LEXITAS ORDER NUMBER:
151046-02

RECORDS REGARDING:
Jacob Ramos

CLAIM NUMBER: 22884873
ATTORNEY OR EXAMINER: Allison Jones

RECORDS FROM:
Carlos Alvarez, MD
6001-B Truxtun Ave Ste 220
Bakersfield, CA 93309

RB
AE

Proof of Service

On this date, Lexitas served the attached copy of records on the parties in said action according to their shipping preferences (mail via overnight courier or First Class Mail, upload, download, or email) addressed as listed below.

Case: Jacob Ramos vs Grimmway Enterprises

Records from: Carlos Alvarez, MD

Date: May 13, 2022

Recipients:
Workers Defenders Law Group - Anaheim 751 S Weir Canyon Rd Ste# 157-455 Anaheim CA, 92808 Paper Qty: 0 CD Qty: 1
Hanna Brophy et al - Oakland P.O. Box 12488 Oakland CA, 94604-2488 Paper Qty: 0 CD Qty: 1
Tristar Risk Management- Fresno 4969 E Mckinley Ave., Ste 204 Fresno Ca, 93727 Paper Qty: 0 CD Qty: 0

SHPTOE-RB

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

Jacob Ramos

Claimant / Applicant

Vs.

Grimmway Enterprises

Employer / Insurance Carrier / Defendant

SUBPOENA DUCES TECUM
Case No: ADJ16108811

The People of the State of California Send Greetings to Custodian of Records or other qualified witness for ***Carlos Alvarez, MD, 6001-B Truxtun Ave Ste 220, Bakersfield, CA 93309***

WE COMMAND YOU to appear before a Notary Public at Lexitas, 2550 Warren Drive, Rocklin, CA 95677 or mail records to RECORDS DEPT. P.O. Box 3010, Rocklin, CA 95677 on / within 15 days from service, at 10:00 o'clock A.M., to testify in the above entitled matter and to bring with you and produce the following described documents, papers, books and records:

Any and all medical and billing records (both electronic and paper) for all dates of injuries or illness, industrial and non-industrial, including and not limited to physician/nurses notes, lab and radiology reports, test results, In/Out/Clinic/ER patient treatment, referrals and correspondence, concerning: Jacob Ramos

Jacob Ramos, DOB: April 29, 1966, SSN # 560-04-2233

(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required you may be deemed guilty of contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

Pursuant to Labor Code §4903.5, notice is hereby provided that there is an industrial injury being claimed.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.
Date May 12, 2022

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Workers' Compensation Judge

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed
SEE FOLLOWING PAGE FOR DECLARATION
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within fifteen (15) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or City Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.
DIA WCAB 32 (Side 1) (rev. 06/94) (PSWCAB-RB)**Lexitas Work Order: 151046-02**

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ16108811

STATE OF CALIFORNIA, County of Placer County

The undersigned states:

That he/she is the representative(s) for the Defendant in the action captioned on the reverse hereof.

That the Custodian of Records: **Carlos Alvarez, MD** has in their possession or under their control the documents described on the reverse hereof.

That said documents are material to issues involved in the case for the following reasons:

To comply with LC 4628 by having a complete medical history that addresses all injuries, conditions, disabilities and treatments that may affect the current injury, information and records are necessary to determine the nature and extent of injury, duration of treatments, needs for future medical care and issues of apportionment and overlapping disabilities, specifically in light of L.C. 4663 and 4664 and the ESCOBEDO en banc decision.

To ascertain benefits provided to applicant from collateral sources that may affect entitlement to benefits owing to applicant via the workers' compensation case in order to determine defendant's full potential liability therefore.

☐ See attached addendum, incorporated herein by reference.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

For Kaiser Records

Declaration regarding Jurisdiction of the Workers' Compensation Appeals Board

☐ That an Application for Adjudication has been filed with the Workers' Compensation Appeals Board. Pursuant to Regulation 10530 jurisdiction has been established once an Application for Adjudication has been filed with the W.C.A.B. Case Number pending W.C.A.B. backlog.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

☑ That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check box if applicable and part of declaration below.)

I declare under penalty of perjury that the foregoing is true and correct.

Client Allison Jones ____/S/____________________ **Lexitas Work Order# 151046-02**

Tristar Risk Management- Fresno
PO Box 2805
Clinton, IA 52733

This order was prepared at the direction of the above client on May 12, 2022 , at Rocklin , California by:

____________________	2550 Warren Drive Rocklin, CA 95677	800-497-7618
Signature	Address	Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of ____

I, the undersigned, state that I served the foregoing subpoena by delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served	Date	Place
		Carlos Alvarez, MD 6001-B Truxtun Ave Ste 220 Bakersfield, CA 93309

I declare under penalty of perjury that the foregoing is true and correct.

Executed on ______________________, 20____, at ____________________________________, CA ____________________________________
Signature

DIA WCAB 32 (Side 2) (CCSWCABSDT2 PSDSDT-RB)

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, state bar number, and address)*
Tristar Risk Management- Fresno
Allison Jones
PO Box 2805
Clinton, IA 52733

TELEPHONE NO: 5594321260 FAX NO.: 5594321267
ATTORNEY FOR (*Name*): Defendant

Lexitas Order #151046-02

NAME OF COURT : **WCAB - Anaheim**
STREET ADDRESS : **1065 N. PacifiCenter Drive, Suite 170**
MAILING ADDRESS:
CITY AND ZIP CODE:**Anaheim, California 92806**
BRANCH NAME:

APPLICANT: **Jacob Ramos**

DEFENDANT/ EMPLOYER: **Grimmway Enterprises**

Case Number:
ADJ16108811

NOTICE TO CONSUMER, APPLICANT, APPLICANT ATTORNEY
Code Civ. Proc., § 1985.3, 1985.6 California Labor Code 4055.2)

Laws concerning

NOTICE TO CONSUMER / EMPLOYEE / PARTY

To (name): **Jacob Ramos c/o Workers Defenders Law Group - Anaheim**
Hanna Brophy et al - Oakland

PLEASE TAKE NOTICE THAT **REQUESTING PARTY *(name)*: Allison Jones**

1. SEEKS RECORDS FOR EXAMINATION OF the parties to this action on (specify date) or within 15 days from date of service. The records are described in the subpoena directed to Carlos Alvarez, MD, 6001-B Truxtun Ave Ste 220, Bakersfield, CA 93309 a copy of the subpoena is attached.

2. CALIFORNIA CODE OF CIVIL PROCEDURES § 1985.3 (J) ''This section shall not apply to proceedings conducted under Division 1 (commencing with Section 50), Division 4 (commencing with Section 3200), Division 4.5 (commencing with Section 6100), or Division 4.7 (commencing with Section 6200), of the Labor Code''.

3. CALIFORNIA LABOR CODE § **4055**.2. ''Any party who subpoenas records in any proceeding under this division shall concurrent with service of the subpoena upon the person who has possession of the records, send a copy of the subpoena to all parties of record in the proceeding''.

4. IF YOU OBJECT to the production of these records, YOU MUST DO THE FOLLOWING BEFORE THE DATE SPECIFIED IN ITEM a. BELOW:
   a. If you are a party to the above-entitled action, you must file a motion pursuant to Code of Civil Procedure section 1987.1 to quash or modify the subpoena and give notice of that motion to the **witness** and the **deposition officer** named in the subpoena at least five days before the date set for production of the records.
   WARNING: IF YOUR OBJECTION IS NOT RECEIVED BEFORE THE DATE SPECIFIED IN ITEM 1, YOUR RECORDS MAY BE PRODUCED AND MAY BE AVAILABLE TO ALL PARTIES.

5. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: May 12, 2022
Allison Jones
TYPE OR PRINT NAME

/S/ Allison Jones
(SIGNATURE OF ☐ REQUESTING PARTY ☒ ATTORNEY)

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1. ☐ I object to the production of all of the records specified in the subpoena.
2. ☐ I object only to the production of the following specified records:
3. The specific grounds for my objection are as follows (Must be within 5 days from date of service):

Date:

TYPE OR PRINT NAME

(SIGNATURE)

Proof of service on reverse (or next page)

Laws concerning

NOTICE TO APPLICANT, CONSUMER OR EMPLOYEE AND OBJECTION

Code of Civil Procedure
§§ 1985.3, 1985.6
2020.010-202.510 Labor Code § 4055.2

Lexitas Work Order 151046-02

PROOF OF SERVICE BY MAIL (CCP 1013a3)

I am employed in the State of California- Placer County; I am over the age of eighteen years and not a party to the above-entitled action. My business address is: Lexitas, 2550 Warren Drive Rocklin, CA 95677.

I am readily familiar with the business practice for collection and processing of correspondence for mailing with the United States Postal Service and that the correspondence described below will be deposited with the United States Postal Service today in the ordinary course of business. I am also aware that service made pursuant to this paragraph, upon motion of a party served, shall be presumed invalid if the postal cancellation date or postage meter date on the envelope is more than one day after the date of deposit for mailing contained in this affidavit.

On May 12, 2022 I served the attached Subpoena, Notice and Request for Copies of Records on the parties or attorneys for all parties pursuant to California Labor Code §4055.2 in said action: **Jacob Ramos v Grimmway Enterprises**

By placing a true copy thereof enclosed in a sealed envelope with postage prepaid for deposit with the United States Postal Service at 2550 Warren Drive Rocklin, CA 95677, addressed as listed below:

Carlos Alvarez, MD, 6001-B Truxtun Ave Ste 220, Bakersfield, CA 93309 Natalia Foley Workers Defenders Law Group - Anaheim of 751 S Weir Canyon Rd Ste# 157-455 Anaheim CA 92808 Representing:
Tim McNally Hanna Brophy et al - Oakland of P.O. Box 12488 Oakland California 94604-2488 Representing:

I am a resident of or employed in the county where the objection to production of records was served or mailed.

My residence or business address is (specify): 2550 Warren Drive Rocklin, CA 95677

My phone number is (specify): (800) 497-7618

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: May 12, 2022

Amber Thompson

(TYPE OR PRINT NAME OF PERSON WHO SERVED)
982(a)(15.5) [Rev. January 1, 2000 JCPSBW-RB

(SIGNATURE OF PERSON WHO SERVED)

Proof of Service by Mail
(Code of Civ. Proc., §§ (CCP 1013a3))

POS 1 2009

:13 PM

T
J RAMOS
04/29/1966
56 yrs
Male
RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	CHRISTINE CRISOSTOMO FNP-C
DATE	08/25/2021
AGE AT DOS	55 yrs

Electronically signed by CHRISTINE CRISOSTOMO FNP-C at 09/01/2021 04:49 pm

Chief complaint

Appt time: 11:30 AM) (Arrival time: 11:30 AM) MRI results M.M

Vitals for this encounter	**08/25/21 11:31 AM**
Height	65 in
Weight	166.8 lb
Temperature	98.60 °F
Pulse	79 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	6 right foot
BMI	27.76
Blood pressure	129/80 mmHg

SUBJECTIVE

55 year old male patient came in today for a follow up on MRI results. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: (+) Right foot pain.

Right foot MRI results dated: 08/04/2021
Impression;

05-12-'22 16:31 FROM- T-814 P0009/0131 F-290

0001

gs consistent with an active osteomyelitis of the base of the fifth metatarsal with surrounding enhancing ... ow edema of the adjacent osseous structures. Question of nondisplaced horizontally-oriented likely stress fracture base of the nd metatarsal. Multiple small fluid collections, as described above. Sinus tract formation/skin wound overlying the proximal aphysis of the fifth metatarsal.

ESSMENT

agnoses attached to this encounter:

- Pain in right foot [ICD-10: M79.671], [ICD-9: 729.5], [SNOMED: 316891000119107]
- Osteomyelitis of foot [ICD-10: M86.8X7], [ICD-9: 730.27], [SNOMED: 28769004]
- Type 2 diabetes mellitus with diabetic neuropathy, unspecified [ICD-10: E11.40], [ICD-9: 250.60], [ICD-9: 357.2], [SNOMED: 368581000119106]
- Person consulting for explanation of examination [ICD-10: Z71.2], [ICD-9: V65.8], [SNOMED: 281036007]
- Body mass index [BMI] 27.0-27.9, adult [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

PLAN

FSBS done now in office 100.
Advised to monitor blood sugars at home.
Reviewed and discussed MRI of the right foot results in detail
Will continue with Home Health Ceftriaxone 2 q
IV Q 24 for 7 days due to active osteomyelitis of
the 5th metatarsal of the right foot, patient will
need a picc line to be placed the IV.
Preventive counseling: Diet and exercise
reviewed with patient
Advised to increase and maintain physical
activity for physical and emotional health
as well as improvement of chronic illness
Advised to increase fluids, stay well hydrated
Low carb - low sugar - low sodium diet
Advised to RTC in two weeks or sooner for a follow up.

Seen by Christine Crisostomo F.N.P, under the supervision of Carlos A. Alvarez M.D..

Medications attached to this encounter:

Norco 10-325 MG Oral Tablet 1 tab po 2 times a day # 20 (start date: 8/25/2021)

05-12-'22 16:31 FROM- T-814 P0010/0131 F-290

0002

05-12-'22 16:32 FROM- T-814 P0011/0131 F-290

:13 PM

T
J RAMOS
04/29/1966
56 yrs
Male
RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY CARLOS ALVAREZ M.D.
DATE 08/10/2021
AGE AT DOS 55 yrs
Electronically signed by CARLOS ALVAREZ M.D. at 08/11/2021 08:51 am

Chief complaint

Appt time: 11:00 AM) (Arrival time: 11:00 AM) pt needs doctor to fill out papers for disability M.M

Vitals for this encounter

	08/10/21 11:23 AM
Height	65 in
Weight	164.80 lb
Temperature	97.90 °F
Pulse	84 bpm
Respiratory rate	18 bpm
O2 Saturation	99 %
Pain	0
BMI	27.42
Blood pressure	145/85 mmHg

SUBJECTIVE

55 year old male patient came in today to talk about disability paper work. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Hypertensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Neuropathy [ICD-10: G62.9], [ICD-9: 355.9], [SNOMED: 386033004]

Essential (primary) hypertension [ICD-10: I10], [ICD-9: 401.0], [ICD-9: 401.1], [ICD-9: 401.9], [SNOMED: 59621000]

Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]

GERD [ICD-10: K21.9], [ICD-9: 530.81], [SNOMED: 235595009]

Body mass index [BMI] 27.0-27.9, adult [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

PLAN

FSBS done now in office 130.
Advised to monitor blood sugars at home.
Discontinued Picc line.
Disability and social security paperwork.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 2 weeks for a follow up.

Seen by Carlos A. Alvarez M.D.

T-814 P0013/0131 F-290
05-12-'22 16:33 FROM-

NT
B RAMOS
04/29/1966
56 yrs
Male
RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY CHRISTINE CRISOSTOMO FNP-C
DATE 07/28/2021
AGE AT DOS 55 yrs
Electronically signed by CHRISTINE CRISOSTOMO FNP-C at 08/03/2021 11:02 am

hief complaint

Appt time: 3:30 PM) (Arrival time: 3:40 PM) PT HERE TO F/U ON SURGERY DONE ON RIGHT FOOT ALSO REQUESTING PARAQUAT XPOSED STUDYS DONE ALSO JURDY DUTY EXCUSE FILLED OUT. MA DE

Vitals for this encounter	**07/28/21 3:52 PM**
Height	65 in
Weight	165 lb
Temperature	98.20 °F
Pulse	85 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	6 RIGHT FOOT
BMI	27.46
Blood pressure	155/86 mmHg

SUBJECTIVE

55 year old male patient came in today for a follow up on right foot surgery. He is requesting a letter for jury duty. He states he had suicidal thoughts 1 month ago. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Hypertensive, In no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: Right foot osteomylitis.

ASSESSMENT

Diagnoses attached to this encounter:

Osteomyelitis of foot [ICD-10: M86.8X7], [ICD-9: 730.27], [SNOMED: 28769004]

Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Hypertensive heart disease without heart failure [ICD-10: I11.9], [ICD-9: 402.00], [ICD-9: 402.10], [ICD-9: 402.90], [SNOMED: 60899001]

Suicide attempt [ICD-10: T14.91XA], [ICD-9: E955.9], [SNOMED: 82313006]

Body mass index [BMI] 27.0-27.9, adult [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

PLAN

NFBS done now in office 235.
Advised to monitor blood sugars at home.
Referred to psychiatrist for consultation and evaluation due to depression and suicidal thoughts.
Advised to do right foot MRI.
Will start on Sertraline 100 mg 1 tab po once at night.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 2 weeks for a follow up.

Seen by Christine Crisostomo F.N.P, under the supervision of Carlos A. Alvarez M.D.

Medications attached to this encounter:

Sertraline HCl 100 MG Oral Tablet 1 po q hs (start date: 10/6/2020)

05-12-'22 16:34 FROM- T-814 P0015/0131 F-290

DOB	04/29/1966	SEEN BY	SHARON VEJVODA FNP
AGE	56 yrs	DATE	07/27/2021
SEX	Male	AGE AT DOS	55 yrs
PRN	RJ438906		

F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

Electronically signed by SHARON VEJVODA FNP at 07/27/2021 03:00 pm

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 11:11 AM) PT IS HERE FOR T2DM SENSOR DATA AND EXTENCION FOR WORK MB

Vitals for this encounter	07/27/21 11:22 AM
Height	65 in
Weight	163 lb
Temperature	98.30 °F
Pulse	82 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	5
BMI	27.12
Blood pressure	138/81 mmHg

SUBJECTIVE

55 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia, patient present in the clinic for follow up freestyle sensor data, Patient denies fevers/chills, headache, dizziness, cough, SOB, chest pain, palpitation, abdominal pain, Nausea, Vomiting, appetite changes, visual changes, tinnitus, urinary changes, bowel movement changes, weakness/fatigue. Patient does report occasional right foot ankle swelling.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft , no tenderness, no masses , BS normal
Skin: Normal color, Warm and Dry. No rashes, lesions, abrasions.

T-814 P0016/0131 F-290

SMENT

Libre Sensor 2 data review for 14 days utilized to ensure medication effectiveness. CPT 95250/95251, Modifier 25 E/M (face-to-
)

gnoses attached to this encounter:

Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Type 2 diabetes mellitus with diabetic neuropathy, unspecified [ICD-10: E11.40], [ICD-9: 250.60], [ICD-9: 357.2], [SNOMED: 368581000119106]

Pain in right foot [ICD-10: M79.671], [ICD-9: 729.5], [SNOMED: 316891000119107]

PAD [ICD-10: I73.9], [ICD-9: 443.9], [SNOMED: 400047006]

Open wound of foot, sequela [ICD-10: S91.309S], [ICD-9: 906.1], [SNOMED: 125663008]

Fracture of toe [ICD-10: S92.911A], [ICD-9: 826.0], [SNOMED: 21351003]

Hypertensive heart disease without heart failure [ICD-10: I11.9], [ICD-9: 402.00], [ICD-9: 402.10], [ICD-9: 402.90], [SNOMED: 60899001]

Adult BMI of 27.0-27.9 [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

Overweight [ICD-10: E66.3], [ICD-9: 278.02], [SNOMED: 238131007]

PLAN

Patient to follow up with Dr. Alvarez in the next few days regarding continued use or discontinued use of PICC Line for IV antibiotics.
Until the PICC Line is discontinued patient should continue to Flush as directed.

NFBS finger stick check-in office 127
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Review sensor data
Placed new sensor libre
Saw Podiatrist who patient states the wound is healing well but that he must continue to wear Uni-boot.
New request for MRI sent by Dr. Alvarez awaiting insurance authorization.
Medical certificate given to patient to return to work on 10/16/2021 medical reasons
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruits
Avoid high saturated fat products, fast food,
fried food.
Reduce high sugars/ caffeine drinks.
Advised to increase fluids and stay well hydrated
Plan reviewed with the patient. The patient verbalized understanding and agreed.
Monitor blood pressure at home
Keep Log of blood pressure and bring log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in two weeks or sooner for a follow up sensor data
Plan reviewed with the patient. The patient verbalized understanding and agreed.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

05-12-'22 16:35 FROM-

/22, 4:13 PM

ATIENT
ACOB RAMOS

OB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	CHRISTINE CRISOSTOMO FNP-C
DATE	07/21/2021
AGE AT DOS	55 yrs

Not signed

Chief complaint

(Appt time: 11:30 AM) (Arrival time: 11:24 AM) follow up on pick line on right arm M.M

Vitals for this encounter	**07/21/21 11:37 AM**
Height	65 in
Weight	165 lb
Temperature	97.90 °F
Pulse	82 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	0
BMI	27.46
Blood pressure	138/83 mmHg

SUBJECTIVE

55 year old male patient came in today on a picc line Denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

right foot diabetic wound compellation erythema/ edema + 2 currently with picc Abx

Diagnoses attached to this encounter:

(S81.802D) Unspecified open wound, left lower leg, subsequent encounter

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

PLAN

FSBS finger stick check-in the office 110

Patient has pending appointment with Podiatry on Monday July 26

Order given for MRI for the right foot with and without contrast at Stockdale Radiology

Advice patient to complete Abx until Saturday and see Podiatry with reevaluate per MRI Results.

Preventive counseling: Advised to increase fluids and stay well hydrated

Low carb - low sugar - low sodium diet

Plan reviewed with the patient. The patient verbalized understanding and agreed.

