAB #	:	SIF11701414, SIF11233336
Social Security No.	:	567-51-8059
Date of Birth	:	05/15/56
Employer	:	Albertsons Distribution Center
Records of	:	SCPMG RANCHO CUCAMONGA, CA
Date of Injury	:	11/12/2015 to 11/12/2015

View records in Zing

Date of Service	Page No.	Provider	Excerpt
07/14/06	12- 13	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient has numbness in hand and feet when goes to sleep. Says may be diabetes. Pain in right hip. Patient says swelling in the heart. Not taking a particular medication for the heart swelling. Makes sick. Dx: Tendonitis. Hypertension with secondary LVH, controlled on Maxzide. Tx plan: Relief with stretching. Iliotibial band tightness, tendonitis. Demonstrated stretching do on a regular basis.
08/25/06	1995-1997	Kaiser Permanente	**Laboratory Rept** Triglyceride, Cholesterol/High density lipoprotein, Creatinine: High. HDL, HGB, HCT, Auto, MCV, MCH: Low.
10/09/06	15	Pierre, Donald R., P.A.-Kaiser Permanente	**Progress Notes** Patient with c/o left lower abdominal pain x 1 day with increase in pain with B.M., no tarry stools or coffee ground emesis. F/u in 1 week.
10/09/06	1998-1999	Kaiser Permanente	**Laboratory Rept** Platelets Automated Count: High. MPV, HGB, HCT, Auto, MCV, MCH: Low. Urinalysis: UA HGB: Trace.
03/08/07	16	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient request Levitra. Hypertension controlled. Knee swollen. Active problem list: Essential hypertension. Irritable colon. Anemia, iron deficiency. Assessment/Plan: Knee bursitis. Injected 40 mg Kenalog plus 1 cc% Lidocaine from

			single dose.
03/08/07	2000-2001	Kaiser Permanente	**Laboratory Rept** HGB, MCV, MCH: Low.
01/17/08	2002-2006	Kaiser Permanente	**Laboratory Rept** RBC, Auto, Creatinine: High. MCV, MCH: Low. Urinalysis: UA HGB: 1+. H. Pylori Antigen: Detected. Mucus, UR SED, OL, Automated count: Present.
08/26/08	17	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Months food gets stuck, and sometime food comes up. Not every time he swallows. GERD. Patient request STD testing. Assessment/Plan: Dysphagia with GERD syndrome, probable esophageal strictures EGD referral sent.
08/26/08	2007-2008	Kaiser Permanente	**Laboratory Rept** Cholesterol, Triglyceride, LDL Calculated, Cholesterol/High density lipoprotein: High. HDL: Low.
02/17/09	22- 23	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Missed some doses of BP meds, went out of town and forgot meds. Patient complaint right mid back pain for months, better with massage. Exam: Trigger point right mid back. Recheck BP still elevated. Tx plan: Injected 5 spots with total of 2 cc 1% Lidocaine with resolution of pain. Advise regular stretching.
05/13/09	24- 25	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient states that a trailer Broke down while driving it on the freeway Stressed, needed meds to sleep. Has been taking blood pressure meds Tylenol as needed works. Neer's time off for stress. Patient states that the other doctor told him he shoulder take testosterone and it comes ma cream, no blood tests were done. Patient goes on on about getting this testosterone. Wants to go to her workers comp to get paid since has neck pain after the truck broke down, states his employer told him he needs to be seen by WC patient states that another doctor told him he probably needs to take testosterone because he is States had no neck trauma, just has strain from trying not to crash truck. Assessment/Plan: AP: Neck strain, 2 weeks off given, Workers comp referral sent. I am skeptical about this testosterone story will check testosterone level and do WU if lowPatient is disappointed I will not just prescribe him the testosterone. Explained increased risk of certain diseases and cancers with unnecessary testosterone supplementation.
05/15/09	26- 27	Shimabukuro, Darren Katsura, M.D.-Kaiser	**Progress Notes** Patient states went to a company doctor and only give 2 days off and he doesn't agree with im etc etc. And he disagrees

		Permanente	that it is work related etc Informed patient i cannot change what his company doctor said. I have already referral him to workers comp here if he would like a second opinion. I am not licensed to do workers comp in this state. Patient wants me to fill out paper work sting i am his doctor. I can do this. However if it states i will be his worker's comp physician then I will not be able to do so.
11/04/09	28- 30	Nguyen. An Xuan, M.D.-Kaiser Permanente	**Progress Notes** Patient of Dr Shimabukuro with history of chronic neck pain secondary to injury suffered at work many years ago who is requesting refill of his Naprosyn. He also requests to be evaluated by urology for erectile difficulty for which Viagra-like medication has not worked very well. ROS: Musculoskeletal: Positive for neck pain. Assessment/Plan: Never smoked. Cervicalgia. Naproxen 500 mg. Essential hypertension. Patient is unsure of which meds is taking. Will bring bottles to next visit with primary care physician. Erectile dysfunction, organic. Referral sent to urology.
12/14/09	31- 34	Quddusi, Tanweer, M.D.-Kaiser Permanente	**Progress Notes** Reason for Consultation: Erectile dysfunction HPI: Patient complains of erectile dysfunction. Problem has existed for 6 months. Dx: Erectile dysfunction. Tx plan: Trial of Levitra. Also wants to see erecaid demo.
12/16/09	35- 37	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient complaint neck problem, seen outside PT that works, Through workers comp, case over but needs more therapy. ROS: Neck pain. Insomnia. Erectile dysfunction. Assessment/Plan: PT referral sent for chronic neck pain after MVA 05/09. Refilled Naproxen. Seeing urology for erectile dysfunction. Hypertension controlled. Refilled Trazodone for insomnia.
12/30/09	38- 40	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient Complaint several days of left knee swelling after falling and twisting knee, pain is minimal now. Exam: Moderate size effusion. Assessment/Plan: Bursitis. Injected 40 mg of Kenalog plus 1 cc 1% Lidocaine into right knee joint after prepping the area and numbing with 1 cc 1% Lidocaine prior, patient tolerated the procedure well.
01/05/10	2326-2328	Kim, Danny, P.T.-Kaiser Permanente	**PT Initial Evaluation** Dx: Cervicalgia. Patient c/o pain in neck, since may 2009 with complaint gradually increasing. Patient reports neck injury at work. Patient reports that he has seen chiropractor in the past. General pain pattern: Intermittent. Quality of pain: Aching, intermittent and localized. Assessment: Impairment: Decreased ROM. Functional limitations: Difficulty with sleeping. Tx plan: PT 1 x/week x 4 weeks.

01/28/10	2332, 2336-2337, 2340-2341, 2345-2346, 2350-2351, 2360-2366	Kim, Danny, P.T.-Kaiser Permanente	Patient participated in PT sessions from 01/05/10 to 01/28/10 in an effort to decrease pain and tenderness and to increase ROM and strength.
02/10/10	43- 44	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Call Documentation** Patient states he has a problem with the esophagus. Patient going on about surgery and it it closing up when sleeps and the AIR doesn't get in and went to the ER for this last night. Patient states he is having problems breathing. Patient wants to know what the x ray on the ER showed, CXR normal, no change. Patient states he will book an appointment to see me next week.
02/22/10	47- 50	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient states gets short of breath when lays down. Patient states not really shortness of breath but wakes himself up. Snores. Wakes up gasping for air. Few weeks. Daytime somnolence. Assessment/Plan: Sinusitis. Flonase nasal spray diphenhydramin possible sleep apnea referral for sleep study sent..
04/28/10	51- 52	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Call Documentation** Patient states has a lot of mucous from the heater and had a gas leak and it was shut off. Patient states that a few months ago had shortness of breath. Patient has no symptoms now. Wants to know if there was a test for gas exposure. Discussed with patient unfortunately not. Will follow up if has any sx.
09/03/10	53- 54	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient has knee swelling without pain, Happened a long time ago and had Cortizone injection that helped resolve problem no trauma, patient doesn't know why it happened. Exam: Knee with moderate size effusion. Bursitis. Injected 40 mg of Kenalog plus 1 cc 1% Lidocaine into right knee joint after prepping the area and numbing with 1 cc 1% Lidocaine prior, pt tolerated the procedure well.
10/13/10	55- 56	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Lower abdomen pain last night. Took Motrin and went away and hasn't returned. Had pain that went to the testicle but no pain in the testicle. Patient request STD testing.

03/02/11	57- 59	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient called wanting amoxicillin for a virus. Advised patient should come in for appointment. Patient states wife got antibiotics for her virus infection and want states he same. Coughing for a week. Fever chills and body aches. Assessment/Plan: Viral URI. Amoxicillin per patient request Robitussin with Codiene weight loss and exercise recommended for weight.
03/04/11	60	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Call Documentation** Reiterated on message what I told him a t Appointment that he has a Viral infection and it will have to run its course. He was prescribed antibiotics at the appointment which would treat a pneumonia but already discussed at appointment that antibiotics do not help pneumonias and will probably have to run its course Which will be several weeks.
03/15/11	61- 62	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Patient admitted for pneumonia. Patient was treated with IV antibitoics and better. Post hosp follow up. Patient had had a pain in the R mid back and states needs an x-ray, states it started even before was in the hospital. Assessment/Plan: X ray per patient request normal muscular back pain instructed patient on stretching it, states he can feel it when stretching, heat Robaxin, as needed.
03/17/11	1967- 1968	Kaiser Permanente	**Radiology/Diagnostics** X-ray of Thoracic Spine. Clinical hx: Pleuritic chest pain, patient request. Impression: There is normal alignment without evidence for fracture or subluxation. There are flowing osteophytes at multiple levels of the thoracic vertebral body which can be seen with DISH. The pedicles are intact.
03/22/11	63- 65	Phan, Christine, M.D.-Kaiser Permanente	**Progress Notes** Patient with low back pain aching, sharp and unilateral onset and Course: Insidious and worsening. Symptoms relieved by: Resting, supine position and modifying activity. Medications tried: Muscle relaxants. Associated symptoms: Pain right LS area. Symptoms aggravated by: Coughing and physical activity: Twisting and rising. Exam: Tenderness at right quadratus lumborum, straight leg raise negative at 90 degrees, DTRs, motor strength and sensation normal and hips and knees with full range of motion without pain. Dx: Myofascial pain. Tx plan: 1/Try Acupuncture. 2/Refer to PT. 3/Tylenol with Codeine #3 , take no more than 3/day.
10/19/11	66- 68	Decked, Christina Noel, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with testicle pain per patient x 5 days. Having pain in testicles. Patient was seen in ED. Told epididimytis. On Cipro. Does feel better with naproxen, has

			taken about 1 per day. But does not feel antibiotics are helping. Pain is better overall. Exam: Cremasteric reflex is present. Assessment/Plan: Patient seen for evaluation and discussion regarding the following medical issues: Epididymitis (primary encounter diagnosis)— symptoms are resolving, pain is improving, no testicular pain, normal symmetric testicles; continue NSAID, complete antibiotics discussed culture was negative so less likely infection as cause and more likely inflammation. Prophylactic vaccine for influenza. Screening. STD due to family concerns last checked 2010.
10/26/11	2017-2019	Kaiser Permanente	**Laboratory Rept** Creatinine, BUN: High. RBC, Auto, HGB, HCT, auto, MCV, MCH: Low.
11/04/11	69- 70	Shimabukuro, Darren Katsura, M.D.-Kaiser Permanente	**Progress Notes** Post hosp for bleeding duodenal ulcer, feels much better complaint several weeks. Right inguinal pain, much worse with sex. Exam: Right inguinal buldge with cough. Assessment/Plan: Inguinal hernia, general surgery referral sent.
12/13/11	71- 73	Paul, Ronald S., M.D.-Kaiser Permanente	**Progress Notes** CC: Mass. HPI: Patient presents with chronic onset of mass located in the right anterior, chest for 20 years. Patient states that his symptoms are stable. Exam: Lesion: Cyst size 1 cm. Dx: Cyst. Tx plan: Excision. F/u in 10 days.
01/10/12	74- 75	Sussewell, Harold Le Roy, M.D.-Kaiser Permanente	**Progress Notes** Patient here for screen colon and hx of iron deficit anemia; patient already had EGD. Assessment/Plan: Fentanyl 125 mcg IV. Versed 6 mg IV. Colon to cecum. Scattered moderate diverticuli entire colon. Grade 1 internal nonbleeding hemorrhoids. Some stool debris noted. Recommend: High fiber diet, repeat colon in 10 years.
05/23/12	111- 113	Padilla, Melody Ramos, D.O.-Kaiser Permanente	**Progress Notes** Subjective: Patient presents with concern about STD exposure. 1. States his partner was diagnosed with trichomonas, but unsure about gonorrhea and chlamydia. Thinks these are possible as well. Denies any symptoms at this time, but wants to get treated for all in office.2. Elevated blood pressure. Has only been taking Triamterene/HCTZ. Was supposed to be on Amlodipine, but not taking it because worried it might cause him drowsiness. Works as a truck driver and worried this may affect his driving. Assessment/Plan: Essential hypertension. Clonidine 0.1 mg. Amlodipine 5 mg. Groin pain. Exposure to STD. Ceftriaxone 250 mg. Metronidazole 500 mg. Recommendations: Lab studies. F/u in 2-3 days.

09/20/12	2020- 2021	Kaiser Permanente	**Laboratory Rept** Creatinine: High. Potassium, Chloride: Low.
10/10/12	155- 156	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** Patient presenting with forms and BP follow up. He is here to follow up on his blood pressure. He is taking Triamterene/HCTZ. He eats a lot of salt. He seasons his food. Patient had a small area of right upper chest issues, pinpoint near the shoulder. This pain resolved on its own. This is over the area of a previous scar. Assessment/Plan: Essential HTN. Losartan 50 mg. Cerumen impaction. Perform ear wash. Obesity (BMI 30-39.9). CKD Stage 3 (GFR 30-59).
10/26/12	157- 159	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** Patient presenting with shoulder pain yesterday woke up with shoulder pain on the right side. Has never been an issue in the past. Took some naproxen. Day before he woke up he did nothing outside of routine. Patient has been taking his BP medications. He is stressed out about work. Pain is not worse with exertion, tenderness does not radiate is focal with pain to anterior shoulder. Limited ROM due to pain. Assessment/Plan: Tendinitis of shoulder. Tramadol 50 mg. Never smoked. Vaccine refused by patient. Essential HTN. Losartan 50 mg.
11/05/12	160- 162	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** Patient presenting with gout and work slip. Patient has been taking his Amlodipine and BP is better. Now here for f/u on gout - better after taking prednisone and Colchicine. Now also stopped Maxide but BP better with Amlodipine. Pain in his right shoulder is better as is range of motion. States feeling well on Amlodipine. Exam: Right shoulder: ROM limited especially anterior and lateral abduction, passive and active. Assessment/Plan: Gout of shoulder. Never smoked. Essential HTN. Amlodipine 5 mg.
05/17/13	163- 167	Castro, Charissa Santos, M.D.-Kaiser Permanente	**Progress Notes** CC: Abdomen pain. HPI: Per patient, just picked up Amlodipine prescription recently but hasn't started it yet. Picks up med at CVS pharmacy. Per patient, do slight burning sensation with urination-started 1 week ago. Assessment/Plan: Dysuria. Lab studies. Essential HTN. Clonidine 0.1 mg. Screening. Lab studies. Stop Triamterene/HCTZ. Amlodipine 10 mg. Start Atenolol 25 mg.
05/17/13	164- 166	Castro, Charissa Santos, M.D.-Kaiser Permanente	**Progress Notes** CC: Abdomen pain. HPI: Per patient, just picked up Amlodipine prescription recently but hasn't started it yet. Picks up med at CVS pharmacy. Per patient, do slight

			burning sensation with urination-started 1 w week ago sexually active, multiple partners. Patient here for f/u. See chronic disease documentation. Assessment/Plan: Dysuria. Lab studies. Ciprofloxacin 500 mg. Vaccine refused by patient. Essential HTN. Clonidine 0.1 mg. Screening. Lab studies. Stop Triamterene/HCTZ. Takes Amlodpine 10 mg. Start Atenolol 25 mg. Ciprofloxacin 500 mg. Tenormin 25 mg. Cipro 500 mg.
05/18/13	176	Castro, Charissa Santos, M.D.-Kaiser Permanente	**Progress Notes** Per patient, he took 1 tab of Cipro 500 mg last night and 1 tab this morning. Advised patient, since UA is negative=he can stop taking Cipro at this time. Urine GC/Chlamydia still pending=informed pt that we will Call him once results. Patient understood and agreed with plan are available.
09/09/13	177- 180	Chen, Donald Yen-Hung, M.D.-Kaiser Permanente	**Progress Notes** Follow up on blood pressure. Patient taking Amlodipine 10 mg daily. Didn't fill Atenolol 25 mg daily.Assessment/Plan: Essential HTN. Atenolol-Chlorthalidone 50/25 mg. Continue Norvasc 10 mg. F/u in 3-4 days.
11/13/13	203- 206	Hong, Jin, M.D.-Kaiser Permanente	**Progress Notes** CC: Blood pressure problem. HPI: Patient is here reports blood pressure high when he had driver license exam by company physician. He only got 3 months valid period for his commercial driver license. Patient admits he hasn't been taking his Atenolol/HCTZ x one week. He had pick up Norvasc 2 months ago and never started taking it. Also admits high sodium diet. He puts seasoned salt on everything. Assessment/Plan: Essential HTN. Patient agrees to take meds regularly. Low sodium diet recommended. Patient states he will obtain blood pressure machine and start Self monitoring of blood pressure at home. RTC for follow up in one month. Gout. Colchicine 0.6 mg. Never smoked. Declines vaccination.
02/28/14	207- 209	Tang, Dan Chieu, M.D.-Kaiser Permanente	**Progress Notes** CC: Multiple complaints. Patient wants papers filled out for FMLA. He states that with his blood pressure, he wants FMLA so that he can get his blood pressure check periodically. He has five days of dysuria and urinary frequency. Assessment: 1) Essential hypertension - had not picked up blood pressure medicines from November and December 2013. 2) Possible cystitis versus prostatitis difficult to differentiate since patient refuse digital rectal examination and UA. Tx plan: He just wants empiric antibiotic. See personal physician as needed. I told patient that hypertension is usually not an indication for FMLA. He will consult with his personal physician.

