Lionize Legal

Prepared: 02/20/2026

Claimant:	John Smith
SSN:	123-45-6789

Records Reviewed

1F: Office Treatment Records (OFFCREC) Src.: Grandview- from clmt Tmt. Dt.: 02/06/2019 - 09/19/2019 (5 pages)
2F: Progress Notes (PROGRESSNOTES) Src.: Grandview Medicine Tmt. Dt.: 12/04/2019 - 12/05/2019 (17 pages)
3F: Progress Notes (PROGRESSNOTES) Src.: GRANDVIEW UNIVERSITY MEDICAL CENTER Tmt. Dt.: 01/10/2023 - 10/31/2023 (151 pages)
4F: Office Treatment Records (OFFCREC) Src.: AL DEPARTMENT OF REHAB SRVS Tmt. Dt.: 09/12/2022 - 11/07/2023 (9 pages)
5F: MER Request (REQMER) Src.: PINNACLE BEHAVIORAL HEALTH HOOVER Tmt. Dt.: Unknown - 11/09/2023 (1 page)
6F: Office Treatment Records (OFFCREC) Src.: PINNACLE BEHAVIORAL HEALTH HOOVER Tmt. Dt.: 02/22/2023 - 11/16/2023 (43 pages)
7F: Medical Opinion - Mental (MEDOPMEN) Src.: Dr. Harrison, PhD Tmt. Dt.: Unknown - 11/17/2023 (1 page)
8F: Office Treatment Records (OFFCREC) Src.: Pinnacle Behavioral Health Hoover Tmt. Dt.: 11/16/2023 - 12/14/2023 (17 pages)
9F: Office Treatment Records (OFFCREC) Src.: Hillcrest Primary Care Vestavia Tmt. Dt.: 12/04/2022 - 03/08/2024 (73 pages)
10F: Office Treatment Records (OFFCREC) Src.: GRANDVIEW UNIVERSITY MEDICAL CENTER Tmt. Dt.: 05/19/2023 - 04/24/2024 (145 pages)
11F: Office Treatment Records (OFFCREC) Src.: Pinnacle Behavioral Health Tmt. Dt.: 05/22/2023 - 06/06/2024 (7 pages)
12F: Consultative Examination Report (CE) Src.: PATRICIA L HOFFMAN, OD Tmt. Dt.: Unknown - 06/20/2024 (4 pages)
13F: Medical Opinion - Physical (MEDOPPHY) Src.: Janet Watkins, LMSW Tmt. Dt.: Unknown - 07/11/2024 (1 page)
14F: Medical Opinion - Mental (MEDOPMEN) Src.: Sarah E Collins, LMSW Tmt. Dt.: Unknown - 07/11/2024 (1 page)
15F: CE Psychology (CEPSYLGY) Src.: ROBERT PIERCE, LPC Tmt. Dt.: Unknown - 07/13/2024 (8 pages)
16F: Office Treatment Records (OFFCREC) Src.: Grandview Medicine Tmt. Dt.: Unknown - 08/28/2024 (8 pages)
17F: Progress Notes (PROGRESSNOTES) Src.: GRANDVIEW UNIVERSITY MEDICAL CENTER Tmt. Dt.: 06/27/2024 - 08/29/2024 (72 pages)
18F: Progress Notes (PROGRESSNOTES) Src.: Grandview Medicine Tmt. Dt.: 02/13/2019 - 08/29/2024 (25 pages)
19F: Progress Notes (PROGRESSNOTES) Src.: GRANDVIEW UNIVERSITY MEDICAL CENTER Tmt. Dt.: 08/29/2024 - 03/24/2025 (183 pages)
20F: Medical Opinion - Physical (MEDOPPHY) Src.: Arjun V. Kapoor, MD Tmt. Dt.: Unknown - 03/18/2025 (1 page)
21F: Office Treatment Records (OFFCREC) Src.: Valley Medical: PRITI C. DESAI, MD Tmt. Dt.: 12/23/2024 - 12/23/2024 (19 pages)
22F: Office Treatment Records (OFFCREC) Src.: Faith Community Health: DANIELLE RAMSEY, NP Tmt. Dt.: 10/24/2024 - 04/25/2025 (50 pages)
23F: Office Treatment Records (OFFCREC) Src.: Grandview Medicine: DAVID CHEN, MD Tmt. Dt.: 04/03/2025 - 05/21/2025 (81 pages)
24F: Medical Opinion - Mental (MEDOPMEN) Src.: Behavioral Neuropsychology Associates LLC Tmt. Dt.: Unknown - 11/07/2023 (6 pages)
25F: Required Disclosure - Medical (REQDISMED) Src.: Medical Opinion Danielle Ramsey CRNP Tmt. Dt.: Unknown - 04/30/2025 (7 pages)

Summary

John Smith's documented care began with management of chronic sickle-cell disease complicated by splenomegaly and post-splenectomy status after a robotic splenectomy on December 4, 2019, followed by routine hematology and ophthalmology surveillance for sickle cell retinopathy. (Exhibit 18F, p. 9; Exhibit 2F, p. 1) He continued to receive ophthalmologic evaluation demonstrating nonproliferative pigmented retinopathy with preserved visual acuity on dilated exam. (Exhibit 18F, p. 25; Exhibit 17F, pp. 1-6; Exhibit 2F, p. 17; Exhibit 11F, pp. 1-3) Early laboratory assessments and hemoglobin electrophoreses documented a hemoglobin S–predominant sickling disorder with elevated fetal hemoglobin and microcytic indices consistent with concomitant beta-thalassemia, establishing the

hematologic basis for recurrent vaso-occlusive events. (Exhibit 3F, pp. 55-56; Exhibit 3F, pp. 125-128; Exhibit 17F, pp. 71-72)

By late 2022 imaging and spine evaluation documented anatomic contributors to his chronic axial pain. CT of the lumbar spine showed multilevel Schmorl's nodes and minimal disc bulges, and CT of the pelvis demonstrated multiple bone infarctions involving the lumbar spine, sacrum, and iliac bones, findings attributed to sickle-cell–related bone ischemia. (Exhibit 9F, pp. 70-71; Exhibit 9F, p. 69) His treating physicians attributed persistent low back and sacroiliac–region pain to a combination of degenerative intervertebral disc disease and multifocal osseous infarcts, prompting initial conservative management with muscle relaxants, neuropathic agents, and referrals for further specialty follow-up. (Exhibit 9F, pp. 32-35; Exhibit 9F, p. 36)