Advised to RTC in one month or sooner for a follow up

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY SHARON VEJVODA FNP
DATE 07/16/2021
AGE AT DOS 55 yrs
Electronically signed by SHARON VEJVODA FNP at 07/20/2021 02:20 pm

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:45 AM) pt here for follow up t2dm MB

Vitals for this encounter	**07/16/21 11:18 AM**
Height	65 in
Weight	163 lb
Temperature	98.20 °F
Pulse	69 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	7
BMI	27.12
Blood pressure	140/73 mmHg

SUBJECTIVE

55 Years old male patient present in the clinic for evaluation EDD extension, patient states he has appoint with Dr. Hawkins for wound care 08/16/21, patient reported right foot pain rates 7/10 in severity, Patient denies fevers/chills, headache, dizziness, cough, SOB, chest pain, palpitation, abdominal pain, Nausea, Vomiting, appetite changes, visual changes, tinnitus, urinary changes, bowel movement changes, weakness/fatigue

OBJECTIVE

General: Normotensive, in no acute distress. OVERWEIGHT
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft , no tenderness, no masses , BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: : Decrease ROM related to RIGHT foot wound that he wears a Uni-boot to protect. Wound with-out signs of infection , no deformities, slight edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Diabetic neuropathy [ICD-10: E11.40], [ICD-9: 250.60], [ICD-9: 355.9], [SNOMED: 230572002]

Open wound of leg [ICD-10: S81.801A], [ICD-9: 894.0], [SNOMED: 26947005]

Long term (current) use of insulin [ICD-10: Z79.4], [ICD-9: V58.67], [SNOMED: 710815001]

Hypertensive heart disease without heart failure [ICD-10: I11.9], [ICD-9: 402.00], [ICD-9: 402.10], [ICD-9: 402.90], [SNOMED: 60899001]

Hypercholesterolemia [ICD-10: E78.00], [ICD-9: 272.0], [SNOMED: 13644009]

Depression [ICD-10: F32.9], [ICD-9: 311], [SNOMED: 35489007]

Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]

Body mass index [BMI] 27.0-27.9, adult [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

Overweight [ICD-10: E66.3], [ICD-9: 278.02], [SNOMED: 238131007]

PLAN

NFBS finger stick check-in office 117
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Advised follow up with Dr. Hawkins for rt foot wound care
F/u on medical leave form given
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Preventive counseling: Diet and exercise daily for
at least 30 minutes
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruits
Avoid high saturated fat products, fast food,
fried food.
Reduce high sugars/ caffeine drinks.
Advised to increase fluids and stay well hydrated
Plan reviewed with the patient. The patient verbalized understanding and agreed.
Monitor blood pressure at home
Keep Log of blood pressure and bring log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in two weeks or sooner for a follow up sensor data
Plan reviewed with the patient. The patient verbalized understanding and agreed.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
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5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	SHARON VEJVODA FNP
DATE	07/14/2021
AGE AT DOS	55 yrs

Electronically signed by SHARON VEJVODA FNP at 07/19/2021 10:56 am

Chief complaint

(Appt time: 3:30 PM) (Arrival time: 3:30 PM) PT IS HERE FOR F/U T2DM MB

Vitals for this encounter	07/14/21 3:46 PM
Height	65 in
Weight	164 lb
Temperature	98.20 °F
Pulse	88 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	6
BMI	27.29
Blood pressure	136/71 mmHg

SUBJECTIVE

55 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia, patient present in the clinic for chronic health conditions follow up and review libre sensor data, patient reported right foot pain rates 6/10 in severity. Patient denies fevers/chills, headache, dizziness, cough, SOB, chest pain, palpitation, abdominal pain, Nausea, Vomiting, appetite changes, visual changes, tinnitus, urinary changes, bowel movement changes, weakness/fatigue

OBJECTIVE

General: Normotensive, in no acute distress. overweight
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft , no tenderness, no masses , BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: Decrease ROM related to RIGHT foot wound that he wears a Uni-boot to protect. Wound with-out signs of infection , no deformities, slight edema, no erythema
Review Libre sensor data
TARGET 78%
HIGH 19%

VERY HIGH 3%

ASSESSMENT

CGM Libre Sensor 2 data review for 14 days utilized to ensure medication effectiveness. CPT 95250/95251, Modifier 25 E/M (face-to-face)

CGM Libre Sensor 2 data placed for set up/Training for 14 days, utilized to ensure medication effectiveness. CPT 95249, Modifier 25 E/M (face-to-face)
Target Range 78%
High Range 19%
Very High Range 3%

Diagnoses attached to this encounter:
- Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]
- Open wound of leg [ICD-10: S81.802A], [ICD-9: 894.0], [SNOMED: 26947005]
- Diabetic neuropathy [ICD-10: E11.40], [ICD-9: 250.60], [ICD-9: 355.9], [SNOMED: 230572002]
- Long term (current) use of insulin [ICD-10: Z79.4], [ICD-9: V58.67], [SNOMED: 710815001]
- Depression [ICD-10: F32.9], [ICD-9: 311], [SNOMED: 35489007]
- Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]
- Adult BMI of 27.0-27.9 [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]
- Overweight [ICD-10: E66.3], [ICD-9: 278.02], [SNOMED: 238131007]

PLAN

NFBS finger stick check-in office 237
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Review freestyle libre sensor data
Patient given Humalog U-100 4 u sq now in the office
Placed new sensor patient tolerated well
Medical certificate given to patient to return to work on 08/16/21/2021 medical reasons
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Preventive counseling: Diet and exercise daily for
at least 30 minutes
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruits
Avoid high saturated fat products, fast food,
fried food.
Reduce high sugars/ caffeine drinks.
Advised to increase fluids and stay well hydrated
Plan reviewed with the patient. The patient verbalized understanding and agreed.
Monitor blood pressure at home
Keep Log of blood pressure and bring log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in two weeks or sooner for a follow up sensor data
Plan reviewed with the patient. The patient verbalized understanding and agreed.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY CARLOS ALVAREZ M.D.
DATE 07/13/2021
AGE AT DOS 55 yrs
Not signed

Chief complaint

F/U ON PICKLINE (Appt time: 11:15 AM) (Arrival time: 11:01 AM)pt i shere for f/u on pick line for infection on the right foot ma rh

Vitals for this encounter	07/13/21 12:05 PM
Height	65 in
Weight	161 lb
Temperature	98.90 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
BMI	26.79
Blood pressure	120/67 mmHg

SUBJECTIVE

55 year old male patient came in today to follow up if he continues with the pick line for the infection he has on the right foot.
Denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

(B99.9) Unspecified infectious disease

(M86.9) Osteomyelitis, unspecified

(M79.671) Pain in right foot

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(I10) Essential (primary) hypertension

(Z68.26) Body mass index [BMI] 26.0-26.9, adult

PLAN

Continue with IV antibiotic and flushing Picc line
for two more weeks.
Advice to follow up with Sharon Vejvoda FNP at
Greenfield this week.
Preventive counseling: Diet and exercise reviewed
Advised to increase fluids and stay well hydrated
Low carb - low sugar - low sodium diet
Plan reviewed with the patient. The patient
verbalized understanding and agreed.
Advised to RTC in two weeks or sooner for a follow up

Seen by Carlos A. Alvarez M.D.

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
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Bakersfield, CA 93309

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	CHRISTINE CRISOSTOMO FNP-C
DATE	07/06/2021
AGE AT DOS	55 yrs

Electronically signed by CHRISTINE CRISOSTOMO FNP-C at 07/06/2021 11:21 am

Chief complaint

(Appt time: 8:33 AM) (Arrival time: 8:35 AM)pt is here to pick up clearance release forms for eye surgery ma rh

Vitals for this encounter	**07/06/21 8:42 AM**
Height	65 in
Weight	168 lb
Temperature	98.20 °F
Pulse	88 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
BMI	27.96
Blood pressure	154/79 mmHg

SUBJECTIVE

55 Year old male patient came in to the clinic today for surgery clearance on left eye cataract in southern California eye institute with Dr. Rohit Varma, MD , MPH on 07/02/2021. Patient denies fevers/chills, headache, dizziness SOB, chest pain, abdominal pain, urinary changes, bowel movement changes.

OBJECTIVE

General: **Hypertensive**, in no acute distress. **BMI 27 Overweight.**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

EXAMINATION: CHEST X-RAY, 2 VIEWS 06/29/2021
FINDINGS: The lungs are well aerated bilaterally. No evidence for mass, consolidation, congestion or pleural effusion. No evidence for pneumothorax. The heart is not enlarged. The visualized osseous structures are intact. The soft tissues and fat planes are normal.

IMPRESSION: Unremarkable chest x-rays. No evidence for acute pulmonary pathology.

Patient has right arm pick line with antibiotic by home health Zithromax IV.

Lab results 06/14/2021
HDL CHOLESTEROL 21
GLUCOSE 21
ALBUMIN/CREATINE RATIO, 161
GLUBULIN 3.9
ALKALINE PHOSPHATASE 153
ALT 5
SPECICIFIC GRAVITY 1.045
GLUCOSE 3+
PROTEIN 1+
WHITE BLOOD CELL COUNT 11.3
ABSOLUTE NEUTROPHILS 8486
HEMOGLOBIN A1C 9.0

ASSESSMENT

Diagnoses attached to this encounter:

- Essential (primary) hypertension [ICD-10: I10], [ICD-9: 401.0], [ICD-9: 401.1], [ICD-9: 401.9], [SNOMED: 59621000]
- Diabetes 2 [ICD-10: E11.9], [ICD-9: 250.00], [SNOMED: 44054006]
- Cataract of left eye [ICD-10: H26.9], [SNOMED: 816119002]
- Encounter for issue of repeat prescription [ICD-10: Z76.0], [ICD-9: V68.1], [SNOMED: 170922004]
- Adult BMI of 27.0-27.9 [ICD-10: Z68.27], [ICD-9: V85.23], [SNOMED: 162863004]

PLAN

Patient is cleared for left eye cataract surgery schedule 07/07/2021.
FSBS finger stick check-in the office 207.
Lab results reviewed with patient and understood.
X- ray results reviewed with patient and understood.
Preventive counseling: Diet and exercise reviewed
Advised to increase fluids and stay well hydrated
Low carb - low sugar - low sodium diet.
Advised to RTC in two weeks or sooner for a follow up.
Lisinopril 40 mg was changed to 20 mg once a day.
Medication E-scripted to the pharmacy.
Advised to take new medications as prescribed.
Advised to continue current medications as prescribed.
Seen by Christine Crisostomo F.N.P, under the supervision of Carlos A. Alvarez M.D.

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
Carlos A Alvarez MD Inc
T (661) 489-5999
F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY CARLOS ALVAREZ M.D.
DATE 06/28/2021
AGE AT DOS 55 yrs
Electronically signed by CARLOS ALVAREZ M.D. at 07/02/2021 08:30 am

Chief complaint

(Appt time: 11:15 AM) (Arrival time: 11:15 AM)PT IS HERE TO F/U ON FREE STYLE LIBRE 2 PT C/O OF NOSE CONGESTION BOTH EARS X 3 DAYS MA RH

Vitals for this encounter	
	06/28/21 12:03 PM
Height	65 in
Weight	163 lb
Temperature	98.80 °F
Pulse	80 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
BMI	27.12
Blood pressure	138/73 mmHg

SUBJECTIVE

55 year old male patient came in today complaining of having nasal congestion and bilateral ear congestion x 3 days. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.

ASSESSMENT

Diagnoses attached to this encounter:

- Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]
- PAD [ICD-10: I73.9], [ICD-9: 443.9], [SNOMED: 400047006]
- Glaucoma of both eyes [ICD-10: H40.9], [SNOMED: 12239421000119101]

05-12-'22 16:41 FROM- T-814 P0028/0131 F-290

PLAN

DMV placard paperwork filled out for permenant placard.
FSBS done now in office 133.
Advised to monitor blood sugars at home.
Increase fluids, rest.
OTC analgesic, Tylenol, ibuprofen prn.
Salt water gargles, ice chips to soothe throat tid.
Steam expectoration is recommended.
Advised to take medication as directed.
Return to office in 2 weeks for a follow up.

Seen by Carlos A. Alvarez M.D.

Medications attached to this encounter:

Zithromax Z-Pak 250 MG Oral Tablet use as directed (start date: 6/28/2021)

Promethazine-DM 6.25-15 MG/5ML Oral Syrup 1 tsp po 3 times a day (start date: 6/28/2021)

AGE	56 yrs
SEX	Male
PRN	RJ438906

F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

SEEN BY M.D.
DATE 06/14/2021
AGE AT DOS 55 yrs
Electronically signed by CARLOS ALVAREZ M.D. at 06/15/2021 10:39 am

Chief complaint

(Appt time: 11:15 AM) (Arrival time: 11:43 AM)PT IS HERE FOR F/U AFTER R FEET SURGERY MA RH

Vitals for this encounter

	06/14/21 12:15 PM
Height	65 in
Weight	180 lb
Temperature	97.60 °F
Pulse	83 bpm
Respiratory rate	18 bpm
O2 Saturation	99 %
BMI	29.95
Blood pressure	119/66 mmHg

SUBJECTIVE

55 year old male patient came in today for pre-op clearance. Denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

BMI 25-29 - overweight [ICD-10: Z68.29], [ICD-9: 278.02], [SNOMED: 162863004]

PLAN

Pre op clearance studies order for eye surgery
EKG done results discussed and understood
LAB ORDER FOR: CBC, CMP, LIPID PANEL, HA1c,
TSH, T3 FREE, UA
Order given for Chest X ray at Stockdale Radiology
Freestyle Libre 2 put it to the patient in the office
Advice to follow up with Sharon at Greenfield
to monitor his Diabetes.
Preventive counseling: Diet and exercise reviewed
Advised to increase fluids and stay well hydrated
Low carb - low sugar - low sodium diet
Advised to RTC in two weeks or sooner for a follow up

Seen by Carlos A. Alvarez M.D.

AGE	56 yrs	F (661) 489-5991	**SEEN BY**	SHARON VEJVODA FNP
SEX	Male	5400 ALDRIN CT	**DATE**	05/17/2021
PRN	RJ438906	BAKERSFIELD, CA 93313	**AGE AT DOS**	55 yrs

Electronically signed by SHARON VEJVODA FNP at 05/20/2021 11:22 am

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 11:09 AM) PT HERE FOR EVALUATION DISABILTY EXTENSION FBS 136 JESPANA

Vitals for this encounter

	05/17/21 11:34 AM
Height	65 in
Weight	173 lb
Temperature	98.10 °F
Pulse	84 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	10 RT FOOT
BMI	28.79
Blood pressure	118/65 mmHg

SUBJECTIVE

55 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia, patient present in the clinic for evaluation extension disability, due to right foot wound, Patient is requesting a refill of current medications. Reports tolerating current medications well without adverse reactions or any other problems. patient reported right foot pain rates 10/10 in severity, patient states wound closed bacterial infections gone 2 more weeks of healing them surgery, patient had vein striping. Patient denies fevers/chills, headache, dizziness, cough, SOB, chest pain, palpitation, abdominal pain, Nausea, Vomiting, appetite changes, visual changes, tinnitus, urinary changes, bowel movement changes, weakness/fatigue

OBJECTIVE

General: Normotensive afebrile, in acute distress due to right foot pain, overweight
Head: No headaches, no vertigo, no injury
Eyes: Normal vision, no diplopia, no tearing, no scotomata, no pain
Ears: EACs clear, TMs intact, no change in hearing, no tinnitus, no bleeding, no vertigo
Nose: No epistaxis, no coryza, no obstruction, no discharge
Mouth: No dental difficulties, no gingival bleeding, no use of dentures
Throat: clear, no pharyngeal erythema

Back: Normal curvature
GU: No urinary urgency, no dysuria, no change in the nature of urine
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Neurologic: No weakness, no tremor, no seizures, no changes in mentation, no ataxia
Psychiatric: No depressive symptoms, no changes in sleep habits, no changes in thought content.
Extremities: right foot + boot

ASSESSMENT

Diagnoses attached to this encounter:

Type 2 diabetes with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Encounter for issue of repeat prescription [ICD-10: Z76.0], [ICD-9: V68.1], [SNOMED: 170922004]

PAD [ICD-10: I73.9], [ICD-9: 443.9], [SNOMED: 400047006]

Dietary counseling in diabetes [ICD-10: Z71.3], [ICD-9: V65.3], [SNOMED: 424928005], [SNOMED: 11816003]

Overweight [ICD-10: E66.3], [ICD-9: 278.02], [SNOMED: 238131007]

Hypertensive heart disease without heart failure [ICD-10: I11.9], [ICD-9: 402.00], [ICD-9: 402.10], [ICD-9: 402.90], [SNOMED: 60899001]

Pain in right foot [ICD-10: M79.671], [ICD-9: 729.5], [SNOMED: 316891000119107]

Open wound of leg [ICD-10: S81.801A], [ICD-9: 894.0], [SNOMED: 26947005]

PLAN

FBS finger stick check-in office 136
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Ordered Drug screening panel 6
Complete disability form until 07/10/2021
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Controlled substance prescription was given to the patient in hand.
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruits
Avoid high saturated fat products, fast food,
fried food.
Reduce high sugars/ caffeine drinks.
Advised to increase fluids and stay well hydrated
Plan reviewed with the patient. The patient verbalized understanding and agreed.
Monitor blood pressure at home
Keep Log of blood pressure and bring log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in one month or sooner for a follow up T2DM
Advised follow up Ophthalmologist for glaucoma on left eye
Plan reviewed with the patient. The patient verbalized understanding and agreed.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

Medications attached to this encounter:

Norco 10-325 MG Oral Tablet 1 tab po 2 times a day (start date: 12/18/2020)

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY SHARON VEJVODA FNP
DATE 04/27/2021
AGE AT DOS 54 yrs
Electronically signed by SHARON VEJVODA FNP at 05/04/2021 12:47 pm

Chief complaint

(Appt time: 4:00 PM) (Arrival time: 3:44 PM)evaluation extender disability eye surgery on 05/10/21 nfbs 220 jespana

Vitals for this encounter	04/27/21 4:21 PM
Height	65 in
Weight	183 lb
Temperature	98.40 °F
Pulse	82 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	10 right foot
BMI	30.45
Blood pressure	97/50 mmHg

SUBJECTIVE

55 Years old male patient with know history of HTN/T2DM patient present in the clinic for extension disability, patient sates he had schedule eye surgery on 05/10/21 due to glaucoma, patient reported right foot pain rates 10/10 in severity, Patient denies fevers/chills, headache, dizziness SOB, chest pain, abdominal pain, urinary changes, bowel movement changes.

OBJECTIVE

General: Normotensive, in no acute distress. obesity
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Back: Normal curvature, no tenderness
Extremities: right foot + boot

ASSESSMENT

Diagnoses attached to this encounter:

BMI 30+ [ICD-10: Z68.30], [ICD-9: 278.00], [SNOMED: 162864005]

Anxiety [ICD-10: F41.9], [ICD-9: 300.00], [SNOMED: 48694002]

Depression [ICD-10: F32.9], [ICD-9: 311], [SNOMED: 35489007]

Obese [ICD-10: E66.9], [ICD-9: 278.00], [SNOMED: 414915002]

Type 2 diabetes mellitus with hyperglycemia [ICD-10: E11.65], [ICD-9: 250.80], [SNOMED: 368051000119109]

Long term (current) use of insulin [ICD-10: Z79.4], [ICD-9: V58.67], [SNOMED: 710815001]

Diabetic neuropathy [ICD-10: E11.40], [ICD-9: 250.60], [ICD-9: 355.9], [SNOMED: 230572002]

Pain in right foot [ICD-10: M79.671], [ICD-9: 729.5], [SNOMED: 316891000119107]

Glaucoma of both eyes [ICD-10: H40.9], [SNOMED: 12239421000119101]

PLAN

NFBS finger stick done in office 220
Advised applying for permanent disability
Skin graft to central valley Nguyen seeing every week 6614671477
Medical certificate given to patient to return to work on 07/10/21 medical purpose
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Preventive counseling: Diet and exercise reviewed
Advised to increase fluids and stay well hydrated
Low carb - low sugar - low sodium diet
Advised to RTC in one month or sooner for a follow up T2DM
Plan reviewed with the patient. The patient verbalized understanding and agreed.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

AGE	56 yrs	F (661) 489-5991	SEEN BY	SHARON VEJVODA FNP
SEX	Male	6001-B TRUXTUN AVE SUITE 220	DATE	02/24/2021
PRN	RJ438906	Bakersfield, CA 93309	AGE AT DOS	54 yrs

Not signed

Chief complaint

(Appt time: 3:45 PM) (Arrival time: 3:16 PM)PT C/O COUGH, RUNNY NOSE X4 DAYS. SMA MG

Vitals for this encounter

	02/24/21 3:25 PM
Height	65 in
Weight	189 lb
Temperature	98.90 °F
Pulse	88 bpm
Respiratory rate	18 bpm
O2 Saturation	93 %
Pain	8
BMI	31.45
Blood pressure	122/67 mmHg

SUBJECTIVE

54 year old male patient came in today complaining of having a cough and stuffy nose x 4 days. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: (+) Erythematous mucosa.
Throat: (+) Erythematous pharynx.
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.

ASSESSMENT

NFBS done in office 247.
Advised to monitor blood sugars at home.
Injections tolerated well.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 2 weeks for a follow up.

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Dexamethasone Sodium Phosphate 10 MG/ML Injection Solution Sig: DEXAMETHASONE 10MG/ML IM GIVEN NOW IN OFFICE BY MA: Jose LUQ NDC: 10079910558950 EXP: FEB2022 LOT: 029407

Triamcinolone Acetonide (Kenalog) 40 MG/ML Injection Suspension Sig: Kenolog 40 1cc given by MA IRMA FUENTES to RUOQ IM NDC=0703-0245-01 LOT# 348049 Exp=04/2021

05-12-'22 16:44 FROM- T-814 P0036/0131 F-290

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	SHARON VEJVODA FNP
DATE	02/18/2021
AGE AT DOS	54 yrs

Not signed

Chief complaint

(Appt time: 10:45 AM) (Arrival time: 10:33 AM) C/O RUNNY NOSE, COUGH FOR 3 DAYS AND FOLLOW UP DISABILITY FBS 155 JESPANA

Vitals for this encounter

	02/18/21 10:43 AM
Height	65 in
Weight	190 lb
Temperature	97.80 °F
Pulse	82 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	6 RIGHT FOOT
BMI	31.62
Blood pressure	140/89 mmHg

SUBJECTIVE

54 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia. patient present in the clinic for complaint of runny nose, cough for 3 days and follow up for disability extension , patient reported right foot pain rates 6/10 in severity Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

OBJECTIVE

Gen: Hypertensive, no acute distress. obesity
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: right foot + boot

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(I11.9) Hypertensive heart disease without heart failure

(Z79.4) Long term (current) use of insulin

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(I99.9) Unspecified disorder of circulatory system

(R05) Cough

(J34.89) Other specified disorders of nose and nasal sinuses

(J30.1) Allergic rhinitis due to pollen

PLAN

FBS finger stick check-in office 155
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Extended disability until April 10th 2021
Advised to take new medications as prescribed
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in three months or sooner for a follow-up for T2DM /HTN
Advised follow up with Central valley Surgical specialist
No psych at this time Advised to go to Mary K shell for evaluation
Plan reviewed with the patient. The patient verbalized understanding and agreed
Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Cetirizine HCl (ZyrTEC Allergy) 10 MG Oral Capsule Sig: Take 1 capsule (10 mg) by mouth daily

Dextromethorphan-Guaifenesin (Robitussin Cough+Chest Cong DM) 20-200 MG/20ML Oral Liquid Sig: 5 ml PO Q6H

T-814 P0039/0131 F-290

AGE	56 yrs		
SEX	Male		
PRN	RJ438906		

F (661) 489-5991
6001-B TRUXTUN AVE SUITE 220
Bakersfield, CA 93309

SEEN BY	CARLOS ALVAREZ M.D.
DATE	02/01/2021
AGE AT DOS	54 yrs
Not signed	

Chief complaint

(Appt time: 4:15 PM) (Arrival time: 4:47 PM) PT HERE FOR RIGHT FOOT SURGERY CHECK AND LAB RESULTS MA DE

Vitals for this encounter

	02/01/21 4:51 PM
Height	65 in
Weight	189 lb
Temperature	98.20 °F
Pulse	92 bpm
Respiratory rate	18 bpm
O2 Saturation	94 %
Pain	7
BMI	31.45
Blood pressure	114/60 mmHg

SUBJECTIVE

54 year old male patient came in today for a follow up on right foot surgery. He is also here for a follow up on lab results. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.

05-12-'22 16:45 FROM-

(M79.671) Pain in right foot

(Z09) Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

(E11.65) Type 2 diabetes mellitus with hyperglycemia

PLAN

Advised to follow up with specialist.
Reviewed and discussed lab results in detail.
Will repeat labs in 3 months.
NFBS done in office 64.
Advised to monitor blood sugars at home.
Injection tolerated well.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 1 month for a follow up.