05/27/14	210- 212	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** Patient presenting with follow up routine. Patient is here today to discuss a few issues. First is some leg swelling- worse at the end of a long day. He also has been urinating frequently and in high volumes. Drinks a lot of water and soda. Adds a lot of salt to his food. Not really taking his blood pressure medications, as usual. Afraid to take too many pills. Has been waking up 3-5 times at night to urinate, and thinks these have been pretty moderate to high volume. Assessment/Plan: Polyuria. Terazosin 2 mg. Lab studies. Never smoked. Essential hypertension. Amlodipine 10 mg. Atenolol-Chlorthalidone 50/25 mg. Obesity, BMI 30-34.9, adult. Erectile dysfunction, organic. BPH (benign prostatic hypertrophy).
06/30/14	213- 216	Kim, Judong, M.D.- Kaiser Permanente	**Progress Notes** CC: Patient is here complaining of ankle pain. Ongoing for 1 week off and on. Pain severe. Pain in the medial malleolus. Associated with swelling. Exam: Positive tenderness to palpation of medial malleolus. Assessment/Plan: Gout- start Colchicine as needed for pain. Prednisone. Hypertension- not controlled. Atenolol/Chlorthalidone stopped per PCP. Continue Amlodipine. Low salt diet. Chronic kidney disease. Contact nephrology department for appointment. Again. Will hold off on arb until follow up with nephrology.
06/30/14	213- 216, 218	Kim, Judong, M.D.- Kaiser Permanente	**Progress Notes** HPI: Patient is here complaining of ankle pain. Ongoing for 1 week. Off and on. Pain severe. Pain in the medial malleolus. Associated with swelling. BP: 150/87. Wt: 249 lbs. Exam: General: Obese. Extremities: +2 distal pulses, positive tenderness to palpation of medial malleolus. Assessment/Plan: Patient presents with: Gout. Start Colchicine as needed for pain. Prednisone. Lab studies. Hypertension- not controlled. Atenolol/Chlorthalidone stopped per PCP. Continue Amlodipine. Low salt diet. Chronic kidney disease - Contact Nephrology department for appointment. Again. Will hold off on ARB until f/u with Nephrology. Lab studies were reviewed. RTC as needed.
09/17/14	217	Kaiser Permanente	**Laboratory Rept** Uric acid: High.
09/17/14	238- 243, 2832- 2834	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** HPI: Patient is presenting with HTN and swollen ankle. Patient is here today with several issues. He continues to have poorly controlled BP, takes Amlodipine but the Atenolol/Thiazide made him pee too much so he stopped it and the Losartan made him feel funny. Would like a refill on Viagra. Also c/o worsening pain and swelling in his right

			ankle. Had bad injury requiring pinning almost 40 years ago and still has pain and swelling at the end of the day, pain pills not really effective nor gout treatment at this point. Swelling does relieve with elevation. He also notes pain in his right upper groin whenever he stands from sitting, or bears down. It gets very tender in that spot, and sometimes he walks bent over from it. BP: 157/101. Wt: 243 lbs. Exam: Abdominal: Right suprapubic region over inguinal region is tender to palpation with hernia check, I don't feel mass but limited exam due to discomfort. Musculoskeletal: Large medial scar over right ankle. Tender to passive ROM and active ROM is not as smooth on right as on left. Lab studies were reviewed. Assessment/Plan: Essential HTN. Note: Poorly controlled, hypoK in the past. Will trial Spirono and see if it helps. Aldo labs sent today. CKD 3 present due to HTN. Plan: Lab studies. Chronic post-operative pain. Note: Doubt gout at this point, check x-ray and send to Ortho for their opinion. Plan: X-ray of right ankle. Referral to Orthopedic. Right inguinal hernia. Note: Patient wants a second surgical opinion on this pain and whether it can be surgically corrected. Plan: Referral to General Surgery. Medication refill. Note: ED symptoms persist, again urged him to work on BP management. F/u with me in 2 weeks. Plan: Sildenafil 20 mg.
09/17/14	1969, 2022	Kaiser Permanente	**Laboratory Rept** Creatinine, CO2: High. Potassium: Low.
09/19/14	1969	Kaiser Permanente	**Radiology/Diagnostics** X-ray of Right Ankle. Clinical Indication: Chronic pain. Findings/Impression: No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified.
09/30/14	244- 249	Lee, Stephen Paul, M.D.-Kaiser Permanente	**Progress Notes** CC: Right testicular pain. HPI: Patient presents with right testicular/lower groin pain that started a couple weeks ago and has since subsided. He c/o sharp local pain. He feels these symptoms have resolved but were moderate to severe when they occurred. Patient is not limited in daily activities by these symptoms. Patient's Active Problem List: Essential HTN. Irritable colon. Anemia, iron deficiency. Erectile dysfunction, organic. Sinusitis, chronic. Post-traumatic stress disorder. Obesity, BMI 30-34.9, adult. Pneumonia. GI hemorrhage. Testicular pain. Diverticulosis of colon. Internal hemorrhoid. CKD (Chronic kidney disease) stage 3 (GFR 30-59). BP: 154/102. Wt: 243 lbs. Allergies: Lisinopril. Meds: Sildenafil 20 mg. Spironolactone 50 mg. Colchicine 0.6 mg. Amlodipine 10 mg. Atenolol-Chlorthalidone 50-25

			mg. Terazosin 2 mg. Losartan 50 mg. Omeprazole 20 mg. Hydrocodone-Acetaminophen 5/325 mg. Tramadol 50 mg. Blood Pressure monitor kit. Zolpidem 5 mg. Exam: HEENT: Benign. Neck: Supple. CT 09/22/14: Teleradiologist's comments: Appendix within normal limits. Diffuse colonic diverticulosis. No diverticulitis. No hernia, no abscess. No acute intra-abdominal diagnosis seen. 6 cm cyst in superior pole of left kidney. Recommend ultrasound to evaluate internal texture of cyst. No hydro. No stone seen. Testicular ultrasound: Impressions: Right epididymal cyst. Right epididymitis. Left epididymal cyst. Bilateral hydrocele with internal echoes, right greater than left. Right hydrocele with internal septations. Bilateral scrotal thickening, right greater than left. No evidence of right inguinal hernia. Assessment: Right epididymitis, no hernia on exam or imaging studies. Patient lost his paper prescription for Ciprofloxacin from the ER. Plan: F/u with primary care for epididymitis. Re-wrote paper prescription. RTC as needed. 0
01/02/15	271- 278	Kim, Judong, M.D.- Kaiser Permanente	**Progress Notes** CC: Patient is here requesting ED medication. Has not followed up for BP. BP high today. Also complaining of pain in his left MCP (metacarpophalangeal) and bunion. Comes and goes. Taking over-the-counter Motrin. BP: 150/74. Wt: 249 lbs. Exam: Extremities: +2 distal pulses. Left MCP bunion. As previously described above. Assessment/Plan: Patient presents with: Essential HTN. Note: Not controlled. Continue Atenolol/Chlorthalidone. Add Amlodipine. Plan: Amlodipine 10 mg. Left bunion. Note: Supportive care. Tylenol as needed for pain. Proper shoes. Toe spacers. Can consider surgical options with conservative fails. Recommend BP control prior. Erectile dysfunction. Note: Viagra. Chronic kidney disease 2. Note: Chronically depressed renal function with microalbuminuria. Likely due to poor underlying renal function. Avoid NSAIDs (nonsteroidal anti-inflammatory drugs). RTC in 2 weeks for BP check.
01/23/15	286- 291	Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** CC: Patient is presenting with: Bunion. HPI: Patient has intense pain in left first metatarsal for the last few days. The pain actually comes on and off in intensity and sometimes does not hurt so badly. Lately he can barely wear a tight shoe and it hurts to touch. He has had a mild bunion there for a while. He loves shrimp and seafood and eats it all the time. BP: 131/77. Wt: 243 lbs. Exam: Musculoskeletal: 1st left MTP (metatarsophalangeal) tender to palpation, warm to palpation, overlying bunion a bit swollen. Lab studies were

			reviewed. Assessment/Plan: Gout. Note: I think the primary issue is gout not bunion, though both may be present. Treat as gout and if no relief then send to Podiatry for bunionectomy. Plan: Colcrys 0.6 mg. Ibuprofen 800 mg. Allopurinol 100 mg. Never smoked. Vaccination for influenza. Note: Refused. Left bunion. Note: As above.
06/14/16	314- 319	Vazquez, Saral, M.A./Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** CC: Patient presents for: Medication request. HPI: Patient is back after losing his insurance for a while. As usual BP is high. He has been taking Amlodipine inconsistently. Wants to renew FMLA so he can come in for appointments, and refill some other medications. Was told outside KP that he had dangerously low potassium in the recent past and went to ED for it. BP: 158/99. Wt: 246 lbs. Exam: Lab studies were reviewed. Assessment/Plan: Essential HTN. Note: Uncontrolled. Clear the slate, start with Thiazide, add Spironolactone next if potassium is low. Can add back Amlodipine and Atenolol as well, he has tolerated these in the past. Plan: Chlorthalidone 25 mg. Lab studies. Never smoked. Plan: Lab studies. Obesity, BMI 31-31.9, adult. Note: Patient is advised to begin progressive daily aerobic exercise program, follow a low fat, low cholesterol diet, attempt to lose weight and attend health education classes for weight control and exercise. Plan: Lab studies. GOUT. Note: No recent flares but I would like him to get back on protective medications for kidneys and gout. Recheck renal function today. Plan: Allopurinol 100 mg. Erectile dysfunction. Note: Due to HTN. Refilled medications and will check labs today. Plan: Sildenafil 20 mg. Hyperlipidemia. Note: High ASCVD risk. I discussed patient's cholesterol at length today as well as discussing new treatment thresholds with the ASCVD risk calculator. Given the relative risks and benefits of treatment, he opts to take a Statin at this time. We will continue to re-evaluate the risk at 5 year intervals. Plan: Atorvastatin 40 mg. Lab studies. F/u in 2 weeks BP appointment.
06/14/16	320	Yung, John Howe, M.D.-Kaiser Permanente	**Call Documentation** Called by laboratory for potassium of 2.5. Called patient and left a voicemail to come into the emergency department for further evaluation.
06/14/16	2023-2027	Kaiser Permanente	**Laboratory Rept** Creatinine, CO_2: High. Chloride: Low. Potassium: 2.6 – Abnormal. Urinalysis. Microalbumin, urine, quantitative, detection limit less than 20 mg/L: 275.3. Microalbumin/Creatinine: 110.3.

06/19/16	321	Chang, Yin Chu Anny, M.D.-Kaiser Permanente	**Call Documentation** Called patient after he left AMA yesterday. I discussed results of MRI abdomen including complex renal cyst that needs to be followed up in 6 month, bilateral adrenal hyperplasia which endocrinology referral is made, Blood pressure medication: Aldactone 50 mg by mouth two times a day, Coreg 25 mg by mouth two times a day, Amlodipine 10 mg by mouth every daily. Discontinue Atenolol and Chlorthalidone. Encouraged patient to be compliance and f/u with primary care physician and endocrinologist. Patient reports understanding.
08/31/16	323- 325	Vela, Arelia, L.V.N./Thiim, Christian, D.O.-Kaiser Permanente	**Telephone Appointment Visit** Patient states scheduled telephone appointment visit 08/31/16 to discuss ER f/u and lab results. HPI: Patient went to ER 08/19/16 with dyspnea, mostly when supine/sleeping for a day prior. Sitting upright driving truck he is fine. Completing antibiotics. Labs noted Hypokalemia and Chest x-ray noted below. BNP high. Some fatigue. ?Dypsnea only at night. Exam: Lab studies were reviewed. Chest x-ray 08/19/16: Findings/Impression: Frontal and lateral radiographs of the chest were obtained. The heart is enlarged. The mediastinal contours are normal. There is patchy consolidation in the left lower lung zone. There may be a right infrahilar infiltrate as well. Thickening of the right minor fissure may represent a small amount of fluid. There may also be a small left pleural effusion. No pneumothorax is seen. No acute osseous abnormalities are seen. Assessment: Dyspnea/Abnormal chest x-ray/Paroxysmal nocturnal dyspnea with elevated BNP, consistent with CHF. Cardiomegaly - per chest x-ray. Hypokalemia. HTN. Plan: Stop Tenoretic (get rid of Thiazide). Continue Coreg twice daily. Add Lasix 20 mg twice daily. Add Losartan 25 mg daily. Echocardiogram. Finish up antibiotics. PCP appointment next week - will forward to MA to schedule. Patient indicates understanding of these issues and agrees with the plan.
11/01/16	2028-2029	Kaiser Permanente	**Laboratory Rept** Anion gap (NA-(CL+CO2)), B-Type natriuretic peptide: High.
11/28/16	327- 331	Hernandez, Eva Evelyn, M.A./Kimmerling, Reuven, M.D.-Kaiser Permanente	**Progress Notes** CC: Patient presents with: Prescription refill requested. HPI: Patient is here for BP f/u. As usual not taking all his medications, works long hours in the truck and can't afford to pee during the shifts. He takes Spironolactone and Amlodipine but not his beta-blocker, ARB, Lasix at this time. Thiazide had to be stopped due to lytes issues. Also has ED and wants a Sildenafil refill. BP: 162/94. Wt: 250 lbs.

			Exam: As previously described above. Lab studies were reviewed. Assessment/Plan: Essential HTN. Note: Uncontrolled, restart ARB, after this could double up Spironolactone or restart beta-blocker, but need to do it stepwise, so he should f/u when he can in the next 2 weeks. He makes a commitment to do so. Never smoked. Vaccination for influenza. Note: Refused. Obesity, BMI 30-34.9, adult. Note: Patient is advised to begin progressive daily aerobic exercise program, follow a low fat, low cholesterol diet, attempt to lose weight and attend health education classes for weight control and exercise. Erectile dysfunction. Note: Erectile dysfunction: Side effects are discussed. He does not have heart disease, and is not using nitrates. He is informed deaths have occurred in men taking Viagra concurrently with nitrates and he should avoid that combination at anytime. Brief sexual counseling is provided. The proper use is discussed. He will return for specific f/u of this problem as needed if symptoms persist or he doesn't respond to the medication. Plan: Viagra 50 mg. CKD stage 3 (GFR 30-59). Note: Likely all HTN related, start ARB again with microalbuminuria and low GFR. Potassium is ok to low as usual. F/u in 1 week BP check.
01/24/17	332- 337, 2035	Mayfield, Miriam, L.V.N./Kimmerling, Reuven, M.D./Ramirez, Brenda, L.V.N.- Kaiser Permanente	**Progress Notes** CC: Patient presents for: Blood pressure check. Shortness of breath: At night, during sleep. HPI: Patient is here today for multiple issues. First is sleep - snoring, gasping per GF. He is a commercial driver. His BP remains through the roof, takes some medications but not sure exactly which at this point, thinks 2-3, but BP still very high. Has had to stop Thiazide in the past due to hypokalemia but hard for me to get him in consistently enough to adjust medications safely and correctly. He tells me today that they noted a mass in his abdomen in the past and was supposed to f/u on it but never mentioned it to me. He states his belly is getting bigger and he thinks that the mass may be growing. BP: 163/101. Wt: 255 lbs. ROS: Headache, erectile dysfunction. Exam: Abdominal: Obese, firmness in left upper quadrant which could be mass versus adiposity, hard to differentiate. Lab studies were reviewed. MRI renal 6/16: Impression: Study is markedly limited by motion artifact. 9 cm complex cystic left renal upper pole mass with mural nodularity, Bosniak class III. 2 indeterminate left renal nodules each measuring 2 cm. Bilateral adrenal hyperplasia. Assessment/Plan: Essential HTN. Note: Uncontrolled, restart Amlodipine and bring in all medications to next visit. Plan: Lab studies. Referral cardiology. Obesity, BMI 32-32.9, adult. Note: Patient is

			advised to begin progressive daily aerobic exercise program, follow a low fat, low cholesterol diet, attempt to lose weight and attend health education classes for weight control and exercise. Never smoked. Vaccination for influenza. Plan: Vaccine Influenza 4 years-adult, trivalent, preservative free, 0.5 ml IM. Sleep apnea, evaluation. Note: Send for sleep study, high risk with BP and observed symptoms + obesity, driver. Plan: Referral Sleep Clinic. Renal mass. Note: Very concerning with growth over the years, re-check with CT urogram and send to urology. Plan: Lab studies. CT of urogram abdominal and pelvis with/without IV contrast only. Referral Urology. HTN (Hypertension). Note: As above. Plan: Amlodipine 10 mg. F/u in 1 week with medications for BP check.
01/24/17	2031-2034	Kaiser Permanente	**Laboratory Rept** Creatinine, Anion gap(NA-(CL+CO2)): High. HGB, HCT automated, MCV, MCH, MCHC, HDL: Low. Urinalysis. Microalbumin, urine, quantitative, detection limit less than or equal to 20 mg/L: 423.5. Creatinine: 433.6. Microalbumin/Creatinine: 97.7.
02/03/17	338- 343	Johnson, Latoya V., M.A./Yew, Jay, M.D.- Kaiser Permanente	**Progress Notes** Reason: History complex renal mass. Patient states CT Urogram ordered, but not scheduled yet. Wt: 250 lbs. Exam: Lab studies were reviewed. Diagnostic studies were reviewed. Assessment: Acquired complex renal cyst. Reviewed imaging studies with patient. I am most concerned about his GFR, and if this lesion cannot be removed via a nephron sparing approach, and the entire left kidney needs to be removed, he may have significant impairment of his overall renal function. Treatment options include active radiographic surveillance, versus surgery (nephrectomy, partial nephrectomy). Briefly, ablative approaches were mentioned, but not favored due to the cystic nature of this lesion. Likewise, I would not advise any kind of percutaneous biopsy, again, due to the cystic nature of the lesion and possible tumor cell spillage. He appears motivated to have this removed, and I would agree. Explained nephrectomy versus partial nephrectomy. Plan: Surgical case request.
02/10/17	1970-1972	Kaiser Permanente	**Radiology/Diagnostics** CT of Abdomen Organs, Kidney, Ureter and Bladder with No Contrast. Clinical Indication: Renal mass evaluate for growth/malignancy or change, unable to use contrast due to decreased GFR. Has patient received a CT KUB within the past 6 months? If the answer is yes, please consider not ordering a CT KUB per recommendation by Urology – No.

			Comparison: 09/22/14. Impression: 1) Right renal mass increased in size Bosniak Class III. 2) Increase in size of the exophytic cyst in the posterior left kidney. 3) No change in the right renal cyst. 4) Hypertrophy of the left adrenal gland no change. 5) The ileocecal valve region needs further evaluation with a barium enema. 6) Lymph node in the right lower quadrant is reactive in nature. The appendix is not seen. 7) Degenerative disease in the spine. The findings were sent to Dr. Kimerling, via a significant finding in Health Connect. Bosniak Class I - No f/u is generally required since there are no identified radiologic criteria of malignancy. Bosniak Class II - No f/u is generally required since there are no identified radiologic criteria of malignancy. Bosniak Class II F - This lesion is likely benign, but f/u imaging is suggested. Bosniak Class III - This lesion has malignant characteristics and urology consultation is suggested. Bosniak Class IV - This lesion has malignant characteristics and urology consultation is suggested. Evaluation of visceral organs is limited by lack of intravenous contrast.
02/21/17	346- 350	Orozco, Belinda, L.V.N./Yew, Jay, M.D.-Kaiser Permanente	**Progress Notes** HPI: Patient had right renal mass (Bosniak III complex cystic lesion). Imaged with MRI and most recently CT-KUB. Patient is here to discuss CT and upcoming surgery with Dr. Chang. Patient has CKD. Wt: 250 lbs. Exam: Lab studies were reviewed. Diagnostic studies were reviewed.
03/07/17	1973-1974, 3138	Kaiser Permanente	**Radiology/Diagnostics** Doppler Echo Transthoracic Complete with Spectral Display and Color Flow. Impression: Technically difficult study. 1) LV systolic function difficult to assess due to suboptimal endocardial definition, appears normal. Visually estimated LVEF 50-55%. Regional wall motion could not be assessed. Mild concentric LVH. Grade I LV diastolic dysfunction. 2) Normal RV size and systolic function. 3) Mild left atrial enlargement. 4) Aortic valve is trileaflet and opens well. 5) Trace-mild MR. 6) PA systolic pressure could not be estimated due to lack of significant TR, incomplete Doppler envelope. 7) Mildly dilated aortic root, 3.8cm at sinus of valsalva. Proximal ascending aorta normal in dimension. Consider repeat limited echo with use of IV echo-contrast - Definity if more accurate LV regional wall motion, EF assessment is clinically indicated.
03/15/17	351- 360	Buycks, Monette, L.V.N./Chang, Allen, M.D.-Kaiser Permanente	**Urology Initial Consult Note** RFC: Left renal mass. HPI: Patient presents with PMH of HTN, HL, obesity, B-Thalassemia here for left renal mass. Patient is a truck driver. Patient has mild right flank discomfort. BP: 182/97. Exam: Abdomen: NT x 4Q. Lab

			studies were reviewed. 02/08/17 - CT A/P shows large left 12cm upper pole renal mass, RK Bosniak 3 cyst. Assessment/Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12cm complex cystic mass. Majority of lesion is 17-20HU but lower portion with nodularity. 2016 MRI shows mural nodules and it was only 6cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5cm complex cyst. RK with 1.5cm 13HU lower pole cyst. I explained to patient the significance of renal cysts. I first explained that a simple renal cyst is a fluid filled lesion that have water density, thin wall, non-enhancing, and do not contain septa, calcifications, or solid elements. I then explained that a complex cyst is one that does not meet simple renal cyst criteria. I briefly discussed the Bosniak classification. I mentioned that if a cyst has solid component (Bosniak 4), then more than 90% probability that it may harbor malignancy. Bosniak 3 would be cysts with thickened irregular septa with measurable enhancement, and there may be more than 50% that it harbors cancer. Bosniak 2 cysts are those with hairline septa with some fine calcification. If it is Bosniak 2 only, then risk of care is rare but if it is 2f, then about 5-20% chance of malignancy exist. I explained to patient that this LK upper pole mass must be presumed to harbor renal cell carcinoma until proven otherwise. Small possibility that final pathology may be a benign lesions also discussed. Role of biopsy also discussed with patient but I do not think it is useful in this case, especially in this cystic lesion. I advised for surgical extirpation of this mass. Approaches includes open or laparoscopic (partial vs. Radical) nephrectomy. Risks of benefits of each discussed. Given location of mass, I advised that partial nephrectomy is feasible and is beneficial in terms of preserving maximal nephron units (and thus lower risk of CKD and future sequale of associated cardiovascular morbidity in setting of CKD); however, there is increased risk of bleeding, urine leak, abscess, and arterio venous malformation. Patient agrees with partial nephrectomy.
03/22/17	361- 374, 2041, 3155	Chang, Allen, M.D.- Kaiser Permanente	**Urology Note** RFC: Left renal mass. HPI: 03/15/17 - First visit- Patient has mild right flank discomfort. No left flank pain. BP: 146/83. Wt: 254 lbs. Exam: As previously described above. Lab studies were reviewed. Diagnostic studies were reviewed. Assessment/Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12cm complex cystic mass. Majority of lesion is 17-20HU but lower portion with nodularity. 2016 MRI shows mural nodules and it was only 6

			cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5cm complex cyst. RK With 1.5 cm 13HU lower pole cyst. I explained to patient the significance of renal cysts. I first explained that a simple renal cyst is a fluid filled lesion that have water density, thin wall, non-enhancing, and do not contain septa, calcifications, or solid elements. I then explained that a complex cyst is one that does not meet simple renal cyst criteria. I briefly discussed the Bosniak classification. I mentioned that if a cyst has solid component (Bosniak 4), then more than 90% probability that it may harbor malignancy. Bosniak 3 would be cysts with thickened irregular septa with measurable enhancement, and there may be more than 50% that it harbors cancer. Bosniak 2 cysts are those with hairline septa with some fine calcification. If it is Bosniak 2 only, then risk of care is rare but if it is 2f, then about 5-20% chance of malignancy exist. I explained to patient that this LK upper pole mass must be presumed to harbor renal cell carcinoma until proven otherwise. Small possibility that final pathology may be a benign lesions also discussed. Role of biopsy also discussed with patient but I do not think it is useful in this case, especially in this cystic lesion. I advised for surgical extirpation of this mass. Approaches includes open or laparoscopic (partial vs. Radical) nephrectomy. Risks of benefits of each discussed. Given location of mass, I advised that partial nephrectomy is feasible and is beneficial in terms of preserving maximal nephron units (and thus lower risk of CKD and future sequale of associated cardiovascular morbidity in setting of CKD); however, there is increased risk of bleeding, urine leak, abscess, and arterio venous malformation. Patient agrees with partial nephrectomy.
03/22/17	2036-2037	Kaiser Permanente	**Laboratory Rept** Creatinine: High. HGB, HCT automated, MCV, MCH: Low.
03/23/17	375- 378	Zamora, James Alexander, M.D.-Kaiser Permanente	**Telephone Appointment Visit** CC: Patient presents for: Referral. HPI: Patient c/o snoring, witnessed apnea, daytime somnolence and fatigue. Symptoms started months ago. Patient request referral since he dka'd previous referral. Dx: Snoring. Plan: Referral Sleep Clinic. Amlodipine 10 mg. Patient indicates understanding of these issues and agrees with the plan. Patient agrees to return to clinic within 1-2 days for worsening symptoms or any concerns.
04/12/17	379- 384, 3194	Buycks, Monette, L.V.N./Chang, Allen, M.D.-Kaiser Permanente	**Urology Note** 04/04/17 - Robot assisted left partial nephrectomy with cyst decortications. Very large left upper pole cystic renal mass approximately l0 x 11 cm. Left adrenal spared. WIT 33m