Throughout 2023 Mr. Smith experienced recurrent vaso-occlusive crises requiring repeated outpatient infusion visits and several hospital admissions for intravenous analgesia and patient-controlled opioid analgesia. (Exhibit 3F, pp. 43-45; Exhibit 10F, pp. 109-111) Hematology instituted disease-modifying therapies including hydroxyurea and initiation of crizanlizumab (Adakveo) with a tolerated first infusion in October 2023 but a significant infusion-related pain exacerbation and subsequent inpatient opioid PCA treatment shortly after the second infusion, which required hospital observation and analgesic escalation. (Exhibit 3F, pp. 79-85; Exhibit 10F, pp. 80-85; Exhibit 3F, pp. 62-65; Exhibit 10F, pp. 70-73; Exhibit 18F, p. 18; Exhibit 2F, p. 10) Concurrently, neurobehavioral assessment and formal neuropsychological testing in 2023 established attention-deficit/hyperactivity disorder, combined type, with marked impulsivity and activity on objective testing, leading to ongoing psychiatric medication management. (Exhibit 6F, pp. 19, 21, 23-25, 27, 29-36; Exhibit 24F, pp. 1-6; Exhibit 25F, pp. 1-6)

In 2024 his course continued to show frequent, unpredictable pain crises necessitating repeated ED and infusion treatments with IV opioids and fluids, and hematology adjusted disease-directed therapy, including changes in hydroxyurea dosing and temporary discontinuation of crizanlizumab per patient preference. (Exhibit 3F, pp. 36-42; Exhibit 10F, pp. 13-21; Exhibit 3F, pp. 146-147; Exhibit 10F, pp. 28-32) Sleep evaluation identified obstructive sleep apnea with an initial apnea–hypopnea index of 18.5 events/hour on overnight polysomnography and effective reduction of events with CPAP titration to an AHI of 1.4, prompting recommendations for positive airway pressure therapy. (Exhibit 19F, pp. 162-163) Routine hematologic monitoring through 2024 documented ongoing microcytosis, elevated red cell distribution width, and persistent hemoglobin S predominance consistent with chronic hemolytic disease and transfusion planning discussions. (Exhibit 17F, pp. 13, 15; Exhibit 3F, pp. 108-111)

In early 2025 his condition progressed to more frequent and disabling pain exacerbations with documented hospital admissions and ambulatory infusion treatments, and he required intermittent red blood cell transfusions for acute management of symptomatic crises, including a documented two-unit leukoreduced A-negative transfusion in April 2025. (Exhibit 19F, pp. 149-152; Exhibit 23F, pp. 13-14) Multimodality imaging in spring 2025 confirmed extensive multifocal bone infarcts of the pelvis and acetabulum without acute marrow edema or fracture on MRI of the sacrum/pelvis, further supporting chronic sickle-cell–related osseous injury as a dominant pain generator. (Exhibit 23F, p. 39; Exhibit 23F, p. 47; Exhibit 23F, p. 48) Physical medicine evaluations described constant throbbing low back pain with lumbar and bilateral sacroiliac tenderness and neuropathic features that limited ambulation and activities of daily living, and PM&R clinicians arranged spine clinic follow-up and multidisciplinary pain management. (Exhibit 19F, pp. 108-111; Exhibit 23F, pp. 15-18)

Cardiac and neurologic surveillance documented intermittent palpitations and brief runs of supraventricular tachycardia on ambulatory monitoring, with Holter and patch monitoring revealing predominantly sinus rhythm but episodes of supraventricular ectopy and brief SVT runs requiring cardiology follow-up. (Exhibit 23F, pp. 2-4, 6; Exhibit 19F, pp. 92-107; Exhibit 19F, pp. 91-92) Neuroimaging for new daily headaches showed no venous sinus thrombosis on MRV and no acute intracranial process on MRI, although radiology noted mild prominence of the optic nerve sheaths for clinical correlation. (Exhibit 19F, p. 115; Exhibit 19F, p. 116; Exhibit 19F, pp. 156-161) Audiology and ENT evaluation in early 2025 documented right middle ear effusion and transient conductive findings with subsequent audiometric testing indicating mild threshold elevations and a component of sensorineural hearing loss under ENT follow-up. (Exhibit 19F, pp. 121-122; Exhibit 19F, pp. 123-128; Exhibit 19F, pp. 164-166)

Overall, from 2020 through mid-2025 John Smith's records show a persistent, progressive pattern of chronic sickle-cell disease (HbS/β-thalassemia and documented HbSS features), post-splenectomy status, recurrent vaso-occlusive crises requiring frequent outpatient infusions and multiple inpatient admissions with IV opioid PCA, multifocal osseous infarction of the pelvis and spine on CT and MRI, ongoing microcytic hemoglobin abnormalities on serial electrophoreses and CBCs, concurrent neurodevelopmental/mental-health diagnoses (ADHD combined type with ongoing pharmacotherapy and mood/anxiety symptoms), obstructive sleep apnea managed with CPAP, and ongoing multidisciplinary management including hematology, PM&R, cardiology, ENT, and psychiatry. (Exhibit

3F, pp. 55-56; Exhibit 17F, pp. 27-28; Exhibit 18F, p. 9; Exhibit 23F, p. 48; Exhibit 19F, pp. 149-152; Exhibit 6F, pp. 19, 21, 23-25; Exhibit 19F, pp. 162-163; Exhibit 23F, pp. 15-18)

Chronology of Events

8 administrative entries without clinical content were excluded.

2019-02-06 | Unknown Facility / Nelson, Victoria L CRNP

Summary: Patient with HbS/β-thalassemia presented for an acute sickle cell pain crisis with 10/10 lower back pain after prior ED treatment with IV fluids and one dose of morphine. Outside labs were stable (Hgb 12 g/dL, Hct 38%, WBC 7.2) and he was managed symptomatically with analgesia (ibuprofen) and supportive care with follow-up as needed.

Diagnoses: Sickle cell anemia with crisis (HbS/β-thalassemia)

Procedures: Received IV fluids and one dose of morphine at the outside hospital prior to this visit. (1F 4)

Laboratory Results: Hgb 12, Hct 38, WBC 7.2, RBC 5.1 WBC 7.2 (K/μL), RBC 5.1 (M/μL), Hgb 12 g/dL, Hct 38%. (18F 3; 1F 4)

Objective: Labs at OSH: Hgb ~12, Hct ~38, WBC 7.2, RBC 5.1; musculoskeletal: back pain in the lower region; no fever, chills, or respiratory findings documented. Review of systems notable for no fever, no chills, no shortness of breath; musculoskeletal: back pain in the lower region; prior OSH labs: WBC 7.2, RBC 5.1. (18F 3; 1F 4)

Subjective: Patient complained of 10/10 lower back pain since yesterday, reported going to ED at an OSH and receiving IV fluids and one dose of morphine with persistent pain; denies fever, cough, shortness of breath, chest pain, abdominal pain, nausea/vomiting. Patient presented for an acute sickle cell visit complaining of 10/10 lower back pain since yesterday and reported prior ED visit where he was treated with IV fluids and one dose of morphine; denies fever, cough, SOB, CP, abdominal pain, N/V. (18F 3; 1F 4)

Medications: Ibuprofen 600 mg oral tablet, 600 mg oral QID Ibuprofen 600 mg oral tablet 600 mg PO QID. (18F 3; 1F 4)

Assessment and Plan: Sickle cell acute visit for pain in the setting of HbS/Beta thalassemia; symptomatic management with analgesia and supportive care, follow-up as needed. Sickle cell acute pain/crisis presenting as severe lower back pain; previously treated with IV fluids and analgesia at OSH and being managed in clinic. (18F 3; 1F 4)

Citation: 18F 3; 1F 4

2019-08-19 | Digestive Health Center / Jackson, Keisha R RN

Summary: Patient with sickle cell beta thalassemia has splenomegaly with concern for sequestration; consultative visit resulted in referral to GI surgery with request for evaluation for laparoscopic splenectomy and follow-up per referral instructions.