Seen by Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Alendronate Sodium (Fosamax) 70 MG Oral Tablet Sig: 1 tab po q weekly

Calcium Carbonate (Antacid) (Tums) 500 MG Oral Tablet Chewable Sig: Chew and swallow 1 tablet (500 mg) by mouth 3 times per day as needed

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: Cynocobalamin 1,000 MGC/ML IM GIVEN NOW IN OFFICE by MA: Jose LUQ NDC:0143-9619-01 LOT:1705169. EXP:10/2021

AGE	56 yrs	F (661) 489-5991	SEEN BY	SHARON VEJVODA FNP
SEX	Male	5400 ALDRIN CT	DATE	01/22/2021
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:45 AM) (Arrival time: 11:46 AM) pt req referral to omni health phyc on pananma also req extension for disability nfbs= 141 ma jflores

Vitals for this encounter	
	01/22/21 12:02 PM
Height	65 in
Weight	190.2 lb
Temperature	97.80 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	6
BMI	31.65
Blood pressure	127/86 mmHg

SUBJECTIVE

54 year old male patient presents to the clinic requesting a referral to establish a new psych provider since his previous provider no longer takes his insurance. Patient requests a referral to Omni Health psych who he states takes his insurance. Pt continues to wear a Uni boot on his right foot due to fractured toes. Patient also states that he is undergoing vein therapy on both his legs to increase circulation to his lower extremities. Patient reported right foot pain rates 6/10 in severity. Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms,

OBJECTIVE

Gen: Normotensive, no acute distress. He continues to wear Uni-boot due to left foot surgery and wound infection being managed by Dr Alvarez, obesity
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits

T-814 P0042/0131 F-290

(F41.9) Anxiety disorder, unspecified

(M79.671) Pain in right foot

(E66.9) Obesity, unspecified

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

(I11.9) Hypertensive heart disease without heart failure

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(Z79.4) Long term (current) use of insulin

(Z71.3) Dietary counseling and surveillance

PLAN

NFBS finger stick check-in office 141
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Refer to psych for evaluation and treatment depression and anxiety
Extend Disability to April 10th, 2021
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in three months or sooner for a follow-up for evaluation disability
Plan reviewed with the patient. The patient verbalized understanding and agreed
Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

REFERRALS:
EAST NILES COMMUN HEALTH CENTER via Fax

05-12-'22 16:47 FROM-

T-814 P0043/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	CARLOS ALVAREZ M.D.
SEX	Male	6001-B TRUXTUN AVE SUITE 220	DATE	01/12/2021
PRN	RJ438906	Bakersfield, CA 93309	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 2:45 PM) (Arrival time: 2:41 PM) patient is here to f/u on his right foot infection. gg

Vitals for this encounter	01/12/21 3:36 PM
Height	65 in
Weight	192 lb
Temperature	98.60 °F
Pulse	88 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	0
BMI	31.95
Blood pressure	104/55 mmHg

SUBJECTIVE

54 year old male patient came in today for a follow up on right foot infection. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.

ASSESSMENT

05-12-'22 16:47 FROM-

PLAN

Injections tolerated well.
Refilled medication.
Advised to take medication as directed.
Ordered Labs; CBC, CMP, Lipids, HGB-A1C, TSH, T3 free, T4 free, UA Complete.
Right foot MRI ordered with and without contrast at Stockdale Radiology.
Referred to Podiatrist for consultation and evaluation due to right foot toe fracture.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 2 weeks for a follow up.

Seen by Christine Crisostomo F.N.P, under the supervision of Carlos A. Alvarez M.D.

REFERRALS:
Anthony Nguyen via Fax

Medications/Prescription orders attached to encounter:

Baclofen 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: Cynocobalamin 1,000 MGC/ML IM GIVEN NOW IN OFFICE by MA: Jose LUQ NDC:0143-9619-01 LOT:1705169. EXP:10/2021

Doxycycline Hyclate 100 MG Oral Tablet Delayed Release Sig: 1 tab po 2 times a day x 7 days

Hydrocodone-Acetaminophen (Norco) 10-325 MG Oral Tablet Sig: 1 tab po 2 times a day # 20

Ketorolac Tromethamine 30 MG/ML Injection Solution Sig: KETOROLAC 30/ML IM GIVEN NOW IN OFFICE BY MA: Jose RUQ NDC: 72611-725-01 LOT: 202001 EXP: 01/2022

AGE	56 yrs	F (661) 489-5991	DATE	12/21/2020
SEX	Male	5400 ALDRIN CT	AGE AT DOS	54 yrs
PRN	RJ438906	BAKERSFIELD, CA 93313	Not signed	

T-814 P0045/0131 F-290

Chief complaint

(Appt time: 10:54 AM) (Arrival time: 10:54 AM) PT HERE FOR DISABILITY EXTENSION MA:PM

Vitals for this encounter

	12/21/20 11:14 AM
Height	65 in
Weight	187 lb
Temperature	98.10 °F
Pulse	86 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	8 R FOOT
BMI	31.12
Blood pressure	109/67 mmHg

SUBJECTIVE

54 years old male patinet present in the clinic for follow up right foot pain rates 8/10 in severity due to infected on right foot after surgery, patient also present for evaluation disability extension, Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

OBJECTIVE

Gen: Normotensive, in acute distress. **obesity**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal

05-12-'22 16:48 FROM-

(E66.9) Obesity, unspecified

(I11.9) Hypertensive heart disease without heart failure

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(Z79.4) Long term (current) use of insulin

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

PLAN

NFBS finger stick check-in office 182
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
A medical certificate is given to the patient from 12/21/2020 to 02/09/20221 and may resume returning to work on 02/10/2021 medical reason
Complete for disability extension.
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in one month or sooner for a follow-up for pain
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

05-12-'22 16:48 FROM- T-814 P0046/0131 F-290

AGE	56 yrs	**F** (661) 489-5991	
SEX	Male	6001-B TRUXTUN AVE SUITE 220	
PRN	RJ438906	Bakersfield, CA 93309	

SEEN BY CARLOS ALVAREZ M.D.
DATE 12/18/2020
AGE AT DOS 54 yrs
Not signed

Chief complaint

(Appt time: 11:30 AM) (Arrival time: 11:36 AM)pt here to f/u on rt foot wound ma ys

Vitals for this encounter

	12/18/20 12:18 PM
Height	65 in
Weight	187.80 lb
Temperature	97.80 °F
Pulse	75 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	5
BMI	31.25
Blood pressure	92/60 mmHg

SUBJECTIVE

54 year old male patient came in today for a follow up on right foot wound care. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.
skin: open wound to right metatarsal fifth digit dime size, mild drainage and tenderness

FSBS done in office 191.
Advised to monitor blood sugars at home.
Wound check done in office.
Dressing change done in office.
Referred to Dr kumar for wound care.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 2 weeks for a follow up.

Seen by Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Hydrocodone-Acetaminophen (Norco) 10-325 MG Oral Tablet Sig: 1 tab po 2 times a day # 20

AGE 56 yrs	F (661) 489-5991	SEEN BY CARLOS ALVAREZ M.D.
SEX Male	6001-B TRUXTUN AVE SUITE 220	DATE 12/15/2020
PRN RJ438906	Bakersfield, CA 93309	AGE AT DOS 54 yrs
		Not signed

Chief complaint

(Appt time: 2:00 PM) (Arrival time: 2:51 PM) pt f/u on rt foot wound ma;mm fsbs 64 office

Vitals for this encounter

	12/15/20 3:27 PM
Height	65 in
Weight	188 lb
Temperature	98 °F
Pulse	79 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	4 rt foot
BMI	31.28
Blood pressure	115/65 mmHg

SUBJECTIVE

54 year old male patient came in today for a follow up on right foot wound. He denies fevers/chills, night sweats, weight changes, headache, dizziness, visual changes, tinnitus, SOB, chest pain, palpitations, abdominal pain, urinary changes, bowel movement changes, weakness/fatigue.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema.

FSBS done in office 64.
Advised to monitor blood sugars at home.
Wound check done in office.
Dressing change done in office.
Injections tolerated well.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 1 week for a follow up.

Seen by Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Ceftriaxone Sodium (cefTRIAXone Sodium) 1 GM Injection Solution Reconstituted Sig: ROCEPHIN 1 GM IM GIVEN NOW IN OFFICE BY MA: JOSE RUQ NDC: 0409-7332-11 LOT# KA2074 EXP: 08/2022

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: Cynocobalamin 1,000 MGC/ML IM GIVEN NOW IN OFFICE by MA: Jose LUQ NDC:0143-9619-01 LOT:1705169. EXP:10/2021

T-814 P0051/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	CARLOS ALVAREZ M.D.
SEX	Male	6001-B TRUXTUN AVE SUITE 220	DATE	12/12/2020
PRN	RJ438906	Bakersfield, CA 93309	AGE AT DOS	54 yrs

Not signed

Chief complaint

(Appt time: 2:30 PM) (Arrival time: 2:34 PM)c/o of wound to right foot

Vitals for this encounter	12/12/20 3:02 PM
Height	65 in
Weight	188 lb
Temperature	97.90 °F
Pulse	86 bpm
Respiratory rate	18 bpm
O2 Saturation	93 %
Pain	5 right foot
BMI	31.28
Blood pressure	116/59 mmHg

SUBJECTIVE

54 year old male presenting to the clinic with c/o of wound to right foot, patient reports mild drainage from area, no fever or warm to touch. Patient denies any chest pain, no sob, no headache, no cough or any changes in bowel movement or urine.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Extremities: FROM, no deformities, no edema, no erythema
Back: normal, no erythema or swelling.

05-12-'22 16:50 FROM-

(Z48.00) Encounter for change or removal of nonsurgical wound dressing

(Z04.9) Encounter for examination and observation for unspecified reason

(Z71.3) Dietary counseling and surveillance

PLAN

Wound care done in office.
FSBS done in office 230.
Advised to monitor blood sugars at home.
Injection tolerated well.
Advised to take medication as directed.
Stay hydrated.
Preventative care; diet and exercise reviewed.
Return to office in 1 week for a follow up.

Seen by Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Ceftriaxone Sodium (cefTRIAXone Sodium) 1 GM Injection Solution Reconstituted Sig: ROCEPHIN 1 GM IM GIVEN NOW IN OFFICE BY MA: JOSE RUQ NDC: 0409-7332-11 LOT# KA2074 EXP: 08/2022

Mupirocin 2 % External Ointment Sig: 1 application topically to affected area 3 times per day for 10 days

T-814 P0052/0131 F-290
05-12-'22 16:50 FROM-

05-12-'22 16:51 FROM- T-814 P0053/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	CARLOS ALVAREZ M.D.
SEX	Male	6001-B TRUXTUN AVE SUITE 220	DATE	12/10/2020
PRN	RJ438906	Bakersfield, CA 93309	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 1:37 PM) (Arrival time: 1:46 PM)pt here to f/u on infected surgery wound ma ys

Vitals for this encounter

	12/10/20 2:39 PM
Height	65 in
Weight	185 lb
Temperature	98.90 °F
Pulse	88 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	5
BMI	30.79
Blood pressure	102/69 mmHg

SUBJECTIVE

OBJECTIVE

ASSESSMENT

PLAN

Medications/Prescription orders attached to encounter:

- Acetaminophen (Tylenol Extra Strength) 500 MG Oral Tablet Sig: Take 1 tablet (500 mg) by mouth every 4 hours as needed
- Sulfamethoxazole-Trimethoprim (Bactrim DS) 800-160 MG Oral Tablet Sig: 1 tablet orally BID for 10 days

T-814 P0054/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	SHARON VEJVODA
SEX	Male	5400 ALDRIN CT		FNP
PRN	RJ438906	BAKERSFIELD, CA 93313	DATE	12/07/2020
			AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 3:45 PM) (Arrival time: 3:29 PM) PT C/O INFECTED SURGHERY WOUND NFBS= 213 MA JFLORES

Vitals for this encounter	
	12/07/20 3:44 PM
Height	65 in
Weight	182.40 lb
Temperature	98.10 °F
Pulse	84 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	9 RIGHT FOOT
BMI	30.35
Blood pressure	121/71 mmHg

SUBJECTIVE

54 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia. patinet present in the for follow up left foot pain rates 9/10 in severity, Patient states that Orthopedic refused to see him for follow up due to non-payment. Patient also requesting a refill of current medications. Reports tolerating current medications well without adverse reactions or any other problems. Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

OBJECTIVE

Gen: Normotensive, **acute distress related to infected wound site of right foot post procedure. obesity**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops

05-12-'22 16:51 FROM-

(Z76.0) Encounter for issue of repeat prescription

(Z68.30) Body mass index [BMI]30.0-30.9, adult

(M79.671) Pain in right foot

(E78.5) Hyperlipidemia, unspecified

(E66.9) Obesity, unspecified

(I11.9) Hypertensive heart disease without heart failure

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(S81.801A) Unspecified open wound, right lower leg, initial encounter

PLAN

NFBS finger stick check-in office 213
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Right outer aspect of foot with open wound, pus noted and surrounding site reddened and warm. Site cleaned I and D preformed. Site dressed with Bactroban ointment and xeroform applied with sterile wrap. RX for dressings sent to pharmacy. Patient instructed to change dressing every day. Patient instructed to make next appointment with Dr. Alvarez.
Injections administered in office and tolerated well.
Advised to take new medications as prescribed
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in one week or sooner for a follow-up for with Dr. Alvarez for wound care
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Baclofen 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

05-12-'22 16:51 FROM- T-814 P0055/0131 F-290

0047

T-814 P0057/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	SHARON VEJVODA FNP
SEX	Male	5400 ALDRIN CT	DATE	12/01/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:15 AM) (Arrival time: 11:08 AM) pt f/u on htn c/o **left** eye pain x 1 week also c/o right foot pain fbs= 214 ma jflores

Vitals for this encounter

	12/01/20 11:30 AM
Height	65 in
Weight	181.40 lb
Temperature	98.30 °F
Pulse	74 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	6 right foot
BMI	30.19
Blood pressure	130/80 mmHg

SUBJECTIVE

54 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia. patient present in the clinic for chronic health conditions follow up and patinet compliant of left eye pain rates 8/10 ins severity for one week, patinet reported right foot pain rates 6/10 in severity due to left foot fracture, Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms.

OBJECTIVE

Gen: Hypertensive, no acute distress. obesity
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: left EAC's Redness, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops

05-12-'22 16:52 FROM-

(I11.9) Hypertensive heart disease without heart failure

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(S92.911A) Unspecified fracture of right toe(s), initial encounter for closed fracture

(Z68.30) Body mass index (BMI)30.0-30.9, adult

(Z02.79) Encounter for issue of other medical certificate

PLAN

FBS finger stick check-in office 214
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
A medical certificate is given to the patient from 12/01/2020 to 01/08/2021 and may resume returning to work on 01/09/2020 medical reason
Stat referral needs to Ophthalmologist for left eye pain
Advised to take new medications as prescribed
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Advised to RTC in one month or sooner for a follow-up for evaluation return to work
Advised follow up with Podiatric 12/09/20
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

REFERRALS:
George Alexandrakis via Fax

Medications/Prescription orders attached to encounter:

Olopatadine HCl (Pataday) 0.1 % Ophthalmic Solution Sig: 1 drop into affected eye daily

05-12-'22 16:53 FROM- T-814 P0058/0131 F-290

AGE	56 yrs	F (661) 489-5991		SEEN BY	SHARON VEJVODA
SEX	Male	5400 ALDRIN CT			FNP
PRN	RJ438906	BAKERSFIELD, CA 93313		DATE	11/10/2020
				AGE AT DOS	54 yrs
				Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:46 AM) pt here for possible edd extension nfbs= 1334 ma jf

Vitals for this encounter	
	11/10/20 11:19 AM
Height	65 in
Weight	184.40 lb
Temperature	98.30 °F
Pulse	79 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	8 right hand
BMI	30.69

SUBJECTIVE

54 years old male patient with know history of Depression, Anxiety, Insomnia, Suicidal Ideation, right foot with toe fractures. Patient present in the clinic for evaluation extension for EDD, patient reported right foot pain rates 8/10 in severity, Patient denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

OBJECTIVE

General: **Mild hypertensive,** in no acute distress. obesity Head: Normocephalic, no lesions.
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal.
Ears: EAC's clear, TM's normal.
Nose: Mucosa normal, no obstruction.
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
GU: Not examined Back: Normal curvature, no tenderness **Neuro: Physiological, under the care of psych for major depression.**
Skin: Normal, no rashes, no lesions noted.
Extremities: Warm, well perfused, no edema, **decrease ROM related to post surgical repair of foot and toe fracture of right foot. patient wearing a uni-boot.**

(E66.9) Obesity, unspecified

(F32.9) Major depressive disorder, single episode, unspecified

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(Z79.4) Long term (current) use of insulin

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

(Z76.0) Encounter for issue of repeat prescription

(Z02.79) Encounter for issue of other medical certificate

(S92.911A) Unspecified fracture of right toe(s), initial encounter for closed fracture

PLAN

NFBS finger stick check-in office 134
Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
A medical certificate is given to the patient from 11/10/2020 to 12/09/2020 and may resume returning to work on 12/10/2020
medical purpose
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
Patient to follow up with pych for management of major depression.
Patient to follow-up with ortho for management of post -surgical care.
Advised to RTC in one month or sooner for a follow-up for HTN
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Sharon Vejvoda F.N.P under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Fish Oil-Cholecalciferol (Fish Oil + D3) 1200-1000 MG-UNIT Oral Capsule Sig: 1 capsule orally twice a day

Insulin Degludec (Tresiba FlexTouch) 200 UNIT/ML Subcutaneous Solution Pen-injector Sig: 48units

T-814 P0060/0131 F-290
05-12-'22 16:53 FROM-
0051

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	kenneth Redon FNP
DATE	10/06/2020
AGE AT DOS	54 yrs

Not signed

Chief complaint

HOSPITAL F/U (Appt time: 9:00 AM) (Arrival time: 8:52 AM) 54 yrs old male patient here to follow-up from Mercy hospital discharge due to low Blood pressure and medications change from the hospital. IFMA
FBS Finger stick check-in office= 158

Vitals for this encounter

	10/06/20 9:00 AM
Height	65 in
Weight	180 lb
Temperature	98 °F
Pulse	70 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	0
BMI	29.95
Blood pressure	110/73 mmHg

SUBJECTIVE

HPI:
54-year old male with Hypertension, Hyperlipidemia, T2DM, Vitamin D, and Obesity present to the office to follow up on his Depression, Anxiety, Insomnia, and Suicidal Ideation.

ROS:
Constitution: Negative except as mentioned in the HPI.
HENT: Negative except as mentioned in the HPI.
Eyes: Negative except as mentioned in the HPI.
Respiratory: Negative except as mentioned in the HPI.
Cardiovascular: Negative except as mentioned in the HPI.
GI: Negative except as mentioned in the HPI.
Endocrine/Allergy/Heme: Negative except as mentioned in the HPI.
GU: Negative except as mentioned in the HPI.
Musc: Negative except as mentioned in the HPI.
Skin: Negative except as mentioned in the HPI.
Neurologic: Negative except as mentioned in the HPI.
Psychiatric: Negative except as mentioned in the HPI.

OBJECTIVE

General: Vital signs stable, pleasant, well-appearing, non-toxic, non-distressed.
HENT: normocephalic, atraumatic, EAC nl, TM intact, oropharynx nl, mucous membranes moist.
Eyes: PERRLA, EOM intact, conjunctivae clear. Fundi is grossly NL.

EARS: (+)Right impacted cerumen
Neck: Supple, no masses, no thyromegaly, no JVD.
Chest: CTA, regular respiratory rate.
Heart: RRR, S1, and S2 noted, No M/R/G,
Abdomen: Soft, non-distended, non-tender, Normoactive BS.
Back: No CVA or Vertebral tenderness, curvature nl.
Skin: Warm to touch, no rash, no lesions.
Extremities: (+) DROM due to Right foot pain, no deformities, no tenderness, no edema.
Neurologic: CN II-XII intact, 5/5 strength, gait nl.
Psych: Alert and oriented X 4. Mood and affect appropriate.

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E78.00) Pure hypercholesterolemia, unspecified

(I48.2) Chronic atrial fibrillation

(K21.9) Gastro-esophageal reflux disease without esophagitis

(R25.2) Cramp and spasm

(M19.90) Unspecified osteoarthritis, unspecified site

(M79.671) Pain in right foot

(F32.9) Major depressive disorder, single episode, unspecified

(T14.91XA) Suicide attempt, initial encounter

(G47.00) Insomnia, unspecified

(G47.00) Insomnia, unspecified

(F41.9) Anxiety disorder, unspecified

PLAN

DC Hydrochlorothiazide 12.5mg , Meloxicam 7.5mg, Alprazolam 1mg.
Sertraline 50mg was increased to 100mg 1 po q hs.
Advised to take new medications as prescribed
Advised to continue other current medications as prescribed.
Side effects and risks of medications reviewed, Precautions emphasized
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
The patient is to follow-up in 1-2 weeks for evaluation on new meds.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	kenneth Redon FNP
DATE	09/24/2020
AGE AT DOS	54 yrs

Not signed

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:46 AM) 54 yrs old male patient here to follow-up on medication change to Alprazolam 1mg 1 po BID. IFMA
NFBS Finger stick check in office = 174

Vitals for this encounter

	09/24/20 11:56 AM
Height	65 in
Weight	181.80 lb
Temperature	98 °F
Pulse	67 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	0
BMI	30.25
Blood pressure	111/75 mmHg

SUBJECTIVE

HPI:
54-year old male with Hypertension, Hyperlipidemia, T2DM, Vitamin D, and Obesity present to the office to follow up on his Depression, Anxiety, Insomnia, and Suicidal Ideation. Patient reported that his depressive episodes has improved a lot since there was a switch on his medication. Patient's citalopram was discontinued and started on Sertraline 50 mg once daily. Patient stated that he started doing stuff at home now. He also started socializing and has never thought of suicide over the 2 weeks period.

ROS:
Constitution: Negative except as mentioned in the HPI.
HENT: Negative except as mentioned in the HPI.
Eyes: Negative except as mentioned in the HPI.
Respiratory: Negative except as mentioned in the HPI.
Cardiovascular: Negative except as mentioned in the HPI.
GI: Negative except as mentioned in the HPI.
Endocrine/Allergy/Heme: Negative except as mentioned in the HPI.
GU: Negative except as mentioned in the HPI.
Musc: Negative except as mentioned in the HPI.
Skin: Negative except as mentioned in the HPI.
Neurologic: Negative except as mentioned in the HPI.
Psychiatric: Negative except as mentioned in the HPI.

OBJECTIVE

Chest: CTA, regular respiratory rate.
Heart: RRR, S1 and S2 noted, No M/R/G,
Abdomen: Soft, non distended, non tender, Normoactive BS.
Back: No CVA or Vertebral tenderness, curvature nl.
Skin: Warm to touch, no rash, no lesions.
Extremities: FROM, no deformities, no tenderness, no edema.
Neurologic: CN II-XII intact, 5/5 strength, gait nl.
Psych: Alert and oriented X 4. Mood and affect appropriate.

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(I48.2) Chronic atrial fibrillation

(K21.9) Gastro-esophageal reflux disease without esophagitis

(E55.9) Vitamin D deficiency, unspecified

(E66.01) Morbid (severe) obesity due to excess calories

(I11.9) Hypertensive heart disease without heart failure

(F32.9) Major depressive disorder, single episode, unspecified

(F41.9) Anxiety disorder, unspecified

(G47.00) Insomnia, unspecified

(R45.851) Suicidal ideations

PLAN

Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness.
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
The patient is to follow-up in 2 weeks for further evaluation on depression.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Sertraline HCl 50 MG Oral Tablet Sig: Take 1 tablet (50 mg) by mouth daily at Bedtime.