			27s. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated. Pathology - pT2bNxR0 papillary RCC Fg 2-3/4 - 11cm tumor. HPI: Patient is tolerating diet. Exam: 04/12/17 - Staples removed and Steri applied. Periumbilical incision with seroma draining but wound closed. Lab studies were reviewed. Assessment/Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12cm complex cystic mass. Majority of lesion is 17-20HU but lower portion with nodularity. 2016 MRI shows mural nodules and it was only 6cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5 cm complex cyst. RK with 1.5 cm 13HU lower pole cyst. 04/04/17 - robot assisted left partial nephrectomy with cyst decortications. Very large left upper pole cystic renal mass approximately l0 x 11 cm. Left adrenal spared. WIT 33m 27s. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated. Pathology- pT2bNxR0 papillary RCC Fg 2-314 - 11cm tumor. Pathology was reviewed with patient and family today. Advised that patient should get future surveillance imaging to r/o local recurrence. CT KUB in September 2017. Patient already followed by nephrology for CKD. Advised to have serial BP checks with primary care. Future serial checks of creatinine and albuminuria should be considered. Indicated pt should be cautious in any future contact sports that may cause renal injury. Patient should maintain good hydration. Patient should avoid NSAIDs if possible. Patient should also adhere to low salt and moderate protein intake diet. F/u in 6 months after CT.
04/20/17	385- 393, 2044	Corpuz, Angelita G., R.N./Huynh, Trung Vo, M.D.-Kaiser Permanente	**Nephrology Clinic Note** HPI: Patient with h/o B-Thalassemia, hyperlipidemia, HTN, RCC s/p left partial nephrectomy who is referred for evaluation of chronic kidney disease. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to approximately 1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but recovered back to 1.8. RCC was diagnosed incidentally during workup for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Reports taking Losartan regularly, Does not take Atenolol and Amlodipine as prescribed. Takes Aldactone only once every other day instead of BID. Currently feels well. BP: 158/92. Wt: 244 lbs. Exam: Lab studies were reviewed. Assessment/Plan: 1) Chronic kidney disease 3 with microalbuminuria secondary to HTN and reduced renal mass after partial nephrectomy on

			04/04/17 for RCC: Acute kidney injury post-procedure, recovered towards baseline, which is probably around 1.7-1.8 now. Continue Losartan and Aldactone. Instructed to repeat labs next week. Encouraged compliance with prescribed meds. 2) HTN: High in clinic, reports home BP mostly below 140's. MRI did show bilateral adrenal hyperplasia - HTN and hypokalemia might be related to hyperaldosteronism (Aldo/Renin 8.7 on 06/17/16, but patient was on Aldactone, which can raise plasma renin, resulting in falsely low aldo/renin). Not compliant with prescribed meds, only on Losartan regularly. Okay to stop Atenolol (causes fatigue); encouraged compliance with Amlodipine and Aldactone. 3) RCC s/p left partial nephrectomy 04/04/17: Wound is healing well. Follows with urology. RTC in 3-4 months.
04/27/17	394- 399	Richardson, Claudia K., L.V.N./Yim Yeh, Susie, M.D.-Kaiser Permanente	**Sleep Medicine Telephone Intake Visit** CC: Patient presents for: Telephone appointment visit. HPI: Patient is a commercial class A driver with who was referred for evaluation of sleep disorder breathing. Recently has partial nephrectomy for renal cell carcinoma 04/04/17 in Downey. Noted to have HTN and PCP requested that patient be evaluated for obstructive sleep apnea. Patient is currently working for Alberton's distribution in Irvine. Medical card expires next year. Wt: 244 lbs. Prior surgeries: Right ankle fracture s/p repair due to football injury – 1950. Hemorrhoidectomy. Nephrectomy, partial, robot assisted laparoscopic - Left - 04/04/17. Assessment and Plan: Screening for obstructive sleep apnea syndrome. Patient is a commercial driver. Discuss with patient the Federal Motor Carrier Safety Administration (FMCSA) guideline. Discussed with patient the potential cardiovascular risks and driving risks associated with obstructive sleep apnea. Proceed with sleep study using NOX study since patient is not being evaluated for DOT purposes. Will have patient f/u with me when he returns the NOX study. Patient was referred to the following below contract facility for an overnight attended sleep study. F/u after sleep study is complete.
05/01/17	2042-2043	Kaiser Permanente	**Laboratory Rept** Creatinine, Anion gap (NA - (CL + CO2)): High.
09/13/17	1975	Kaiser Permanente	**Radiology/Diagnostics** X-ray of Cervical Spine. Clinical Indication: WC - Patient reports he strained/jarred left neck when slipped off last step coming down from truck. Findings/Impression: Cervical vertebral bodies are normal in height. There is slight anterolisthesis of C3 over C4 No fracture is identified. Multilevel DJD changes with osteophytic spurring and disc space narrowing from C4 through C7 levels. No significant

			soft tissue abnormality.
09/27/17	2045	Kaiser Permanente	**Laboratory Rept** Creatinine: High.
12/04/17	443- 450	Mendoza, Gabriela C., M.A./Kimmerling, Reuven, M.D.- Kaiser Permanente	**Progress Notes** CC: Patient with: Hypertension – f/u. HPI: Patient is here for a check in. I forced him to come because of uncontrolled BP. He admits he does not take most of his medications, just Losartan and Amlodipine. He feels great, much better since getting partial kidney resection for a malignancy. Uses 2 Sildenafil to get and keep erections, with success. BP: 166/87. Wt: 242 lbs. Meds: Sildenafil 20 mg. Spironolactone 50 mg. Amlodipine 10 mg. Atorvastatin 40 mg. Potassium Chloride 10 mEq. Losartan 50 mg. Exam: General: Obese. Lab studies were reviewed. Assessment/Plan: Essential HTN. Note: Uncontrolled because he does not take medication. Stressed importance of Spironolactone for him as it was better controlled in the past and low potassium issues. He promises to try to take these from now on. F/u nurse BP 10 visit in 1-2 weeks. Obesity, BMI 31-31.9, adult. Note: Patient is advised to begin progressive daily aerobic exercise program, follow a low fat, low cholesterol diet, attempt to lose weight and attend health education classes for weight control and exercise. Vaccination for influenza. Note: I have recommended that this patient have a flu shot but she declines at this time. I have discussed the risks and benefits of this procedure with her. Patient verbalizes understanding. Erectile dysfunction. Note: Well controlled, continue current medication. Plan: Sildenafil 20 mg. H/o kidney cancer. Note: Status post resection, has f/u CT scan this week, no current evidence of cancer or symptoms. Creatinine also dropped due to renal mass loss after surgery. F/u in 2 weeks BP check.
12/08/17	1977-1978	Kaiser Permanente	**Radiology/Diagnostics** CT of Abdomen and Pelvis with No Contrast. Clinical Indication: Creatinine 1.39 08/21/17, CKD - s/p partial nephrectomy, r/o gross local recurrence Creatinine 1.53 09/27/17 GFR 56 09/27/17. Comparison: 02/08/17. Impression: Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site. Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast.
01/05/18	457- 467, 3873-3874	Escalante, Gretchen Alia, M.A./Huynh, Trung Vo, M.D.- Kaiser Permanente	**Nephrology Clinic Note** HPI: Patient with h/o: B-thalassemia. Hyperlipidemia. Hypertension. RCC s/p left partial nephrectomy in 04/2017. Patient returns for f/u of CKD. Baseline Cr 1.3-1.5 since

			2006, worsening in 2016 to 1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but recovered back to baseline. RCC was diagnosed incidentally during work-up for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Reports he is taking Losartan and Amlodipine regularly. Does not take Aldactone. Feels well today. BP: 144/96. Wt: 246 lbs. Exam: Lab studies were reviewed. Assessment/Plan: 1) Chronic kidney disease 2 with microalbuminuria secondary to HTN and reduced renal mass after partial nephrectomy on 04/04/17 for RCC: Acute kidney injury post-procedure, recovered towards baseline 1.3-1.5. Increase Losartan to 50 mg BID due to uncontrolled HTN. Instructed to repeat labs next week. Encouraged compliance with prescribed meds. 2) Hypertension with possible hyperaldosteronism: Patient does not like Aldactone due to side effects. BP High in clinic. Increase Losartan to 50 mg BID. Continue Amlodipine 10 mg daily. Okay to cont KCI 10 mEq daily for now. Repeat labs in 2 weeks. Encouraged home BP check. 3) RCC s/p left partial nephrectomy 04/04/17: Stable. Follows with urology. 4) Anemia secondary to chronic kidney disease. Lab studies. Stable, no need for EPO. 5) Secondary hyperparathyroidism. Lab studies. Will start Vitamin D2 every 2 weeks. RTC in 6 months.
02/02/18	500- 505	Chang, Allen, M.D.- Kaiser Permanente	**Urology Note** 12/06/17 CT A/P - Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast. Area is likely Tisseel from surgery. Advise shorter interval imaging in May 2018. HPI: Patient is doing well. Exam: Lab studies were reviewed. Diagnostic studies were reviewed. Assessment/Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12cm complex cystic mass. Majority of lesion is 17-20HU but lower portion with nodularity. 2016 MRI shows mural nodules and it was only 6cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5cm complex cyst. RK with 1.5 cm 13HU lower pole cyst. 04/04/17 - robot assisted left partial nephrectomy with cyst decortications. Very large left upper pole cystic renal mass approximately 10 x 11 cm. Left adrenal spared. WIT 33m 27s. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated. Path - pT2bNxR0 papillary RCC Fg 2-

			314 - 11cm tumor. Pathology was reviewed with patient and family today. Advised that pt should get future surveillance imaging to r/o local recurrence. 12/06/17 CT a/P - Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast. Area is likely Tisseel from surgery. Advise shorter interval imaging in May 2018 01/25/18 chest x-ray – clear. CT KUB in May 2018. Patient is already followed by nephrology for CKD. Advised to have serial BP checks with primary care. Future serial checks of creatinine and albuminuria should be considered. Indicated patient should be cautious in any future contact sports that may cause renal injury. Patient should maintain good hydration. Patient should avoid NSAIDs if possible. Patient should also adhere to low salt and moderate protein intake diet. F/u after CT in May.
03/08/18	525- 526	Flores, Claudia M., L.V.N./Kimmerling, Reuven, M.D.-Kaiser Permanente	**Call Documentation** Please call, tell patient that he is due for f/u echocardiogram of the heart to examine the valves and pipes and pump function.
03/23/18	1979-1980	Kaiser Permanente	**Radiology/Diagnostics** Transthoracic Echo Real Time with 20 Image, Spectral and Color Flow Doppler Complete. Impression: The left ventricle is normal in size. Left ventricular wall thickness Is moderately Increased (1.4 cm). Global left ventricular systolic function normal Estimate LVEF is: 45-50%; cannot r/o focal wall motion abnormalities. No gross valvular disease. No significant change from 3/2017.
03/23/18	2050	Kaiser Permanente	**Laboratory Rept** CO_2: High. Potassium, Chloride: Low.
03/26/18	548- 549	Espinoza, Janette, M.A.-Kaiser Permanente	**Call Documentation** Complete care note. Spoke with patient regarding returning his call. Patient stated he called last week and to discard his message.
05/09/18	563- 568	Chang, Allen, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Subjective: Doing well. Exam: Lab studies were reviewed. MRI renal, CT abdomen and CT KUB were reviewed. Assessment and Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12 cm complex cystic mass. Majority of lesion is 17-20 HU but lower portion with modularity. 2016 MRI shows mural nodules and it was only 6 cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5 cm complex cyst. RK with 1.5 cm 13HU lower pole cyst. 04/04/17 - robot assisted left

			partial nephrectomy with cyst decortications. Very large left upper pole cystic renal mass -10 x 11 cm. Left adrenal spared. WIT 33m 27s. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated. Path - pT2bNxR0 papillary RCC Fg 2-3/4 – 11 cm tumor. Pathology was reviewed with patient and family today. Advised that patient should get future surveillance imaging to r/o local recurrence. 12/06/17 CT NP - Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast. Area is likely Tisseel from surgery. Advise shorter interval imaging in May 2018. 01/25/18 chest x-ray – clear. 04/27/18 CT A/P - Focal area of soft tissue density again seen superior to the area of sutures in the resection bed which is stable to minimally decreased in size. It measures 1.5 x 1 x 1.8 cm compared to 1.5 x 1.2 x 2. 2 cm. CT KUB in January 2019. Patient already followed by nephrology for CKD. Advised to have serial BP checks with primary care. Future serial checks of creatinine and albuminuria should be considered. Indicated patient should be cautious in any future contact sports that may cause renal injury. Patient should maintain good hydration. Patient should avoid NSAIDs if possible. Patient should also adhere to low salt and moderate protein intake diet.
05/25/18	571- 580	Hamilton, Nicole Kathryn, O.D.-Kaiser Permanente	**Progress Notes** Patient presents with eyelid problem. HPI: Right lower lid droops for “a long time” (years), not worsening but sometimes has to push lid up with finger. Has tried Murine and other drops in past. Not swollen, no pain or tenderness. No vision change. Patient wants new reading specs. PMH: HTN. Exam: Eye exam was performed. External: Right and left: Mild orbital fat sup and inf but no swelling. Lids/lashes: Right: 2+ senile ectropion LL with poor globe apposition, 2+ MGD. Left: Slight LL laxity, 2+ MGD. Cornea: Right and left: Poor tear film. Assessment and Plan: Right lower ectropion. Moderate RLL senile ectropion with poor opposition to globe. Disc surgical repair, patient not interested. Refresh Liquigel or Systane gel TID, but disc that lubricating drops will not improve lid position which is a mechanical problem. Bilateral dry eye syndrome. As above. Presbyopia. Spec prescription released, patient wants SVN. RTC: 1 year/PRN.
07/11/18	592- 602	Nguyen, Trung Buu, M.D.-Kaiser Permanente	**Progress Notes** Referred by his MD for correction of ectropion and symptomatic blepharochalasis. Drooping eyelids/brows and

			everted lower eyelid showing conjunctiva. PMH: Essential HTN. Obesity, BMI 30-34.9, adult. H/o duodenal ulcer. CKD stage 3 (GFR 30-59). Hyperlipidemia. Prior surgeries: Nephrectomy, partial, robot assisted laparoscopy. Laparoscopic. Hemorrhoidectomy. Meds: Sildenafil 20 mg. Losartan 50 mg. Allopurinol 100 mg. Spironolactone 50 mg. Atenolol 25 mg. Vitamin D2 50,000 unit. Potassium Chloride. Amlodipine 10 mg. Atorvastatin 40 mg. Albuterol 90 mcg. Assessment and Plan: Ectropion. Blepharochalasis Plan blepharoplasty Correction of ectropion. Procedure risks complications alternative treatment were explained in detail to patient. All questions were answered. Also there is no warranty or guaranty regarding the outcome of the operation. Patient agrees with the treatment plan and strongly request to proceed with surgery. Risks including but not limited to: Allergy. Bleeding. Blindness. Dry eye. Recurrent ectropion and ptosis. Infection. Scar deformity. Disfigurement. Asymmetry pain. Unsatisfactory result. Delayed wound healing. DVT. Pulmonary embolism and even death. Psychological problem. Poor cosmetic outcome. Need for additional surgery.
08/08/18	603- 608	Nguyen, Trung Buu, M.D.-Kaiser Permanente	**H and P Examination** CC: Bilateral blepharochalasis. Bilateral lower eyelid ectropion. BP: 171/96. Wt: 252 lbs. Allergies: Lisinopril. Thiazides. ROS: Gastrointestinal: H/o hemorrhoidectomy. Genitourinary: H/o partial nephrectomy. Musculoskeletal: H/o- joint pain. Exam: Drooping eyelid/brows with peripheral obstructive vision. Evened bilateral lower eyelid. Dx: Bilateral blepharochalasis. Bilateral ectropion. Tx plan: Correction.
08/08/18	613- 618	Vega. Yvonne, M.A.-Kaiser Permanente	**Call Documentation** Complete Care Program - BP outreach call (LM/UTC). BP: 164/106. Patient Active Problem List: Essential HTN. Irritable colon. Iron deficiency anemia. Organic erectile dysfunction. Chronic sinusitis. Posttraumatic stress disorder. Obesity, BMI 30-34.9, adult. GI hemorrhage. Diverticulosis of colon. Internal hemorrhoid. CKD stage 3 (GFR 30-59). Hyperlipidemia. Hypokalemia. HTN, uncontrolled. Renal mass. Beta thalassemia. Acquired complex renal cyst. Dilated aortic root. Left ventricular diastolic dysfunction. H/o kidney cancer. H/o partial nephrectomy. Neck muscle strain. Chest pain. Right age related ectropion. Bilateral blepharochalasis. Exam: Lab studies were reviewed. RTC 08/17/18 Edquid, Maria Myrissa Trinidad R.N. and Huynh, Trung Vo, M.D. and 08/27/18 Nguyen, Trung Buu, M.D.