Diagnoses: Sickle cell beta thalassemia, Splenomegaly

Subjective: Referral needed for patient; message states 'Referral needed for pt. please see orders and advise.' (18F 4)

Assessment and Plan: Referral to GI Surgery for patients with sickle cell disease and splenomegaly/sequestration; follow-up via referral per messages. Referral to GI surgery for splenomegaly related to sickle cell disease with request for laparoscopic removal; follow-up per referral instructions. (18F 4; 1F 5)

Citation: 18F 4; 1F 5; 15F 1

2019-11-12 | Unknown Facility / Monroe, Karen D CRNP

Summary: Patient with sickle cell disease (history of post-splenectomy and reported splenomegaly) and sickle cell retinopathy, noted to be at increased risk for venous thromboembolism. A single dose of naloxone 4 mg (0.1 mL) was administered intranasally (both nares) on 11/12/2019.

Diagnoses: Sickle cell disease, Sickle cell retinopathy, Post-splenectomy, Spleen enlarged, At risk of venous thromboembolus

Medications: Naloxone 4 mg/0.1 mL nasal spray; dose 4 mg, frequency once, route both nares, started 11/12/2019. (4F 6)

Citation: 4F 6-8

2019-12-05 | Gen Surg - Grandview Highlands / Crawford, Robert L MD

Summary: Patient with chronic LUQ pain and splenomegaly underwent a robotic splenectomy on 12/04/2019; postoperative course was stable with ambulation without assistance, tolerating diet, afebrile and hemodynamically stable. Pain managed

with acetaminophen, ibuprofen and morphine PRN; patient was transferred from PACU to the floor and deemed suitable for discharge with surgical follow-up.

Diagnoses: Splenomegaly, Postoperative status: splenectomy

Procedures: Robotic splenectomy performed on 12/04/19 (documented as robotic adrenalectomy heading but actual procedure: robotic splenectomy). Robotic splenectomy (procedure performed 12/04/2019). (18F 9; 2F 1)

Functional Assessment: Patient reports quitting his job recently due to high physical demand; no other specific work restrictions documented. (2F 1)

Objective: Post-operative course stable; patient transferred from PACU to floor in stable condition, ambulating without assistance, tolerating diet, vital signs stable and afebrile. Postoperative course stable with ambulation without assistance, tolerated regular diet, no urinary catheter, vital signs stable and afebrile. Patient transferred from PACU to floor in stable condition. (18F 9; 2F 1)

Subjective: Patient reported chronic localized LUQ pain since Feb, worse with movement and post-activity, pain controlled with Tylenol, ibuprofen and morphine PRN; denies shortness of breath. Patient reported chronic localized LUQ pain progressively worsening since February, worse with movement and post hydroxyurea; pain controlled with Tylenol, ibuprofen and morphine PRN. Patient denied shortness of breath and reported quitting his job recently due to high physical demand. (18F 9; 2F 1)

Medications: Post-op pain medications, anti-emetics, and IV fluids administered (specific drug names/doses not listed). Tylenol, ibuprofen, morphine PRN; prior hydroxyurea noted. (18F 9; 2F 1)

Assessment and Plan: Postoperative course after splenectomy for splenomegaly was favorable; patient recovered in PACU and floor and was deemed suitable for discharge. Splenomegaly status post robotic splenectomy with stable postoperative course; transferred to PACU then floor and deemed suitable for discharge. Follow-up per surgical service as noted. (18F 9; 2F 1)

Citation: 18F 9; 2F 1

2020-06-26 | Premier Eye Associates / Parker, Melissa OD

Summary: Dilated eye exam showed best-corrected VA 20/20 OU and normal IOPs, with documented nonproliferative pigmented retinopathy related to sickle cell disease and bilateral keratoconjunctivitis sicca; plan for repeat dilated fundus exam and fundus photography in 3 months. Labs notable for mild hyperkalemia (K+ 5.4 mmol/L), low bicarbonate (21 mmol/L), hemolyzed specimen noted, and CBC with microcytosis (MCV 76 fL); blood pressure was 143/81 mmHg.

Diagnoses: CMA OU, Sickle Cell Disease with Nonproliferative Retinopathy, Sickle-cell disease with pain, Keratoconjunctivitis sicca (KCS) OU, ADHD, combined type, Generalized Anxiety Disorder, Adverse effect of drug

Procedures: Dilated eye examination performed. Brief emotional/behavioral assessment (96127) on 11/16/2023 and 06/22/2023. Psychological testing/evaluation codes PSYCL/NRPSYC TECH 1ST (96138) and NRPSYC TST EVAL PHYS/QHP 1ST (96132) on 05/22/2023. (18F 25; 11F 3)

Imaging: Fundus photographs taken today. Plan for dilated fundus examination (DFE) and fundus photography in 3 months. (18F 25)

Laboratory Results: Collected 08/09/2024 07:58 CDT. Basic metabolic panel: Sodium 135 mmol/L, Potassium 5.4 mmol/L (high), Chloride 103 mmol/L, Bicarbonate 21 mmol/L (low), Anion gap 11.0 mmol/L, Glucose 74 mg/dL, BUN 13 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73 m2, Calcium 9.6 mg/dL, Adjusted calcium 9.0 mg/dL, Protein 7.8 g/dL, Albumin 4.7 g/dL. Liver tests: Total bilirubin 0.8 mg/dL, Alkaline phosphatase 48 U/L, ALT 15 U/L, AST 37 U/L, LDH 443 U/L. Specimen hemolyzed noted affecting some results. CBC: WBC 6.64 x10^3/µL, Hgb 12.2 g/dL, Hct 36%, RBC 4.77 x10^6/µL, Platelets 314.4 x10^3/µL, MCV 76 fL, MCH 26 pg, Neutrophils 35% (Absolute neutrophils 2.32 x10^3/µL), Lymphocytes 54% (Absolute lymphocytes 3.59 x10^3/µL), Retic 2.0%, Retic absolute 0.0927 x10^6/µL, RBC retic 4.73 x10^6/µL. Urine drug screen: negative for benzodiazepines, buprenorphine, cannabis, cocaine metabolites, fentanyl; positive for hydrocodone and opiates; heroin/methadone/oxycodone negative. Urine drug screen cutoff values and KDIGO GFR category interpretive data provided in source. (17F 4-6)