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY kenneth Redon FNP
DATE 09/10/2020
AGE AT DOS 54 yrs
Not signed

Chief complaint

(Appt time: 9:00 AM) (Arrival time: 8:50 AM) 54 yrs old male patient here requesting to extend time off due to a Psy appointment was re-schedule for 09/29/20, the Patient states he still having suicidal thoughts. The patient has been off from June to 09/10/20.
FBS finger stick check-in office=105

Vitals for this encounter	09/10/20 10:00 AM
Height	65 in
Weight	182 lb
Temperature	98.10 °F
Pulse	66 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	0
BMI	30.29
Blood pressure	97/61 mmHg

SUBJECTIVE

A 54-year-old patient with a known history of T2DM, INSOMNIA, HYPERLIPIDEMIA. The patient here to follow-up and stated he has not been seen by Psy therapy, they have re-scheduled his appointment once again until the end of next month (09/26/20). The patient denies any chest pain, no SOB, no dizziness, no headache, no cough, or any changes in bowel movement or urine.

OBJECTIVE

General: Normotensive, **(+) Mild acute distress, (+) obese**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E78.00) Pure hypercholesterolemia, unspecified

(E66.9) Obesity, unspecified

(I11.9) Hypertensive heart disease without heart failure

(F32.9) Major depressive disorder, single episode, unspecified

(T14.91XA) Suicide attempt, initial encounter

(G47.00) Insomnia, unspecified

(F41.9) Anxiety disorder, unspecified

Follow-up

(R45.851) Suicidal ideations

PLAN

DC Citalopram 40mg starting today.
Advised to continue other current medications as prescribed
Advised to take new medications as prescribed
A controlled substance prescription was given to the patient in hand for Alprazolam 1mg 1 po bid # 60 / 0 refills.
FBS finger stick check-in office=105, Advised to monitor blood sugar at home daily; keeping a log with blood sugar readings.
Advised to bring the log to the next visit, accompanied with the glucometer
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
The patient is to follow-up in 2 weeks for further evaluation on a medication regiment
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Alprazolam (ALPRAZolam) 1 MG Oral Tablet Sig: Take 1 tablet (1 mg) by mouth 2 times per day as needed
Encounter Comments:
Prescription given 7/27/20. #60. No refill. by CARLOS A ALVAREZ on 07/27/20

Sertraline HCl 50 MG Oral Tablet Sig: Take 1 tablet (50 mg) by mouth daily at Bedtime.

T-814 P0068/0131 F-290

AGE	56 yrs	F (661) 489-5991		SEEN BY	Kenneth Redon FNP
SEX	Male	5400 ALDRIN CT		DATE	08/17/2020
PRN	RJ438906	BAKERSFIELD, CA 93313		AGE AT DOS	54 yrs
				Not signed	

Chief complaint

(Appt time: 11:15 AM) (Arrival time: 11:03 AM) F/U on anxiety. Patient states he is currently seeing the therapist. MA:Faby G

Vitals for this encounter	
	08/19/20 **4:27 PM**
Height	65 in
Weight	180 lb
Pulse	72 bpm
Respiratory rate	18 bpm
Pain	0
BMI	29.95
Blood pressure	112/103 mmHg left

SUBJECTIVE

A 54-year-old patient with a known history of T2DM, INSOMNIA, HYPERLIPIDEMIA. The patient here to follow-up and stated he has not been seen by Psy therapy, they have re-scheduled his appointment once again until the end of next month (09/26/20).
The patient denies any chest pain, no SOB, no dizziness, no headache, no cough, or any changes in bowel movement or urine.

OBJECTIVE

General: Vital signs stable. **NAD. (+)Obese.**
Head: Normocephalic, Atraumatic.
Eyes: PERRLA, EOM's full, conjunctivae clear.
Ears: EAC normal. TM is intact.
Nose: Mucosa normal, no obstruction.
Throat: Clear, no exudates, no lesions.
Neck: Supple, no masses, no thyromegaly, no bruits.
Chest: CTA, regular respiratory rate.
Heart: RRR, S1, and S2 noted, No M/R/G,
Abdomen: Soft, non-distended, non-tender, Normoactive BS.
Back: Normal curvature, no tenderness.
Skin: Normal. No rash, lesions.
Extremities: FROM, no deformities, no edema.
Psych: Alert and oriented X 4. Mood and affect appropriate.

ASSESSMENT

05-12-'22 16:57 FROM-

(F32.9) Major depressive disorder, single episode, unspecified

(Z79.4) Long term (current) use of insulin

PLAN

Advised to continue schedule appointments by Omni-Health (Psych).
Advised to continue current medications as prescribed.
Side effects and risks of medications reviewed, Precautions emphasized.
Medication E-scripted to pharmacy
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness.
FBS Finger stick check-in office= 137, Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150.
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
The patient is to follow-up in 2 weeks for further extension for EDD.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Apixaban (Eliquis) 5 MG Oral Tablet Sig: 1 PO BID

Cetirizine HCl 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

AGE	56 yrs	F (661) 489-5991	SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	07/27/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:57 AM)54 yrs old male patient here to f/u on med increased (Xanax) in the last visit. IFMA

Vitals for this encounter

	07/27/20 **11:00 AM**
Height	65 in
Weight	181 lb
Temperature	98 °F
Pulse	69 bpm
Respiratory rate	18 bpm
O2 Saturation	93 %
Pain	0
BMI	30.12
Blood pressure	114/66 mmHg left

SUBJECTIVE

HPI: 54-year old male is here for depression and anxiety follow up. In addition, patient is also here complaining of coughing, chest congestion, bilateral ear pain, sore throat, and difficulty swallowing. Patient reported that he hasn't taken any medications or home remedy for symptom relief.

ROS: All systems reviewed and are negative except those mentioned in HPI.

OBJECTIVE

General: Vital signs stable. Obese. Mild distress noted.
Head: Normocephalic, Atraumatic.
Eyes: PERRLA, EOM's full, pale conjunctiva noted.
Ears: EAC normal. TM intact.
Nose: Turbinates swollen
Throat: Erythematous pharynx noted, mild tonsilar exudates noted.
Neck: cervical node tenderness noted.
Chest: CTA, regular respiratory rate.
Heart: RRR, S1 and S2 noted, No M/R/G,
Abdomen: Soft, non distended, non tender, Normoactive BS.

(M19.90) Unspecified osteoarthritis, unspecified site

(E55.9) Vitamin D deficiency, unspecified

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(I11.9) Hypertensive heart disease without heart failure

(E78.5) Hyperlipidemia, unspecified

(R07.0) Pain in throat

(R09.81) Nasal congestion

(H92.03) Otalgia, bilateral

(J06.9) Acute upper respiratory infection, unspecified

(J02.9) Acute pharyngitis, unspecified

PLAN

Refill Xanax 1mg 1 po bid prn #60/0 refill controlled substance prescription was given to the patient in hand today.
Advised to take new medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Increase fluids, rest.
OTC decongestants of choice, prn
Saltwater gargles, ice chips to soothe throat tid.
Steam expectoration is recommended
Please take Tylenol as needed for headaches and fever. Home quarantine, social distancing, and hand hygiene recommended
Please return to the clinic in 3 da(s) if not better. Call or return to the clinic sooner if your condition worsens or if you have any concerns.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Alprazolam (ALPRAZolam) 1 MG Oral Tablet Sig: Take 1 tablet (1 mg) by mouth 2 times per day as needed
Encounter Comments:
Prescription given 7/27/20. #60. No refill. by CARLOS A ALVAREZ on 07/27/20

Amoxicillin & Pot Clavulanate (Amoxicillin-Pot Clavulanate) 500-125 MG Oral Tablet Sig: Take 1 tablet (500 mg) by mouth every 12 hours for 10 days

Chlorhexidine Gluconate (Mouth-Throat) (Chlorhexidine Gluconate) 0.12 % Mouth/Throat Solution Sig: Take 15 ml swish and spit twice a day as needed for 7 days

Fluticasone Propionate (Nasal) (Fluticasone Propionate) 50 MCG/ACT Nasal Suspension Sig: 1 spray intranasally 2 times per day in each nostril for 7 days

AGE	56 yrs	F (661) 489-5991	SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	07/20/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:30 AM) (Arrival time: 10:49 AM) 54 yrs old male patient here to follow-up t2dm and personal evaluation on depression . fbs finger stick 155. ifma

Vitals for this encounter	
	07/20/20 11:05 AM
Height	65 in
Weight	178.6 lb
Temperature	97.90 °F
Pulse	79 bpm
Respiratory rate	18 bpm
O2 Saturation	94 %
Pain	0
BMI	29.72
Blood pressure	118/73 mmHg left

SUBJECTIVE

54 yrs old male patient with a known history of T2DM, HTN, HYPERLIPIDEMIA, DEPRESSION, INSOMNIA, and Lately personal family problem that have caused him suicidal thoughts.
the patient also reported that he has an upcoming appointment with his therapist on July 15but was re-schedule, he was told they will call him as soon they're open for consultations. He still has an upcoming appointment with the Psychiatrist on August 11.
Otherwise, the patient described general well-being as good with no further acute complaints at this time. Denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

ROS: All systems reviewed and are negative except those mentioned in HPI.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E78.00) Pure hypercholesterolemia, unspecified

(K21.9) Gastro-esophageal reflux disease without esophagitis

(R25.2) Cramp and spasm

(E78.6) Lipoprotein deficiency

(E55.9) Vitamin D deficiency, unspecified

(Z79.4) Long term (current) use of insulin

(I11.9) Hypertensive heart disease without heart failure

(F32.9) Major depressive disorder, single episode, unspecified

(T14.91XA) Suicide attempt, initial encounter

(G47.00) Insomnia, unspecified

(F41.9) Anxiety disorder, unspecified

(R45.851) Suicidal ideations

PLAN

A controlled substance prescription was given to the patient in hand for Xanax 1mg 1 po bid #60/0refills.
Increased Xanx 0.5mg 1 po q hs to 1mg 1 po bid prn #60/0 refills .
Advised to continue other current medications as prescribed.
EDD will be extende until 09/11/20 until seen by the psych specialist.
FBS finger stick check-in office= 155 , Keep finger stick log and bring log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150.
The patient was advised to continue in contact with the psych specialist office for an appointment ASAP.
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
The patient is to follow-up in 1 week for further evaluation on medication increased for Xanax.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

T-814 P0073/0131 F-290
05-12-'22 16:59 FROM-
0064

AGE	56 yrs	F (661) 489-5991	SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	07/06/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

wants to extend his EDD (Appt time: 11:00 AM) (Arrival time: 10:44 AM) here to follow-up on T2DM regiment . ifma
nfbs finger stick check in office= 190

Vitals for this encounter

	07/06/20 11:37 AM
Height	65 in
Weight	179.40 lb
Temperature	97.80 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	94 %
Pain	0
BMI	29.85
Blood pressure	110/74 mmHg left

SUBJECTIVE

HPI: 54-year old male with T2DM, HTN, Hyperlipidemia, GERD, Neuropathy Major depression, anxiety is here for follow up on depression and medication evaluation. Patient was started on Citalopram 20 mg then the dose adjusted to 40 mg after one week. Patient described that depression has improved. Patient reported that prior to starting on medication, patient doesn't have interest in talking to other people. Now, he is able to socialize again. In addition, patient also reported that he has an upcoming appointment with his therapist on July 15 and has an upcoming appointment with the Psychiatrist on August 11. Otherwise, patient described general well-being as good with no further acute complaints at this time. Denies fever/chills, denies rashes/pruritus, denies headache/dizziness, denies cough or SOB, denies chest pain/palpitations, denies abdominal pain, no N/V/D, denies any urinary symptoms, denies weakness/malaise.

ROS: All systems reviewed and are negative except those mentioned in HPI.

OBJECTIVE

General: Vital signs stable. NAD.
Head: Normocephalic, Atraumatic.
Eyes: PERRLA, EOM's full, conjunctivae clear.
Ears: EAC normal. TM intact.

ASSESSMENT

Diagnoses attached to this encounter:

- (I48.2) Chronic atrial fibrillation
- (K21.9) Gastro-esophageal reflux disease without esophagitis
- (F32.9) Major depressive disorder, single episode, unspecified
- (E55.9) Vitamin D deficiency, unspecified
- (M54.9) Dorsalgia, unspecified
- (E78.5) Hyperlipidemia, unspecified
- (I11.9) Hypertensive heart disease without heart failure
- (E11.65) Type 2 diabetes mellitus with hyperglycemia
- (Z68.29) Body mass index (BMI) 29.0-29.9, adult
- (T14.91XA) Suicide attempt, initial encounter

PLAN

NFBS Finger stick check in office= 190, Keep finger stick log and bring log to every visit
Check finger stick fasting, 2 hours post meal and at bed time- alternate on different days
Fasting sugars should range between 70-120
2 hours post meal sugars should be < 160
Bedtime sugars should be 90-150
EKG is to be done next visit.
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Patient is to continue off work until 08/04/20.
Advised patient to continue appointment with psychiatrist.
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Patient is to follow-up in 2 weeks for routine evaluation on depression and anxiety.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Citalopram Hydrobromide 40 MG Oral Tablet Sig: Take 1 tablet (40 mg) by mouth daily

T-814 P0075/0131 F-290
05-12-'22 17:00 FROM-
0066

T-814 P0076/0131 F-290

AGE	56 yrs	F (661) 473-1751	SEEN BY NORMA BUENROSTRO np
SEX	Male	8929 PANAMA RD suite A	DATE 06/29/2020
PRN	RJ438906	Lamont, CA 93241	AGE AT DOS 54 yrs
			Not signed

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:57 AM) pt here edd extension due to depression, anxiety and insomnia nfsbs:97 ma:mm

Vitals for this encounter

	06/29/20 11:24 AM
Height	65 in
Weight	178 lb
Temperature	97.10 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	0
BMI	29.62
Blood pressure	122/73 mmHg left

SUBJECTIVE

54 years old male patient with a known history of Hypertension, Diabetes Mellitus - type 2, Hyperlipidemia present to the clinic for evaluation on EDD extension due to depression , anxiety, and insomnia. Patient states depression has improved but anxiety continues. He reports has not been able to get appt with psychiatrist through his insurance and has not been following up with his appt as instructed, he was instructed to schedule appt with psychiatrist asap. HE states has difficult staying asleep but for the most part sleeping well. Patient denies any suicidal or homicidal ideation. Patient denies any chest pain, any SOB, any dizziness, any headache, any cough, or any changes in bowel movement or urine.

OBJECTIVE

General: Normotensive, in no acute distress. **overweight**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops

05-12-'22 17:00 FROM-

(F32.9) Major depressive disorder, single episode, unspecified

(F32.9) Major depressive disorder, single episode, unspecified

(G47.00) Insomnia, unspecified

(F41.9) Anxiety disorder, unspecified

Follow-up

(Z68.29) Body mass index (BMI) 29.0-29.9, adult

(E66.3) Overweight

PLAN

pt to schedule appt with psychiatrist through his insurance (by the end of the day today)
Extend disability for 6 weeks
ER precautions discussed
Advised to take new medications as prescribed
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home
Keep Log of blood pressure and bring the log to appointments
Keep SBP <140 and DBP <90
A medical certificate is given to the patient from 6/29/2020 to 8/10/2020 and may resume returning to work on 8/11/2020 with no restrictions or limitations
Advised to RTC in two weeks or sooner for a follow-up for edd extension evaluation
Plan reviewed with the patient. The patient verbalized understanding and agreed
Seen by Norma Buenrostro F.N.P under the supervision of Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Baclofen 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

PATIENT
JACOB RAMOS

DOB	04/29/1966
AGE	56 yrs
SEX	Male
PRN	RJ438906

FACILITY
LAMONT
T (661) 473-1753
F (661) 473-1751
8929 PANAMA RD suite A
Lamont, CA 93241

ENCOUNTER
Office Visit

NOTE TYPE	SOAP Note
SEEN BY	kenneth Redon FNP
DATE	06/17/2020
AGE AT DOS	54 yrs

Not signed

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:37 AM) pt c/o depression x1 month ma:mm

Vitals for this encounter

	06/17/20 11:22 AM
Height	65 in
Weight	178 lb
Temperature	97.40 °F
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	0
Pulse	74 bpm
BMI	29.62
Blood pressure	125/72 mmHg

SUBJECTIVE

OBJECTIVE

ASSESSMENT

Diagnoses attached to this encounter:

- (F32.9) Major depressive disorder, single episode, unspecified
- (T14.91XA) Suicide attempt, initial encounter
- (I10) Essential (primary) hypertension
- (Z68.29) Body mass index (BMI) 29.0-29.9, adult
- (I11.9) Hypertensive heart disease without heart failure
- (Z79.4) Long term (current) use of insulin
- (E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified
- (E66.3) Overweight

PLAN

Referral needed for psychotherapy . RE: depression and suicidal thoughts
Increased Alprazolam from DAILY to BID
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
A controlled substance prescription was given to the patient in hand.
Medication E-scripted to pharmacy

Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Advised to RTC in one week or sooner for a follow-up for anxiety and depress
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

- Alprazolam (ALPRAZolam) 0.5 MG Oral Tablet Sig: Take 1 tablet (0.5 mg) by mouth 2 times per day
- Citalopram Hydrobromide 20 MG Oral Tablet
- Citalopram Hydrobromide 20 MG Oral Tablet Sig: Take 1 tablet (20 mg) by mouth daily for 7 days
- Citalopram Hydrobromide 40 MG Oral Tablet Sig: Take 1 tablet (40 mg) by mouth daily x 30 days START 6/24/20

AGE	56 yrs	F (661) 489-5991	SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	06/08/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:57 AM) 54 yrs old male patient here to follow-up on hypotension meds decrease.
NFBS FINGER STICK CHECK IN OFFICE= 144
The patient also wants to talk to the provider confidential. IFMA

Vitals for this encounter

	06/08/20 **11:26 AM**
Height	65 in
Weight	178.40 lb
Temperature	98.20 °F
Pulse	82 bpm
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	0
BMI	29.69
Blood pressure	138/78 mmHg left

SUBJECTIVE

HPI: 54-year old male is here to follow up after staying at a behavioral center overnight due to unsuccessful suicide attempt. Patient expressed that due to family issues, he attempted committing suicide. Patient reported that over the past couple weeks, he has bee depressed and having a lot of anxiety attacks especially at night.

ROS: All systems reviewed and are negative except those mentioned in HPI.

OBJECTIVE

General: Vital signs stable.
Head: Normocephalic, Atraumatic.
Eyes: PERRLA, EOM's full, conjunctivae clear.
Ears: EAC normal. TM intact.
Nose: Mucosa normal, no obstruction.
Throat: Clear, no exudates, no lesions.
Neck: Supple, no masses, no thyromegaly, no bruits.
Chest: CTA, regular respiratory rate.

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(E78.00) Pure hypercholesterolemia, unspecified

(I48.2) Chronic atrial fibrillation

(K21.9) Gastro-esophageal reflux disease without esophagitis

(M54.9) Dorsalgia, unspecified

(R25.2) Cramp and spasm

(M19.90) Unspecified osteoarthritis, unspecified site

(E87.5) Hyperkalemia

(Z79.4) Long term (current) use of insulin

(F32.9) Major depressive disorder, single episode, unspecified

(T14.91XA) Suicide attempt, initial encounter

(Z68.29) Body mass index (BMI) 29.0-29.9, adult

(E66.9) Obesity, unspecified

(G47.00) Insomnia, unspecified

PLAN

NFBS Finger stick check-in office= 144, Advised to monitor blood sugar at home daily; keeping a log with blood sugar readings.
Advised to bring the log to the next visit, accompanied by a glucometer.
The patient was Referral to Kern Behavioral Health and Recovery services 06/11/20 @ 2 pm. (661)868-8156.
Advised to take new medications as prescribed
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Controlled substance prescription was given to the patient in hand for **Alprazolam 0.5mg 1 po at bedtime** for insomnia and anxiety. # 14/0 refills.
Medical certificate given to the patient to be off for 06/08/20 to 07/08/20 may return to work on 07/09/20.
Advised to increase and maintain physical activity for physical and emotional health, as well as improvement of chronic illness
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Alprazolam (ALPRAZolam) 0.5 MG Oral Tablet Sig: Take 1 tablet (0.5 mg) by mouth 2 times per day

AGE	56 yrs	F (661) 489-5991	SEEN BY	Kenneth Regoli FNP	
SEX	Male	5400 ALDRIN CT	DATE	06/01/2020	
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs	
			Not signed		

T-814 P0082/0131 F-290

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 11:09 AM) 54 yrs old male patient here to folow-up on T2DM, requesting medications refillss, patient also complaints of dizziness and mild headache notice low blood pressure at home x 3 days. IFMA
per patient FBS at home 179 this morming .

Vitals for this encounter

	06/01/20 11:18 AM
Height	65 in
Weight	183.2 lb
Temperature	97.80 °F
Pulse	80 bpm
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	0
BMI	30.49
Blood pressure	97/63 mmHg left

SUBJECTIVE

HPI:
54-year old male with known history of HTN, Hypercholesterolemia, T2DM, Osteoarthritis, A-Fib, present to the office for laboratory result follow up Patient reported of compliance to medication regimen, diet modification, and exercise. Patient reported tolerating well the medication and denies any adverse reaction to medication. Patient is also here requesting pain or anti inflammatory injection for his bilateral hand arthritis. Otherwise, patient states to be doing well with no other acute complaints at this time. Patient denies fever, chills. N/V, appetite changes, denies any chest pain, any SOB, any dizziness, any headache, any cough, or any changes in bowel movement or urination.

05-12-'22 17:08 FROM-

ROS:
Constitution: Negative except as mentioned in the HPI.
HENT: Negative except as mentioned in the HPI.
Eyes: Negative except as mentioned in the HPI.
Respiratory: Negative except as mentioned in the HPI.
Cardiovascular: Negative except as mentioned in the HPI.
GI: Negative except as mentioned in the HPI.
Endocrine/Allergy/Heme: Negative except as mentioned in the HPI.

05-12-'22 17:03 FROM- T-814 P0083/0131 F-290

Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Extremities:

- BUE: + wrist joint tenderness. + MIP, +PIP joint tenderness. Limited ROM.
- BLE: Limited ROM.

Psych: Alert and oriented X 4. Mood and affect appropriate to the situation. No suicidal thoughts.

Reviewed and discussed **labs dated on 05/11/20**

- HDL CHOLESTEROL= 27
- ALT=8
- ABSOLUTE EOSINOPHILS= 519
- HEMOGLOBIN A1C= 7.3

URINALYSIS

- GLUCOSE=3+

ASSESSMENT

Diagnoses attached to this encounter:

(I48.2) Chronic atrial fibrillation

(E55.9) Vitamin D deficiency, unspecified

(R25.2) Cramp and spasm

(K21.9) Gastro-esophageal reflux disease without esophagitis

(M19.90) Unspecified osteoarthritis, unspecified site

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(M25.649) Stiffness of unspecified hand, not elsewhere classified

(I11.9) Hypertensive heart disease without heart failure

(E78.5) Hyperlipidemia, unspecified

(I95.9) Hypotension, unspecified

(R42) Dizziness and giddiness

PLAN

Lab results reviewed with patient and understood
Injections administered in office and tolerated well.
DC Rosuvastatin 40mg starting today.