08/17/18	626- 636	Huynh, Trung Vo, M.D.-Kaiser Permanente	**Nephrology Clinic Note** Patient with an h/o B-thalassemia, hyperlipidemia and HTN. RCC s/p left partial Nx in 04/2017 who returns for f/u of CKD. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to -1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but recovered back to baseline. RCC was diagnosed incidentally during workup for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Takes Amlodipine and Atenolol. Prescribed Losartan but does not take, unclear reason. Does not take Aldactone either. Reports trace ankle swelling, probably due to Amlodipine. Has right eyelid surgery on 08/21/18 for right ectropion. BP: 153/82. Wt: 256 lbs. Exam: Lab studies were reviewed. Assessment and Plan: 1) Chronic kidney disease 2 with microalbuminuria secondary to HTN and reduced renal mass after partial nephrectomy on 04/04/17 for RCC: Cr stable at baseline 1.3-1.5. Proteinuria slightly up, probably due to self discontinue Losartan. Instructed to restart Losartan 50 mg daily. Decrease Amlodipine to 5 mg daily for ankle swelling. Encouraged compliance with prescribed meds. 2) Hypertension with possible hyperaldosteronism: Patient does not like Aldactone due to side effects. Not compliant with Losartan. Instructed to restart Losartan 50 mg daily for proteinuria. Decrease Amlodipine to 5 mg daily for ankle swelling. Encouraged home BP check. 3) RCC s/p left partial nephrectomy 04/04/17: Stable. Follows with urology. 4) Anemia secondary to Chronic kidney disease. HGB 13.5 01/25/18. Stable, no need for EPO. 5) Secondary hyperparathyroidism. Lab studies. Will re-check next visit. RTC in 5 months.
08/17/18	2053	Kaiser Permanente	**Laboratory Rept** RDW, blood: High. HGB, HCT, automated, MCV, MCH, MCHC: Low.
08/20/18	637- 639	Ramirez, Viviana A., R.N./Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Call Documentation** Kimmerling, Reuven Eli, M.D. (08/20/18 11:50 AM): Patient's hypokalemia may derail surgery. Took 2 Ktab today. Will take 2 more this evening and 50 mg Spironolactone. Then 2 more Ktab in am and 50 mg Spironolactone in AM. Then get stat potassium test in am prior to surgery. The results should be available prior to the procedure. Ramirez, Viviana A., R.N. (08/20/18 11:50 AM): Situation: Patient walked in the office concerned regarding K results. Assessment: Denies any CP, no complaints at this time just concerned regarding results. Patient stated he is

			scheduled for surgery tomorrow and doesn't want to cancel it spoke with Dr Kimmerling talking to patient. Recommendation: Following instructions given to patient by PCP. Called CVS pharmacy spoke with Michelled verbal verification given for the following medication. Spironolactone 50 mg.
08/20/18	640- 642	Romana, Maria Corazon, R.N./Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Call Documentation** Romana, Maria Corazon, R.N. (08/20/18 09:34 AM): Request to MD: Per Dr. Trung Nguyen, called patient to see PCP today, due to low Potassium level, patient is for surgery tomorrow. Situation/background: Caller is requesting test results for pre-op labs- serum potassium level too low. Has/have the test(s) been resulted. Has physician reviewed results and provided instructions in another encounter. Serum potassium is 2.5 ad of 08/17/18- pre-op labs. Surgery/procedure performed and date: Surgery is tomorrow 08/21/18- OR/BEL for bilateral upper blepharoplasty. Bilateral brow lift. Correction of bilateral lower eyelid ectropion. Last seen 08/08/18 pre-op appointment with Dr. Trung. Next visit with dept: 08/27/18 post-op. Action: Par Dr. Trung Nguyen call this patient and advice to see PCP today. Called patient and left voice mail to call office. Left message for him to see her PCP today per Dr. Trung. Kimmerling, Reuven Eli, M.D. (08/20/18 10:21 AM): I have no further slots available today to see patient. Hypokalemia for him is common given his history. Patient has chronic issues with low potassium because of high Aldosterone output, HTN and not great adherence to Spironolactone and Losartan. Typically if he takes these medications his potassium is controlled. He should be encouraged to stay on these medications including on the day of surgery to keep BP and potassium under control. In the short term he can take his Ktab supplement as well but this is only temporary. Romana, Maria Corazon, R.N. (08/20/18 12:25 PM): Patient having to see Nurse Visit at Cerritos Kaiser Internal medicine for repeat potassium level. Dr. Trung is aware.
08/20/18	643- 644	Zambrano, Liliana-Kaiser Permanente	**Call Documentation** Zambrano, Liliana 08/20/18 10:04 AM): Type of result? blood - Patient had labs and states his results show his potassium levels are low. Patient requesting to have potassium medication today as he has eye surgery tomorrow.
08/27/18	650- 661	Nguyen. Trung Buu, M.D.-Kaiser Permanente	**Progress Notes** Patient is 1 week's s/p surgery blepharoplasty. Wound is healing. Discontinue suture. Patient is happy with post-op result. Steri-strip application. Return to clinic 1 week or if needed. Continue current treatment. BP: 143/79. Wt: 253 lbs.

08/27/18	662- 671	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with back pain right lower back pain x 1.5 week. HPI: Patient is here today because of back pain for the last 10 days. He states this pain is worse when he is getting up from a lying position. The pain lasts a few seconds and then goes away. He pretty much does not feel it when he is sitting upright or standing. However because it is in the right flank area he worries about his kidney. He only has one kidney remaining after a prior kidney blood menses. He states he has not really been taking his Cholesterol medication, and is only taking one of the Spironolactone tablets daily. BP: 176/96. Wt: 255 lbs. Exam: Mildly tender to palpation over the right flank, the muscle is a bit tight, ROM is not limited. Lab studies were reviewed. Assessment and Plan: Back pain. Note: I think the back pain is likely musculoskeletal rather than due to an internal organ. It seems actually quite mild and very positional. He is taking some Naproxen, I have asked him to use this sparingly, because of his reduced renal function. Follow up if not improving. Essential HTN. Note: As usual this is not well controlled, and as usual he is not taking the full dose of the medication as requested. I told him to start taking the second Spironolactone daily. We will re-check his kidney and electrolyte function in the coming days. Plan: Lab studies. Hyperlipidemia. Note: I have recommended that patient restart his statin because of high ASCVD risk. Plan: Lab studies. Atorvastatin 40 mg. F/u 2 weeks BP check.
08/30/18	676- 680	Mendoza, Gabriela C., M.A./Martinez, Soledad/Kimmerling, Reuven Eli, M.D./Men, Carolina-Kaiser Permanente	**Call Documentation** Men, Carolina 08/30/18 08:19 AM: Reason for request: Member request to message PCP to request for an MRI order to be placed for him. If PCP is not available today member is fine with any provider on duty responding to his message today. Mendoza, Gabriela C., M.A. (08/30/18 09:49 AM): Patient is requesting MRI for his back pain. States he continues with severe pain and would like to know the cause. Was seen on 08/27/18. Assessment and Plan: Back pain. Note: I think the back pain is likely musculoskeletal rather than due to an internal organ. It seems actually quite mild and very positional. He is taking some Naproxen, I have asked him to use this sparingly, because of his reduced renal function. Follow up if not improving. Kimmerling, Reuven Eli, M.D. (08/30/18 08:46 PM): We really do not order MRI of back for back pain that is recently diagnosed. If his pain is severe or worsening, he may need to be evaluated in the ER. If he feels the pain is tolerable I could refer him to a back specialist, which may take a few days or a week to get in. We

			could also check some labs to confirm that none of his organs are affected. Martinez, Soledad at 08/31/18 8:56 AM: Calling back re: Request for MRI. Mendoza, Gabriela C., M.A. at 08/31/18 10:31 AM: We really do not order MRI of back for back pain that is recently diagnosed. If his pain is severe or worsening, he may need to be evaluated in the ER. If he feels the pain is tolerable I could refer him to a back specialist, which may take a few days or a week to get in. We could also check some labs to confirm that none of his organs are affected. Patient states he will go to the ER for severe back pain. States he thinks he is coughing up blood as well. Informed him to go to ER to be evaluated. Will go to ER today.
08/31/18	681- 696	Park, Denise Helena, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with back pain mid area, 3-4 days. Cough with some blood spit up. He was just seen for the same issue 4 days ago by PCP Kimmerling, Reuven Eli (M.D.) on 08/27/18. Anxious regarding right-sided paralumbar region discomfort only with certain turning position in bed (to reach for something). But not when sitting. Occasionally feels it when stands up initially from seated position. Can get in/out of chair and car easily. Stopped taking Naproxen but did help. Last 3 days with some cough and phlegm. Yesterday night after vigorous coughing, had scant dark tinged sputum maybe it was blood. No further incidents after that. BP: 172/88. Wt: 250 lbs. Exam: Patient able to lie down supine and get up sitting to standing without any difficulty or pain. Lower extremities: Trace ankle edema. Lab studies were reviewed. Assessment and Plan: Lumbar muscle strain, subsequent - no red flags. Vaccination for influenza. Hypertension - BP elevated. Patient followed by nephrology. Has appt in 4 days. Low sodium diet discussed in detail. (He does like salami/ham and chips, etc). Elevate legs when possible. Continue current meds for now. RTC 09/04/18 Nguyen, Trung Buu, M.D. and 09/10/18 Mayfield, Miriam, L.V.N.
08/31/18	697- 699	Huynh, Trung Vo, M.D./Corpuz, Angelita G., R.N.-Kaiser Permanente	**Call Documentation** Corpuz, Angelita G., R.N. (08/31/18 08:54 AM): C/o severe back pain for few weeks and saw PCP on 08/27/18 for this. Assessment/Plan: Back pain. Note: I think the back pain is likely musculoskeletal rather than due to an internal organ. It seems actually quite mild and very positional. He is taking some Naproxen, I have asked him to use this sparingly, because of his reduced renal function. Follow up if not improving. Patient called PCP's office today requesting MRI to be done. Patient states, PCP didn't order any test what's

			causing his back pain neither pain medication. Patient called PCP's office again yesterday and PCP's notes below: We really do not order MRI of back for back pain that is recently diagnosed. If his pain is severe or worsening, he may need to be evaluated in the ER. If he feels the pain is tolerable I could refer him to a back specialist, which may take a few days or a week to get in. We could also check some labs to confirm that none of his organs are affected. Patient is requesting your assistance for this matter. What will he do? Patient is very disappointed for this matter. Advise to go UCC for evaluation or contact PCP's office again. If pain worsen to go ER. Assured his message is forwarded to Dr. Huynh. Huynh, Trung Vo, M.D. (08/31/18 10:35 AM): Spoke with patient on phone. States that he is also coughing up blood along with back pain. He is on his way to ED for further evaluation.
08/31/18	700- 701	Toney, Artis/Ledesma, Abigail D., L.V.N.-Kaiser Permanente	**Call Documentation** Toney, Artis (08/31/18 09:43 AM): Reporting a medical problem. Caller states symptoms are: Patient says that he is having a problem with his right side kidney and he wants to speak to the doctor about this. Ledesma, Abigail D., L.V.N. (08/31/18 10:37 AM): Situation/Background: Patient c/o: Left flank pain and coughing up blood x today. Patient states he has had a cough x 3 days. Additional Info: Patient states he was already planning to go to the Emergency Room or Urgent Care to be evaluated. Patient of Dr. Chang, h/a Kidney Ca. Last seen on 02/02/18 by Dr. Chang, scheduled to f/u on N/A.
09/04/18	702- 708	Nguyen, Trung Buu, M.D.-Kaiser Permanente	**Progress Notes** Patient is 2 weeks s/p surgery correction of ectropion bilateral lower eyelid. Wound is well healing. Patient is happy with post-op result. Return to clinic 4 weeks or if needed. Continue current treatment. Wt: 250 lbs.
09/07/18	722- 729	Kimmerling, Reuven Eli, M.D./Kimmerling, Rudy, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with insomnia, dizzy and diagnostic tests requested. Patient requesting blood work. HPI: Patient is here today because of feeling poorly. When he nods off he has a feeling of choking. He can't sleep right now. He does not have chest pain but does have shortness of breath. When he walks he gets tired real quickly. He can't sleep because of gasping, shortness of breath when he is about to nod off. Generally over the last few days he has felt truly terrible. He is not sure which came first, the feeling badly or the lack of sleep. That being said the lack of sleep and inability to fall asleep as well as a sensation of choking when he nods off is very distressing to him. In the past we have tried to get him

			tested for sleep apnea, however he has refused to go under the worry that if he is diagnosed with sleep apnea he may lose his job. BP: 186/97. Wt: 255 lbs. ROS: Headache, shortness of breath, snoring. Exam: Lab studies were reviewed. Assessment and Plan: Adult obstructive sleep apnea. Note: I am very worried about patient. Clinically he looks poorly and his BP is severely out of control. His clinical h/o sleep apnea events is also very concerning given that he is a driver. I have urged him again to f/u for sleep apnea testing, if he has this then it could be life saving to get him on treatment. At the same time there is a consideration for flash pulmonary edema because of his vastly elevated BP. At this time his lungs do sound clear and it sounds like his shortness of breath is only when he is trying to fall asleep. We will get stat labs today to make sure there is nothing going on with his potassium, but I would urge him to go to the emergency room if anything else is worse. In fact today I encouraged him to go directly to the emergency room but he declined which is why we decided to order labs and treat BP as below. Plan: Referral sleep clinic. Vaccination for influenza. Note: I have recommended that this patient have a flu shot but he declines at this time. I have discussed the risks and benefits of this procedure with him. Patient verbalizes understanding. Never smoked. Obesity, BMI 32-32.9, adult. Shortness of breath. Note: See discussion above but I think his shortness of breath is likely due to HTN as well as a component of obstructive sleep apnea. I am very concerned about him and recommended he go to the emergency room but he declined. We will check stat labs including potassium creatinine and BNP, and if these are way off and I will have him proceed to the emergency department. That said his oxygen saturations were normal today even though his respiratory rate was increased. Plan: Lab studies. Essential HTN. Note: Patient's BP control has been poor for a while although he states now that he has been taking his Spironolactone his Losartan and his Atenolol consistently at least for the last few days. We really need to get urgent labs on him so I have ordered them right away. Depending on these results I may have him increase the Atenolol or f/u in the ED, I worry about of very high amount of Aldosterone given his severe hypokalemia and HTN in the recent past. Pheochromocytoma is also possible though extremely unlikely given the absence of tachycardia and the relative chronicity of the problem. Plan: Atenolol 50 mg. Lab studies. F/u ASAP after labs.

09/07/18	730- 732	Kaiser Permanente	**KP On Call Telephone** CC: Can't sleep. HPI: Patient states he thinks he has sleep apnea. ROS: Able to speak in full sentences. Making sense AND seems able to answer questions appropriately or caretaker perceives mental status/speech pattern/affect is within normal limits. Insomnia.
09/07/18	733- 735	Kimmerling, Reuven Eli, M.D./Lacson-Wood, Mariflo J., R.N.-Kaiser Permanente	**Call Documentation** Kimmerling, Reuven Eli, M.D. (09/07/18 01:44 PM): Please call, tell patient that labs show kidney function is about the same as before, maybe a bit lower, and potassium looks much better than before, a bit on the low side but not as bad as before. I think he feels bad because of sleep apnea issues and HTN. It is ok to take an extra Losartan this afternoon to try to get the BP down further and help him feel better. The BNP level which is a measure of possible heart failure is very high. This shows his heart is under strain. If he still is getting worse and can't breathe or sleep, he should go to the ER for urgent evaluation because I think if he can't get his BP down he may fall into a heart failure event. Lacson-Wood, Mariflo J., R.N. (09/07/18 02:34 PM): Please call, tell patient that labs show kidney function is about the same as before, maybe a bit lower, and potassium looks much better than before, a bit on the low side but not as bad as before. I think he feels bad because of sleep apnea issues and HTN. It is ok to take an extra Losartan this afternoon to try to get the BP down further and help him feel better. The BNP level which is a measure of possible heart failure is very high. This shows his heart is under strain. If he still is getting worse and can't breathe or sleep, he should go to the ER for urgent evaluation because I think if he can't get his BP down he may fall into a heart failure event.
09/07/18	2056-2059	Kaiser Permanente	**Laboratory Rept** Creatinine, Aldosterone/Rennin ratio, B type natriuretic peptide: High. Potassium, Renin: Low.
09/10/18	737- 740	Jose, Tina Kolattukudy, M.D./Mayfield, Miriam, L.V.N.-Kaiser Permanente	**Call Documentation** Mayfield, Miriam, L.V.N. (09/10/18 11:24 AM): Patient in for a BP check. States he has discharged from hospital last night. Advised to keep previously BP f/u appointment for today. Patient is taking medication consistently. Only took one tablet of Spironolactone this AM. States was not aware SIG was 2 tablets 2 times a day. Blood pressure taken, informed patient that BP is elevated. Repeated BP after few minutes (standing), with reading of 170/95 p: 70. Patient is asymptomatic. Advised DOD of BP readings. Prescriptions printed and provided to patient. Continue on current medication, compliance is important. Schedule POSH

			appointment with PCP within one week. Recommended following a moderately low sodium, low fat diet. (DASH diet provided). Increase intake of fruits and vegetables. If your BMI is > than or = to 25, weight-loss is effective in reducing BP. Alcohol intake should be no more than 1 (for women) or 2 (for men) drinks per day. Exercise at least 30 minutes 3 x/week. IF you smoke it is strongly recommend that you quit smoking. Do not stop or change medication without consulting with your Physician. Hypertension/ER precautions instructions provided on AVS, member encouraged to read information. Follow up with PCP PRN. RTC 09/14/18 Kimmerling, Reuven Eli, M.D. 09/28/18 Castellon-Shelton, Maria, L.V.N. and 10/01/18. Jose, Tina Kolattukudy, M.D. (09/10/18 11:45 AM): New prescriptions created.
09/14/18	758- 768	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with hospital f/u. Medication issues. HPI: Patient is here to f/u on recent hospitalization. He was put in the hospital for shortness of breath, and it turned out that he had heart failure and likely volume overload from uncontrolled HTN and likely diastolic dysfunction. No echocardiogram was done during the admission, but with BP control and a little bit of diuresis his breathing improved and he was sent home. He continued to have extreme hypokalemia and so they started him on Triamterene. However he was unable to fill this at his outside pharmacy and only recently the prescription has been changed. He has not picked it up yet. BP: 174/97. Wt: 249 lbs. Exam: Lab studies were reviewed. Assessment and Plan: Essential HTN. Note: Patient's BP is still high but slightly improved from before. I had a long conversation with Dr. Fernandez in Endocrinology regarding future treatment of this patient. He has decreased renal function but the best combination of medications would be Spironolactone, Losartan, and Amiloride which I have just restarted. Hopefully with these medications we can eliminate the Clonidine and even the potassium tablets. He will continue on Atenolol for now. I have stopped the Clonidine as it makes him feel funny and short-acting. If his BP remains elevated at the next visit I would either double the Amiloride or increase the Spironolactone up towards the max dose of 200 milligrams daily. He will bring in his bottles next time, there continues to be confusion about how much of each pill he is taking on a daily basis. Never smoked. Obesity, BMI 32-32.9, adult. CHF (congestive heart failure). Note: This was a clinical diagnosis rather than echocardiogram diagnosis, as none of

			this imaging was done at his hospitalization. However this should be undertaken in the future once his BP is under better control. Most likely he will have left ventricular hypertrophy and diastolic dysfunction given his long-term poorly controlled HTN. Aftercare following hospitalization. Note: Patient seems to be doing better, though BP still needs work. I will see him back in one week with all his medications and to re-assess where his BP goes on the Amiloride. F/u 1 week.
09/21/18	782- 790	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with f/u routine. HPI: Patient is here today because of ongoing issues with BP. He finely brings his pills in. His BP Continues to be high and he has some shortness of breath, likely because of heart failure. He has not been on Lasix and has not been taking enough of the Losartan. He takes some of his medications intermittently, but tends to take one Amiloride one Losartan and four Spironolactone daily. He will take 10-20 mill equivalents of potassium on some days but not others. His Atorvastatin is rare and intermittent, as is Allopurinol. He has stopped Atenolol at this time. BP: 170/111. Wt: 244 lbs. ROS: Shortness of breath. Dyspnea on exertion. Exam: General: Obese. Lab studies were reviewed. Assessment and Plan: Never smoked. Essential HTN. Note: Patient's BP is again uncontrolled but I feel like we finally have a sense of what he is taking. We will double the Amiloride and Losartan today and see where we are in a few weeks. If still elevated I would increase his Spironolactone up to 100 milligrams twice daily. At that point we can re-check potassium and if the potassium is actually elevated or coming up we could consider adding a diuretic either Lasix or Chlorthalidone. My fear with Chlorthalidone is that it would really drop his potassium a lot as he likely has continued to have low potassium despite all these medications. His shortness of breath is likely due to the residuals of his diastolic heart failure, until we get the BP under control I fear this will continue. He also has bad sleep apnea but will finally be getting tested for this in a week or so. Plan: Amiloride 5 mg. Losartan 50 mg. HTN. Plan: Amiloride 5 mg. Losartan 50 mg. HTN, uncontrolled. CKD stage 3 (GFR 30-59). Note: Patient's kidney function remains a concern and until we get BP under control this always a risk for him. However I feel like we are finally making progress in terms of him consistently taking medication and realizing the gravity of the situation. Plan: Losartan 50 mg. CHF (congestive heart failure). Note: This was recently diagnosed with in the hospital, he is not on Lasix but this can

			happen once we get a better control on his potassium-sparing medications and he has maximized those doses. Plan: Losartan 50 mg. Hyperlipidemia. Note: I have urged him to take his Atorvastatin consistently and will refill this medication today. Plan: Losartan 50 mg. F/u 2 weeks BP check.
10/11/18	1982-1984, 4017	Kaiser Permanente	**Radiology/Diagnostics** Sleep Study, Unattended, Including Ventilations, Resp Effort, Heart Rate and O2 Sat. Summary: Patient recorded: Airflow (nasal pressure); airflow (thermistor); thoracic and abdominal RIP effort belts; oxygen saturation; position. The Noxturnal software was used to auto-score the data collected on this study. Scoring of hypopneas was based on the following definition: 30% decrease inflow compared to the baseline and associated with a 4% oxygen desaturation. Impressions: Patient demonstrates severe obstructive sleep apnea (OSA) with an apnea-hypopnea index (AHI) of 36.9 events/hour. Oxygen saturation by pulse oximetry fell to as low as 85.0 during the study. Plan: Patient offered home APAP trial. Follow up with the referring physician or PCP. Patient returned HST with chain of custody bracelet intact and verified by a license provider.
10/12/18	794- 795	Haun, Spencer, Tech-Kaiser Permanente	**Call Documentation** CC: Sleep apnea. Patient with obstructive sleep apnea. Epworth Sleepiness Scale: 3/24. Tx plan: CPAP, self titrating (DME). CPAP or BPAP humidifier, heated (DME). Follow-up visit in 30-120 days for compliance use.
10/25/18	824- 830	Chen, Donald Yen-Hung, M.D.-Kaiser Permanente	**Progress Notes** Patient reports 2 week h/o progressive shortness of breath. He reports dyspnea on exertion. Patient is h/o congestive heart failure. Was last hospitalized last month. Patient is somewhat compliant with his medications. Patient takes Losartan spur lacked own and Amiloride every day at bedtime. He is less comply with the Atorvastatin and Allopurinol. He takes those 2 drugs some days. Patient is worried he has a pericardial effusion. Assessment and Plan: CHF (congestive heart failure). Note: Resume Lasix every other day. Workup chest x-ray, BNP. Follow up cardiology. Plan: Lab studies. X-ray chest. Referral cardiology. Obesity, BMI 31-31.9, adult. Note: Assessment: Obesity - unchanged. Plan: Patient is advised to begin progressive daily aerobic exercise program, follow a low fat, low cholesterol diet, attempt to lose weight and attend health education classes for weight control and exercise. Plan: Lab studies. Never smoked. Obstructive sleep apnea. Note: CPAP.