Objective: Best-corrected visual acuity OD 20/20, OS 20/20. Intraocular pressure OD 14 mmHg, OS 13 mmHg. Blood pressure 143/81 mmHg. (18F 25; 2F 17)

Subjective: Current systemic medication includes hydroxyurea; no other subjective complaints documented. (2F 17)

Medications: Hydroxyurea 500 mg capsule listed as current systemic medication. ADHD/anxiety medications listed: Strattera 25 mg capsule; Intuniv ER 1 mg tablet (extended release); Qelbree 100 mg capsule and Qelbree 200 mg capsule; Focalin XR 20 mg capsule, extended release (prescribed 05/22-05/23/2023). Given sample: Refresh Relieva with instructions to use three times daily (TID). (18F 25; 2F 17; 11F 2-3)

Assessment and Plan: Sickle cell disease with retinopathy, non-proliferative pigmented lesions OU; keratoconjunctivitis sicca (KCS) OU. Plan: continue monitoring, return in 3 months for DFE and fundus photography; patient educated on lid hygiene and given eye drop sample. Follow-up letters to PCP and hematologist planned. Encounters document long-term drug therapy for ADHD, generalized anxiety disorder, and adverse drug effects; follow-up/office visits recorded. (18F 25; 2F 17; 11F 3)

Citation: 18F 25; 17F 1-6; 2F 17; 11F 1-3

2021-03-24 | Heritage Physician Services (Pelham) / Unknown Provider

Summary: Immunizations were documented: COVID-19 mRNA (Pfizer-BioNTech) administered 03/24/2021 and an influenza vaccine 0.5 mL IM administered 11/16/2022. No other clinical findings or procedures were reported.

Procedures: Immunizations documented for the claimant, including COVID-19 mRNA (Pfizer-BioNTech) 03/24/21 and influenza vaccine 11/16/22 0.5 mL IM. (9F 72)

Citation: 9F 72-73; 3F 1-4

2022-03-23 | Unknown Facility / Bennett, Amanda K MD

Summary: Status post splenectomy for sickle cell disease, lab work shows mild microcytic anemia (Hgb 11.7 g/dL, Hct 33%, MCV 74 fL) with elevated RDW (18.6%) and a low absolute neutrophil count (1.55 x10^3/µL). Basic metabolic panel and renal function were normal (creatinine 0.9 mg/dL, eGFR >90), glucose mildly low at 64 mg/dL, and urine drug screens were negative.

Diagnoses: Sickle cell disease

Procedures: Splenectomy on 12/04/2019. Immunizations documented: Haemophilus b conjugate (PRP-T) vaccine given 11/12/2019; Influenza virus vaccine, inactivated given 12/5/2019 and 12/8/2022. (16F 2; 3F 101)

Laboratory Results: Collected 4/24/2024 12:13 CDT: Basic metabolic panel: Sodium 139 mmol/L, Potassium 4.4 mmol/L, Chloride 105 mmol/L, Bicarbonate 23 mmol/L, Glucose 64 mg/dL, BUN 8 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.3 mg/dL, Albumin 4.6 g/dL. Multiple urine drug screens: negative. Urine drug screen cutoff values provided: Amphetamines 500 ng/mL; Barbiturates/Benzodiazepines 200 ng/mL; Buprenorphine 5 ng/mL; Cannabinoids 50 ng/mL; Cocaine metabolites 150 ng/mL. CBC (4/24/2024 12:13 CDT): WBC 5.55 x10^3/µL, RBC 4.49 x10^6/µL, Hemoglobin 11.7 g/dL (low), Hematocrit 33% (low), MCV 74 fL (low), MCH 26 pg (low), Platelets 323.9 x10^3/µL, RDW 18.6% (high), Neutrophils 28% (absolute neutrophils 1.55 x10^3/µL low), Lymphocytes 56% (absolute 3.13 x10^3/µL), Reticulocyte % 2.1, Retic absolute 0.0972 x10^6/µL, RBC retic 4.61 x10^6/µL. eGFR category interpretive ranges included: G1 ≥90, G2 60-89, G3a 45-59, G3b 30-44, G4 15-29, G5 <15. (10F 8-10)

Subjective: The claimant reported sleeping concerns and feeling highly stressed related to work. (16F 2)

Citation: 17F 71-72; 16F 1-2; 3F 101-103; 10F 5-10

2022-09-16 | Hematology Clinic / Cooper, Michelle L RN

Summary: Telehealth visit for severe musculoskeletal back pain causing limited mobility and need for assistance with toileting; clinician confirmed patient was not in a vaso-occlusive sickle cell crisis. Recommended conservative management including daily exercises, referral to physical therapy, consideration of ultrasound/dry needling and massage, provision of a pain chair, and avoidance of IV/opiate medications.

Diagnoses: Musculoskeletal back pain

Functional Assessment: Patient had limited function from back pain, requiring help to use the restroom and needing consideration for a pain chair and physical therapy. | Patient needed help using the restroom and was in significant pain; recommended daily exercises and referral to PT and consideration of a pain chair. (18F 2; 1F 3)

Objective: Clinician documented the pain as musculoskeletal in nature, confirmed patient was not in vaso-occlusive crisis, and noted difficulty with mobility/using restroom due to pain. RN noted patient was not in crisis but had musculoskeletal back pain and was hurting badly; discussed prior notes and that Opiate/ViOpioid meds are not appropriate for this pain. (18F 2; 1F 3)

Subjective: Spouse called and stated patient is still in a lot of pain today, was having difficulty using the restroom, was not in a sickle cell crisis but had musculoskeletal (back) pain, and requested a pain chair and possible PT or massage. Spouse called expressing concerns about instructions and care from prior day and stated patient remains in a lot of pain and needed help using the restroom; spouse asked to be called. Patient reported musculoskeletal back pain, not a sickle cell crisis. (18F 2; 1F 3)

Assessment and Plan: Musculoskeletal back pain; recommended daily exercises, referral to physical therapy, consider ultrasound/dry needling and massage, avoid IV/opiate meds for this pain, and arrange pain chair if needed. Musculoskeletal back pain; recommended PT referral, discussed ultrasound/dry needling and massage, provided pain chair consideration and follow-up planning. (18F 2; 1F 3)

Citation: 18F 2; 1F 3

2022-11-16 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: New patient with ~1 year of sharp, left-sided low back/SI-region pain (7/10) worse with movement and leg lift, tender at the left sacroiliac joint with normal motor strength and no improvement after ~1 month of physical therapy; symptomatic management (muscle relaxant, NSAID, opioid PRN) noted. History significant for sickle cell disease and the patient requested restarting ADHD medication.