0074

Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks.
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Hydrochlorothiazide (hydroCHLOROthiazide) 12.5 MG Oral Tablet Sig: Take 1 tablet (12.5 mg) by mouth daily in the morning

Ketorolac Tromethamine 30 MG/ML Injection Solution Sig: Ketorolac Tromethamine 60mg/2ml 1cc given by MA IRMA FUENTES to RUOQ IM NDC: 47781-585-46 LOT: ADN925 Exp: 09/2021

Metoprolol Succinate (Metoprolol Succinate ER) 25 MG Oral Tablet Extended Release 24 Hour Sig: Take 1 tablet (25 mg) by mouth daily

Simvastatin 20 MG Oral Tablet Sig: TAKE 1 TABLET BY MOUTH ONCE DAILY IN THE EVENING

Triamcinolone Acetonide (Kenalog) 40 MG/ML Injection Suspension Sig: Triamcinolone 400mg per 10ml Kenolog 40 1cc given by MA IRMA FUENTES to RUOQ IM NDC: 0703-0245-01 LOT: 799079 Exp=07/2021

05-12-'22 17:04 FROM- T-814 P0085/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	Kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	05/11/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	54 yrs
			Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 11:17 AM) 54 yrs old female patient here to follow-up on T2DM, requesting medications refill, Patient also complains of bilateral hands pain. ifma
FBS finger stick check-in office= 119

Vitals for this encounter	
	05/11/20 11:20 AM
Height	65 in
Weight	189 lb
Temperature	97.7 °F
Pulse	71 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	6 BILATERAL HANDS
BMI	31.45
Blood pressure	121/65 mmHg LEFT

SUBJECTIVE

HPI:
54-year old male with known history of HTN, Hypercholesterolemia, T2DM, Osteoarthritis, A-Fib, present to the office for chronic health condition follow up. Patient is due for his routine blood work. Patient reported of compliance to medication regimen, diet modification, and exercise. Patient reported tolerating well the medication and denies any adverse reaction to medication. Patient is also here requesting pain or anti inflammatory injection for his bilateral hand arthritis. Otherwise, patient states to be doing well with no other acute complaints at this time. Patient denies fever, chills. N/V, appetite changes, denies any chest pain, any SOB, any dizziness, any headache, any cough, or any changes in bowel movement or urination.

ROS:
Constitution: Negative except as mentioned in the HPI.
HENT: Negative except as mentioned in the HPI.
Eyes: Negative except as mentioned in the HPI.
Respiratory: Negative except as mentioned in the HPI.
Cardiovascular: Negative except as mentioned in the HPI.

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Extremities:

- BUE: + wrist joint tenderness. + MIP, +PIP joint tenderness. Limited ROM.
- BLE: Limited ROM.

Psych: Alert and oriented X 4. Mood and affect appropriate to the situation. No suicidal thoughts.

ASSESSMENT

Diagnoses attached to this encounter:

(E78.00) Pure hypercholesterolemia, unspecified

(I11.9) Hypertensive heart disease without heart failure

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(I48.2) Chronic atrial fibrillation

(M19.90) Unspecified osteoarthritis, unspecified site

(M25.649) Stiffness of unspecified hand, not elsewhere classified

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

(E66.9) Obesity, unspecified

PLAN

FBS finger stick check-in office= 119, Keep finger stick log and bring the log to every visit
Check finger stick fasting, 2 hours post-meal and at bedtime- alternate on different days
Fasting sugars should range between 70-120
2 hours post-meal sugars should be < 160
Bedtime sugars should be 90-150
Injections administered in office and tolerated well.
Order labs for LIP, CMP,CBC, TSH,T4 FREE,VIT-D, A1C,U/A MICRO,U/A W/REFLEX TO CULTURE.
Advised to continue current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Order fasting lab for
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low-fat meats such as chicken

T-814 P0086/0131 F-290
05-12-'22 17:04 FROM-
0077

Ketorolac Tromethamine 30 MG/ML Injection Solution Sig: KETOROLAC 30/ML IM GIVEN NOW IN OFFICE BY MA. JOSE RUQ
NDC: 72611-725-01 LOT: 202001 EXP: 01/2022

Triamcinolone Acetonide (Kenalog) 40 MG/ML Injection Suspension Sig: Kenolog 40 1cc given by MA IRMA FUENTES to
RUOQ IM NDC=0703-0245-01 LOT# 348049 Exp=04/2021

AGE	56 yrs	F (661) 489-5991	SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT	DATE	01/30/2020
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	53 yrs
			Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:49 AM) 53 yrs old male patient here to follow-up on upper respiratory infection . IFMA

Vitals for this encounter

	01/30/20 11:26 PM
Height	65.5 in
Weight	199 lb
Temperature	98 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	99 %
Pain	0
BMI	32.61
Blood pressure	120/65 mmHg left

SUBJECTIVE

HPI:

53-year old male present to the office for complaints of nasal congestion. Patient was seen last 01/28/20 for acute upper respiratory infection. Patient was on an antibiotic therapy and patient reported that he feel much better now. He still coughing a little bit but not too much. He is only complaining about nasal congestion which caused him to have difficulty breathing at night when laying down. Otherwise, patient states to be doing well with no other acute complaints at this time. Patient denies fever, chills. N/V, appetite changes, denies any chest pain, any SOB, any dizziness, or any changes in bowel movement or urine.

ROS:

Constitution: Denies activity change, appetite change, fevers, chills, fatigue, wt change.
HENT: report of nasal congestion.
Eyes: Denies eye pain, eye discharge, eye itching, eye redness, photophobia, vision change.
Respiratory: report of difficulty breathing.
Cardiovascular: Denies chest pain, chest pressure, leg swelling, palpitations.
GI: Denies abdominal pain, abdominal distention, bloody stools, constipation, diarrhea, nausea, vomiting, poor appetite.
Endocrine/Allergy/Heme: Denies cold intolerance, heat intolerance, polyuria, polydipsia.
GU: Denies dysuria, frequency, urgency, hematuria, flank pain, pelvic pain.
Musc: Denies back pain, neck pain, arthralgias, joint swelling, myalgias, stiffness.
Skin: Denies rash, color change, pallor, wound, laceration.

Eyes: [illegible]
Ears: EAC's clear, TM's normal
Nose: turbinates swollen. sinus tenderness noted.
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

(R09.81) Nasal congestion

(J34.89) Other specified disorders of nose and nasal sinuses

(R51) Headache

(E11.65) Type 2 diabetes mellitus with hyperglycemia

PLAN

NFBS Finger stick check in office = 359 LM @ 10:00 am, Advised to monitor blood sugar at home daily; keeping a log with blood sugar readings.
Advised to bring log to next visit, accompanied with glucometer.
Advised to take new medications as prescribed
Advised to continue other current medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Increase fluids, rest.
OTC analgesic, Tylenol, ibuprofen prn.
OTC decongestants of choice, prn
Salt water gargles, ice chips to soothe throat tid.
Steam expectoration is recommended
RTC prn or within 3-5 days if no signs of improvement.
Plan of care discussed with the patient. The patient verbalized understanding and agreeable.

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Fluticasone Propionate (Nasal) (Fluticasone Propionate) 50 MCG/ACT Nasal Suspension Sig: 1 spray intranasally 2 times per day in each nostril for 7 days

Pseudoephedrine HCl (Sudafed 12 Hour) 120 MG Oral Tablet Extended Release 12 Hour Sig: Take 1 tablet (120 mg) by mouth every 12 hours as needed for 7 days

AGE	56 yrs	F (661) 489-5991		SEEN BY	kenneth Redon FNP
SEX	Male	5400 ALDRIN CT		DATE	01/28/2020
PRN	RJ438906	BAKERSFIELD, CA 93313		AGE AT DOS	53 yrs
				Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:46 AM) PT HERE FOR C/O COUGH AND BILATERAL EAR PAIN X 3 DAYS FBS 194
JESPANA

Vitals for this encounter	
	01/28/20 11:03 AM
Height	65.5 in
Weight	195 lb
Temperature	97.80 °F
Pulse	69 bpm
Respiratory rate	18 bpm
O2 Saturation	98 %
Pain	6 BILATERAL EAR
BMI	31.96
Blood pressure	123/71 mmHg

SUBJECTIVE

HPI:
53-year old male present to the office for complaints of coughing, mild sore throat, bilateral ear pain, and nasal congestion for 3 days. Patient stated he doesn't have any fever, chills, or night sweats. Patient denies taking any medications for symptom relief. No further acute complaint at this time.

ROS:
Constitution: see HPI.
HENT: see HPI.
Eyes: Denies eye pain, eye discharge, eye itching, eye redness, photophobia, vision change.
Respiratory: see HPI.
Cardiovascular: Denies chest pain, chest pressure, leg swelling, palpitations.
GI: Denies abdominal pain, abdominal distention, bloody stools, constipation, diarrhea, nausea, vomiting, poor appetite.
Endocrine/Allergy/Heme: Denies cold intolerance, heat intolerance, polyuria, polydipsia.
GU: Denies dysuria, frequency, urgency, hematuria, flank pain, pelvic pain.
Musc: Denies back pain, neck pain, arthralgias, joint swelling, myalgias, stiffness.
Skin: Denies rash, color change, pallor, wound, laceration.
Neurologic: Denies weakness, dizziness, headache, numbness, speech problem, facial weakness, vision change, confusion.

T-814 P0091/0131 F-290

Neck: cervical node tenderness noted.
Chest: + rhonchi
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Back: Normal curvature, no tenderness
Extremities: FROM, no deformities, no edema, no erythema

ASSESSMENT

Diagnoses attached to this encounter:

- (R05) Cough
- (R09.81) Nasal congestion
- (R07.0) Pain in throat
- (J06.9) Acute upper respiratory infection, unspecified
- (E11.65) Type 2 diabetes mellitus with hyperglycemia
- (I10) Essential (primary) hypertension
- (E78.00) Pure hypercholesterolemia, unspecified
- (Z68.31) Body mass index (BMI) 31.0-31.9, adult
- (E66.9) Obesity, unspecified
- (H92.03) Otalgia, bilateral

PLAN

FBS finger stick check in office 194
Keep finger stick log and bring log to every visit
Check finger stick fasting, 2 hours post meal and at bed time- alternate on different days
Fasting sugars should range between 70-120
2 hours post meal sugars should be < 160
Bedtime sugars should be 90-150
Injections administered in office and tolerated well.
Medical certificate given to patient to return to work from 01/27/20 to 01/29/20 and may resume to return to work on 01/30/20 with no restrictions or limitations
Advised to continue current medications as prescribed
Advised to take new medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy
Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Monitor blood pressure at home

05-12-'22 17:06 FROM-

Medications/Prescription orders attached to encounter:

Ceftriaxone Sodium (cefTRIAXone Sodium) 1 GM Injection Solution Reconstituted Sig: Ceftriaxone 1gm given by MA JACQUELINE ESPANA to LUOQ IM NCD:0409-7332-11 LOT=JH6069 Exp=09/2021

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: Cyanocobalamin1cc given by MA JACQUELINE ESPANA to RUOQ IM NDC=0143-9619-01 LOT=1705169.1 Exp=10/2021

Dexamethasone Sodium Phosphate 10 MG/ML Injection Solution Sig: Daxamethazone Sodium10mg/ml 1cc given by MA Jacqueline espana to RUOQ IMNDC# 0641-0367-21LOT=029407Exp= 02/2021

Dextromethorphan-Guaifenesin (Mucinex DM) 30-600 MG Oral Tablet Extended Release 12 Hour Sig: 1 tablet orally every 12 hours as needed for 10 days

Sulfamethoxazole-Trimethoprim 400-80 MG Oral Tablet Sig: 1 tablet by mouth BID for 10 days.

AGE	56 yrs	F (661) 489-5991		SEEN BY	Kenneth Redon FNP
SEX	Male	5400 ALDRIN CT		DATE	12/04/2019
PRN	RJ438906	BAKERSFIELD, CA 93313		AGE AT DOS	53 yrs
				Not signed	

Chief complaint

(Appt time: 10:15 AM) (Arrival time: 10:43 AM) PT HERE FRO MEDICINE REFIILS AND FOLLOW UP PHARYNGITIS NFBS FINGER STICK CHECK IN OFFICE 88 LM 7 AM JESPANA

Vitals for this encounter

	12/04/19 10:51 AM
Height	65.5 in
Weight	197 lb
Temperature	97.20 °F
Pulse	69 bpm left
Respiratory rate	18 bpm
O2 Saturation	96 %
Pain	0
BMI	32.28
Blood pressure	124/73 mmHg left

SUBJECTIVE

HPI:

53-year old male present to the office to follow up on his chronic health condition. Patient has known history of DM, Hyperlipidemia, HTN, and GERD. Patient is requesting medication refill. In addition, patient is here for complaints of dry cough, sore throat, right ear discomfort, and nasal congestion. Patient is requesting medication for it. States that he went to urgent care and he received oral antibiotic. Otherwise, patient states to be doing well with no other acute complaints at this time. Patient denies fever, chills. N/V, appetite changes, denies any chest pain, any dizziness, any headache, or any changes in bowel movement or urine.

Review of Systems:

Constitution: Denies activity change, appetite change, fevers, chills, fatigue, wt change.

HENT: report of sore throat. right ear discomfort. nasal congestion.

Eyes: Denies eye pain, eye discharge, eye itching, eye redness, photophobia, vision change.

Respiratory: report of shortness of breath and wheezing, dry cough.

Cardiovascular: Denies chest pain, chest pressure, leg swelling, palpitations.

GI: Denies abdominal pain, abdominal distention, bloody stools, constipation, diarrhea, nausea, vomiting, poor appetite.

Endocrine/Allergy/Heme: Denies cold intolerance, heat intolerance, polyuria, polydipsia.

GU: Denies dysuria, frequency, urgency, hematuria, flank pain, pelvic pain.

Eyes: PERRLA, EOMI. No icteric sclera or erythema, conjunctivae clear, fundi grossly normal
ENT: right ear EAC slightly erythematous. right TM intact - slightly bulging. + post nasal drip. Erythematous pharynx noted. + post nasal drip.
Cardiovascular: Regular rate and rhythm. Peripheral pulses intact. No murmurs, gallops, or rubs.
Respiratory: wheezing heard during expiration.
Abdomen: Soft, non-tender, non-distended. Bowel sounds present in 4 abdominal quadrants.
Back: No CVA or vertebral tenderness. Good ROM.
Skin: Normal color. Warm and Dry. No rashes, lesions, abrasions.
Extremities: Non-tender. No pedal edema.
Neuro: Oriented. No gross motor deficits.
Psych: Alert and oriented X 4. Mood and affect appropriate to the situation. No suicidal thoughts.

ASSESSMENT

Diagnoses attached to this encounter:

- (E11.65) Type 2 diabetes mellitus with hyperglycemia
- (I10) Essential (primary) hypertension
- (I48.2) Chronic atrial fibrillation
- (K21.9) Gastro-esophageal reflux disease without esophagitis
- (E78.00) Pure hypercholesterolemia, unspecified
- (J30.9) Allergic rhinitis, unspecified
- (R06.2) Wheezing
- (J02.9) Acute pharyngitis, unspecified
- (Z68.32) Body mass index (BMI) 32.0-32.9, adult
- (E66.9) Obesity, unspecified
- (Z71.3) Dietary counseling and surveillance
- (Z04.9) Encounter for examination and observation for unspecified reason
- (Z76.0) Encounter for issue of repeat prescription
- (Z79.4) Long term (current) use of insulin

PLAN

NFBS finger stick check in office 88 LM 7 am
Keep finger stick log and bring log to every visit
Check finger stick fasting, 2 hours post meal and at bed time- alternate on different days
Fasting sugars should range between 70-120
2 hours post meal sugars should be < 160
Bedtime sugars should be 90-150
Injections administered in office and tolerated well.
Discontinuous Ranitidine and change it to Famotidine 20mg at bedtime
Advised to take new medications as prescribed
Side effects and risks of medications reviewed, Precautions emphasized
Medication E-scripted to pharmacy

Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Albuterol Sulfate (Albuterol Sulfate HFA) 108 (90 Base) MCG/ACT Inhalation Aerosol Solution Sig: 2 puffs inhaled orally one a day as needed

Apixaban (Eliquis) 5 MG Oral Tablet Sig: 1 PO BID

Ceftriaxone Sodium (cefTRIAXone Sodium) 1 GM Injection Solution Reconstituted Sig: Ceftriaxone 1mg given by MA JACQUELINE ESPANA to LUOQ IM NCD=0409-7332-1 LOT=820108M Exp=10/2020c

Cetirizine HCl 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: CYANOCOBALAMIN 1000 MG/ML IM INJECTION ADMINISTERED RUOQ IN OFFICE BY MA:Jacqueline espana NDC: 0143962001 LOT: 1705035.1 EXP: 02/19

Dexamethasone Sodium Phosphate 10 MG/ML Injection Solution

Dulaglutide (Trulicity) 1.5 MG/0.5ML Subcutaneous Solution Pen-injector Sig: 1.5 mg subcutaneously weekly

Famotidine 20 MG Oral Tablet Sig: Take 1 tablet (20 mg) by mouth daily at bedtime

Fluticasone Propionate (Nasal) (Fluticasone Propionate) 50 MCG/ACT Nasal Suspension Sig: Inhale 2 sprays (100 mcg) into nostril daily in each nostril

Insulin Degludec (Tresiba FlexTouch) 200 UNIT/ML Subcutaneous Solution Pen-injector Sig: 48units

Insulin Lispro (HumaLOG) 100 UNIT/ML Subcutaneous Solution Sig: USE SQ 5 UNITS SQ WITH EACH MEAL

Omeprazole 40 MG Oral Capsule Delayed Release Sig: Take 1 capsule by mouth once daily

05-12-'22 17:08 FROM- T-814 P0095/0131 F-290

AGE	56 yrs	F (661) 489-5991	SEEN BY	Kenneth Reduri FNP
SEX	Male	5400 ALDRIN CT	DATE	10/31/2019
PRN	RJ438906	BAKERSFIELD, CA 93313	AGE AT DOS	53 yrs
			Not signed	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 12:02 PM) 53 YEARS OLD MALE PATIENT DIABETIC PRESENT IN THE CLINIC COMPLAINT OF SORE THROAT, NASAL CONGESTION BILATERAL EAR PAIN, COUGH, CHILLS, HEADACHE X 2 DAYS NFBS finger stick check in office 252 LM 6 am JESPANA

Vitals for this encounter

	10/31/19 12:20 PM
Height	65.5 in
Weight	195.4 lb
Temperature	97.20 °F
Pulse	71 bpm left
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	6 head
BMI	32.02
Blood pressure	138/72 mmHg left

SUBJECTIVE

HPI:

Patient is a 53-year old male present to the office for complaints of headache, nasal congestion, sore throat, chest congestion, fever, and chills for 2 days. Patient states he hasn't taken any medication to relieve the symptoms. Otherwise, he states he is okay.

Review of Systems:
Constitution: report of fever, chills.
HENT: report of nasal congestion, bilateral ear pain, and headaches.
Eyes: Denies eye pain, eye discharge, eye itching, eye redness, photophobia, vision change.
Respiratory: report of cough, congestion.
Cardiovascular: Denies chest pain, chest pressure, leg swelling, palpitations.
GI: Denies abdominal pain, abdominal distention, bloody stools, constipation, diarrhea, nausea, vomiting, poor appetite.
Endocrine/Allergy/Heme: Denies cold intolerance, heat intolerance, polyuria, polydipsia.
GU: Denies dysuria, frequency, urgency, hematuria, flank pain, pelvic pain.
Musc: Denies back pain, neck pain, arthralgias, joint swelling, myalgias, stiffness.

05-12-'22 17:09 FROM- T-814 P0097/0131 F-290

nasal mucosa. Mild tonsillar exudates noted.
Eyes: PERRL, EOM normal, vision intact, **pale conjunctiva noted.**
Neck: ROM normal, supple, no meningismus. **Anterior cervical adenopathy.**
Cardiovascular: normal rate, regular rhythm, heart sounds normal, no jvd.
Respiratory: Mild crackles heard on bilateral lung bases.
Abdominal: soft, nontender, bowel sounds normal, no rebound or guarding, negative Murphy's sign, negative McBurney's tenderness.
Back: No CVA or vertebral tenderness.
Extremities: Non-tender. No pedal edema.
Neurological: alert, oriented x3, CN II-XII intact, 5/5 strength throughout, normal sensation throughout, normal gait.
Skin: normal color, warm, dry.
Psychiatric: normal affect, judgement normal, no suicidal thoughts.

ASSESSMENT

Diagnoses attached to this encounter:

- (E11.65) Type 2 diabetes mellitus with hyperglycemia
- (J02.9) Acute pharyngitis, unspecified
- (I10) Essential (primary) hypertension
- (J03.90) Acute tonsillitis, unspecified
- (I48.2) Chronic atrial fibrillation
- (K21.9) Gastro-esophageal reflux disease without esophagitis
- (R51) Headache
- (R05) Cough
- (R68.83) Chills (without fever)
- (H92.03) Otalgia, bilateral
- (R09.81) Nasal congestion
- (Z68.32) Body mass index (BMI) 32.0-32.9, adult
- (E66.9) Obesity, unspecified

PLAN

NFBS finger stick check in office 252 LM 6 am
Keep finger stick log and bring log to every visit
Check finger stick fasting, 2 hours post meal and at bed time- alternate on different days
Fasting sugars should range between 70-120
2 hours post meal sugars should be < 160
Bedtime sugars should be 90-150
Injections administered in office and tolerated well.
(Rocephin injection IM given. Patient tolerated.
Dexamethasone injection IM given. Patient tolerated.)
Advised to continue current medications as prescribed
Started on Z-pack. Instructed to take it as directed.

Preventive counseling: Diet and exercise daily for at least 30 min
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
Advised to increase oral fluid intake.
Advised to increase rest period.
Monitor blood pressure at home
Keep Log of blood pressure and bring log to appointments
Keep SBP <140 and DBP <90
Advised to RTC in two weeks for a follow up pharyngitis
Plan reviewed with the patient. The patient verbalized understanding and agreed

Seen by Kenneth Adrian Redon F.N.P, under the supervision of Carlos A Alvarez M.D

Medications/Prescription orders attached to encounter:

Ceftriaxone Sodium (cefTRIAXone Sodium) 1 GM Injection Solution Reconstituted Sig: ROCEPHIN 1 GM IM GIVEN NOW IN OFFICE BY MA: JOSE RUQ NDC: 0409-7332-11 LOT# KA2074 EXP: 08/2022

Dexamethasone Sodium Phosphate 10 MG/ML Injection Solution Sig: DEXAMETHASONE 10MG/ML IM GIVEN NOW IN OFFICE BY MA: Jose LUQ NDC: 10079910558950 EXP: FEB2022 LOT: 029407

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY JOSEPH FRANCISCO FNP-C
DATE 08/12/2019
AGE AT DOS 53 yrs
Not signed

Chief complaint

refills (Appt time: 12:00 PM) (Arrival time: 11:53 AM) Pt here for F/U T2DM HTN c/o pain in both hands jespana NFBS 200 IN OFFICE

Vitals for this encounter	**08/12/19 12:02 PM**
Height	65.5 in
Weight	193.6 lb
Temperature	97.20 °F
Pulse	73 bpm left
Respiratory rate	18 bpm
O2 Saturation	95 %
Pain	6 hands
BMI	31.73
Blood pressure	129/67 mmHg left

SUBJECTIVE

53 year old male patient is presented in office today due to left hand pain x 1 mo. Patient rates current pain a 6/10. Patient denies any chest pain, any SOB, any dizziness, any headache, any cough, or any changes in bowel movement or urine. Patient denies any chest pain, any SOB, any dizziness, any headache, any cough, or any changes in bowel movement or urine. ROS negative except as listed above.