10/25/18	831- 837	Garcia, Jannice J., L.V.N./Chen, Donald Yen-Hung, M.D./Aragon, Jesadhel Alaba L.V.N.-Kaiser Permanente	**Call Documentation** Chen, Donald Yen-Hung, M.D. 10/25/18 7:54 PM: Lab studies were reviewed. 09/07/18 is elevated suggested congestive heart failure. Plan: Take Lasix daily. Aragon, Jesadhel Alaba L.V.N. 10/26/18 9:00 AM: BNP 1267 09/07/18 is elevated suggested congestive heart failure. Plan: Take Lasix daily. Aragon, Jesadhel Alaba L.V.N. 10/26/18 9:02 AM: I pended Lasix - patient states he is out. Please review message and advise. Chen, Donald Yen-Hung, M.D. (10/26/18 09:12 AM): Furosemide 40 mg. Please call above medication ordered and at the Pharmacy for pick up. Garcia, Jannice J., L.V.N. (10/26/18 09:25 AM): Informed patient medication Furosemide 40 mg is ready for pick up. Patient verbalized understanding and compliance.
10/25/18	2060-2062	Kaiser Permanente	**Laboratory Rept** B type natriuretic peptide, BUN, Creatinine: High.
10/26/18	838- 847	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** Patient present with shortness of breath x 2 weeks/seen for this yesterday. HPI: Patient is here today because of ongoing shortness of breath symptoms. He has felt a racing heart every night. Can't go to sleep, scared to go to sleep because something might happen. Unable to tolerate his old CPAP mask but got a new one today. Patient is a commercial driver and has to loaded on load trucks. However because of his worsening heart failure, BP, renal dysfunction, and shortness of breath with exertion he does not feel like he is able to carry out the job anymore. His sleep apnea is not yet under control as he has not found a mask that works for him, but sleep apnea which is severe was recently confirmed. He was seen the other day and a BNP level came back extremely elevated. BP: 165/107. Wt: 244 lbs. ROS: ROS: Shortness of breath, orthopnea. Exam: Constitutional: Breathing heavily and shallowly. Cardiovascular: Tachycardic but regular without murmurs rubs or gallops. Lab studies were reviewed. Assessment and Plan: Diastolic heart failure, acute on chronic. Note: Patient has an h/o diastolic heart failure with mildly depressed ejection fraction as well. He currently is probably having some pulmonary edema causing the shortness of breath, and his orthopnea is due both the sleep apnea and heart failure. The ongoing difficulty controlling his BP also contributes to his issues of diastolic dysfunction, he states he is taking all his medication. At least his potassium has come back up to the normal range which could also be a sign of worsening renal failure. He is on the borderline for needing to be admitted to the hospital, hopefully with the increased Furosemide and the addition of

			a new mask for CPAP tonight we will drive some fluid back intravascularly from his lungs and then out through his urine, but I told him that he if he does not improve he should report to the emergency room for IV diuretics positive airway pressure treatment. Long-term he likely is a candidate for disability given that he has been so unstable recently and I fear that until he gets his BP renal function and heart failure under control he will continue to have severe dyspnea and be unable to exert himself appropriately given his current vocation. Plan: Referral social service. Never smoked. Essential HTN. Note: Not well controlled today, I really can't increase the Spironolactone given where his potassium was recently and he did not bring in his pills. For now we will give him more time with the Lasix he has only taken two doses of hopefully getting some of the volume down will help. Adult obstructive sleep apnea. Note: Severe as it was tested recently but he has not found a successful mask for treatment, treatment of this will be very critical. F/u 2 weeks.
10/26/18	848- 853	Garcia, Jannice J., L.V.N.-Kaiser Permanente	**Call Documentation** Informed patient medication Furosemide 40 mg is ready for pick up. Also patient wanted to tell PCP he wants to retire now due to chronic diseases and heart failure. Informed patient he needs appointment, no sooner TAV to offer. Patient wants to be seen sooner. RTC 10/26/18 Kimmerling, Reuven Eli, M.D. and 11/09/18 Mayfield, Miriam, L.V.N.
10/31/18	827, 1985	Kaiser Permanente	**Radiology/Diagnostics** X-ray of Chest. Clinical indication: SOB. Comparison: 09/07/18. Findings/Impression: Right perihilar opacity. Elevated left hemidiaphragm. Suggestion of small effusions.
11/06/18	878- 881	Skiles, Kalyn, D.O.-Kaiser Permanente	**Call Documentation** Please inform patient I received message from cardiology department stating: "Current EF does not qualify for congestive heart failure clinic. Patient should see Dr. Farvid for f/u. Has appointment on November 19." therefore, patient will not be scheduled for congestive heart failure clinic f/u.
11/07/18	882- 884	Skiles, Kalyn, D.O.-Kaiser Permanente	**Telephone Appointment Visit** I Called and spoke to patient. I informed him K 5.4 11/06/18 I advised patient to stop Ktab and repeat labs tomorrow morning. I also informed patient of Dr. Duong's message below that his "Current EF does not qualify for congestive heart failure clinic. Patient should see Dr. Farvid for f/u. Has appointment on November 19." Message: Current EF does not qualify for Congestive heart failure clinic. Patient should see Dr. Farvid for f/u. Has appointment on November 19.

11/13/18	885- 894	Jakosalem, Josie Rose Anto Manso, R.N./Sim, William Peter, M.D.-Kaiser Permanente	**Call Documentation** Sim, William Peter, M.D. 11/13/18 10:45 AM: Patient is here for BP check with HTN today. Not taking Bisoprolol due to not liking how he feels on it as well as not taking Losartan due to recent hyperkalemia. Hasn't rechecked his potassium yet 1 week later. Advised to go to lab today. Will switch Bisoprolol to Carvedilol and see if he tolerates it better. Once we have normal labs can resume Losartan and then re-check BP in a week. Jakosalem, Josie Rose Anto Manso, R.N. (11/13/18 10:49 AM): Hx: Patient is here for BP check with HTN today. Not taking Bisoprolol due to not liking how he feels on it as well as not taking Losartan due to recent hyperkalemia. Hasn't rechecked his potassium yet 1 week later. Advised to go to lab today. Will switch Bisoprolol to Carvedilol and see if he tolerates it better. Once we have normal labs can resume Losartan and then re-check BP in a week. BP: 167/115. Assessment: Asymptomatic. Recommendation/Outcome: Encouraged to continue taking prescribed medications. Consulted PCP Dr. Kimmerling, Reuven Eli (M.D.)/Quan Ho Pharm/Matt Kamada Pharm. DASH diet. Exercise. Keep scheduled BP f/u appointment. Patient verbalized understanding. RTC 11/19/18 and 11/20/18.
11/13/18	2063-2065	Kaiser Permanente	**Laboratory Rept** Potassium, Creatinine: High.
11/14/18	2066-2067	Kaiser Permanente	**Laboratory Rept** Creatinine: High. Anion gap (NA-(CL+CO2)): Low.
11/19/18	924- 936	Farvid, Ali Reza, M.D.-Kaiser Permanente	**Outpatient Cardiology Consultation** Reason for consultation: Diastolic HF and dyspnea on exertion. Patient c/o shortness of breath and decreased exercise tolerance. HPI: Patient with past medical h/o HTN, CKD, and h/o fluid retention from diastolic HF being referred for dyspnea on exertion. BP: 149/94. Wt: 238 lbs. ROS: Cardiovascular: Positive for - dyspnea on exertion. Exam: Lab studies were reviewed. Echo was reviewed. Assessment and Plan: Patient with past medical h/o HTN, CKD, and h/o fluid retention from diastolic HF being referred for dyspnea on exertion. No prior known coronary artery disease. Dyspnea on exertion. Given RF and EF in 45% range, recommending patient having diagnostic angiogram to evaluation for obstructive ca. On ASA, bb, statins. Discuss with patient the risk of not doing catheterization and wants to wait. He is aware of the increased risk of mi/death. Hypertension. Usually controlled. Didn't take meds this AM. Stressed compliance. Return to

			clinic in 2-3 months or sooner PRN.
11/20/18	937- 942	Silva Sanchez, Denise, M.A.-Kaiser Permanente	**Call Documentation** Patient walked-in for BP check. Patient took medications. BP: 137/91. Wt: 238 lbs. Exam: Lab studies were reviewed. Scheduled patient 2 week f/u BP check on 12/4 at 10:30 AM. Notified patient of appointment scheduled.
11/23/18	943- 948	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare and medication questions. Phone visit documentation: Patient is calling about medication questions. He stopped the Losartan, but his BP has been ok. He had cardiology f/u and they cut his Spironolactone dose. Recently had hyperkalemia, perhaps because renal function worsening, perhaps because he is finally taking all his medications. Assessment: Essential HTN. Left ventricular diastolic dysfunction. Tx plan: Discussed that Losartan should be safe if received from Kaiser Permanente. He already got work off note extension. He should stay off Losartan for now with recent hyperkalemia but if BP high in 1 week, then restart at lower dose and re-check potassium in a few days with creatinine. Advised patient to call back if symptoms do not improve.
12/07/18	954- 957	Kimmerling, Reuven Eli, M.D./Mayfield, Miriam, L.V.N.-Kaiser Permanente	**Call Documentation** Mayfield, Miriam, L.V.N. (12/07/18 10:10 AM): Patient in for a BP check. Member c/o sob x 3 days , thinks it may be related to his potassium. States last time his potassium was abnormal he had same symptoms. Blood pressure taken, informed patient that BP is elevated. Repeated BP after few minutes (standing) ,with reading of 147/106 p: 97. Patient is asymptomatic. Spoke to Dr. Kimmerling, ordering stat labs. Ok to discharge patient now, asymptomatic. Keep appointment with Dr Oh as scheduled. Recommended following a moderately low sodium, low fat diet. (DASH diet provided). Increase intake of fruits and vegetables. If your BMI is > than or = to 25, weight-loss is effective in reducing BP. Alcohol intake should be no more than 1 (for women) or 2 (for men) drinks per day. Exercise at least 30 minutes 3x/week. IF you smoke it is strongly recommend that you quit smoking. Do not stop or change medication without consulting with your Physician. Hypertension/ER precautions instructions provided on AVS, member encouraged to read information. Follow up with PCP PRN. RTC 12/07/18, 12/19/18 and 01/25/18. Kimmerling, Reuven Eli, M.D. (12/07/18 10:32 AM): Patient is feeling poorly. Concern for hyperkalemia or acute CHF flare again. Ordered stat labs. Will see Dr. Oh today at 1:30 as well for exam.

12/07/18	958- 980	Oh, Timothy Keesun, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with shortness of breath. HPI: Patient with CHF, Chronic Kidney Disease stage 3, here for worsening shortness of breath over the past 3 weeks. He has stopped taking Carvedilol (Coreg) due to complaints that he believes it had caused pain in the left side of his neck. Takes Furosemide (Lasix) daily and has been checking his weight daily. No significant weight gain. However, he does have orthopnea. Denies any wheezing. No fevers, no chest pain. No lightheadedness. Declined BP check this afternoon (Had BP checked this morning). Wt: 241 lbs. Assessment and Plan: CHF (congestive heart failure). Shortness of breath. Chronic kidney disease stage 3. Note: Chronic systolic on diastolic dysfunction. Lab studies. Lungs clear on exam, no rales. Plan: Metoprolol Succinate 25 mg. Continue Furosemide (Lasix) 40mg two times a day, (may take and extra dose today). Continue Aspirin and statin. Watch daily weights, limit sodium in diet. Reviewed laboratory results with patient. Follow up with PCP in 1 week (already has appointment). Never smoked. Obesity, BMI 31-31.9, adult. RTC in 1 week.
12/07/18	2068-2070	Kaiser Permanente	**Laboratory Rept** Creatinine, B type natriuretic peptide, BUN: High.
12/19/18	985- 993	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** Patient presents with f/u routine. HPI: Patient is here today for f/u. Some days he is better than others, but he misses medications sometimes, and the next day he will breathe poorly. Overall he is feeling better than he was last week when he came in. He is only taking one Amiloride daily but thinks he is taking Hydralazine which is no longer on his list. He has not brought his medications today so it is hard to know what he is actually taking. On top of this he feels outside Kaiser Permanente today, so we never really know the date that he actually filled something. He has not been using his CPAP lately although he states that his paroxysmal nocturnal dyspnea and orthopnea are much improved. He does get trouble when he does not take his antihypertensives within 24-48 hours. BP: 150/76. Wt: 243 lbs. ROS: Shortness of breath on occasion. Exam: Lab studies were reviewed. Assessment and Plan: Combined systolic and diastolic heart failure, chronic. Note: Patient has an h/o low-grade systolic election fraction decrease as well as more acute on chronic issues of diastolic dysfunction which will frequently cause shortness of breath. This is exquisitely related to his h/o HTN and as usual we are trying to get this to arrange for it is better controlled. I have explicitly written out to him what he

			should be taking and I have asked him to bring his pills at the next nurse visit in a couple weeks so that we can get him to goal. If he is not a goal then we could increase the Hydralazine or consider adding Minoxidil as the next drugs. Never smoked. Essential HTN. Note: As above. CKD stage 3 (GFR 30-59). Note: Due to a combination of chronic HTN and a partial nephrectomy from of previous renal malignancy. This has been okay at the last check and merits continued f/u by both myself and the nephrologists and neurologists on a quarterly to semiannual basis. Plan: Ergocalciferol, Vitamin D2, 50,000 unit. F/u 2 weeks BP check.
01/03/19	994- 1003	Espinoza, Janette, M.A./Guzman, Yvonne S., M.A.-Kaiser Permanente	**Call Documentation** Espinoza, Janette, M.A. (01/03/19 01:04 PM): Complete care program - outreach call (LM/UTC) Reason = Outreach List for HTN fair event. Lab studies were reviewed. Guzman, Yvonne S., M.A. (02/01/19 02:07 PM): Complete care program - outreach call (LM/UTC) Reason = Outreach List for HTN fair event. Lab studies were reviewed. RTC 02/06/19 and 04/29/19.
01/18/19	1004-1013	Lou, Amy M., R.N./Cabrera, Patricia, L.V.N./Lacson-Wood, Mariflo, J., R.N./Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Call Documentation** Cabrera, Patricia, L.V.N. 01/18/19 3:45 PM: Labs were ordered by Nephrologists Dr. Huynh. Labs are abnormal (patient has TAV until 01/25. Please advise). Cabrera, Patricia, L.V.N. 01/18/19 4:00 PM: Situation: C/o having slight SOB, cp and palpitations. Background: States had requested from his Nephrologists to have his K checked because he was having slight symptom of cp, sob and palpitations. Has TAV with Nephrology MD on 01/25/19. Request: Lab results from 01/15/19. Action: Warm transferred call to RN Joy for further assistance. Lacson-Wood, Mariflo, J., R.N. at 01/18/19 4:04 PM: Situation: Patient was transferred to my line by Patricia Cabrera, LVN, patient with abnormal labs ordered by nephrologists and patient c/o SOB per Patty, LVN. Nephrologists ordered labs for patient on 01/15/19 and results back with abnormalities. Patient stated he hasn't heard from nephrologists and was requesting for results to be reviewed. Upon talking to the patient when asked if he had symptoms patient stated ,“ No not really all I want to know is my results and if my potassium is low” Assessment: Patient denies symptoms at time of call. Recommendation: Advised patient to f/u with nephrologists. Please advise patient's results. Kimmerling, Reuven Eli, M.D. 01/18/19 4:15 PM: Potassium was high, 5.4. He needs to cut the Spironolactone in half for now and re-check on Sunday or Monday. If worsening symptoms,

			may need to go to the ER this weekend. Kimmerling, Reuven Eli, M.D. 01/18/19 4:33 PM: Potassium was high, 5.4. He needs to cut the Spironolactone in half for now and re-check on Sunday or Monday. If worsening symptoms, may need to go to the ER this weekend. But his potassium is definitely not low. Lou, Amy M., R.N. (01/18/19 04:49 PM): Spoke with patient, informed per below message from Dr Kimmerling.
01/21/19	1022-1028	Moreno, Melissa Marie, M.A./Cornejo, Iris/Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Call Documentation** Cornejo, Iris 01/21/19 2:31 PM: REQUEST: Member requests refill of the medications from an Outside Pharmacy. The medications have been verified. Outside Pharmacy Information Is below. Rx has been validated by pharmacy. Meds: SPS 15 gm/60 ml. Kimmerling, Reuven Eli, M.D. at 01/21/19 2:51 PM: Please call, tell patient that we should not be rechecking this prescription without a repeat potassium check- it is used for treatment of high potassium in the acute setting. Mendoza, Gabriela C., M.A. 01/22/19 2:16 PM: Per HC review labs completed today. Moreno, Melissa Marie, M.A. 01/22/19 02:27 PM Spoke with patient, informed per MD's notes: Please call, tell patient that we should not be rechecking this prescription without a repeat potassium check- it is used for treatment of high potassium in the acute setting.
01/25/19	1034-1038	Huynh, Trung Vo, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare. Patient with an h/o B-thalassemia. Hyperlipidemia. Hypertension. RCC s/p left partial Nx in 04/2017 who returns for f/u of CKD. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to - 1.7, peaked at 2.5 after left partial nephrectomy on 4/4/17 but recovered back to baseline. RCC was diagnosed incidentally during workup for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Does not check home BP. Was admitted 10/2018 for fluid overload, now on Lasix, Aldactone, Amiloride. Cr increased to 2.2-2.5 after hospital admission. Lab studies were reviewed. Assessment: Essential HTN. HTN. CKD stage 3 (GFR 30-59). H/o kidney cancer. Cr stays 2.2-2.5 after hospital admission in 10/2018, ? over-diuresis (patient on 3 diuretics, including Lasix, Aldactone, Amiloride. No edema). Proteinuria stable. Not sure if BP controlled (does not check at home). Tx plan: Lab studies. Amiloride 5 mg. Decrease Amiloride to 5 mg 1 tablet daily. Continue Lasix 40 mg daily and Aldactone 50 mg daily. Repeat labs in 2 weeks. Refer to choices class if GFR

			remains less than 30. RTC in 3 months.
02/06/19	1046-1054	Chang, Allen, M.D.-Kaiser Permanente	**Progress Notes** RFC: Left renal mass. Patient with PMH of HTN, HL, obesity, B-thalassemia here for left renal mass. 02/08/17 CT A/P shows large left 12 cm upper pole renal mass, RK Bosniak 3 cyst. 03/15/17 - first visit- No hematuria. Never smoker. Truck driver. No family h/o GU malignancy. Has mild right flank discomfort. No left flank pain. 04/04/17 - robot assisted left partial nephrectomy with cyst decortication - very large left upper pole cystic renal mass 10 x 11 cm. Left adrenal spared. WIT 33 minutes 27 seconds. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated. Path - pT2bNxR0 papillary RCC Fg 2-3/4 – 11 cm tumor. 12/06/17 CT A/P - Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast. Area is likely Tisseel from surgery. Advise shorter interval imaging in May 2018 01/11/19 CT KUB - post surgical changes with interval decrease in size of soft tissue in surgical bed, 2 mm LK nonobstructing nephrolithiasis. Subjective: Doing well. No hematuria. No flank pain. 04/04/17 left partial nephrectomy pathology, 06/18/16 MRI renal, 02/08/17 CT A/P, 12/06/17 CT A/P, 01/11/19 CT CAP was reviewed. Assessment and Plan: Renal mass. Imaging reviewed with patient. Large left upper pole 12 cm complex cystic mass. Majority of lesion is 17-2OHU but lower portion with nodularity. 2016 MRI shows mural nodules and it was only 6 cm in size. This is a Bosniak 3-4 cyst. Another separate lower pole posterior 27HU 1.5 cm complex cyst. RK. With 1.5 cm 13HU lower pole cyst. 04/04/17 - robot assisted left partial nephrectomy with cyst decortication - very large left upper pole cystic renal mass 10 x 11 cm. Left adrenal spared. WIT 33 m 27s. Collecting system was not entered. Left anterior simple renal cyst just below renal hilum decorticated - path - pT2bNxR0 papillary RCC Fg 2-314 – 11 cm tumor. Pathology was reviewed with patient and family today. Advised that patient should get future surveillance imaging to r/o local recurrence. 12/06/17 CT NP - Focal soft tissue prominence as described above is contiguous with the superior left kidney at the surgery site Possibility of a small residual recurrent mass cannot excluded, especially without intravenous contrast. 01/25/18 x-ray of chest clear. 01/11/19 CT KUB - post surgical changes with interval decrease in size of soft tissue in