Diagnoses: Low back pain, Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Attention deficit hyperactivity disorder, Pain of left hip joint, SI joint tenderness

Objective: Vitals: height 6 ft, weight 189 lbs, BMI 25.6; BP 128/76 sitting; pulse 66 bpm; RR 16; O2 sat 98% on room air; temperature 98.4°F. Pain scale 7/10. Review of systems largely negative. General: well-appearing. HEENT and cardiopulmonary exams normal. Musculoskeletal: normal motor strength and tone; pain with flexion and rotation of the left hip; tender to palpation at the left sacroiliac (SI) joint. (9F 37, 40)

Subjective: The claimant presented as a new patient reporting low left-sided low back pain, sharp and worse with movement and with lifting his leg off the table. Pain duration ~1 year; improves with heat and Epsom salts. Tried approximately 1 month of physical therapy with no improvement. History of sickle cell disease with a prior ER visit two years ago. History of ADHD; claimant stopped ADHD medication and requested consideration of restarting. (9F 37, 39-40)

Medications: Cyclobenzaprine 5 mg nightly; ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) capsule weekly; hydrocodone 10 mg/acetaminophen 325 mg PRN q4h; hydroxyurea 500 mg daily; ibuprofen 800 mg PRN q6h (do not exceed 4/day). (9F 37)

Assessment and Plan: New patient with left-sided low back/SI region pain with SI joint tenderness. ADHD medication restart discussed/requested. Plan not detailed. (9F 37, 40)

Citation: 9F 37-40

2022-11-16 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient with sickle cell disease and >1 year of persistent low back pain (normal gait/station on exam) evaluated for possible avascular necrosis/osteonecrosis; CT lumbar spine without contrast and CT pelvis/hip ordered and CBC/CMP labs requested. Influenza vaccine administered and medication list (including hydroxyurea and PRN opioids) reviewed.

Diagnoses: Low back pain, Degeneration of lumbar intervertebral disc, Pain in left hip, Sickle cell hemoglobin SS disease, History of splenectomy

Procedures: Influenza vaccination (Flucelvax Quad) 0.5 mL IM administered on 11/16/2022. (9F 41)

Imaging: CT lumbar spine w/o contrast recommended to evaluate low back pain; CT pelvis/hip recommended to evaluate left hip pain. (9F 41)

Laboratory Results: CBC with differential/platelet and comprehensive metabolic panel ordered. (9F 41)

Objective: Neurologic: gait and station normal. Skin inspection and palpation: no rash; height 6 ft, weight 189 lbs. (9F 41)

Subjective: Patient reported persistent low back pain for over 1 year and has a known history of sickle cell disease. (9F 41)

Medications: Flucelvax Quadrivalent 0.5 mL IM (influenza vaccine) administered. Medications reviewed: atomoxetine 25 mg daily; baclofen 5 mg three times daily; ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) weekly; fluticasone propionate nasal spray 50 mcg, 2 sprays each nostril daily; guanfacine ER 1 mg daily; hydrocodone 5 mg/acetaminophen 325 mg PRN every 4 hours; hydrocortisone 2.5% topical 2-4 times daily; hydroxyurea 500 mg daily; ibuprofen 800 mg PRN q6h; meloxicam 15 mg daily; morphine 15 mg PRN q4h; Qelbree (viloxazine) 100 mg daily. (9F 41-42)

Assessment and Plan: Assessment/plan includes low back pain with concern for avascular necrosis or osteonecrosis given sickle cell disease; orders placed for CT imaging and labs; vaccination administered and follow-up arranged. (9F 41)

Citation: 9F 41-42

2022-11-17 | Regional Laboratory Birmingham / Graham, Kenneth DO

Summary: Routine metabolic labs within normal limits: glucose 74 mg/dL, BUN 7 mg/dL, creatinine 1.02 mg/dL with eGFR 103 mL/min/1.73m2 indicating preserved renal function. Electrolytes and liver enzymes unremarkable though potassium at the upper limit (5.0 mmol/L).

Laboratory Results: Glucose 74 mg/dL; BUN 7 mg/dL; Creatinine 1.02 mg/dL; eGFR 103 mL/min/1.73m2; Sodium 141 mmol/L; Potassium 5.0 mmol/L; Calcium 9.9 mg/dL; AST 19 IU/L; ALT 10 IU/L. (9F 66)

Citation: 9F 66-67

2022-12-04 | Heritage Physician Services (Pelham) / Harper, David W MD

Summary: CT lumbar spine without contrast shows straightening of the lumbar spine with Schmorl's nodes at multiple levels, minimal multilevel disc bulges, and mild bilateral foraminal narrowing at L5–S1 (and possibly L4–5) without focal herniation or central canal stenosis; impression notes possible Scheuermann's disease and mild degenerative changes. These findings correlate with the patient's low back pain and may contribute to radicular risk from foraminal compromise, though no dominant disc herniation or canal stenosis was identified.

Diagnoses: Scheuermann's disease, Lumbar degenerative changes, Lumbar disc bulges, Foraminal narrowing

Imaging: CT lumbar spine w/o contrast: Schmorl's nodes, minimal disc bulges, mild foraminal narrowing at L5-S1 and possibly L4-5; no dominant herniation or canal stenosis. (9F 70)

Objective: Straightening of the lumbar spine; Schmorl's nodes at multiple levels; minimal disc bulges at multiple levels with mild bilateral foraminal narrowing at L5-S1 and possibly L4-5. (9F 70)

Subjective: Reported low back pain per indication (M54.50). (9F 70)

Medications: Medication list includes atomoxetine 25 mg daily; baclofen 5 mg TID; ergocalciferol (vitamin D2) 50,000 unit weekly; fluticasone propionate nasal spray 2 sprays each nostril daily; guanfacine ER 1 mg daily; hydrocodone 5 mg/ acetaminophen 325 mg PRN q4h; hydrocortisone 2.5% topical; hydroxyurea 500 mg daily; ibuprofen 800 mg q6h PRN; meloxicam 15 mg daily; morphine 15 mg PRN q4h; Qelbree 100 mg at bedtime. (9F 71)

Assessment and Plan: Impression: Scheuermann's disease might be a consideration and mild degenerative changes of the lumbar spine as described. (9F 70)

Citation: 9F 70-71

2022-12-05 | Heritage Physician Services (Pelham) / Morrison, James T MD

Summary: CT pelvis without contrast demonstrates multiple bone infarctions involving the lumbar spine, right sacral ala, bilateral iliac bones and the subtrochanteric region of the right hip consistent with sickle cell osteopathy, with H-type lumbar vertebrae changes noted. No acute pelvic fracture or soft tissue abnormality identified.