OBJECTIVE

General: Normotensive, in no acute distress. **Obese**
Head: Normocephalic, no lesions
Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal
Ears: EAC's clear, TM's normal
Nose: Mucosa normal, no obstruction
Throat: Clear, no exudates, no lesions
Neck: Supple, no masses, no thyromegaly, no bruits
Chest: Lungs clear, no rales, no rhonchi, no wheezes
Heart: RR, no murmurs, no rubs, no gallops
Abdomen: Soft, no tenderness, no masses, BS normal
Extremities: **(+) left hand tenderness with LROM**

ASSESSMENT

Diagnoses attached to this encounter:

(I10) Essential (primary) hypertension

(I48.2) Chronic atrial fibrillation

(R25.2) Cramp and spasm

(M79.642) Pain in left hand

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

(E66.9) Obesity, unspecified

(E11.40) Type 2 diabetes mellitus with diabetic neuropathy, unspecified

PLAN

FBS finger stick check in office 200.
Injections administered in office and tolerated well.
Ordered routine lab tests: CBC, CMP, LIPID PANEL, HA1C, THYROID, UA.
Advised to continue current medications as prescribed
Side affects and risks of medications reviewed, Precautions emphasized
Advised to take new medications as prescribed
Medication E-scripted to pharmacy
Medications prescribed as listed. Indications, benefits, A/E of prescribed medications discussed with patient
Preventive counseling: Diet and exercise
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Exercise daily for at least 30 min
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
RTC in 2 weeks for re-eval, sooner if worsening or for any other health concerns
Plan of care discussed with patient, patient is agreeable and verbalized understanding. Out of clinic in no distress

Seen by Joseph Francisco F.N.P under the supervision of Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Baclofen 10 MG Oral Tablet Sig: Take 1 tablet by mouth once daily

Cyanocobalamin 1000 MCG/ML Injection Solution Sig: Cynocobalamin 1,000 MGC/ML IM GIVEN NOW IN OFFICE by MA: Jose LUQ NDC:0143-9619-01 LOT:1705169. EXP:10/2021

AGE	56 yrs	F (661) 489-5991		SEEN BY	MELVIN GALINATO
SEX	Male	5400 ALDRIN CT		DATE	05/13/2019
PRN	RJ438906	BAKERSFIELD, CA 93313		AGE AT DOS	53 yrs
				Not signed	

Chief complaint

(Appt time: 12:15 PM) (Arrival time: 11:56 AM) patient is here for lab results
fsbs 170-kmaldonado

Vitals for this encounter

	05/13/19 12:14 PM
Height	65.5 in
Weight	190 lb
Temperature	97.50 °F
Pulse	73 bpm
Respiratory rate	18 bpm
O2 Saturation	94 %
Pain	6 hands
BMI	31.14
Blood pressure	134/69 mmHg

SUBJECTIVE

53 y/o patient in for followup on lab results. Patient also requesting if he can take his meloxicam twice a day instead of once for better pain control. Reports tolerating current medications well without adverse reaction or any other problems.

OBJECTIVE

GEN: AOX3, afebrile, no signs of distress
EENT: Eyes: PERRL, anicteric sclera; EARS: EACs clear, TMs intact; NOSE: mucosa normal, no obstruction; THROAT: clear, no pharyngeal erythema
CHEST: lungs clear to auscultation bilaterally
CARDIO: regular rate and rhythm
ABDOMEN: soft, no tenderness, bowel sounds normal
BACK: no mass, no muscle spasms, mild thoracic and lumbar tenderness, no CVAT

Reviewed and discussed labs dated on 04/22/19.

- HDL CHOLESTEROL= 31
- MAGNESIUM= 2.6
- UREA NITROGEN(BUN)= 37
- BUN/CREATININE RATION= 35

ASSESSMENT

Diagnoses attached to this encounter:

- (E87.5) Hyperkalemia
- (Z71.2) Person consulting for explanation of examination or test findings
- (E87.5) Hyperkalemia
- (E11.65) Type 2 diabetes mellitus with hyperglycemia
- (E78.6) Lipoprotein deficiency
- (E55.9) Vitamin D deficiency, unspecified
- (E83.41) Hypermagnesemia
- (Z68.37) Body mass index (BMI) 37.0-37.9, adult
- (E66.01) Morbid (severe) obesity due to excess calories
- (Z76.0) Encounter for issue of repeat prescription

PLAN

FBS finger stick check in office 170.
Lab results reviewed in detail with patient, concerns addressed
Repeat serum potassium and magnesium ordered, hold on magnesium oxide as prescribed
Medications prescribed as listed. Indications, benefits, A/E of prescribed medications discussed with patient
Preventive counseling: Diet and exercise
Low carb - low sugar - low sodium diet
Diet rich in vegetables and fruit, Low fat meats such as chicken
Exercise daily for at least 30 min
Avoid high saturated fat products such as beef, pork, cheese, butter, and egg yolk. Avoid fast foods, fried food
Advised to increase fluids and stay well hydrated
Reduce high sugars/ caffeine drinks
RTC in 2 weeks for re-eval, sooner if worsening or for any other health concerns
Plan of care discussed with patient, patient is agreeable and verbalized understanding. Out of clinic in no distress

Seen by Melvin Galinato F.N.P under the supervision of Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

- Capsaicin 0.025 % External Cream Sig: 1 application topically to affected area 3 times per day as needed
- Fish Oil-Cholecalciferol (Fish Oil + D3) 1200-1000 MG-UNIT Oral Capsule Sig: 1 capsule orally twice a day
- Meloxicam 7.5 MG Oral Tablet Sig: Take 1 tablet (7.5 mg) by mouth twice a day as needed

PATIENT
JACOB RAMOS
DOB 04/29/1966
AGE 56 yrs
SEX Male
PRN RJ438906

FACILITY
CARLOS A. ALVAREZ MD., INC
T (661) 489-5999
F (661) 489-5991
5400 ALDRIN CT
BAKERSFIELD, CA 93313

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY MELVIN GALINATO
DATE 04/22/2019
AGE AT DOS 52 yrs
Not signed

Chief complaint

(Appt time: 12:00 PM) (Arrival time: 12:06 PM) patient is here to establish provider rx refills needed-kmaldonado fsbs 185

Vitals for this encounter

	04/22/19 12:37 PM
Height	65.5 in
Weight	194 lb
Temperature	97.30 °F
Pulse	78 bpm
Respiratory rate	18 bpm
O2 Saturation	97 %
Pain	0
BMI	31.79
Blood pressure	108/57 mmHg RIGHT

SUBJECTIVE

52 yo male in clinic to establish provider. Patient has h/o DM2 with peripheral neuropathy, HTN, high cholesterol, GERD, afib, leg cramps and back pain from arthritis. Denies any acute exacerbation of symptoms.
ROS: Gen: denies fever/chills, no body malaise
SKIN: denies rashes/lesions/pruritus
HEENT: denies headache, denies visual changes/eye pain, no otalgia/hearing loss, no rhinorrhea or congestion, no sore throat
RESP: denies cough, no dyspnea/SOB
CARDIAC: denies chest pain/palpitations
GI: denies abd pain, no N/V/D, no change in bowel movement
GU: denies urgency/dysuria/hesitancy
MUSC: denies joint pain, no muscle pain
NEURO: denies weakness/numbness, no dizziness/lightheadedness

OBJECTIVE

GEN: AOX3, afebrile, no signs of distress
EENT: Eyes: PERRL, anicteric sclera; EARS: EACs clear, TMs intact; NOSE: mucosa normal, no obstruction; THROAT: clear, no pharyngeal erythema
NECK: supple, no masses, thyroid non-palpable
CHEST: lungs clear to auscultation bilaterally
CARDIO: regular rate and rhythm
ABDOMEN: soft, no tenderness, bowel sounds normal
BACK: no mass, no muscle spasms, mild thoracic and lumbar tenderness, full ROM

EXTREM: (+) superfical wound on bilateral anterior lower legs with scabbing, well perfused, no edema, normal range of motion, steady gait

ASSESSMENT

Diagnoses attached to this encounter:

(E11.65) Type 2 diabetes mellitus with hyperglycemia

(I10) Essential (primary) hypertension

(E78.00) Pure hypercholesterolemia, unspecified

(I48.2) Chronic atrial fibrillation

(K21.9) Gastro-esophageal reflux disease without esophagitis

(M54.9) Dorsalgia, unspecified

(R25.2) Cramp and spasm

(M19.90) Unspecified osteoarthritis, unspecified site

(S81.801A) Unspecified open wound, right lower leg, initial encounter

(S81.802A) Unspecified open wound, left lower leg, initial encounter

(Z00.01) Encounter for general adult medical examination with abnormal findings

(Z68.31) Body mass index (BMI) 31.0-31.9, adult

PLAN

LABS ordered: CBC, CMP, lipid, A1C, TSH with reflex FT4, Mg, vit D3, vit B12, U/A
Baseline EKG done
Current medications reviewed with patient. Discussed indications, benefits, side effects
Medication E-scripted to pharmacy
RTC in 2 weeks for re-eval, sooner for any other health concerns
Plan of care discussed with patient, patient is agreeable and verbalized understanding. Out of clinic in no distress

Seen by Melvin Galinato F.N.P under the supervision of Carlos A. Alvarez M.D.

Medications/Prescription orders attached to encounter:

Cetirizine HCl 10 MG Oral Tablet Sig: Take 1 tablet (10 mg) by mouth daily

Dulaglutide (Trulicity) 1.5 MG/0.5ML Subcutaneous Solution Pen-injector Sig: 1.5 mg subcutaneously weekly

Fluticasone Propionate (Nasal) (Fluticasone Propionate) 50 MCG/ACT Nasal Suspension Sig: Inhale 2 sprays (100 mcg) into nostril daily in each nostril

Gabapentin 600 MG Oral Tablet Sig: TAKE 1 TABLET BY MOUTH THREE TIMES DAILY

Glimepiride 4 MG Oral Tablet

Insulin Degludec (Tresiba FlexTouch) 200 UNIT/ML Subcutaneous Solution Pen-injector Sig: 48units

Insulin Lispro (HumaLOG) 100 UNIT/ML Subcutaneous Solution Sig: USE SQ 5 UNITS SQ WITH EACH MEAL

Magnesium Oxide (Mg Supplement) (MagOx 400) 400 (241.3 Mg) MG Oral Tablet Sig: 1 tablet orally 2 times per day with food

Metoprolol Succinate (Metoprolol Succinate ER) 25 MG Oral Tablet Extended Release 24 Hour Sig: Take 1 tablet by mouth twice daily

Pantoprazole Sodium 40 MG Oral Tablet Delayed Release Sig: Take 1 tablet (40 mg) by mouth daily

Ranitidine HCl (raNITIdine HCl) 150 MG Oral Capsule Sig: Take 1 capsule (150 mg) by mouth qhs

Rosuvastatin Calcium 40 MG Oral Tablet Sig: Take 1 tablet (40 mg) by mouth daily

TIME: 11:30
DATE COLLECTED: 06/29/2021
DATE RECEIVED: 06/29/2021
DATE REPORTED: 06/29/2021 14:10

U.I.D. #: RAM523268

WESTPAC LABS
PAL—BAKERSFIELD
A Sonic Healthcare Company

PATIENT: RAMOS, JACOB
D.O.B.: 04/29/1966 AGE: 55,M
SPEC #: A3081369
PATIENT PHONE: 661-348-8355
ATT. PHYS.: ALVAREZ,CARLOS A, MD

CLIENT #: 2848
CLIENT NAME:
Optimal Home Health
1227 Chester Ave
Bakersfield, CA 93301

DIRECTOR
Zoltan Nagymanyoki, M.D., Ph.D
DIPLOMATE AMERICAN BOARD OF PATHOLOGY
820 34th Street Bakersfield, CA 93301
(661) 325-0744 Fax(661) 327-9163

MRN:
CHART#:
STATUS:

TEST REQUESTED	TEST RESULTS	ABNORMAL/FLAG		UNITS	REFERENCE RANGE	LAB

Copy To Optioncare
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Reprinted On: 06/29/2021 14:29

TEST REQUESTED	TEST RESULTS	ABNORMAL	FLAG	UNITS	REFERENCE RANGE
Comp Metabolic Panel					
Sodium	141			mEq/L	135-146
Potassium	4.2			mEq/L	3.5-5.4
Chloride		109	H	mEq/L	95-107
Carbon Dioxide	21			mEq/L	19-31
-Anion Gap	11			mEq/L	7.0-17.0
Glucose		137	H	mg/dL	70-99
Blood Urea Nitrogen (BUN)	15			mg/dL	6-20
Creatinine		0.7	L	mg/dL	0.8-1.4
-BUN/Creatinine Ratio	21			Ratio	9-28
-GFR African American	123			UOM	>=60
	UNITS ml/min/1.73m^2				
Note: GFR value now derived from CKD-EPI equation.					
-GFR Non-African American	106			UOM	>=60
Calcium	9.4			mg/dL	8.5-10.5
Protein Total	7.9			g/dL	6.1-8.3
Albumin	4.4			g/dL	3.5-5.2
-Globulin	3.5			gm/dl	2.0-3.7
-Albumin/Globulin Ratio	1.3			Ratio	1.0-2.6
ALT (SGPT)		<5	L	U/L	5-50
AST (SGOT)	12			U/L	9-50
Alkaline Phosphatase		194	H	U/L	39-118
Bilirubin Total	0.2			mg/dL	<1.3
CBC w/ Auto Diff					
WBC	8.3			1000/cmm	3.5-10.0
RBC	4.83			mil./cmm	4.30-5.90
Hemoglobin	13.9			gm/dl	13.5-17.5
Hematocrit	44.0			%	40.0-53.0
MCV	91.1			fl	80.0-100.0
MCH	28.8			pg	26.0-34.0
MCHC	31.6			gm/dl	31.0-37.0
Red Cell Dist. Width		15.3	H	%	11.5-14.5
Mean Platelet Volume	10.2			fl	7.4-11.9
Platelet Count	346			1000/cmm	150-450
Neutrophils %	71.0			%	40.0-74.0
Lymphocytes %		17.8	L	%	19.0-48.0
Monocytes %	8.2			%	2.0-12.0
Eosinophils %	2.3			%	0.0-7.0
Basophils %	0.7			%	0.0-2.0

WESTPAC LABS
PAL–BAKERSFIELD
A Sonic Healthcare Company

DIRECTOR
Zoltan Nagymanyoki, M.D., Ph.D
DIPLOMATE AMERICAN BOARD OF PATHOLOGY
20 34th Street Bakersfield, CA 93301
(661) 325-0744 Fax(661) 327-9163

U.I.O. #: RAM523268

PATIENT: RAMOS, JACOB
D.O.B.: 04/29/1966 AGE: 55,M
SPEC #: A3081369
PATIENT PHONE: 661-348-8355
ATT. PHYS.: ALVAREZ,CARLOS A, MD

MRN:
CHART#:
STATUS:

TIME: 11:30
DATE COLLECTED: 06/29/2021
DATE RECEIVED: 06/29/2021
DATE REPORTED: 06/29/2021 14:10

CLIENT #: 2848
CLIENT NAME:
Optimal Home Health
1227 Chester Ave
Bakersfield, CA 93301

TEST REQUESTED	TEST RESULTS	ABNORMAL/FLAG	UNITS	REFERENCE RANGE	LAB
		Copy To: Optioncare Copy To			
Neutrophils Absolute	5.9		1000/cmm	1.50-7.00	
Lymphs Absolute	1.5		1000/cmm	0.90-3.50	
Monos Absolute	0.7		1000/cmm	0.10-1.10	
Eosinophils Absolute	0.2		1000/cmm	0.00-0.80	
Basophils Absolute	0.1		1000/cmm	0.00-0.30	

TIME: 12:25
DATE COLLECTED: 07/20/2021
DATE RECEIVED: 07/20/2021
DATE REPORTED: 07/20/2021 15:35

U.I.D. #: RAM523268

PATIENT: RAMOS, JACOB
D.O.B.: 04/29/1966 AGE: 55,M
SPEC #: A3174804
PATIENT PHONE: 661-348-8355
ATT. PHYS.: ALVAREZ,CARLOS A, MD

CLIENT #: 2848
CLIENT NAME:
Optimal Home Health
1227 Chester Ave
Bakersfield, CA 93301

IECTOR
Ian Nagymanyos, M.D., Ph.D
DIPLOMATE AMERICAN BOARD OF PATHOLOGY
34th Street Bakersfield, CA 93301
1) 326-0744 Fax(661) 327-9163

MRN:
CHART#:
STATUS: STAT

TEST REQUESTED	TEST RESULTS	ABNORMAL/FLAG		UNITS	REFERENCE RANGE	LAB

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Copy To: DR ALVAREZ

Reprinted On: 07/21/2021 06:30

TEST REQUESTED	TEST RESULTS	ABNORMAL/FLAG		UNITS	REFERENCE RANGE	LAB
Comp Metabolic Panel						
Sodium	145			mEq/L	135-146	
Potassium	5.1			mEq/L	3.5-5.4	
Chloride	104			mEq/L	95-107	
Carbon Dioxide	30			mEq/L	19-31	
-Anion Gap	11			mEq/L	7.0-17.0	
Glucose		125	H	mg/dL	70-99	
ADA DESIGNATES FBS RANGE OF 101-125 AS PREDIABETIC						
Blood Urea Nitrogen (BUN)	13			mg/dL	6-20	
Creatinine	0.8			mg/dL	0.8-1.4	
-BUN/Creatinine Ratio	16			Ratio	9-28	
-GFR African American	116			UOM	>=60	
	UNITS ml/min/1.73m^2					
Note: GFR value now derived from CKD-EPI equation.						
-GFR Non-African American	101			UOM	>=60	
Calcium	10.0			mg/dL	8.5-10.5	
Protein Total	7.8			g/dL	6.1-8.3	
Albumin	4.5			g/dL	3.5-5.2	
-Globulin	3.3			gm/dl	2.0-3.7	
-Albumin/Globulin Ratio	1.4			Ratio	1.0-2.6	
ALT (SGPT)		<5	L	U/L	5-50	
AST (SGOT)	12			U/L	9-50	
Alkaline Phosphatase		166	H	U/L	39-118	
Bilirubin Total	0.2			mg/dL	<1.3	
CBC w/ Auto Diff						
WBC	8.2			1000/cmm	3.5-10.0	
RBC	4.98			mil./cmm	4.30-5.90	
Hemoglobin	14.0			gm/dl	13.5-17.5	
Hematocrit	44.1			%	40.0-53.0	
MCV	88.6			fl	80.0-100.0	
MCH	28.1			pg	26.0-34.0	
MCHC	31.7			gm/dl	31.0-37.0	
Red Cell Dist. Width		14.8	H	%	11.5-14.5	
Mean Platelet Volume	9.7			fl	7.4-11.9	
Platelet Count	328			1000/cmm	150-450	
Neutrophils %	70.8			%	40.0-74.0	
Lymphocytes %		14.9	L	%	19.0-48.0	
Monocytes %	8.9			%	2.0-12.0	

TIME: 12:25
DATE COLLECTED: 07/20/2021
DATE RECEIVED: 07/20/2021
DATE REPORTED: 07/20/2021 15:35

U.I.D. #: RAM523268

WESTPAC LABS
PAL—BAKERSFIELD
A Sonic Healthcare Company

PATIENT: RAMOS, JACOB
D.O.B.: 04/28/1966 AGE: 55,M
SPEC #: A3174804
PATIENT PHONE: 661-348-8355
ATT. PHYS.: ALVAREZ,CARLOS A. MD
MRN:
CHART#:
STATUS: STAT

CLIENT #: 2848
CLIENT NAME:
Optimal Home Health
1227 Chester Ave
Bakersfield, CA 93301

DIRECTOR
Istvan Nagymanyoki, M.D., Ph.D
DIPLOMATE AMERICAN BOARD OF PATHOLOGY
420 34th Street Bakersfield, CA 93301
(661) 326-0744 Fax(661) 327-8163

Copy To:
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TEST REQUESTED	TEST RESULTS	ABNORMAL/FLAG	UNITS	REFERENCE RANGE	LAB
Eosinophils %	3.9		%	0.0-7.0	
Basophils %	1.3		%	0.0-2.0	
Neutrophils Absolute	5.8		1000/cmm	1.50-7.00	
Lymphs Absolute	1.2		1000/cmm	0.90-3.50	
Monos Absolute	0.7		1000/cmm	0.10-1.10	
Eosinophils Absolute	0.3		1000/cmm	0.00-0.80	
Basophils Absolute	0.1		1000/cmm	0.00-0.30	

To: "CARLOS ALVAREZ MD" From: Stockdale Radiology Pages: 1

4000 Empire Drive, Suite 100, Bakersfield, CA 93309
Phone (661) 631-8000 Fax (661) 631-8005
www.stockdalerad.com

Patient name: RAMOS, JACOB		Patient ID: 321399
Patient DOB: 29-Apr-1966		Date of exam: 03-Feb-2021 01:00:00 PM
Gender: M	Acc #: 845969	Referring Physician: ALVAREZ, CARLOS MD

EXAMINATION: RIGHT FOOT, 2 VIEWS

HISTORY: Right foot pain. Prior right foot surgery.

TECHNIQUE: AP and lateral views of the right foot. No prior study is available for comparison.

FINDINGS: Post-surgical changes are identified in the fifth metatarsal bone. Plate and screws are identified. Mild tarsometatarsal joint arthritis is identified.

IMPRESSION:

1. Post-surgical changes are identified in the fifth metatarsal bone. Plate and screws are identified.
2. Mild degenerative changes of the tarsometatarsal joint are identified.

Thank you for the courtesy of this referral.

Reading Physician: IRUVURI, SIREESHA PID: 93309	
Transcribed: KITE, PAM	Electronically Signed by IRUVURI, SIREESHA at 2/8/2021 12:00:53 PM

Gabriel Gelves, DO
Diplomate, American Osteopathic Board of Radiology
Fellowship trained MRI

Carol Ann Browning, MD
Diplomate, American Board of Radiology
Fellowship trained in Pediatric and Women's Imager

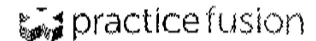
David Suadi, DO
Diplomate, American Osteopathic Board of Radiology
Fellowship trained in Women's Imager

Roel Galope, DO
Diplomate, American Osteopathic Board of Radiology
Fellowship trained in Neuro, Body, and MSK MRI

Viken Manjikian, MD
Diplomate, American Board of Radiology
Fellowship trained in Vascular, Interventional and MRI

Edward Iuliano, DO
Diplomate, American Osteopathic Board of Radiology
Fellowship trained Neuroradiology

Lab Results for RAMOS, JACOB (Male, 04/29/1966)



Laboratory

Collection: 06/14/2021 01:30 pm
Order #: EN628349J
Accession #: EN628349J

Name: Quest Diagnostics (QDRT)

Patient information

Patient ID: RJ438906
Mobile: 661-439-0403
Address: 3805 LA TONIA CT.
Bakersfield, CA 93313

Requesting Provider

Name: CARLOS A ALVAREZ

Attachments

attachment1
attachment1
attachment1
attachment1

Vendor note: FASTING:YES

FASTING: YES

LIPID PANEL WITH REFLEX TO DIRECT LDL

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL, TOTAL [1]	67	<200 mg/dL	06/15/2021 08:10 pm
HDL CHOLESTEROL [1]	● 21	> OR = 40 mg/dL Below low normal	06/15/2021 08:10 pm
TRIGLYCERIDES [1]	135	<150 mg/dL	06/15/2021 08:10 pm
LDL-CHOLESTEROL [1]	24	mg/dL (calc)	06/15/2021 08:10 pm
Vendor note: Reference range: <100 Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors. LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C. Martin SS et al. JAMA. 2013;310(19): 2061-2068 (http://education.QuestDiagnostics.com/faq/FAQ164 (http://education.QuestDiagnostics.com/faq/FAQ164))			
CHOL/HDLC RATIO [1]	3.2	<5.0 (calc)	06/15/2021 08:10 pm
NON HDL CHOLESTEROL [1]	46	<130 mg/dL (calc)	06/15/2021 08:10 pm
Vendor note: For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.			