			surgical bed. CT KUB in 1 year. Check PSA and UA. With regards to 2 mm LK nonobstructing nephrolithiasis, advise for observation given small size. General Dietary Recommendations to patient as follow: 1) Oral fluid intake to maintain urine output 2-3 L a day. 2) Low sodium diet. 3) Low animal protein diet. 4) Low oxalate diet (avoid beets, spinach, chocolate/cocoa, liver, tea, peanuts, rhubarb, strawberries, potatoes). 5) Moderate calcium intake (800-1000 mg/day). 6) avoId high doses of Vitamin C (>500 mg) and Vitamin D. 7) Call MD if persistent pain, inability to tolerate PO intake, and fevers more than 38C. 8) Strain urine with urine strainer and to keep captured specimen for stone analysis and culture. 9) Usage of Vicodin and NSAIDS such as Ibuprofen for pain control. Patient already followed by nephrology for CKD. Advised to have serial BP checks with primary care. Future serial checks of creatinine and albuminuria should be considered. Indicated patient should be cautious in any future contact sports that may cause renal injury. Patient should maintain good hydration. Patient should avoid NSAIDs if possible. Patient should also adhere to low salt and moderate protein intake diet. F/u 1 year.
03/08/19	1061-1068	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** CC: Patient presents with f/u routine. HPI: Patient is here for BP f/u. He says he tends to take his BP medications and all medications at one time. Was not taking his medications correctly recently in his estimation. Has recently started taking more amiloride. He is feeling ok but feels his BP is high. Lately he has been feeling like he can't sleep correctly or flat, worried his fluid levels may be up again. BP: 155/100. Wt: 259 lbs. ROS: Positive light dyspnea on exertion. Exam: General: Obese. Abdomen: A bit more distended than usual. Lab studies were reviewed. Assessment and Plan: 1) Left ventricular diastolic dysfunction. Note: Patient has an h/o mild systolic dysfunction and moderate diastolic dysfunction due to hypertensive heart disease most likely. He never did show up for cardiac catheterization. I think that he is a bit volume overloaded today and back in some heart failure which is causing his shortness of breath. We will get some labs and I will try to arrange f/u with Cardiology. Plan: Lab studies. 2) Never smoked. 3) Obesity, BMI 33-33.9, adult. 3) Essential HTN. Note: As usual this is poorly controlled, he will increase his Lasix and double his amiloride. We have to stay on top of his renal function as he lives on the edge of hyperkalemia. Does not check his BP at home frequently enough. Plan: Lab studies. 4) CHF (congestive heart failure). Note: See above, will get labs and

			discuss further with Cardiology. Plan: Lab studies. Rx: Amiloride 5 mg, Ergocalciferol, Vitamin D2, Metoprolol Succinate 25 mg, Spironolactone 50 mg, Furosemide 40 mg, Atorvastatin 40 mg, Sildenafil 20 mg, Aspirin 81 mg. F/u 2 weeks.
03/19/19	1069-1078	Dickerhoof, Elaine Dorthea, NP-Kaiser Permanente	**Progress Notes** HPI: Patient is here for severe pain left ankle times 2 days. No injection. States he started taking his gout pills and has had some relief. States he is taking his other meds. Recent pertinent lab, imaging studies and vital signs reviewed. ROS: Musculoskeletal: Positive for joint pain. Exam: EXT: Left ankle, slightly swollen and pink, slightly warm, tender to touch and movement. DTR and pulses- present. Assessment and Plan: Gout. Note: Info given on diet, patient to get lab today- he agrees, refill med for patient. Plan: Lab studies. Allopurinol 300 mg. Never smoked. Essential HTN. Note: Continue routine meds, diet and exercise. Enc. Patient to take meds as dir. Get f/u lab done. Plan: Lab studies.
03/25/19	2077-2078	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Creatinine, Anion GAP (NA-(CL+ CO2)), B Type Natriuretic Peptide: High.
03/26/19	1086-1089	Franca, Christina, MA-Kaiser Permanente	**Call Documentation** Franca, Christina (M.A.), M.A. at 03/26/19 4:21 PM. Please call patient, let him know that kidney function looks pretty good. I know his fluid levels have been up a bit lately. I want him to double his furosemide (Lasix) for one week then drop back down to his usual dose and see if this helps the pressure and shortness of breath when he lays down. Franca, Christina (M.A.), M.A. at 03/26/19 4:22 PM. Messaged relayed per MD Kimmerling. Patient has no further questions. Patient verbalized understanding.
04/29/19	1097-1102, 2079-2083	Huynh, Trung Vo., M.D.-Kaiser Permanente	**Progress Notes** HPI: Patient with an h/o B-thalassemia. Hyperlipidemia. Hypertension. RCC s/p left partial Nx in 4/2017 who returns for f/u of CKD. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to - 1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but recovered back to baseline. RCC was diagnosed incidentally during workup for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Does not check home BP. Was admitted 10/2018 for fluid overload, now on Lasix, Aldactone, Amiloride. Cr increased to 2.2-2.5 after hospital admission and has remained elevated. BP: 148/80. Wt: 250 lbs. Exam: Lab studies were reviewed. Assessment and Plan: 1) Chronic kidney disease 3 with microalbuminuria

			secondary to HTN and reduced renal mass after partial nephrectomy on 04/04/17 for RCC: Cr was elevated after hospital admission in 10/2018 for fluid overload. Now remains around 2, which is stable this month. Proteinuria stable. Continue Lasix 40 mg BID. Counseled on low salt diet. 2) Hypertension with possible hyperaldosteronism: BP high in clinic. Has h/o of med noncompliance. Instructed to start Metoprolol 25 mg daily (prescribed in 12/2018, has not picked up. Continue Amiloride, Aldactone, Lasix at same dose. 3) RCC s/p L partial nephrectomy 04/04/17: Stable. Follows with urology. 4) Anemia secondary to Chronic kidney disease. HGB 12.4 03/25/19 - stable, no need for EPO. 5) Secondary hyperparathyroidism. Resume Vitamin D2 every week. TAV in 4 months.
04/29/19	1103-1107	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare and medication questions. Phone Visit Documentation: Patient is calling today for f/u on chronic issues. Just added metop. Having issues with ED as well. Taking 40 mg sildenafil without effect. Assessment: Organic erectile dysfunction. Plan: Recommended increasing sildenafil to 60-100 mg per encounter, if still not effective let me know. Blood pressure likely effecting the erectile abilities. Advised patient to call back if symptoms do not improve.
05/08/19	1108-1116	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** CC: Patient presents with HTN, URI symptoms. HPI: Patient is here for upper respiratory infection symptoms. He was taking metop for a few days but it made him feel poorly. So he is off it. He has cough and congestion and is spitting up mucus. As usual his BP is not well controlled, he is taking two Lasix pills daily but is not sure whether he is taking one or two Amiloride daily. BP: 148/92. Wt: 249 lbs. ROS: Positive cough, congestion, runny nose. Exam: ENT: Nose is congested. Lab studies were reviewed. Assessment and Plan: 1) URI (upper respiratory infection). Note: Patient cannot take pseudoephedrine because of his BP issues, I have recommended a few symptomatic remedies for his cough and congestion. Plan: Guaifenesin 600 mg, Benzonatate 100 mg. 2) CHF. Note: Patient has an h/o heart failure with volume overload issues though he currently seems euvolemic. Will continue current Lasix dosing but try a little better with the other medications to alleviate his BP. He did not tolerate the beta-blocker and has stopped it. Plan: Furosemide 40 mg. 3) HTN. Note: Increase amiloride two pills daily with consistency. Plan: Furosemide 40 mg, Amiloride 5 mg. 4) CKD stage 3 (GFR 30-59). Note: This has been stable but

			needs checked every 3-4 months, continue Nephrology f/u as well. Plan: Furosemide 40 mg. 5) Left ventricular diastolic dysfunction. Note: Would probably benefit long-term from beta-blocker but did not tolerate the metoprolol, consider Carvedilol or Bisoprolol next. Plan: Furosemide 40 mg. 6) Erectile dysfunction. Note: Sildenafil has not been successful so he is ask for alternative agent which has been prescribed today. He is not to combine this with the sildenafil and use it only as needed. His BP heart failure issues likely contribute significantly to worsening erectile ability. Plan: Vardenafil 10 mg. Rx: Guaifenesin 600 mg, Benzonatate 100 mg, Ergocalciferol, Vitamin D2, Allopurinol 300 mg, Spironolactone 50 mg, Atorvastatin 40 mg, Sildenafil 20 mg, Aspirin 81 mg. F/u 2 months.
05/20/19	1117-1122	Kimmerling, Reuven Eli, M.D./Ong, Carla Lynn, RN-Kaiser Permanente	**Call Documentation** Kimmerling, Reuven Eli, M.D. at 05/20/19 10:14 AM. Patient informed he still has a severe Cough and thinks he may have pneumonia. Requests for prescription to be authorized to help current condition and a call back to further advise. Ong, Carla Lynn, R.N. at 05/21/19 9:01 AM. Spoke with patient, requesting for antibiotics. Patient states cough started again yesterday, requesting antibiotics, thinks he has pneumonia. Per chart review, patient was seen 05/08/19 for cough, patient states cough resolved and came back. Recommended to be evaluated if he thinks he needs antibiotics. Same day appointment booked. F/u 05/21/19.
05/21/19	1123-1134	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Office Visit** CC: Patient presents with cough, congestion. HPI: Patient is here because of repeat illness. He was having runny nose, mucus, cough. Took some medications, got better for a few days then he got worse again. Now all the symptoms are back, even worse than before. Positive sweats. BP: 154/104. Wt: 251 lbs. ROS: Positive severe cough, mild wheezing. Exam: ENT: Nose is congested. Lab studies were reviewed. Assessment and Plan: 1) Acute sinusitis. Note: Given double sickening and duration, will treat for acute sinusitis with antibiotics today, and refill his previous symptomatic medications. Plan: Doxycycline Monohydrate 100 mg. 2) Never smoked. 3) Obesity, BMI 32-32.9, adult. 4) URI. Note: As above. Plan: Guaifenesin 600 mg, Benzonatate 100 mg. F/u 2 weeks.
07/16/19	1187-1197	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Office Visit** CC: Patient presents with BP check, chest discomfort upper left. HPI: Patient is here for chest pain. It is upper left chest. It is not tender to palpation. But if he is washing his hair he feels it. Depending on the position of the arm it hurts more.

			Not new, has been there for a while but worrying him that it will be his heart. No shortness of breath. He needs his disability extended as he still has HF symptoms. He does not wear his CPAP and takes spironolactone only sporadically. BP: 139/96. Wt: 255 lbs. ROS: Chest pain. Exam: General: Obese. Lab studies were reviewed. Assessment and Plan: 1) Dilated aortic root. Note: Noted on previous echocardiogram, a future echocardiogram was ordered for him but has not yet been processed. I would like him to f/u with Cardiology given his chest issues, and if they do not order imaging then we can order it here. A CT with contrast is probably contraindicated due to his renal function. Long-term HTN obviously exacerbates this. 2) Never smoked. 3) Obesity, BMI 32-32.9, adult. 4) Essential HTN. Note: Not well controlled. Restart Spironolactone, f/u nurse BP 10 visit in 1-2 weeks. 5) Organic erectile dysfunction. Note: Mild improvement with sildenafil, recently refilled. Stable. 6) CKD stage 3 (GFR 30-59). Note: Chronic, check labs in one month and f/u with renal as scheduled. Renal Failure Risk: 5 Year. Estimate is invalid during acute kidney injury/recovery. Repeat creatinine/GFR if not at baseline. 7) Systolic heart failure, chronic. Note: Work note extended given his inability to exert himself for long periods, untreated obstructive sleep apnea, he would be unsafe to drive at this time. 8) Chest wall pain. Note: Seems like upper pectoral muscle, no overlying the chest cavity on my exam. The pain seems to be located just proximal to the axilla and anterior. F/u with cardiology.
08/02/19	1198-1202	Huynh, Trung Vo, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare. Phone Visit Documentation: Patient with an h/o B-thalassemia. Hyperlipidemia. Hypertension. RCC s/p left partial Nx in 4/2017 who has TAV for f/u of CKD. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to 1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but improved. Baseline Cr now around 2. RCC was diagnosed incidentally during workup for hypokalemia/HTN. Pathology showed papillary type. Post-op was complicated by seroma, resolved. Regarding HTN, has been difficult to control, probably due to non-adherence with meds. Does not check home BP. Exam: Lab studies were reviewed. Assessment and Plan: 1) CKD stage 3 (GFR 30-59). 2) Essential HTN. 3) Hx of kidney cancer. 4) Hx of partial nephrectomy. Cr fluctuates around 2. Subnephrotic range proteinuria. Stable. BP not well controlled. Not complaint with meds. Not able to lose weight. Plan: Lab studies. Continue same medications. Keep

			same dose of diuretics for now. Repeat labs in 1 month. If creatinine worse, might need to reduced Lasix dose. Encouraged weight loss. Encouraged compliance with meds. RTC in 3 months.
09/06/19	1264-1272	Kaiser Permanente	**Allied Health/Nurse Visit** HPI: Patient walked in for BP Check. BP: 175/101. Wt: 252 lbs. PMH: Essential HTN. Irritable colon. Iron deficiency anemia. Posttraumatic stress disorder after MVA in truck. Obesity, BMI 30-34.9, adult. Hx of duodenal ulcer. EGD. CKD stage 3 (GFR 30-59). Hyperlipidemia. Hx of kidney cancer. Hx of partial nephrectomy. Rx: Carvedilol 3.125 mg, Furosemide 40 mg, Amiloride 5 mg, Allopurinol 300 mg, Spironolactone 50 mg, Atorvastatin 40 mg, 81 Aspirin mg. Recommendation/Outcome: Patient would rather discuss his BP reading with Dr Kimmerling, Reuven Eli (M.D.) during TAV today and schedule f/u appointment face to face to discuss disability status. DASH diet. Exercise. Keep scheduled BP f/u/or appointment with provider/s. F/u 09/20/19.
09/06/19	1274-1281	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare and referral. Phone Visit Documentation: Patient is calling because of ongoing chest symptoms. He is still out of breath with exertion most of the time. He admits he has missed a lot of his medications lately. Takes spironolactone and amiloride every day but inconsistent with the rest. He states water pill makes him drowsy. Assessment: Combined systolic and diastolic heart failure, acute on chronic. Essential HTN. Plan: Patient's dyspnea symptoms are not well controlled, likely because of his chronic heart failure in combination with poorly controlled BP. I urged him to actually take his BP pills which is always been a challenge for him. I will also have him f/u with cards. Advised patient to call back if symptoms do not improve.
09/17/19	1285-1286	Farvid, All Reza, M.D./Marquez, Margarita/Baes, Laura, LVN-Kaiser Permanente	**Call Documentation** Spoke with patient, was unable to make previous accommodated appointment on 09/16/19. Requesting to be accommodated sooner than next available on 11/4. Patient has congestive heart failure, needs to be checked. Sometimes has SOB, tiredness, fatigue. Denied any symptoms at time of call. Stated he “Just needs an appointment” I asked for patient to confirm call back contact number stated “it's the one you are looking at”. Aware of MD schedule. F/u 09/20/19.
09/20/19	1287-1303	Farvid, Ali Reza, M.D.-Kaiser	**Office Visit** Reason for Consultation: Diastolic HF and dyspnea on

		Permanente	exertion. Patient c/o shortness of breath and decreased exercise tolerance. HPI: Patient with past medical h/o HTN, CKD, and h/o fluid retention from diastolic HF being referred for dyspnea on exertion. 09/20/19, F/u visit; no acute events; no cp/sob; random CP in chest but does get more dyspnea on exertion. Patient didn't f/u with catheterization last year. BP: 149/104. Wt: 244 lbs. Allergies: Lisinopril. Thiazides. Prior Surgeries: Nephrectomy, partial, robot assisted Laparoscopy left. Blepharoplasty bilateral upper. Reconstruction of eyelid bilateral. Hemorrhoidectomy. Exam: CTA bilateral. Abdomen exam deferred. Echocardiogram 3/2018 was reviewed. Assessment: Patient with past medical h/o HTN, CKD, and h/o fluid retention from diastolic HF being referred for dyspnea on exertion. No prior known coronary artery disease. Dyspnea on exertion. Given RF and EF in 45% range, recommending patient having diagnostic angiogram to eval for obstructive CA. On ASA, BB, statins. Patient didn't go to catheterization last year, will refer again given lower EF and more symptoms. Patient aware of the increased risk of HO and ARF on CKD but given more symptoms will refer to catheterization. Echocardiogram -direct book. Hypertension. Usually controlled. Didn't take meds this morning. Stressed compliance. Return to clinic after catheterization.
09/20/19	1304-1314	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Office Visit** CC: Patient presents with state disability discuss disability. HPI: Patient is here today for f/u on chronic issues. Has poorly controlled HTN and severe CKD, h/o partial nephrectomy. He is feeling a bit less short of breath when he walked to his car. However he still gets chronic fatigue, and difficulty with exerting himself over long distances because of heart failure secondary to HTN. BP: 143/90. Wt: 244 lbs. ROS: Positive dyspnea on exertion. Assessment and Plan: 1) Essential HTN. Note: This continues to be poorly controlled because he does not take all the medications as he should. He does not bring in his bottles and so it is not possible to reconcile what he is actually taking, but he is very soupy with his medication adherence. 2) Obesity, BMI 31-31.9, adult. 3) Vaccination for influenza. Note: Declined. 4) CKD stage 3 (GFR 30-59). Note: Borderline stage IV due to hypertensive and postsurgical changes, he is at risk if he gets too much contrast which is why it will try to proceed with cardiac catheterization without left ventriculogram. 5) CHF. Note: He still has short-term disability needs and may need permanent disability because of his heart failure and hypertensive issues. Will send the social worker. Plan:

			Referral social service. 6) Systolic heart failure, acute on chronic. Note: Continue to f/u with cardiology for catheterization to determine if any ischemic disease. Labs this week. Rx: Carvedilol 3.125 mg, Ergocalciferol Vitamin D2 50000 unit, Sildenafil 20 mg, Furosemide 40 mg, Amiloride 5 mg, Allopurinol 300 mg, Spironolactone 50 mg, Atorvastatin 40 mg, Aspirin 81 mg. F/u 2 weeks.
09/20/19	1315-1321	De Loon, Leizel F., MSW-Kaiser Permanente	**Medical Social Work Adult Initial Assessment** SUMMARY: Patient presents today in conjunction with PCP's visit. Case discussed with PCP who referred to this MSW for reason below. MSW met with patient briefly. Patient is inquiring about long-term disability. Patient states that his supplemental short-term disability through his employer will be terminating in November 2019. Reports he is also a MFAP recipient, benefits authorized 07/12/19 - 12/19/19. Patient reports he receives SS retirement income, amount undisclosed. Patient is inquiring about SSDI. MSW explains to patient that he is already receiving SS retirement income, would not be eligible for SSDI. Patient states that he was informed about this in the past, but wanted confirmation. Patient is appreciative of information provided. Reports no other questions or concerns, no other SW assistance needed. Impression: Judgment: Unimpaired.
10/28/19	1329-1342	Huynh, Trung Vo., M.D.-Kaiser Permanente	**Office Visit** HPI: Patient with an h/o hyperlipidemia. Hypertension. RCC s/p left partial Nx in 4/2017 who returns for f/u of CKD. Baseline Cr 1.3-1.5 since 2006, worsening in 2016 to - 1.7, peaked at 2.5 after left partial nephrectomy on 04/04/17 but partially recovered. Was admitted 10/2018 for fluid overload, now on Lasix, Aldactone, Amiloride. Cr increased to 2.2-2.5 after hospital admission and has remained elevated. Cr increased to 3.3 this month 10/2019. No leg swelling. Was having DOE, now feels better (attributes to taking apple cider vinegar). Does not check home BP. Clinic BP always elevated. Was prescribed Coreg by cardiologist but has not started. Was also recommended cardiac cath but patient declined due to risk of contrast. BP: 156/89. Wt: 247 lbs. Assessment and Plan: 1) Chronic kidney disease 3-4 with microalbuminuria secondary to HTN and reduced renal mass after partial nephrectomy on 04/04/17 for RCC: Cr this month 3.3, above baseline of 2.2-2.5. Patient has no leg swelling. Lungs clear on exam. Currently on Lasix, Aldactone, Amiloride. Suspect rise in creatinine due to Over diuresis. Instructed to decrease Lasix to 20 mg daily. Gently increase fluid intake. Repeat labs in 2 weeks. Counseled on med compliance. 2) Hypertension with possible

			hyperaldosteronism: Not controlled. Decrease Lasix as above. Instructed to start Coreg as prescribed by cardiologist. Continue other meds at same dose. Counseled on med compliance. Counseled on home BP checks. 3) RCC s/p left partial nephrectomy 04/04/17: Follows with urology. 4) Anemia secondary to Chronic kidney disease. Stable, no need for EPO. 5) Secondary hyperparathyroidism. Continue Vitamin D2 every week. RTC in 3 months.
10/30/19	1349, 3441-3449	Jakosalem, Josle Rose Anto Manso, RN-Kaiser Permanente	**Progress Notes** Patient walked in for BP check. BP: 134/79. Wt: 247 lbs. Assessment: Asymptomatic. Recommendation/Outcome: Encouraged to continue taking prescribed medication. DASH diet. Exercise. Patient verbalized understanding.
11/08/19	1375-1386, 1397-1399	Skiles, Kalyn, DO-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Bridge clinic hospital f/u. Hospital Course: Patient admitted for hyperkalemia and melena. The etiology of his severe hyperkalemia was unclear, but his spironolactone and amiloride were stopped. He was treated medically with Kayexalate, bicarbonate, insulin, albuterol nebs, Lasix with eventual normalization of his hyperkalemia and EKG changes. As a result of being given increased dosages of Lasix, however, patient's renal function worsened. Per nephrology input, patient was placed on gentle hydration. On the day of discharge, patient's creatinine, though improved, was not at baseline, but patient was insistent on leaving (he had wanted to leave AMA 2 days earlier, but was convinced to stay at that time). Risks/benefits were discussed with patient and he opted to get discharged and have f/u labs drawn to monitor his renal function. He was instructed on avoiding high-potassium containing foods, as diet may have contributed to his presentation (he had been drinking orange juice and excess apple cider vinegar prior to admission). Once his hyperkalemia was corrected, patient was seen by GI and underwent an EGD. The exam demonstrated gastritis and 2 clean based ulcers that were not bleeding. His hemoglobin was monitored over the next several days, and though there was a gradual decline, patient had no further melena. He was counseled on stopping the apple cider vinegar, aspirin, and other NSAID use to avoid recurrent of ulcers. Subjective: Patient states he feels well. Denies any symptoms including chest pain, shortness of breath, abdomen pain, or melena. Tolerate PO. Assessment and Plan: Aftercare following hospitalization. Recheck cbc, Also do labs ordered by nephrology, including lytes and cr 11/04/19 H pylori positive. Patient with h/o nonsustained V tach so clarithromycin contraindicated. Bismuth salicylate

			contraindicated given renal function. Levaquin also has warning for potential torsades denies pointes for h/o v tach. I called and spoke to ID consult Dr. Jared Goodman who said he would recommend patient to be treated given EGD finding showing gastritis and ulcers. He recommends Levaquin even with the potential for pointes/h/o v tach as the benefits out weight the risks. He advised to have patient start Levaquin 500 mg 1 tab daily x 10 days and Amoxicillin 500 mg 2 caps twice a day x 10 days. Patient already on Omeprazole 20 mg 1 tab twice a day x 6 weeks. ID Dr. Goodman also recommends that patient get EKG midway through the H pylori regimen and emergency room precautions. I called patient back and informed him of Infectious disease Dr. Goodman's recommendations. Risks/benefits discussed with patient and he wants to take the H pylori regimen recommended by Dr. Goodman, including Levaquin. Patient wants medicine ordered to be picked up at CVS so will have LVN call in order to CVS Take Levaquin, Amoxicillin, and Omeprazole as directed. Advised lifestyle changes, including avoid Aspirin/NSAIDS. Will have LVN schedule nurse visit for EKG midway through H pylori regimen. Will have LVN schedule appointment with nephrology. Follow up with primary care physician as needed. Emergency room precautions advised.
11/11/19	1400-1406	Kimmerling, Reuven Eli, M.D./Mendoza, Gabrlela C., MA-Kaiser Permanente	**Call Documentation** Domingo, Ryan Inguito at 11/11/19 11:51 AM. Spironolactone 50 mg. Kimmerling, Reuven Eli, M.D. at 11/11/19 3:25 PM. This medication was recently stopped due to high potassium at the last hospitalization. We will hold off on refilling it for now. Rudy Kimmerling, M.D.
11/26/19	1407-1425	McAuley, Josette, RN/Mayfield, Miriam, LVN-Kaiser Permanente	**Allied Health/Nurse Visit** Patient having symptoms of headaches mid shortness of breath. SOB with cough, edema, and headache. BP: 188/122. Wt: 252 lbs. Assessment: Patient came in for BP and c/o SOB with accessory muscle use for 2 days, cough, BLE, edema, patient unable to lay flat when sleeping. Recommendation: Consulted with Linda Corgan NP covering DOD today, patient appointed to mentor slot to be seen by provider today.
11/26/19	1426-1438	Corgan, Linda Carol, PA-Kaiser Permanente	**Office Visit** CC: Patient presents with shortness of breath, cough, BLE edema. HPI: Patient is here 11/26/19 for a BP check with the RN. Blood pressure taken, informed patient that BP is elevated. Repeated BP after few minutes, with reading of 188/122 P 103. Patient is symptomatic. He was noted to be short of breath and a same-day visit was initiated. Discussion

			Today: Patient was admitted on 11/01/19 for hyperkalemia and melena. The etiology of his severe hyperkalemia was unclear, but his spironolactone and amiloride were stopped. He was treated medically with Kayexalate, bicarbonate, insulin, albuterol nebs, Lasix with eventual normalization of his hyperkalemia and EKG changes. As a result of being given increased dosages of Lasix, however, patient's renal function worsened. Per nephrology input, patient was placed on gentle hydration. On the day of discharge, patient's creatinine, though improved, was not at baseline, but patient was insistent on leaving. Patient had an electrolyte panel, creatinine, BUN, and a CBC drawn today at 9:35 a.m. Subsequent EGD found 2 ulcers. Patient reports he took Lasix this morning. He has been experiencing increased swelling in his ankles and abdomen over the last couple of days with shortness of breath he is not sleeping well at night and cannot lay flat. BP: 173/116. Wt: 258 lbs. Exam: General: Patient is shortness of breath. Respiratory: Shortness of breath. Extremity: 3+ edema bilaterally. Assessment: CHF. Essential HTN. Obesity, BMI 33-33.9, adult. Plan: Patient was seen and evaluated with Dr Joyce Chou. Patient was advised to go to the ER at Downey and he was agreeable to go directly from here.
11/26/19	2084-2087	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** BUN, RDW, blood, Platelets, automated count, Creatinine, Anion GAP (NA-(CL+ CO2)), Immature Granulocytes, automated count: High. RBC, auto, HGB, HCT, auto, MCH, MCHC, Glomerular Filtration Rate: Low.
12/03/19	1442-1452	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Office Visit** CC: Patient presents with hospital f/u. HPI: Patient was recently in the hospital for congestive heart failure exacerbation due to BP out of control and fluid overload. After he had diuresis he felt much improved. He has recently had to stop taking many of his BP medications because of hyperkalemia and progressive renal dysfunction. Right now he feels like his BP is high but he also has not taken the hydralazine as he did not pick it up after discharge. He states he is going to pick up the new medications today. BP: 155/95. Wt: 251 lbs. ROS: Positive leg swelling, ankle pain. Exam: General: Obese. BLE with trace to mild edema, right greater than left. Assessment and Plan: 1) Essential HTN. Note: Not well controlled. Follow up nurse BP 10 visit in 1-2 weeks. Add amiloride back if still low potassium and HTN. Alternative is to increase hydralazine until BP is controlled. 2) Vaccination for influenza. Note: Declined for today. 3) Obesity, BMI 32-32.9, adult. 4) Hyperlipidemia. Note:

			Restart Statin. Plan: Atorvastatin 40 mg. 5) Aftercare following hospitalization. Note: Overall doing ok but medication adherence always an issue, continue to track closely, I encouraged him to f/u with Cardiology as soon as possible, he has not managed to do this as yet. 6) CKD stage 3 (GFR 30-59). 7) Left ventricular diastolic dysfunction. Note: Patient has some chronic heart failure issues which are exacerbated by poorly controlled HTN and hyperkalemia. Lasix will be continued and we will use hydralazine as well, but he tends to recollect fluid very easily due to poor adherence to medication. 8) Gout. Note: Patient states his ankle sometimes hurt but I think this is from edema, his last uric acid levels were okay. We will continue the allopurinol though he need to be careful with decreasing renal function. At this point I think it is safe to contain. F/u 1 week.
12/03/19	1453-1454	Aragon, Jesadhel Alaba, LVN-Kaiser Permanente	**Call Documentation** I spoke with member and confirmed that he is coming in for the post hospital f/u appointment. Instructed to bring current medications or list of medications, and to bring meter if diabetic. Readmission Risk Score 8.
12/10/19	1459-1465	De Leon, Leizel F., MSW-Kaiser Permanente	**Telephone Appointment Visit** Outreach call made to patient. Patient answers call. MSW introduces self, returning call from patient message received. Patient is inquiring about Medical/IHSS benefits and criteria. Benefits and criteria educated - income and asset limits. Patient reports he is single, states he receives SS and pension -$3000, has <$2000 in assets. MSW educates about Medi-cal/IHSS share of cost, would not meet criteria for full scope Medical/IHSS. Patient verifies understanding. All questions answered. Patient reports no other issues or concerns, no other SW assistance needed at this time. Will remain available and f/u as needed.
12/11/19	1466-1475, 1481-1484	Skiles, Kalyn, DO-Kaiser Permanente	**Telephone Appointment Visit** I received message from nursing staff today stating that "patient requested to speak to you, states he has a couple questions. Patient refused to specify states it is personal. Did not wish to schedule an appointment to come in."I called and spoke to patient. Patient states he was recently hospitalized for bilateral leg swelling, which improved with Lasix but they are still quite swollen. No chest pain, shortness of breath, leg redness any other symptoms associated. Patient is taking Lasix 40 mg 1 tab daily. Patient states he saw his primary care physician 12/03/19 for hospital f/u but it was not discussed much. Per chart, patient was admitted 11/26/19-11/27/19 for congestive heart failure exacerbation, treated with IV Lasix and discharged with increase dose of

			PO Lasix 40 mg 1 tab daily. 11/27/19 TTE showed EF EF 30-35%. Patient was referred to cardiology and has f/u appointment with cardiology scheduled for 12/23/19. I advised patient to increase Lasix 40 mg 1 tab twice a day x 3 days, and if swelling is better to resume Lasix 40 mg 1 tab daily. Otherwise continue Lasix 40 mg 1 tab twice a day unless otherwise directed by congestive heart failure clinic or cardiologist While on the higher dose of Lasix take KTAB 10 MEQ 2 tabs PO daily. Re-check lytes, CR in 1 week. Patient states he has KTAB at home from when he used to take KTAB and he does not need refill at this time. He also has enough Lasix at home. Low salt diet. 1.5 L fluid restriction. I told patient I will send message to congestive heart failure clinic NP to help f/u with him. I advised patient to f/u cardiology 12/23/19 as scheduled. I advised patient to f/u with his primary care physician or any available provider sooner if needed. Any emergent symptoms go to emergency room.
12/11/19	1476-1480	Skiles, Kalyn, DO/Heredia, Patricia B., LVN-Kaiser Permanente	**Call Documentation** Skiles, Kalyn at 12/11/19 8:27 AM. Reason for request patient states he has some questions he'd like to ask the doctor. Heredia, Patricia B., L.V.N. at 12/11/19 9:08 AM. Situation: Patient requested to speak to you , states he has a couple questions. Patient refused to specify states it is personal. Did not wish to schedule an appointment to come in. Call back from Dr Skyles.
12/12/19	1485-1486	Skiles, Kalyn, DO-Kaiser Permanente	**Call Documentation** This is a patient of Dr. Farvid who was recently hospitalized for congestive heart failure exacerbation and discharged with higher dose of Lasix at 40 mg 1 tab daily. Patient states bilateral leg swelling, which improved with Lasix but they are still quite swollen, no other symptoms associated. 11/27/19 TTE showed EF EF 30-35%. I advised patient to increase Lasix 40 mg 1 tab twice a day x 3 days, and if swelling is better to resume Lasix 40 mg 1 tab daily. Otherwise continue Lasix 40 mg 1 tab twice a day unless otherwise directed by congestive heart failure clinic or cardiologist While on the higher dose of Lasix take Ktab 10 MEQ 2 tabs PO daily (patient was not discharged with any Ktab but has some from previous prescription 11/27/19 K=3.0). Patient's appointment with Dr. Farvid is not until 12/23/19. Can you please help me have the congestive heart failure clinic staff contact patient to f/u on him. Please see me telephone encounter from yesterday for details. I sent message to NP Celina Marchena yesterday to help f/u with patient but I have not heard back from her so I am sending

			you this message as well in case she's out of office. Thank you for his help.
12/16/19	2088	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Anion GAP(NA-(CL+CO2)), Creatinine: High. Potassium, Glomerular Filtration Rate: Low.
12/17/19	1505-1506	Skiles, Kalyn, DO-Kaiser Permanente	**Call Documentation** Please inform patient potassium lab is low. Please let me know if patient has been taking Ktab 10 MEQ 2 tabs daily with Lasix 40 mg 1 tab twice a day since I spoke to him on 12/11/19 so I can tell him what to do regarding his low potassium.
12/26/19	1515-1523	Kaiser Permanente	**After Visit Summary** CC: Hypertension, uncontrolled. Combined cystous and diastolic heart failure, acute. Patient reported, restarted, and new medications relevant to this visit. Hydralazine 25 mg. Recommendation: Lab studies. F/u 7 days.
01/06/20	2089	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** B Type Natriuretic Peptide: High.
01/14/20	1554-1563	Huynh, Trung Vo., M.D.-Kaiser Permanente	**Office Visit** HPI: In today's visit, reports worsening shortness of breath and leg swelling for 10 days. Gained 20 lbs since hospital discharge. On Lasix 40 mg BID. BP: 154/87. Wt: 260 lbs. ROS: Constitutional: Positive for malaise/fatigue. Cardiovascular: Positive for leg swelling. Exam: Musculoskeletal: He exhibits edema. 3-4+ bilat leg edema. Assessment and Plan: 1) Chronic kidney disease 3-4: Secondary to cardiorenal syndrome and reduced renal mass after partial nephrectomy on 04/04/17 for RCC: Cr fluctuates. Most recent creatinine okay. However, patient appears very fluid overloaded on today's exam, despite Lasix 40 mg BID. Instructed to go back to ED for IV diuresis. Discussed in clinic about preparation for RRT, as I think he is very high risk. Patient refused to prepare. Will follow peripherally while patient is admitted. Might consider changing diuretic to Bumex upon discharge. 2) Hypertension: Clinic BP high today. Patient is fluid overloaded - advised to go to ED for IV diuresis. 3) RCC s/p left partial nephrectomy 04/04/17: Follows with urology. 4) Anemia secondary to Chronic kidney disease. 5) Secondary hyperparathyroidism. Continue Vitamin D2 every week.
01/22/20	1586-1596	Marchena, Celina J., NP-Kaiser Permanente	**Telephone Appointment Visit** TAV for heart failure management and post hospital f/u. Patient of Dr Farvid. Patient reporting he doesn't “feel good”. Still has same exertional SOB and slight edema on legs.

			Currently taking Lasix 80 mg AM and 40 mg PM, no increase in urination. Exam: Echo 03/2018, Echocardiogram 3/2018 was reviewed. Lab studies were reviewed. Assessment and Plan: 1) Heart failure, with EF 30-35%. Do labs tomorrow. Might need diuretic adjustment if still hypervolemic. Schedule CHF clinic f/u soon for further management. Strict ED precautions for worsening symptoms. Continue 1.5 gm salt restriction and 1.5 L/day fluid restriction. Recommend physical activity as tolerated. HF TCP will continue to monitoring patient's HF status. Instructions given to call Heart Care Clinic PRN for SOB, leg swelling, rapid weight gain. Patient has HF clinic. 2) HTN. At goal, continue moth. 3) Hyperlipidemia. Continue Statin. Follow low cholesterol diet and f/u with PCP for further management. Needs current lipid panel. 4) Anemia.
01/23/20	1597-1607	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Office Visit** CC: Patient presents with hospital f/u, ongoing SOB. HPI: When patient was recently hospitalized he feels he was doing well, euvolemic, was diuresing enough. At home he feels he is not having effective diuresis with the by mouth furosemide (Lasix). He has been missing the afternoon dosing of furosemide (Lasix) sometimes. BP: 131/84. Wt: 241 lbs. ROS: Positive edema, decreased urination. Exam: General: Obese. Pitting edema present up to mid shin. Assessment and Plan: 1) Aftercare following hospitalization. Note: Patient has had recurrent hospitalizations for heart failure exacerbation. Intravenous Lasix has been affective but poor adherence at home causes rapid fluid accumulation. He is once again put on a lot of weight likely due to fluid. He admits to taking his Lasix only once a day, rarely twice. He may need an increase morning dose for he may need the addition of metolazone. If we are unable to get some fluid off rapidly he may end up back in the hospital. I will forward the chart to the cardiologist's as well. 2) Never smoked. 3) Obesity, BMI 36-36.9, adult. 4) Essential HTN. Note: Ok control today, still a bit high, continue current medication. Missed some doses recently. 5) Systolic heart failure, chronic. Note: With recent acute exacerbation, needs more diuresis. 6) Hypervolemia. Note: As above, recollecting fluid will f/u with cards tomorrow. F/u tomorrow with cards.
01/23/20	2090-2093	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Creatinine, BUN, B type Natriuretic Peptide: High. Glomerular Filtration Rate: Low.
01/24/20	1611-1619, 3455-	Marchena, Celina J., NP-Kaiser Permanente	**Office Visit** HPI: Office visit for heart failure management and post hospital f/u. Patient of Dr Farvid. Patient in clinic for f/u.

	3464		Patient reporting only mild improvement with fluid overload symptoms since hospital discharge. Patient has orthopnea still. Patient had exertional SOB walking today. LE edema is still about the same, also has abdominal distention. Reports that he doesn't have more urination with current Lasix dose. BP: 133/85. Wt: 251 lbs. ROS: Cardiovascular: Positive for orthopnea and leg swelling. Respiratory: Positive for shortness of breath. Exam: Echo 03/2018, Echocardiogram 3/2018, Echo 11/27/19 was reviewed. Lab studies were reviewed. Abdominal: He exhibits distension. Musculoskeletal: (+ 2 pitting edema BLE up to thighs). Assessment and Plan: 1) Heart failure, with EF 30-35%. Possibly Hypertensive Heart disease - had previous referral for LHC as recommended by Dr Farvid, patient cancelled. But now has worsening cream. Schedule f/u with Dr Farvid. Hypervolemic on exam. Stop Lasix and switch to Bumex 2 mg BID. Added Metolazone 1.25 mg x 2 days. Take additional K tab x 2 days. Labs in 3 days to monitor renal function. Continue all BP/cardiac meds as above. Strict ED precautions. Continue 1.5 gm salt restriction and 1.5 L/day fluid restriction. Recommend physical activity as tolerated. HF TCP will continue to monitoring patient's HF status. Instructions given to call Heart Care Clinic PRN for SOB, leg swelling, rapid weight gain. Patient has HF clinic. 2) HTN. 3) Hyperlipidemia. Continue statin. Follow low cholesterol diet and f/u with PCP for further management.
01/29/20	2094-2097	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Creatinine, BUN, Anion GAP(NA-(CL+CO2)), B type Natriuretic Peptide: High. Glomerular Filtration Rate, Potassium, Chloride: Low.
02/19/20	2100-2102	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** B type Natriuretic Peptide, Creatinine, BUN: High. Potassium, Glomerular Filtration Rate: Low.
03/27/20	1730-1743	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telephone appointment visit and throat problems. Phone Visit Documentation: Patient is calling because of sore throat. He wants to get antibiotics. He has a film on the back of his throat that he keeps spitting. It is bothersome. No fevers. Not using over the counter medications. He also continues to have erectile dysfunction issues, and would like to use a different medication for this. He had been taking sildenafil concurrently with isosorbide mononitrate. Assessment: Erectile dysfunction. Never smoked. Pharyngitis. Plan: Tadalafil 20 mg, Cetirizine 10 mg, Benzocaine-Menthol 15-3.6 mg. It sounds like patient has a viral pharyngitis, I would not recommend antibiotics.