Diagnoses: Sickle cell osteopathy, Bone infarcts, Low back pain

Imaging: CT pelvis without contrast: multiple bone infarctions in lumbar spine, right sacrum, bilateral iliac bones and subtrochanteric portion of right hip; no fracture or acute pelvic soft tissue findings. (9F 69)

Objective: CT pelvis without contrast obtained; no acute soft tissue abnormality identified. Multiple bone infarctions noted in right sacral ala, iliac bones and subtrochanteric right hip; H-type lumbar vertebrae changes. (9F 69)

Subjective: Patient reported low back pain (indication M54.50). (9F 69)

Assessment and Plan: Impression: sickle cell osteopathy with multiple bone infarcts within the lumbar spine, right sacrum, bilateral iliac bones and subtrochanteric right hip; no acute pelvic findings. (9F 69)

Citation: 9F 69

2022-12-15 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Patient with chronic low back and leg pain (pain 7/10) had CT showing multiple areas of decreased blood flow consistent with sickle cell disease and possible lumbar degenerative disc disease; orthopedic spine surgeon ordered an MRI. Cyclobenzaprine was prescribed/refilled and hydroxyurea refill was requested.

Diagnoses: Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Attention deficit hyperactivity disorder, Degeneration of lumbar intervertebral disc, Chronic low back pain

Procedures: History of splenectomy listed in surgical history. (9F 34)

Imaging: CT pelvis 12/05/22 and CT lumbar 12/04/22: multiple areas of decreased blood flow thought secondary to sickle cell disease and possible lumbar degenerative disc disease. (9F 35)

Objective: Ht 6 ft, Wt 191 lbs, BMI 25.9; BP 110/78 sitting, Pulse 60 regular, RR 16, O2Sat 100% on room air, Temp 98.2°F, Pain scale 7. General: healthy-appearing, well-nourished, in no acute distress, ambulating normally. Cardiovascular: RRR. Lungs: without dyspnea. Neurologic: normal gait and station. (9F 32, 35)

Subjective: The claimant reported continued low back and leg pain, stated the back still hurts, and requested refills for a muscle relaxant and hydroxyurea. Reviewed problems include sickle cell-beta-thalassemia, sickle cell-hemoglobin SS disease, attention deficit hyperactivity disorder, degeneration of lumbar intervertebral disc, low back pain, chronic low back pain, and pain of left hip joint. The claimant presented for follow-up to review CT results and reported seeing an orthopedic spine surgeon who ordered an MRI and requested a refill of his muscle relaxant. (9F 32, 34-35)

Medications: Cyclobenzaprine 5 mg tablet; ergocalciferol (vitamin D2) 1,250 mcg weekly; Hydrocodone/acetaminophen 10 mg/325 mg; hydroxyurea 500 mg capsule; ibuprofen 800 mg tablet. The claimant requested a refill of his muscle relaxant. (9F 32, 35)

Assessment and Plan: 1-month follow-up for continued low back and leg pain with request for medication refills; cyclobenzaprine prescribed. CT findings concerning for multiple areas of decreased blood flow related to sickle cell disease

and possible lumbar degenerative disc disease. Orthopedic spine surgeon ordered MRI and requested muscle relaxant refill. (9F 32, 35)

Citation: 9F 32-35

2022-12-15 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient with chronic low back pain attributed to lumbar intervertebral disc degeneration; provider refilled muscle relaxant (cyclobenzaprine) and ordered an MRI of the lumbar spine. Follow-up visit scheduled.

Diagnoses: Chronic low back pain, Degeneration of lumbar intervertebral disc, Sickle-cell disease

Imaging: Plan for MRI of the lumbar spine. (9F 36)

Objective: Skin inspection and palpation: no rash. (9F 36)

Subjective: Patient reported low back pain and reviewed prior CT; requested medication refill and agreed to plan for MRI of the lumbar spine. (9F 36)

Medications: Cyclobenzaprine 5 mg tablet, take 1 tablet three times daily as needed; qty 20. (9F 36)

Assessment and Plan: Chronic low back pain with lumbar intervertebral disc degeneration; refilled muscle relaxant and plan for MRI, follow-up scheduled. (9F 36)

Citation: 9F 36

2023-01-10 | Grandview / Douglas, Tanya L CRNP

Summary: Patient with sickle cell disease and several months of significant chronic low back pain; CT lumbosacral spine showed vertebral infarcts, mild disc extrusion and Schmorl's nodes but no canal stenosis, and patient denies current radicular symptoms or bowel/bladder dysfunction. Treatment plan is conservative with short-course high-dose ibuprofen, initiation/titration of gabapentin for neuropathic pain, PRN cyclobenzaprine, restart physical therapy, and a 3-month work-from-home accommodation.

Diagnoses: Sickle-cell disease, Lumbar disc extrusion, Vertebral infarcts, Neurogenic claudication

Functional Assessment: Requested work excuse to continue working from home due to back pain for the next 3 months; no formal lifting/sitting limits documented. (3F 7)

Imaging: CT lumbar/sacral spine: vertebral infarcts, mild disc extrusion, no canal stenosis; Schmorl's nodes noted. (3F 7)

Objective: CT lumbar/sacral noted vertebral infarcts, mild disc extrusion, no canal stenosis, and Schmorl's nodes. General: alert and oriented, no acute distress; eye: extraocular movements intact; neck: supple; respiratory: respirations non-labored; neurologic: alert and oriented; cognition and speech: articulation and speech show a stutter. (3F 7-8)

Subjective: Patient reported several months of significant back pain, denies current leg pain, numbness, or bowel/bladder incontinence, and has been taking ibuprofen with partial relief; noted prior leg pain in Sept 2022 and drowsiness with cyclobenzaprine. Denies recent ER visits or hospitalizations and denies shortness of breath, chest pain, fever, chills, cough, abdominal pain, N/V/D, sore throat, runny nose, and loss of taste/smell. (3F 7-8)

Medications: Patient adherent to HU 1 tab daily, penicillin V, and vitamin D; plan discussed ibuprofen 800 mg BID short course, consider starting gabapentin and continue cyclobenzaprine PRN. Outpatient medications include hydroxyurea 500 mg daily, cyclobenzaprine 5 mg nightly (and PRN 5 mg TID for back pain), dexrtroamphetamine-amphetamine 10 mg daily, gabapentin 100 mg with titration instructions, ibuprofen 800 mg TID, naloxone nasal spray 4 mg once, penicillin V 250 mg BID, and others listed. (3F 7-8)

Assessment and Plan: Sickle cell disease with chronic low back pain; plan to consider ADAKVEO, start ibuprofen then PRN, initiate gabapentin for neuropathic pain, continue cyclobenzaprine PRN, and restart physical therapy; provide work excuse paperwork. (3F 7)

Citation: 3F 7-8

2023-01-27 | Unknown Facility / Torres, Lisa CRNP

Summary: Telehealth evaluation for back pain in a patient with HbS/Beta thalassemia who is currently on gabapentin and reports intolerable drowsiness with cyclobenzaprine and amnesia/palpitations with hydroxyurea. Plan includes obtaining an EKG, considering medication changes (pregabalin or baclofen trial), titrating gabapentin as needed, and review of sickle cell transition and emergency plans.