ALBUMIN, RANDOM URINE W/CREATININE

Observations	Result	Reference / UoM	Date/Status
CREATININE, RANDOM URINE [1]	59	20-320 mg/dL	06/15/2021 08:10 pm
ALBUMIN, URINE [1]	9.5	See Note: mg/dL	06/15/2021 08:10 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: Reference Range: Reference Range Not established			
ALBUMIN/CREATININE RATIO, RANDOM URINE [1]	● 161	<30 mcg/mg creat Above high normal	06/15/2021 08:10 pm
Vendor note: The ADA defines abnormalities in albumin excretion as follows: Category Result (mcg/mg creatinine) Normal <30 Microalbuminuria 30-299 Clinical albuminuria > OR = 300 The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.			

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
GLUCOSE [1]	● 180	65-99 mg/dL Above high normal	06/15/2021 08:10 pm
Vendor note: Fasting reference interval For someone without known diabetes, a glucose value >125 mg/dL indicates that they may have diabetes and this should be confirmed with a follow-up test.			
UREA NITROGEN (BUN) [1]	17	7-25 mg/dL	06/15/2021 08:10 pm
CREATININE [1]	0.84	0.70-1.33 mg/dL	06/15/2021 08:10 pm
Vendor note: For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN [1]	99	> OR = 60 mL/min/1.73m2	06/15/2021 08:10 pm
eGFR AFRICAN AMERICAN [1]	114	> OR = 60 mL/min/1.73m2	06/15/2021 08:10 pm
BUN/CREATININE RATIO [1]	NOT APPLICABLE	6-22 (calc)	06/15/2021 08:10 pm
SODIUM [1]	140	135-146 mmol/L	06/15/2021 08:10 pm
POTASSIUM [1]	4.6	3.5-5.3 mmol/L	06/15/2021 08:10 pm
CHLORIDE [1]	109	98-110 mmol/L	06/15/2021 08:10 pm
CARBON DIOXIDE [1]	21	20-32 mmol/L	06/15/2021 08:10 pm
CALCIUM [1]	9.7	8.6-10.3 mg/dL	06/15/2021 08:10 pm
PROTEIN, TOTAL [1]	7.9	6.1-8.1 g/dL	06/15/2021 08:10 pm
ALBUMIN [1]	4.0	3.6-5.1 g/dL	06/15/2021 08:10 pm
GLOBULIN [1]	● 3.9	1.9-3.7 g/dL (calc) Above high normal	06/15/2021 08:10 pm
ALBUMIN/GLOBULIN RATIO [1]	1.0	1.0-2.5 (calc)	06/15/2021 08:10 pm
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	06/15/2021 08:10 pm
ALKALINE PHOSPHATASE [1]	● 153	35-144 U/L Above high normal	06/15/2021 08:10 pm

Observations	Result	Reference / UoM	Date/Status
AST [1]	10	10-35 U/L	06/15/2021 08:10 pm
ALT [1]	● 5	9-46 U/L Below low normal	06/15/2021 08:10 pm

PARTIAL THROMBOPLASTIN TIME, ACTIVATED

Observations	Result	Reference / UoM	Date/Status
PARTIAL THROMBOPLASTIN TIME, ACTIVATED [1]	29	23-32 sec	06/15/2021 08:10 pm

Vendor note:
This test has not been validated for monitoring unfractionated heparin therapy. For testing that is validated for this type of therapy, please refer to the Heparin Anti-Xa assay (test code 30292).

For additional information, please refer to http://education.QuestDiagnostics.com/faq/FAQ159 (http://education.QuestDiagnostics.com/faq/FAQ159) (This link is being provided for informational/educational purposes only.)

URINALYSIS, COMPLETE

Observations	Result	Reference / UoM	Date/Status
COLOR [1]	YELLOW	YELLOW	06/15/2021 08:10 pm

Vendor note: The preferred specimen for urinalysis is urine preserved using a Quest standard urine preservative tube (yellow capped, blue band) that may be obtained from your Quest Diagnostics supplier.
Please review results with caution. Urinalysis testing on unpreserved urine may produce alteration of chemical constituents and deterioration of formed elements.

Observations	Result	Reference / UoM	Date/Status
APPEARANCE [1]	CLEAR	CLEAR	06/15/2021 08:10 pm
SPECIFIC GRAVITY [1]	● 1.045	1.001-1.035 Above high normal	06/15/2021 08:10 pm
PH [1]	5.5	5.0-8.0	06/15/2021 08:10 pm
GLUCOSE [1]	● 3+	NEGATIVE Abnormal (applies to non-numeric results)	06/15/2021 08:10 pm
BILIRUBIN [1]	NEGATIVE	NEGATIVE	06/15/2021 08:10 pm
KETONES [1]	NEGATIVE	NEGATIVE	06/15/2021 08:10 pm
OCCULT BLOOD [1]	NEGATIVE	NEGATIVE	06/15/2021 08:10 pm
PROTEIN [1]	● 1+	NEGATIVE Abnormal (applies to non-numeric results)	06/15/2021 08:10 pm
NITRITE [1]	NEGATIVE	NEGATIVE	06/15/2021 08:10 pm
LEUKOCYTE ESTERASE [1]	NEGATIVE	NEGATIVE	06/15/2021 08:10 pm
WBC [1]	NONE SEEN	< OR = 5 /HPF	06/15/2021 08:10 pm
RBC [1]	NONE SEEN	< OR = 2 /HPF	06/15/2021 08:10 pm
SQUAMOUS EPITHELIAL CELLS [1]	NONE SEEN	< OR = 5 /HPF	06/15/2021 08:10 pm
BACTERIA [1]	NONE SEEN	NONE SEEN /HPF	06/15/2021 08:10 pm
HYALINE CAST [1]	NONE SEEN	NONE SEEN /LPF	06/15/2021 08:10 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	● 11.3	3.8-10.8 Thousand/uL Above high normal	06/15/2021 08:10 pm

Observations	Result	Reference / UoM	Date/Status
RED BLOOD CELL COUNT [1]	4.95	4.20-5.80 Million/uL	06/15/2021 08:10 pm
HEMOGLOBIN [1]	14.1	13.2-17.1 g/dL	06/15/2021 08:10 pm
HEMATOCRIT [1]	43.0	38.5-50.0 %	06/15/2021 08:10 pm
MCV [1]	86.9	80.0-100.0 fL	06/15/2021 08:10 pm
MCH [1]	28.5	27.0-33.0 pg	06/15/2021 08:10 pm
MCHC [1]	32.8	32.0-36.0 g/dL	06/15/2021 08:10 pm
RDW [1]	13.6	11.0-15.0 %	06/15/2021 08:10 pm
PLATELET COUNT [1]	388	140-400 Thousand/uL	06/15/2021 08:10 pm
MPV [1]	10.4	7.5-12.5 fL	06/15/2021 08:10 pm
ABSOLUTE NEUTROPHILS [1]	● 8486	1500-7800 cells/uL Above high normal	06/15/2021 08:10 pm
ABSOLUTE LYMPHOCYTES [1]	1661	850-3900 cells/uL	06/15/2021 08:10 pm
ABSOLUTE MONOCYTES [1]	723	200-950 cells/uL	06/15/2021 08:10 pm
ABSOLUTE EOSINOPHILS [1]	305	15-500 cells/uL	06/15/2021 08:10 pm
ABSOLUTE BASOPHILS [1]	124	0-200 cells/uL	06/15/2021 08:10 pm
ABSOLUTE NUCLEATED RBC [1]	0	0 cells/uL	06/15/2021 08:10 pm
NEUTROPHILS [1]	75.1	%	06/15/2021 08:10 pm
LYMPHOCYTES [1]	14.7	%	06/15/2021 08:10 pm
MONOCYTES [1]	6.4	%	06/15/2021 08:10 pm
EOSINOPHILS [1]	2.7	%	06/15/2021 08:10 pm
BASOPHILS [1]	1.1	%	06/15/2021 08:10 pm

PROTHROMBIN TIME-INR

Observations	Result	Reference / UoM	Date/Status
INR [1]	1.0		06/15/2021 08:10 pm
Vendor note: Reference Range 0.9-1.1 Moderate-intensity Warfarin Therapy 2.0-3.0 Higher-intensity Warfarin Therapy 3.0-4.0			
PT [1]	10.3	9.0-11.5 sec	06/15/2021 08:10 pm
Vendor note: For additional information, please refer to http://education.questdiagnostics.com/faq/FAQ104 (http://education.questdiagnostics.com/faq/FAQ104) (This link is being provided for informational/ educational purposes only.)			

TSH

Observations	Result	Reference / UoM	Date/Status
TSH [1]	0.63	0.40-4.50 mIU/L	06/15/2021 08:10 pm

T3, FREE

Observations	Result	Reference / UoM	Date/Status
T3, FREE [1]	2.6	2.3-4.2 pg/mL	06/15/2021 08:10 pm

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c [1]	● 9.0	<5.7 % of total Hgb Above high normal	06/15/2021 08:10 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test. For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations. Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.			

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			06/14/2021 01:30 pm

Performing Laboratory
[1] Quest Diagnostics-West Hills-Tab Toochinda MD 8401 Fallbrook Ave West Hills, CA 91304-3226

Lab Results for RAMOS, JACOB (Male, 04/29/1966)

Collection: 01/13/2021 11:18 am
Order #: EN452495C
Accession #: EN452495C

Laboratory

Name: Quest Diagnostics (QDRT)

Requesting Provider

Name: CARLOS A ALVAREZ

Patient information

Patient ID: RJ438906
Mobile: 661-439-0403
Address: 3805 LA TONIA CT.
Bakersfield, CA 93313

Attachments

attachment1
attachment1
attachment1

Vendor note: FASTING:YES

FASTING: YES

LIPID PANEL, STANDARD

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL, TOTAL [1]	106	<200 mg/dL	01/14/2021 12:40 pm
HDL CHOLESTEROL [1]	● 30	> OR = 40 mg/dL Below low normal	01/14/2021 12:40 pm
TRIGLYCERIDES [1]	63	<150 mg/dL	01/14/2021 12:40 pm
LDL-CHOLESTEROL [1]	62	mg/dL (calc)	01/14/2021 12:40 pm

Vendor note: Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
(http://education.QuestDiagnostics.com/faq/FAQ164 (http://education.QuestDiagnostics.com/faq/FAQ164))

Observations	Result	Reference / UoM	Date/Status
CHOL/HDLC RATIO [1]	3.5	<5.0 (calc)	01/14/2021 12:40 pm
NON HDL CHOLESTEROL [1]	76	<130 mg/dL (calc)	01/14/2021 12:40 pm

Vendor note: For patients with diabetes plus 1 major ASCVD risk
factor, treating to a non-HDL-C goal of <100 mg/dL
(LDL-C of <70 mg/dL) is considered a therapeutic
option.

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
GLUCOSE [1]	● 133	65-99 mg/dL Above high normal	01/14/2021 12:40 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: Fasting reference interval For someone without known diabetes, a glucose value >125 mg/dL indicates that they may have diabetes and this should be confirmed with a follow-up test.			
UREA NITROGEN (BUN) [1]	● 32	7-25 mg/dL Above high normal	01/14/2021 12:40 pm
CREATININE [1]	1.22	0.70-1.33 mg/dL	01/14/2021 12:40 pm
Vendor note: For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN [1]	67	> OR = 60 mL/min/1.73m2	01/14/2021 12:40 pm
eGFR AFRICAN AMERICAN [1]	77	> OR = 60 mL/min/1.73m2	01/14/2021 12:40 pm
BUN/CREATININE RATIO [1]	● 26	6-22 (calc) Above high normal	01/14/2021 12:40 pm
SODIUM [1]	142	135-146 mmol/L	01/14/2021 12:40 pm
POTASSIUM [1]	● 5.6	3.5-5.3 mmol/L Above high normal	01/14/2021 12:40 pm
CHLORIDE [1]	107	98-110 mmol/L	01/14/2021 12:40 pm
CARBON DIOXIDE [1]	29	20-32 mmol/L	01/14/2021 12:40 pm
CALCIUM [1]	9.6	8.6-10.3 mg/dL	01/14/2021 12:40 pm
PROTEIN, TOTAL [1]	7.2	6.1-8.1 g/dL	01/14/2021 12:40 pm
ALBUMIN [1]	4.6	3.6-5.1 g/dL	01/14/2021 12:40 pm
GLOBULIN [1]	2.6	1.9-3.7 g/dL (calc)	01/14/2021 12:40 pm
ALBUMIN/GLOBULIN RATIO [1]	1.8	1.0-2.5 (calc)	01/14/2021 12:40 pm
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	01/14/2021 12:40 pm
ALKALINE PHOSPHATASE [1]	123	35-144 U/L	01/14/2021 12:40 pm
AST [1]	15	10-35 U/L	01/14/2021 12:40 pm
ALT [1]	● 8	9-46 U/L Below low normal	01/14/2021 12:40 pm

SED RATE BY MODIFIED WESTERGREN

Observations	Result	Reference / UoM	Date/Status
SED RATE BY MODIFIED WESTERGREN [1]	2	< OR = 20 mm/h	01/14/2021 12:40 pm

URINALYSIS, COMPLETE

Observations	Result	Reference / UoM	Date/Status
COLOR [1]	YELLOW	YELLOW	01/14/2021 12:40 pm
APPEARANCE [1]	CLEAR	CLEAR	01/14/2021 12:40 pm
SPECIFIC GRAVITY [1]	1.029	1.001-1.035	01/14/2021 12:40 pm
PH [1]	5.5	5.0-8.0	01/14/2021 12:40 pm
GLUCOSE [1]	● 3+	NEGATIVE Abnormal (applies to non-numeric results)	01/14/2021 12:40 pm
BILIRUBIN [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm
KETONES [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm
OCCULT BLOOD [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm
PROTEIN [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm
NITRITE [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm
LEUKOCYTE ESTERASE [1]	NEGATIVE	NEGATIVE	01/14/2021 12:40 pm

Observations	Result	Reference / UoM	Date/Status
WBC [1]	NONE SEEN	< OR = 5 /HPF	01/14/2021 12:40 pm
RBC [1]	NONE SEEN	< OR = 2 /HPF	01/14/2021 12:40 pm
SQUAMOUS EPITHELIAL CELLS [1]	NONE SEEN	< OR = 5 /HPF	01/14/2021 12:40 pm
BACTERIA [1]	NONE SEEN	NONE SEEN /HPF	01/14/2021 12:40 pm
HYALINE CAST [1]	NONE SEEN	NONE SEEN /LPF	01/14/2021 12:40 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	9.6	3.8-10.8 Thousand/uL	01/14/2021 12:40 pm
RED BLOOD CELL COUNT [1]	5.42	4.20-5.80 Million/uL	01/14/2021 12:40 pm
HEMOGLOBIN [1]	16.0	13.2-17.1 g/dL	01/14/2021 12:40 pm
HEMATOCRIT [1]	48.4	38.5-50.0 %	01/14/2021 12:40 pm
MCV [1]	89.3	80.0-100.0 fL	01/14/2021 12:40 pm
MCH [1]	29.5	27.0-33.0 pg	01/14/2021 12:40 pm
MCHC [1]	33.1	32.0-36.0 g/dL	01/14/2021 12:40 pm
RDW [1]	13.4	11.0-15.0 %	01/14/2021 12:40 pm
PLATELET COUNT [1]	240	140-400 Thousand/uL	01/14/2021 12:40 pm
MPV [1]	11.2	7.5-12.5 fL	01/14/2021 12:40 pm
ABSOLUTE NEUTROPHILS [1]	5894	1500-7800 cells/uL	01/14/2021 12:40 pm
ABSOLUTE LYMPHOCYTES [1]	2131	850-3900 cells/uL	01/14/2021 12:40 pm
ABSOLUTE MONOCYTES [1]	● **960**	200-950 cells/uL Above high normal	01/14/2021 12:40 pm
ABSOLUTE EOSINOPHILS [1]	● **518**	15-500 cells/uL Above high normal	01/14/2021 12:40 pm
ABSOLUTE BASOPHILS [1]	96	0-200 cells/uL	01/14/2021 12:40 pm
ABSOLUTE NUCLEATED RBC [1]	0	0 cells/uL	01/14/2021 12:40 pm
NEUTROPHILS [1]	61.4	%	01/14/2021 12:40 pm
LYMPHOCYTES [1]	22.2	%	01/14/2021 12:40 pm
MONOCYTES [1]	10.0	%	01/14/2021 12:40 pm
EOSINOPHILS [1]	5.4	%	01/14/2021 12:40 pm
BASOPHILS [1]	1.0	%	01/14/2021 12:40 pm

RHEUMATOID FACTOR

Observations	Result	Reference / UoM	Date/Status
RHEUMATOID FACTOR [1]	<14	<14 IU/mL	01/14/2021 12:40 pm

C-REACTIVE PROTEIN

Observations	Result	Reference / UoM	Date/Status
C-REACTIVE PROTEIN [1]	0.7	<8.0 mg/L	01/14/2021 12:40 pm

T3, TOTAL

Observations	Result	Reference / UoM	Date/Status
T3, TOTAL [1]	94	76-181 ng/dL	01/14/2021 12:40 pm

T3, FREE

Observations	Result	Reference / UoM	Date/Status
T3, FREE [1]	3.3	2.3-4.2 pg/mL	01/14/2021 12:40 pm

TSH W/REFLEX TO FT4

Observations	Result	Reference / UoM	Date/Status
TSH W/REFLEX TO FT4 [1]	1.16	0.40-4.50 mIU/L	01/14/2021 12:40 pm

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c [1]	● 8.7	<5.7 % of total Hgb Above high normal	01/14/2021 12:40 pm

Vendor note: For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.

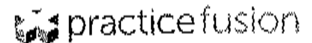
For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			01/13/2021 11:18 am

Performing Laboratory
[1] Quest Diagnostics-West Hills-Tab Toochinda MD 8401 Fallbrook Ave West Hills, CA 91304-3226



Lab Results for RAMOS, JACOB (Male, 04/29/1966)

Laboratory

Collection: 05/11/2020 12:11 pm
Order #: EN783886M
Accession #: EN783886M

Name: Quest Diagnostics (QDRT)

Patient information

Patient ID: RJ438906
Mobile: 661-439-0403
Address: 3805 LA TONIA CT.
Bakersfield, CA 93313

Requesting Provider

Name: CARLOS A ALVAREZ

Attachments

attachment1
attachment1
attachment1
attachment1
attachment1
attachment1

Vendor note: FASTING: NO

LIPID PANEL, STANDARD

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL, TOTAL [1]	84	<200 mg/dL	05/14/2020 05:57 pm
HDL CHOLESTEROL [1]	● 27	> OR = 40 mg/dL Below low normal	05/14/2020 05:57 pm
TRIGLYCERIDES [1]	65	<150 mg/dL	05/14/2020 05:57 pm
LDL-CHOLESTEROL [1]	43	mg/dL (calc)	05/14/2020 05:57 pm

Vendor note: Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
(http://education.QuestDiagnostics.com/faq/FAQ164 (http://education.QuestDiagnostics.com/faq/FAQ164))

Observations	Result	Reference / UoM	Date/Status
CHOL/HDLC RATIO [1]	3.1	<5.0 (calc)	05/14/2020 05:57 pm
NON HDL CHOLESTEROL [1]	57	<130 mg/dL (calc)	05/14/2020 05:57 pm

Vendor note: For patients with diabetes plus 1 major ASCVD risk
factor, treating to a non-HDL-C goal of <100 mg/dL
(LDL-C of <70 mg/dL) is considered a therapeutic
option.

ALBUMIN, RANDOM URINE W/CREATININE

Observations	Result	Reference / UoM	Date/Status
CREATININE, RANDOM URINE [1]	105	20-320 mg/dL	05/14/2020 05:57 pm
ALBUMIN, URINE [1]	0.8	See Note: mg/dL	05/14/2020 05:57 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: Reference Range: Reference Range Not established			
ALBUMIN/CREATININE RATIO, RANDOM URINE [1]	8	<30 mcg/mg creat	05/14/2020 05:57 pm
Vendor note: The ADA defines abnormalities in albumin excretion as follows: Category Result (mcg/mg creatinine) Normal <30 Microalbuminuria 30-299 Clinical albuminuria > OR = 300 The ADA recommends that at least two of three specimens collected within a 3-6 month period be abnormal before considering a patient to be within a diagnostic category.			