			Rather recommended a decongestant and some medicine for the pain. Cannot take non-steroidal because of his renal function. I switched him to Cialis but warned him that he cannot take this Cialis the isosorbide in the same day. He states that he will stop Isosorbide for a few days if he is going to try the Cialis.
04/10/20	1755-1762	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare and sore throat. Phone Visit Documentation: Patient is calling because of slightly sore throat. No fever, no mucus. He just wants to have some Amoxicillin on hand in case of a sore throat. The other day he had fever, sore throat and redness in the throat. Assessment: Erectile dysfunction. Pharyngitis. Plan: Amoxicillin 250 mg. I explained that it was unlikely bacterial. Given COVID crisis will provide future antibiotics to keep on hand so he can avoid pharmacy visits should true strep throat occur.
04/24/20	1776-1787	Nguyen, Hoaithi T., Pharm.D-Kaiser Permanente	**Heart Failure Care Management Program** HPI: Spoke with patient, reports he is doing okay but did gain weight. Weight now is at 245 lbs, breathing is normal, no orthopnea/PND. However, reporting bilateral ankle edema now. No edema when we last spoke. Not checking his BPs but reports he is fine on bisoprolol. No dizziness/LH. BP: 142/80. Dietary issues identified: Was eating dill pickles and drinking more than 48 oz a day- discussed with patient importance of fluid restriction and to minimize salt intake. Fluid intake: Discussed with patient fluid restriction - no more than 48 oz a day. Support system at home: Self. Medications managed by: Self. Assessment/Plan: Fluid status: Hypervolemic per weight/swelling. Last labs: BNP high (DAP done), 5cr elevated but stable, and K+ still low. No new BPs, started on bisoprolol and tolerating meds well. Overdue for labs – aware. Increase Bumex 2 mg to: 2 tablets in AM and 1 in PRN x 3 days then back to 1 tablet BID. Increase KCl 10 mEq to: 3 tablets BID x 3 days then back to 3 tablets in AM and 2 in PM. Call CHF clinic if weight continues to increase or if swelling gets worse. Patient is aware to continue with daily BP/HR check, to call CHF clinic if SBP <90; HR les than 60 or if patient is experiencing dizziness/lightheadedness or syncope. Stress importance of fluid restrictions and low salt diet. Reviewed all basics of HF education - dx state, importance of medications, low salt diet (1.5 gm/day) and fluid limits (1.5 L/day). Instructed patient to record daily weights, BP/HR, monitor for sign/symptoms of CHF, and limit salt and fluid intake. Reviewed signs/symptoms of worsening HF (SOB, weight gain,

			swelling, fatigue, etc.). Advised patient to call HF clinic if experiences worsening HF symptoms. Reviewed DAP with patient. Patient verbalized understanding. Advised patient to continue current medications for now. Will potentially titrate acei and/ar BB, if tolerate by patient. Advised patient to continue current medications for now. Will potentially titrate acei and/ar BB, if tolerate by patient. Will continue to monitor patient clinic # given.
04/27/20	1788-1796	Kimmerling, Reuven Eli., M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare and sore throat. Phone Visit Documentation: Patient is calling for ongoing sore throat or tickle in his throat. We last discussed it 3 weeks ago. Never took antibiotics he had asked for. He also asks about a BiV pacer for his CHF as it may help with his symptoms. Has declined a cath previously because of concerns for contrast induced ESRD. Assessment: Pharyngitis. Systolic heart failure, chronic. Plan: Recommended over the counter loratadine (Claritin) for the sore throat symptoms. Patient instructions on BiV placed. Will notify cardiologist he would benefit from phone f/u.
04/27/20	2103-2104	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Creatinine, BUN: High. Potassium, Glomerular Filtration Rate: Low.
05/11/20	1813-1825	Farvid, Ali Reza, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare. Assessment/Plan: 1) Heart failure, with EF 30-35%. Possibly Hypertensive Heart disease. Had previous referral for LHC as recommended by Dr Farvid, patient cancelled. But now has worsening cream. Schedule f/u with Dr Farvid. Hypervolemic on exam. Stop Lasix and switch to Bumex 2 mg BID. Added Metolazone 1.25 mg x 2 days. Take additional K tab x 2 days. Labs in 3 days to monitor renal function. Continue all BP/cardiac meds as above. Strict ED precautions. Continue 1.5 gm salt restriction and 1.5 L/day fluid restriction. Recommend physical activity as tolerated. HF TCP will continue to monitoring pts HF status. Instructions given to call Heart Care Clinic PRN for SOB, leg swelling, rapid weight gain. Patient has HF clinic #. Plan: Echocardiogram direct book. Increase Bisoprolol to 5 mg BID. Vitals log. Gave beta blocker use warnings/precautions. TAV next 1-2 weeks to review vitals and questions.
05/13/20	1828-1838, 1862-1866	Corgan, Linda Carol, PA-Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Telecare; ear problem; and prescription refill requested. Phone Visit Documentation: Right ear feels clogged after cleaning with Q Tip. No pain. Patient is requesting ear lavage. Patient is requesting his testosterone

			level be checked. He is complain of ED. Medication refill: Patient requesting refill of Hydralazine. Assessment and Plan: 1) HTN, uncontrolled. Hydralazine 25 mg. 2) Erectile dysfunction. Testosterone, Hydralazine 25 mg. Right cerumen impaction. Patient was advised not to use 0 tips in his ears. Advised patient that ear cleaning kits are available over the counter, he prefers to have his ear washed out in the clinic and will be scheduled for a nurse visit. If symptoms persist worsen, patient will contact us or make an appointment to be seen. This was a telephone appointment-patient was not examined. Discussed with patient regarding limits of telephone appointment which is an assessment without examination. Patient understands and agrees with plan.
05/13/20	1839-1850	Lacson-Wood, Mariflo J., RN-Kaiser Permanente	**Allied Health/Nurse Visit** After ear wash: Patient able to tolerate procedure well without adverse effects. Unable to complete ear wash, advised member to continue soaking with Debrox ear drops and return. Patient unable to return this week for ear wash. Patient walked in for bilat ear wash. Debrox ear drops used: Yes applied to bilat ear canal at 1130. Patient aware to wait for at least 20 minutes for ear wash. F/u 05/18/20.
05/13/20	2105-2110	Kaiser Permanente/SCPMG Reg Lab	**Laboratory Rept** Creatinine, B Type Natriuretic Peptide: High. Potassium, Glomerular Filtration Rate: Low.
05/15/20	1867-1874	Larson-Wood, Mariflo J., R.N.-Kaiser Permanente	**Allied/Nurse Visit** Debrox ear drops used: Patient has been applying Debrox for more than 3 days at home. After ear wash: Patient able to tolerate procedure well without adverse effects. Unable to complete ear wash. Comments: Send referral to ENT for ear wax removal. Attempted in clinic x 2 and difficult removal. Plan: Referral to HNS.
05/19/20	1875-1878	Novak. Melissa Anne, L.V.N./Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Call Documentation** Novak. Melissa Anne (L.V.N.) at 05/19/20 12:13 PM: Patient had lab work done on 05/13/20 Testosterone, may I review results with patient? Kimmerling, Reuven Eli (M.D.) at 05/19/20 1:40 PM: Yes they were normal levels. Novak. Melissa Anne (L.V.N.) at 05/19/20 2:08 PM: Spoke to patient. Informed of the following: Notified patient Testosterone is within normal limits.
05/26/20	1879-1881, 1884-1892	Kuo, Frank, M.D.-Kaiser Permanente	**Office Visit** HPI: Patient is here for anterior left upper neck bump for more than one month. Exam: Left upper anterior adenopathy on exam. Assessment/Plan: 1) HTN. Give patient 2 gram of low sodium diet to follow, advice to loose weight, be compliant with BP meds, BP check with RN visit 2 weeks. 2)

			Left cervical adenopathy-will check CBC Today and Keep appt with ENT As Scheduled tomorrow. F/u care PRN.
05/26/20	1881-1882	Kaiser Permanente	**Laboratory Rept** RDW, blood: High. HGB, HCT, automated, MCV, MCH, MCHC: Low.
05/26/20	2111-2113	Kaiser Permanente	**Laboratory Rept** B type natriuretic peptide, Creatinine: High. Potassium, Glomerular filtration rate: Low.
05/27/20	1893-1899	Ahmed, Sameer, M.D.-Kaiser Permanente	**Telephone Appointment Visit** Due to COVID-19 pandemic and public health concern, patient consented to receive health care services via telehealth for this encounter.
05/27/20	3470-3483	Nguyen, Hoaithi T., Pharm.D.-Kaiser Permanente	**Heart Failure Care Management Program** Inclusion criteria for TCP/Heart Failure Management: EF: 30-35%. Hospital Admission: 11/26 to 11/27. Hospital Admission: 12/21 to 12/24-CHF. Recent readmission x2. Was admitted from 11/26 to 11/27/19 for CHF Lasix increased to 40 mg daily, dose increased to 40 mg BID by CHF clinic. Re-admitted from 12/22 to 12/24/19 for CHF, per note: Non compliance to fluid/salt - home on Lasix 80mg in Am and 40mg in PM, dose increased to 80 mg BID by CHF clinic. Readmitted 01/14/20 to 01/16/20. 05/07/20: S/w patient feels a little better but still with labored breathing. Reports breathing were labored the yesterday and today. Legs are still swollen and stomach still distended. Took Metolazone as directed but didn't take it 30 minutes prior to Bumex. Reports he is taking all his KCl as directed, didn't miss any doses the last week or so.
06/10/20	1901, 3499-3503	Ahmed, Sameer, M.D.-Kaiser Permanente	**Progress Notes** HPI: Feels clogged up. Exam: Ears: Dry, scaly skin at the external auditory meati bilaterally. Assessment: 1) Bilateral partial cerumen impaction. 2) Bilateral chronic eczematous otitis externa. Plan: Use triamcinolone topical cream 0.025% for the chronic eczematous otitis externa (which is causing your ears to itch). Apply a small amount to the bilateral external auditory meatus once a night for 3 months. Use your finger to apply the medicine (do not use a Q tip). After applying the medicine, clean your finger tips and do not touch your eyes. Stop using Q tips. Do not scratch or rub your ears. If you continue to scratch or rub your ears, you will experience recurrent ear infections. Return to see me in 1 year for a repeat examination.
06/18/20	1902, 4226	Chen, Donald Yen-Hung, M.D.-Kaiser Permanente	**Telephone Appointment Visit** CC: Patient presents with tele care and referral request. Allergies: NSAIDS, Non-Selective [Non-Steroidal Anti-

			Inflammatory Agents]. Lisinopril. Thiazides. Assessment/Plan: Health advice, education, or counseling. Note: No acupuncture other than chronic pain more than 3 months. Patient indicates understanding of these issues and agrees with the plan.
06/22/20	2115-2117	Kaiser Permanente	**Laboratory Rept** B type natriuretic peptide, Creatinine, Bun: High. Potassium, Glomerular filtration rate: Low.
07/06/20	1930-1933, 3560-3564	Kimmerling, Reuven Eli, M.D.-Kaiser Permanente	**Progress Notes** CC: Patient presents with knee pain left. HPI: Patient is here for knee pain but also swelling. He has had left knee pain for over a week, there is pain when he tries to extend the knee. He can walk on it and load up the joint. Took Acetaminophen early in the morning, did not take BP till late last night. He really only has trouble extending against gravity. Exam: Obese. Diffuse pitting edema from waist down. Legs are heavy. Tender to palpation over left lower patella. Pain with active extension of the knee but not passive extension. Lab studies were reviewed. Assessment/Plan: 1) Bursitis of left knee. Note: Follow up with Polaris, seems like a tendon issue not joint issue. 2) Obesity, BMI 33-33.9, adult. Note: Lots of water weight, increases Bumex. 3) Essential HTN. Note: Not well controlled, poor dietary and medication adherence. Consider low dose ACE-Inhibitor again. 4) Left ventricular diastolic dysfunction. Note: With acute volume overload, increase furosemide (Lasix). 5) Hypokalemia. Note: Poor K-tab adherence, urged him to take. 6) CKD stage 3 (GFR 30-59). Note: Stable but severe renal disease precludes spironolactone and other potassium sparing medications. Labs needed. 7) Edema. Note: Due to volume overload. As above. 8) Acute CHF, unspecified. Note: With volume overload, increase Bumex. Isosorbide Mononitrate 30 mg. Omeprazole 20 mg. 9) Hyperlipidemia. Note: On statin, continue current medication. Atorvastatin 40 mg. 10) GOUT. Note: Don't think knee is current flare up, no passive joint rotation, continue Allopurinol. Lab studies. Allopurinol 300 mg.
07/13/20	2118-2120	Kaiser Permanente	**Laboratory Rept** Creatinine, Bun: High. Glomerular filtration rate: Low.
07/14/20	1934-1937, 3591-3595, 3606-3609	Woodworth, Paul Howard, M.D.-Kaiser Permanente	**Knee Evaluation** HPI: Patient with chief complaint of pain of the knee for several months. Degree of pain is no pain. Overall, patient feels his knee problem is staying the same. Exam: X-ray of knee and MRI of knee were reviewed. Assessment: Left knee joint pain. Tendinitis of left patellar tendon.Plan: Injection of knee. X-ray of bilateral knees. MRI of left knee.

			Ferumoxytol.
07/14/20	1986-1987	Kaiser Permanente	**Radiology/Diagnostics** X-ray of Bilateral Knees. Clinical hx: Pain. Impression: No acute fracture is identified. The alignment is normal. Minimal DJD of both knee joints. No significant soft tissue abnormality is Identified.
07/24/20	3632-3634, 3636-3639	Ramirez, Vivlana A., R.N.-Kaiser Permanente	**Nurse Visit** Patient in for a BP check. Reports HTN medication taken today at 1000 AM. Meds: Bumetanide 2 mg. Hydralazine 25 mg. Plan: Recommended following moderately low sodium, low fat diet. (DASH diet provided). Increase intake of fruits and vegetables. If your BMI is more than or to 25, weight-loss is effective in reducing BP. Alcohol intake should be no more than 1 (for women) or 2 (for men) drinks per day. Exercise at least 30 minutes 3x a week. IF you smoke it is strongly recommend that you quit smoking. Do not stop or change medication without consulting with your Physician.
07/30/20	2121-2122	Kaiser Permanente	**Laboratory Rept** B type natriuretic peptide, Creatinine: High. Potassium, Glomerular filtration rate: Low.
08/09/20	1987-1988	Kaiser Permanente	**Radiology/Diagnostics** MRI of Left Knee without Contrast. Clinical hx: Left knee pain. Impression: Cartilage thinning and fissuring involving all 3 compartments, as detailed above. Findings suspicious for an oblique horizontal tear of the posterior horn of the medial meniscus extending to the superior articular facet.
08/10/20	3680-3683, 3685-3688	Ramirez, Vivlana A., R.N.-Kaiser Permanente	**Nurse Visit** Called patient at home to schedule BP f/u. Appointment scheduled in 3 weeks per patient request. Patient stated he is taking medications for BP daily, when I asked if he ever missed any doses pt stated “I don't thinks so”. Patient instructed to make sure he takes his medication every day. Patient Verbalized understanding and agreed with the plan. BP check appt schedule in 3 weeks.
08/11/20	1938-1941, 3689-3692	Kaiser Permanente	**Telephone Appointment Visit** Reason for TAV: Tele care. Assessment/Plan: Heart failure, with EF approximately 30-35%. Possibly Hypertensive Heart disease. Had previous referral for LHC as recommended by Dr Farvid, patient cancelled? But now has worsening creatinine. Schedule f/u with Dr Farvid. Hypervolemic on exam. Stop Lasix and switch to Bumex 2 mg BID. Added Metolazone 1.25 mg x 2 days. Take additional K tab x 2 days. Labs in 3 days to monitor renal function. Continue all BP/cardiac meds as above. Strict ED precautions continue

			1.5 gm salt restriction and 1 full day fluid restriction. Recommend physical activity as tolerated HF TCP will continue to monitoring pts HF status. Instructions given to call Heart Care Clinic PRN for SOB, leg swelling, rapid weight gain. Pt has HF clinic #. Phone visit documentation: Called patient. Patient asymptomatic cardiac wise. No change in symptoms but gets fatigued fast. Ef less than 20% which lower than before. Plan: Discussed with patient reg Catheterization and risk of rd, given EF is decreased and patient is not getting better clinically, patient willing to risk HD given ESRD that is also not improving. Patient aware of risks of HD earlier with catheterization and need to r/o CAD given lower EF and will need catheterization before ICD.
09/03/20	2123-2127	Kaiser Permanente	**Laboratory Rept** B type natriuretic peptide, Bun, Creatinine: High. Potassium, Glomerular filtration rate, Lymphocytes, automated count: Low.
09/22/20	3761-3762	Vazquez. Sarai, M.A.-Kaiser Permanente	**Call Documentation** Spoke with patient. Patient states that he is having pain in his right knee. Patient has been seen for his left knee but not his right POLARIS appointment was booked for tomorrow morning.
09/23/20	1942-1948	Auman, Lori Ann, N.P.-Kaiser Permanente	**Call Documentation** Patient scheduled appointment with MSK at 815 AM. Called patient who was currently en route on Downey Kaiser campus to the ED. He stated that he wanted a cortisone injection. Patient offered assistance and asked if I could help him and he stated no and hung up. Patient has been seen in ortho previously for left knee. Follow up with ortho PRN.
09/23/20	1949-1950, 3766-3770	Ortenzo, Nicholas A., P.A.-Kaiser Permanente	**Office Visit** HPI: Patient c/o right knee pain for 1 month, states he had left knee injected in July, request injection today, no injury. Exam: Right knee-mild swelling. Joint line tenderness. Tenderness to palpation patella tendon. Assessment: Knee OA and patella tendonitis. Plan: I discussed the risks and benefits of injections with patient at length. Skin discoloration and subcutaneous fat depletion causing dimpling are common side effects. Under sterile skin prep, a 3cc mixture of Kenalog (1cc of 40mg/mi) and Lidocaine (1% plain), was injected into right knee joint with good result and no adverse effect. Band-aid applied. Patient was advised that 2 medications were injected; a local anesthetic which has rapid onset but brief duration and a corticosteroid which does not take effect for 1-2 days but which has a more sustainable effect. Any fevers, chills, redness or swelling could indicate an infection and patient was advised to go to the emergency

			room if any of these occur. Blood sugar levels can also be affected in Diabetic patients. Discussed cortisone flare and frequency of injections and application of ice.
09/24/20	3755-3756	Kaiser Permanent	**Laboratory Rept** B type natriuretic peptide, Creatinine, Bun: High. Potassium, Glomerular filtration rate: Low.
10/29/20	3800-3802	Mendoza, Gabriela C., M.A.-Kaiser Permanent	**Call Documentation** Spoke to patient states he has had blood in his tissue when blowing his nose.
11/04/20	3803, 3805-3809	Farvid, All Reza, M.D.-Kaiser Permanent	**Call Documentation** Please schedule TAV for patient. He didn't go to catheterization in 08/2020 for low EF.
11/13/20	2128-2129	Kaiser Permanent	**Laboratory Rept** B type natriuretic peptide, Creatinine: High. Potassium, Glomerular filtration rate: Low.
11/27/20	471- 493, 1118-1122, 1203-1255, 1487-1488, 1490-1500, 1507-1514, 1524-1549, 1564-1566, 1620-1633, 1639, 1645-1672, 1677-1714, 1719-1729, 1744-1754, 1774-1775, 1797-1809, 1851-	Nguyen, Hoaithi T., Pharm.D.-Kaiser Permanente	Patient participated in the heart failure care management program from 05/27/20 to 11/27/20.

	1861, 1900, 1903-1929, 1951-1961, 2662-2665, 2712-2714, 3465-3468, 3484-3495, 3504-3515, 3529-3552, 3565-3588, 3596-3605, 3610-3619, 3640-3650, 3655-3665, 3669-3679, 3694-3716, 3731-3740, 3744-3754, 3771-3781, 3783-3793, 3810-3845		
11/30/20	1962-1965, 3848-3851	Farvid, All Reza, M.D.-Kaiser Permanent	**Telephone Appointment Visit** Reason for TAV: Follow up routine. Phone visit documentation: Called patient. Patient asymptomatic cardiac wise- no change in symptoms; didn't keep date for

			catheterization given he got “scared of dialysis. Assessment/Plan: 1) Heart failure, with EF 30-35%. Possibly Hypertensive Heart disease. Had previous referral for LHC as recommended by Dr Farvid, pt cancelled? But now has worsening creatinine. Schedule f/u with Dr Farvid. Hypervolemic on exam. Stop Lasix and switch to Bumex 2 mg BID. Added Metolazone 1.25 mg x 2 days. Take additional K tab x 2 days. Labs in 3 days to monitor renal function. Continue all BP/cardiac meds as above. Strict ED precautions. Continue 1.5 gm salt restriction and 1.5l/day fluid restriction. Recommend physical activity as tolerated. HF TCP will continue to monitoring pt's HF status. Instructions given to call Heart Care Clinic PRN for SOB, leg swelling, rapid weight gain. Patient has HF clinic #. Plan: Re-schedule catheterization. Cr chronically in 2-3 range; patient aware of risk of and given EF is low, will need catheterization minimal contrast and No LV gram.