Diagnoses: HbS/Beta thalassemia, Back pain

Functional Assessment: Reports profound drowsiness from cyclobenzaprine limiting tolerance; no other formal work restrictions documented. (3F 12)

Laboratory Results: Ferritin 25 ng/mL (12/19/2022); Albuminuria/proteinuria 12/19/2022 - interpretation: none. (3F 13)

Objective: ROS otherwise negative; musculoskeletal: back pain and muscle pain; neurologic: alert and oriented x4, no confusion or headache. No vital signs recorded - TELEHEALTH VISIT. General: Alert and oriented, no acute distress; Respiratory: non-labored respirations; Speech clear and coherent with pronounced stutter; Psychiatric: cooperative. (3F 12-13)

Subjective: Patient called reporting back pain and that he is taking gabapentin 300 mg BID; he cannot tolerate cyclobenzaprine due to profound drowsiness and reports amnesia and palpitations when taking hydroxyurea. (3F 12)

Medications: Gabapentin 300 mg BID; cyclobenzaprine 5 mg (intolerant); hydroxyurea 1 tab QD; folate (PVK) BID; dextroamphetamine-amphetamine 10 mg BID; plan to try baclofen 5 mg TID if needed. Hydroxyurea 500 mg daily; gabapentin titration instructions starting 1 cap at night increasing as needed; ibuprofen 800 mg TID and PRN options; morphine 15 mg q4h PRN for pain. (3F 12-13)

Assessment and Plan: Back pain in patient with HbS/Beta thalassemia; will obtain EKG and follow up in one week, consider switching to pregabalin 75 mg BID and assess medication side effects. Sickle cell plan and transition care reviewed; patient received transition policy, updated care and emergency plans, and self-assessment; no subspecialty referrals and PCP follow-up not due. (3F 12-13)

Citation: 3F 12-13

2023-01-27 | Grandview / Torres, Lisa CRNP

Summary: Patient with sickle cell disease presenting by telehealth for follow-up of muscle spasms and lower back pain and reporting palpitations and possible gabapentin side effects. Clinician started baclofen 5 mg TID, continued gabapentin and other meds, arranged in-office follow-up in one week and an EKG to evaluate palpitations, and provided sickle cell education.

Diagnoses: Sickle cell disease, Sickle cell crisis, Lower back pain, Muscle spasms, Palpitations

Subjective: The claimant reported questionable side effects from gabapentin, endorsed muscle spasms in his back, and complained of palpitations. (3F 14)

Medications: Start Baclofen 5 mg TID; continue Gabapentin; continue Ibuprofen 800 mg PRN; hydroxyurea 1 cap daily; Pen VK 1 tab twice daily; weekly vitamin D3. (3F 14)

Assessment and Plan: Change muscle relaxer to baclofen 5 mg TID; continue current medications; arrange in-office follow-up in 1 week and obtain EKG to evaluate palpitations; sickle cell disease education provided. (3F 14)

Citation: 3F 14-17

2023-02-02 | Grandview Highlands / Unknown Provider

Summary: 12-lead ECG demonstrates sinus rhythm at ~60 bpm with PR 150 ms, QRS 98 ms, QT/QTc 354/435 ms and possible right ventricular conduction delay. Findings are considered borderline and the report recommends clinical correlation.

Diagnoses: Sinus rhythm, Right ventricular conduction delay

Imaging: 12-lead ECG: sinus rhythm with possible right ventricular conduction delay and borderline ECG; intervals as above. (19F 67)

Objective: ECG shows sinus rhythm; ventricular rate 60 bpm; PR interval 150 ms; QRS duration 98 ms; QT/QTc 354/435 ms; possible right ventricular conduction delay and borderline ECG. (19F 67)

Assessment and Plan: ECG interpreted as sinus rhythm with possible right ventricular conduction delay and borderline findings; recommend clinical correlation. (19F 67)

Citation: 19F 67-68

2023-02-16 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Patient endorsed symptoms of anxiety, depressed mood, OCD, and ODD on screening; GAD-7=13 and PHQ-9=12, consistent with moderate anxiety and moderate depression. Plan: behavioral health follow-up as indicated for symptom management.

Diagnoses: Anxiety, Depression, Obsessive-compulsive disorder (OCD), Oppositional defiant disorder (ODD)

Subjective: Patient reported anxiety, depressed mood, OCD and ODD symptoms on the screening form and endorsed several symptoms on GAD-7 and PHQ-9. (8F 15)

Assessment and Plan: GAD-7 total 13 and PHQ-9 total 12 consistent with moderate anxiety and depression; plan per behavioral health follow-up as indicated. (8F 15)

Citation: 8F 15

2023-02-22 | Pinnacle Behavioral Health Hoover / Wagner, Jennifer

Summary: Patient reports prominent inattentive/restless symptoms on the Adult ADHD Self-Report Scale (many items rated 'Very Often') consistent with adult ADHD, along with anxious/worried mood, racing thoughts, frequent anger and low frustration tolerance. Also endorses repetitive behaviors (nail biting and skin picking) suggesting a body-focused repetitive behavior disorder that may impair functioning.

Diagnoses: Attention-deficit/hyperactivity disorder (adult), Generalized anxiety, Body-focused repetitive behavior disorder (skin picking/nail biting), Emotional dysregulation/anger issues

Subjective: Patient endorsed being clumsy, anxious/worried, frequent anger, low frustration tolerance, racing thoughts, and repetitive behaviors including nail biting and skin picking. Patient completed Adult ADHD Self-Report Scale and endorsed multiple symptoms as 'Very Often' including distractibility, restlessness, interrupting others, and difficulty waiting turns. (6F 38, 42)

Citation: 6F 38, 42

2023-02-22 | Pinnacle Behavioral Health Hoover / Unknown Provider

Summary: Claimant presents for ADHD evaluation due to persistent inattention, task incompletion, distractibility, interpersonal impacts, and academic/work accommodations despite a prior trial of Adderall described as ineffective; heavy video game use has contributed to neglected responsibilities and some sleep disruption. Plan is to combine intake packet data with FDA-cleared objective testing to aid diagnosis; notable medical history includes sickle cell disease on hydroxyurea and prior splenectomy, with no substance use reported.