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
GLUCOSE [1]	108	65-139 mg/dL	05/14/2020 05:57 pm
Vendor note: Non-fasting reference interval			
UREA NITROGEN (BUN) [1]	23	7-25 mg/dL	05/14/2020 05:57 pm
CREATININE [1]	0.97	0.70-1.33 mg/dL	05/14/2020 05:57 pm
Vendor note: For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN [1]	88	> OR = 60 mL/min/1.73m2	05/14/2020 05:57 pm
eGFR AFRICAN AMERICAN [1]	102	> OR = 60 mL/min/1.73m2	05/14/2020 05:57 pm
BUN/CREATININE RATIO [1]	NOT APPLICABLE	6-22 (calc)	05/14/2020 05:57 pm
SODIUM [1]	144	135-146 mmol/L	05/14/2020 05:57 pm
POTASSIUM [1]	5.1	3.5-5.3 mmol/L	05/14/2020 05:57 pm
CHLORIDE [1]	107	98-110 mmol/L	05/14/2020 05:57 pm
CARBON DIOXIDE [1]	30	20-32 mmol/L	05/14/2020 05:57 pm
CALCIUM [1]	9.8	8.6-10.3 mg/dL	05/14/2020 05:57 pm
PROTEIN, TOTAL [1]	7.2	6.1-8.1 g/dL	05/14/2020 05:57 pm
ALBUMIN [1]	4.5	3.6-5.1 g/dL	05/14/2020 05:57 pm
GLOBULIN [1]	2.7	1.9-3.7 g/dL (calc)	05/14/2020 05:57 pm
ALBUMIN/GLOBULIN RATIO [1]	1.7	1.0-2.5 (calc)	05/14/2020 05:57 pm
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	05/14/2020 05:57 pm
ALKALINE PHOSPHATASE [1]	101	35-144 U/L	05/14/2020 05:57 pm
AST [1]	14	10-35 U/L	05/14/2020 05:57 pm
ALT [1]	● 8	9-46 U/L Below low normal	05/14/2020 05:57 pm

URINALYSIS, COMPLETE W/REFLEX TO CULTURE

Observations	Result	Reference / UoM	Date/Status
COLOR [1]	YELLOW	YELLOW	05/14/2020 05:57 pm

Observations	Result	Reference / UoM	Date/Status
APPEARANCE [1]	CLEAR	CLEAR	05/14/2020 05:57 pm
SPECIFIC GRAVITY [1]	1.035	1.001-1.035	05/14/2020 05:57 pm
PH [1]	< OR = 5.0	5.0-8.0	05/14/2020 05:57 pm
GLUCOSE [1]	● 3+	NEGATIVE Abnormal (applies to non-numeric results)	05/14/2020 05:57 pm
BILIRUBIN [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
KETONES [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
OCCULT BLOOD [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
PROTEIN [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
NITRITE [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
LEUKOCYTE ESTERASE [1]	NEGATIVE	NEGATIVE	05/14/2020 05:57 pm
WBC [1]	NONE SEEN	< OR = 5 /HPF	05/14/2020 05:57 pm
RBC [1]	NONE SEEN	< OR = 2 /HPF	05/14/2020 05:57 pm
SQUAMOUS EPITHELIAL CELLS [1]	NONE SEEN	< OR = 5 /HPF	05/14/2020 05:57 pm
BACTERIA [1]	NONE SEEN	NONE SEEN /HPF	05/14/2020 05:57 pm
HYALINE CAST [1]	NONE SEEN	NONE SEEN /LPF	05/14/2020 05:57 pm
REFLEXIVE URINE CULTURE [1]	NO CULTURE INDICATED		05/14/2020 05:57 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	8.5	3.8-10.8 Thousand/uL	05/14/2020 05:57 pm
RED BLOOD CELL COUNT [1]	5.47	4.20-5.80 Million/uL	05/14/2020 05:57 pm
HEMOGLOBIN [1]	16.2	13.2-17.1 g/dL	05/14/2020 05:57 pm
HEMATOCRIT [1]	48.1	38.5-50.0 %	05/14/2020 05:57 pm
MCV [1]	87.9	80.0-100.0 fL	05/14/2020 05:57 pm
MCH [1]	29.6	27.0-33.0 pg	05/14/2020 05:57 pm
MCHC [1]	33.7	32.0-36.0 g/dL	05/14/2020 05:57 pm
RDW [1]	13.0	11.0-15.0 %	05/14/2020 05:57 pm
PLATELET COUNT [1]	252	140-400 Thousand/uL	05/14/2020 05:57 pm
MPV [1]	11.3	7.5-12.5 fL	05/14/2020 05:57 pm
ABSOLUTE NEUTROPHILS [1]	5092	1500-7800 cells/uL	05/14/2020 05:57 pm
ABSOLUTE LYMPHOCYTES [1]	2091	850-3900 cells/uL	05/14/2020 05:57 pm
ABSOLUTE MONOCYTES [1]	723	200-950 cells/uL	05/14/2020 05:57 pm
ABSOLUTE EOSINOPHILS [1]	● 519	15-500 cells/uL Above high normal	05/14/2020 05:57 pm
ABSOLUTE BASOPHILS [1]	77	0-200 cells/uL	05/14/2020 05:57 pm
ABSOLUTE NUCLEATED RBC [1]	0	0 cells/uL	05/14/2020 05:57 pm
NEUTROPHILS [1]	59.9	%	05/14/2020 05:57 pm
LYMPHOCYTES [1]	24.6	%	05/14/2020 05:57 pm
MONOCYTES [1]	8.5	%	05/14/2020 05:57 pm
EOSINOPHILS [1]	6.1	%	05/14/2020 05:57 pm
BASOPHILS [1]	0.9	%	05/14/2020 05:57 pm

T4, FREE

Observations	Result	Reference / UoM	Date/Status
T4, FREE [1]	1.1	0.8-1.8 ng/dL	05/14/2020 05:57 pm

TSH

Observations	Result	Reference / UoM	Date/Status

Observations	Result	Reference / UoM	Date/Status
TSH [1]	1.96	0.40-4.50 mIU/L	05/14/2020 05:57 pm

VITAMIN D, 1,25 DIHYDROXY

Observations	Result	Reference / UoM	Date/Status
VITAMIN D, 1,25 (OH)2, TOTAL	39	18-72 pg/mL	05/14/2020 05:57 pm
Vendor note: See Note 1			
VITAMIN D3, 1,25 (OH)2	39	pg/mL	05/14/2020 05:57 pm
Vendor note: See Note 1			
VITAMIN D2, 1,25 (OH)2	<8	pg/mL	05/14/2020 05:57 pm

Vendor note:

Vitamin D3, 1,25(OH)2 indicates both endogenous production and supplementation. Vitamin D2, 1,25(OH)2 is an indicator of exogenous sources, such as diet or supplementation. Interpretation and therapy are based on measurement of Vitamin D, 1,25 (OH)2, Total.
See Note 1
See Note 2

Note 1

This test was developed and its analytical performance characteristics have been determined by Quest Diagnostics. It has not been cleared or approved by the FDA. This assay has been validated pursuant to the CLIA regulations and is used for clinical purposes.

Note 2

For additional information, please refer to http://education.QuestDiagnostics.com/faq/FAQ199 (http://education.QuestDiagnostics.com/faq/FAQ199) (This link is being provided for informational/ educational purposes only.)

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c [1]	● 7.3	<5.7 % of total Hgb Above high normal	05/14/2020 05:57 pm

Vendor note: For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.

For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

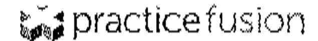
PDF Report1

Observations	Result	Reference / UoM	Date/Status

Observations	Result	Reference / UoM	Date/Status
See Attachment			05/11/2020 12:11 pm

Performing Laboratory
[1] Quest Diagnostics-West Hills-Tab Toochinda MD 8401 Fallbrook Ave West Hills, CA 91304-3226

Lab Results for RAMOS, JACOB (Male, 04/29/1966)



Laboratory

Collection: 08/12/2019 12:37 pm
Order #: EN890361X
Accession #: EN890361X

Name: Quest Diagnostics (QDRT)

Patient information

Patient ID: RJ438906
Mobile: 661-439-0403
Address: 3805 LA TONIA CT.
Bakersfield, CA 93313

Requesting Provider

Name: CARLOS A ALVAREZ

Attachments

attachment1
attachment1
attachment1

Vendor note: FASTING: NO

LIPID PANEL, STANDARD

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL, TOTAL [1]	82	<200 mg/dL	08/13/2019 05:03 pm
HDL CHOLESTEROL [1]	● 28	>40 mg/dL Below low normal	08/13/2019 05:03 pm
TRIGLYCERIDES [1]	75	<150 mg/dL	08/13/2019 05:03 pm
LDL-CHOLESTEROL [1]	38	mg/dL (calc)	08/13/2019 05:03 pm

Vendor note: Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
(http://education.QuestDiagnostics.com/faq/FAQ164 (http://education.QuestDiagnostics.com/faq/FAQ164))

Observations	Result	Reference / UoM	Date/Status
CHOL/HDLC RATIO [1]	2.9	<5.0 (calc)	08/13/2019 05:03 pm
NON HDL CHOLESTEROL [1]	54	<130 mg/dL (calc)	08/13/2019 05:03 pm

Vendor note: For patients with diabetes plus 1 major ASCVD risk
factor, treating to a non-HDL-C goal of <100 mg/dL
(LDL-C of <70 mg/dL) is considered a therapeutic
option.

URIC ACID

Observations	Result	Reference / UoM	Date/Status
URIC ACID [1]	6.9	4.0-8.0 mg/dL	08/13/2019 05:03 pm

Vendor note: Therapeutic target for gout patients: <6.0 mg/dL

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status

Observations	Result	Reference / UoM	Date/Status
GLUCOSE [1]	● 196	65-139 mg/dL Above high normal	08/13/2019 05:03 pm
Vendor note: Non-fasting reference interval			
UREA NITROGEN (BUN) [1]	● 36	7-25 mg/dL Above high normal	08/13/2019 05:03 pm
CREATININE [1]	1.18	0.70-1.33 mg/dL	08/13/2019 05:03 pm
Vendor note: For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.			
eGFR NON-AFR. AMERICAN [1]	70	> OR = 60 mL/min/1.73m2	08/13/2019 05:03 pm
eGFR AFRICAN AMERICAN [1]	81	> OR = 60 mL/min/1.73m2	08/13/2019 05:03 pm
BUN/CREATININE RATIO [1]	● 31	6-22 (calc) Above high normal	08/13/2019 05:03 pm
SODIUM [1]	139	135-146 mmol/L	08/13/2019 05:03 pm
POTASSIUM [1]	5.1	3.5-5.3 mmol/L	08/13/2019 05:03 pm
CHLORIDE [1]	104	98-110 mmol/L	08/13/2019 05:03 pm
CARBON DIOXIDE [1]	25	20-32 mmol/L	08/13/2019 05:03 pm
CALCIUM [1]	9.9	8.6-10.3 mg/dL	08/13/2019 05:03 pm
PROTEIN, TOTAL [1]	7.2	6.1-8.1 g/dL	08/13/2019 05:03 pm
ALBUMIN [1]	4.4	3.6-5.1 g/dL	08/13/2019 05:03 pm
GLOBULIN [1]	2.8	1.9-3.7 g/dL (calc)	08/13/2019 05:03 pm
ALBUMIN/GLOBULIN RATIO [1]	1.6	1.0-2.5 (calc)	08/13/2019 05:03 pm
BILIRUBIN, TOTAL [1]	0.4	0.2-1.2 mg/dL	08/13/2019 05:03 pm
ALKALINE PHOSPHATASE [1]	114	40-115 U/L	08/13/2019 05:03 pm
AST [1]	16	10-35 U/L	08/13/2019 05:03 pm
ALT [1]	12	9-46 U/L	08/13/2019 05:03 pm

URINALYSIS, COMPLETE W/REFLEX TO CULTURE

Observations	Result	Reference / UoM	Date/Status
COLOR [1]	YELLOW	YELLOW	08/13/2019 05:03 pm
APPEARANCE [1]	CLEAR	CLEAR	08/13/2019 05:03 pm
SPECIFIC GRAVITY [1]	1.027	1.001-1.035	08/13/2019 05:03 pm
PH [1]	5.5	5.0-8.0	08/13/2019 05:03 pm
GLUCOSE [1]	● 3+	NEGATIVE Abnormal (applies to non-numeric results)	08/13/2019 05:03 pm
BILIRUBIN [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
KETONES [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
OCCULT BLOOD [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
PROTEIN [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
NITRITE [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
LEUKOCYTE ESTERASE [1]	NEGATIVE	NEGATIVE	08/13/2019 05:03 pm
WBC [1]	NONE SEEN	< OR = 5 /HPF	08/13/2019 05:03 pm
RBC [1]	NONE SEEN	< OR = 2 /HPF	08/13/2019 05:03 pm
SQUAMOUS EPITHELIAL CELLS [1]	NONE SEEN	< OR = 5 /HPF	08/13/2019 05:03 pm
BACTERIA [1]	NONE SEEN	NONE SEEN /HPF	08/13/2019 05:03 pm
HYALINE CAST [1]	NONE SEEN	NONE SEEN /LPF	08/13/2019 05:03 pm
REFLEXIVE URINE CULTURE [1]	NO CULTURE INDICATED		08/13/2019 05:03 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	9.8	3.8-10.8 Thousand/uL	08/13/2019 05:03 pm
RED BLOOD CELL COUNT [1]	5.49	4.20-5.80 Million/uL	08/13/2019 05:03 pm
HEMOGLOBIN [1]	15.7	13.2-17.1 g/dL	08/13/2019 05:03 pm
HEMATOCRIT [1]	47.8	38.5-50.0 %	08/13/2019 05:03 pm
MCV [1]	87.1	80.0-100.0 fL	08/13/2019 05:03 pm
MCH [1]	28.6	27.0-33.0 pg	08/13/2019 05:03 pm
MCHC [1]	32.8	32.0-36.0 g/dL	08/13/2019 05:03 pm
RDW [1]	13.2	11.0-15.0 %	08/13/2019 05:03 pm
PLATELET COUNT [1]	249	140-400 Thousand/uL	08/13/2019 05:03 pm
MPV [1]	11.3	7.5-12.5 fL	08/13/2019 05:03 pm
ABSOLUTE NEUTROPHILS [1]	6360	1500-7800 cells/uL	08/13/2019 05:03 pm
ABSOLUTE LYMPHOCYTES [1]	2234	850-3900 cells/uL	08/13/2019 05:03 pm
ABSOLUTE MONOCYTES [1]	676	200-950 cells/uL	08/13/2019 05:03 pm
ABSOLUTE EOSINOPHILS [1]	441	15-500 cells/uL	08/13/2019 05:03 pm
ABSOLUTE BASOPHILS [1]	88	0-200 cells/uL	08/13/2019 05:03 pm
ABSOLUTE NUCLEATED RBC [1]	0	0 cells/uL	08/13/2019 05:03 pm
NEUTROPHILS [1]	64.9	%	08/13/2019 05:03 pm
LYMPHOCYTES [1]	22.8	%	08/13/2019 05:03 pm
MONOCYTES [1]	6.9	%	08/13/2019 05:03 pm
EOSINOPHILS [1]	4.5	%	08/13/2019 05:03 pm
BASOPHILS [1]	0.9	%	08/13/2019 05:03 pm

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c [1]	● 8.1	<5.7 % of total Hgb Above high normal	08/13/2019 05:03 pm

Vendor note: For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.

For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			08/12/2019 12:37 pm

Performing Laboratory
[1] Quest Diagnostics-West Hills-Tab Toochinda MD 8401 Fallbrook Ave West Hills, CA 91304-3226

Lab Results for RAMOS, JACOB (Male, 04/29/1966)

practice fusion

Laboratory

Collection: 04/22/2019 01:15 pm
Order #: EN135639R
Accession #: EN135639R

Name: Quest Diagnostics (QDRT)

Patient information

Patient ID: RJ438906
Mobile: 661-439-0403
Address: 3805 LA TONIA CT, Bakersfield, CA 93313

Requesting Provider

Name: CARLOS A ALVAREZ

Attachments

attachment1
attachment1
attachment1

Vendor note: FASTING: YES

LIPID PANEL, STANDARD

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL, TOTAL [1]	109	<200 mg/dL	04/23/2019 05:58 pm
HDL CHOLESTEROL [1]	● 31	>40 mg/dL Below low normal	04/23/2019 05:58 pm
TRIGLYCERIDES [1]	116	<150 mg/dL	04/23/2019 05:58 pm
LDL-CHOLESTEROL [1]	58	mg/dL (calc)	04/23/2019 05:58 pm

Vendor note: Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.
Martin SS et al. JAMA. 2013;310(19): 2061-2068
(http://education.QuestDiagnostics.com/faq/FAQ164 (http://education.QuestDiagnostics.com/faq/FAQ164))

Observations	Result	Reference / UoM	Date/Status
CHOL/HDLC RATIO [1]	3.5	<5.0 (calc)	04/23/2019 05:58 pm
NON HDL CHOLESTEROL [1]	78	<130 mg/dL (calc)	04/23/2019 05:58 pm

Vendor note: For patients with diabetes plus 1 major ASCVD risk
factor, treating to a non-HDL-C goal of <100 mg/dL
(LDL-C of <70 mg/dL) is considered a therapeutic
option.

MAGNESIUM

Observations	Result	Reference / UoM	Date/Status
MAGNESIUM [1]	● 2.6	1.5-2.5 mg/dL Above high normal	04/23/2019 05:58 pm

COMPREHENSIVE METABOLIC PANEL

Observations	Result	Reference / UoM	Date/Status
GLUCOSE [1]	● 154	65-99 mg/dL Above high normal	04/23/2019 05:58 pm

05-12-'22 17:22 FROM- T-814 P0129/0131 F-290

	For someone without known diabetes, a glucose value >125 mg/dL indicates that they may have diabetes and this should be confirmed with a follow-up test.		
UREA NITROGEN (BUN) [1]	● 37	7-25 mg/dL Above high normal	04/23/2019 05:58 pm
CREATININE [1]	1.07	0.70-1.33 mg/dL	04/23/2019 05:58 pm
Vendor note:	For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.		
eGFR NON-AFR. AMERICAN [1]	79	> OR = 60 mL/min/1.73m2	04/23/2019 05:58 pm
eGFR AFRICAN AMERICAN [1]	92	> OR = 60 mL/min/1.73m2	04/23/2019 05:58 pm
BUN/CREATININE RATIO [1]	● 35	6-22 (calc) Above high normal	04/23/2019 05:58 pm
SODIUM [1]	139	135-146 mmol/L	04/23/2019 05:58 pm
POTASSIUM [1]	● 5.6	3.5-5.3 mmol/L Above high normal	04/23/2019 05:58 pm
CHLORIDE [1]	105	98-110 mmol/L	04/23/2019 05:58 pm
CARBON DIOXIDE [1]	28	20-32 mmol/L	04/23/2019 05:58 pm
CALCIUM [1]	9.7	8.6-10.3 mg/dL	04/23/2019 05:58 pm
PROTEIN, TOTAL [1]	7.6	6.1-8.1 g/dL	04/23/2019 05:58 pm
ALBUMIN [1]	4.7	3.6-5.1 g/dL	04/23/2019 05:58 pm
GLOBULIN [1]	2.9	1.9-3.7 g/dL (calc)	04/23/2019 05:58 pm
ALBUMIN/GLOBULIN RATIO [1]	1.6	1.0-2.5 (calc)	04/23/2019 05:58 pm
BILIRUBIN, TOTAL [1]	0.3	0.2-1.2 mg/dL	04/23/2019 05:58 pm
ALKALINE PHOSPHATASE [1]	● 125	40-115 U/L Above high normal	04/23/2019 05:58 pm
AST [1]	14	10-35 U/L	04/23/2019 05:58 pm
ALT [1]	11	9-46 U/L	04/23/2019 05:58 pm

URINALYSIS, COMPLETE W/REFLEX TO CULTURE

Observations	Result	Reference / UoM	Date/Status
COLOR [1]	YELLOW	YELLOW	04/23/2019 05:58 pm
APPEARANCE [1]	CLEAR	CLEAR	04/23/2019 05:58 pm
SPECIFIC GRAVITY [1]	1.025	1.001-1.035	04/23/2019 05:58 pm
PH [1]	5.5	5.0-8.0	04/23/2019 05:58 pm
GLUCOSE [1]	● 3+	NEGATIVE Abnormal (applies to non-numeric results)	04/23/2019 05:58 pm
BILIRUBIN [1]	NEGATIVE	NEGATIVE	04/23/2019 05:58 pm
KETONES [1]	NEGATIVE	NEGATIVE	04/23/2019 05:58 pm
OCCULT BLOOD [1]	NEGATIVE	NEGATIVE	04/23/2019 05:58 pm
PROTEIN [1]	NEGATIVE	NEGATIVE	04/23/2019 05:58 pm
NITRITE [1]	NEGATIVE	NEGATIVE	04/23/2019 05:58 pm

Observations	Result	Reference / UoM	Date/Status
HYALINE CAST [1]	NONE SEEN	NONE SEEN /LPF	04/23/2019 05:58 pm
REFLEXIVE URINE CULTURE [1]	NO CULTURE INDICATED		04/23/2019 05:58 pm

CBC (INCLUDES DIFF/PLT)

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELL COUNT [1]	● 11.8	3.8-10.8 Thousand/uL Above high normal	04/23/2019 05:58 pm
RED BLOOD CELL COUNT [1]	5.60	4.20-5.80 Million/uL	04/23/2019 05:58 pm
HEMOGLOBIN [1]	16.1	13.2-17.1 g/dL	04/23/2019 05:58 pm
HEMATOCRIT [1]	49.2	38.5-50.0 %	04/23/2019 05:58 pm
MCV [1]	87.9	80.0-100.0 fL	04/23/2019 05:58 pm
MCH [1]	28.8	27.0-33.0 pg	04/23/2019 05:58 pm
MCHC [1]	32.7	32.0-36.0 g/dL	04/23/2019 05:58 pm
RDW [1]	13.2	11.0-15.0 %	04/23/2019 05:58 pm
PLATELET COUNT [1]	247	140-400 Thousand/uL	04/23/2019 05:58 pm
MPV [1]	11.3	7.5-12.5 fL	04/23/2019 05:58 pm
ABSOLUTE NEUTROPHILS [1]	● 8685	1500-7800 cells/uL Above high normal	04/23/2019 05:58 pm
ABSOLUTE LYMPHOCYTES [1]	1805	850-3900 cells/uL	04/23/2019 05:58 pm
ABSOLUTE MONOCYTES [1]	743	200-950 cells/uL	04/23/2019 05:58 pm
ABSOLUTE EOSINOPHILS [1]	472	15-500 cells/uL	04/23/2019 05:58 pm
ABSOLUTE BASOPHILS [1]	94	0-200 cells/uL	04/23/2019 05:58 pm
NEUTROPHILS [1]	73.6	%	04/23/2019 05:58 pm
LYMPHOCYTES [1]	15.3	%	04/23/2019 05:58 pm
MONOCYTES [1]	6.3	%	04/23/2019 05:58 pm
EOSINOPHILS [1]	4.0	%	04/23/2019 05:58 pm
BASOPHILS [1]	0.8	%	04/23/2019 05:58 pm

VITAMIN B12

Observations	Result	Reference / UoM	Date/Status
VITAMIN B12 [1]	● 1794	200-1100 pg/mL Above high normal	04/23/2019 05:58 pm

TSH W/REFLEX TO FT4

Observations	Result	Reference / UoM	Date/Status
TSH W/REFLEX TO FT4 [1]	1.48	0.40-4.50 mIU/L	04/23/2019 05:58 pm

VITAMIN D,25-OH,TOTAL,IA

Observations	Result	Reference / UoM	Date/Status
VITAMIN D,25-OH,TOTAL,IA [1]	● 28	30-100 ng/mL Below low normal	04/23/2019 05:58 pm

Observations	Result	Reference / UoM	Date/Status

Vendor note: Vitamin D Status 25-OH Vitamin D:

Deficiency: <20 ng/mL
Insufficiency: 20 - 29 ng/mL
Optimal: > or = 30 ng/mL

For 25-OH Vitamin D testing on patients on D2-supplementation and patients for whom quantitation of D2 and D3 fractions is required, the QuestAssureD(TM) 25-OH VIT D, (D2,D3), LC/MS/MS is recommended: order code 92888 (patients >2yrs).

For more information on this test, go to: http://education.questdiagnostics.com/faq/FAQ163 (http://education.questdiagnostics.com/faq/FAQ163) (This link is being provided for informational/educational purposes only.)

HEMOGLOBIN A1c

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1c [1]	● 7.5	<5.7 % of total Hgb Above high normal	04/23/2019 05:58 pm

Vendor note: For someone without known diabetes, a hemoglobin A1c value of 6.5% or greater indicates that they may have diabetes and this should be confirmed with a follow-up test.

For someone with known diabetes, a value <7% indicates that their diabetes is well controlled and a value greater than or equal to 7% indicates suboptimal control. A1c targets should be individualized based on duration of diabetes, age, comorbid conditions, and other considerations.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes for children.

PDF Report1

Observations	Result	Reference / UoM	Date/Status
See Attachment			04/22/2019 01:15 pm

Performing Laboratory
[1] Quest Diagnostics-West Hills-Tab Toochinda 8401 Fallbrook Ave West Hills, CA 91304-3226