Diagnoses: Attention-Deficit/Hyperactivity Disorder, Sickle cell disease

Procedures: Splenectomy noted in surgical history. (6F 40)

Objective: Review of systems documented with problems falling asleep marked Yes and other systems largely No. (6F 37)

Subjective: The claimant reports struggling to finish tasks, getting sidetracked, difficulty focusing, interpersonal conflicts, increased stuttering when repeating, rushing conversations, heavy video game use causing neglected responsibilities and sleep disruption. The claimant has no allergies and is taking other medications; current medications listed include Hydroxyurea and Penicillin. Prior trial of ADHD medication (Adderall) was not effective. The claimant has school accommodations (extra time, change or due dates). Sleep: sleep latency approximately 30 minutes, typically sleeps 6–7 hours nightly, denies history of sleeping problems or daytime tiredness. Highest education: Bachelor's degree; not currently in school. Employed full-time in cyber security for 3 years. Caffeine intake <1 caffeinated beverage/day. Denies alcohol, tobacco, and illicit drug use. (6F 37, 39-41, 43)

Medications: Hydroxyurea; Penicillin. (6F 39)

Assessment and Plan: Intake for ADHD evaluation with plan to combine packet information and FDA-cleared objective testing to aid diagnosis. (6F 37)

Citation: 6F 37, 39-41, 43; 5F 1

2023-03-09 | Unknown Facility / Chakraborty, Priya MD

Summary: Hemoglobin electrophoresis shows predominant HbS (66.2%) with elevated HbF (12.4%) and HbA2 (5.5%), consistent with sickle cell disease. CBC demonstrates microcytosis (MCV 74 fL), elevated RDW (18.5%) and low ferritin (20 ng/mL) suggesting concomitant iron deficiency, and renal panel shows creatinine 1.3 mg/dL with eGFR 77 mL/min/1.73m2 (mildly reduced).

Diagnoses: Sickle cell disease

Laboratory Results: Sodium 137 mmol/L, Potassium 4.3 mmol/L, Chloride 103 mmol/L, Bicarbonate 29 mmol/L, AGAP 5.0 mmol/L, Glucose 69 mg/dL, BUN 13 mg/dL; Creatinine 1.3 mg/dL, eGFR 77 mL/min/1.73m2; Calcium 9.4 mg/dL, Albumin 4.4 g/dL; Ferritin 20 ng/mL; Hgb total ~15.9 g/dL with Hgb S 66.2%, Hgb A2 5.5%, Hgb F 12.4%, WBC 5.40 x10^3/cmm, RBC 4.97 x10^6/cmm. Hgb 12.4 g/dL, Hct 37%, MCV 74 fL, MCH 25 pg, MCHC 34 g/dL, Platelets 329 x10^3/cmm, RDW 18.5%, MPV 8 fL; Neutrophils 48% (Abs 2.60 x10^3/cmm), Lymphocytes 40% (Abs 2.18 x10^3/cmm), Monocytes 7%, Eosinophils 3%, Basophils 1%; Retic 2.0%, Retic absolute 0.1034 x10^6/cmm, RBC retic 5.03 x10^6/cmm. (3F 55-56)

Citation: 3F 55-56

2023-03-15 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient with sickle cell disease (both SS and sickle cell–beta-thalassemia documented) and degenerative lumbar disc disease presented for 3-month follow-up; vitals stable but reported significant pain (8/10) and has history of splenectomy.

Influenza vaccine was administered and medications include hydroxyurea, analgesics (hydrocodone, meloxicam, cyclobenzaprine) and weekly high-dose vitamin D.

Diagnoses: Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Attention deficit hyperactivity disorder, Degeneration of lumbar intervertebral disc

Procedures: Influenza vaccine administered 11/16/22 0.5 mL intramuscular, left deltoid (record includes multiple prior vaccine dates). History of splenectomy listed in surgical history. (9F 29-30)

Objective: Vitals: Ht 6 ft, Wt 188 lbs, BMI 25.5, BP 122/68 sitting, Pulse 87 bpm regular, RR 17, O2 sat 100% on room air, T 97.9°F oral, Pain scale 8. (9F 28)

Subjective: Reviewed social history: patient reported never smoker, no illicit drug use, no alcohol, occasional caffeine and exercise; married. (9F 30)

Medications: Cyclobenzaprine 5 mg tablet (take 1 TID PRN); Ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) capsule weekly; Hydrocodone 10 mg/acetaminophen 325 mg tablet PRN; Hydroxyurea 500 mg capsule daily; Mobic (meloxicam) 15 mg tablet daily (prescribed 03/15/23). (9F 28)

Citation: 9F 28-30

2023-03-18 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient with sickle cell-hemoglobin SS disease presents with persistent low back pain now worse in the thoracic region; prior CT showed multiple areas of decreased blood flow attributed to sickle cell disease and possible lumbar degenerative disc disease. Orthopedics ordered an MRI, the clinician started meloxicam (Mobic) and provided care instructions while neurologic/musculoskeletal exam was normal; patient had intolerance to gabapentin and requested a muscle relaxant refill.

Diagnoses: Thoracic back pain, Sickle cell disease, hemoglobin SS

Imaging: CT: multiple areas of decreased blood flow secondary to sickle cell and possible lumbar degenerative disc disease; orthopedic surgeon ordered MRI. (9F 31)

Objective: General: healthy-appearing, well-nourished, NAD. Neuro/musculoskeletal: motor strength and tone normal, normal gait; other systems (HEENT, lungs, CV, abdomen, skin) normal. (9F 31)

Subjective: Patient reported continued low back pain with worse thoracic pain, tried and failed gabapentin due to side effects, has tried naproxen, and requests a refill of his muscle relaxant; reports prior CT findings and orthopedic evaluation. (9F 31)

Medications: Mobic 15 mg tablet, take 1 tablet daily, qty 30, pharmacy: Walgreens. (9F 31)

Assessment and Plan: 1) Thoracic back pain — will add Mobic. 2) Sickle cell-hemoglobin SS disease; care instructions provided and MRI ordered by orthopedics, return to office scheduled. (9F 31)

Citation: 9F 31

2023-05-18 | Pinnacle Behavioral Health Hoover / Unknown Provider

Summary: 28-year-old underwent psychological evaluation without specific complaints; tester observed the patient was attentive to instructions, motivated to perform testing, and sometimes impatient during instructions. No abnormal movements were noted on exam.

Objective: Tester noted patient seemed to pay attention to instructions, seemed motivated to perform test, and appeared impatient during instructions; no abnormal movements noted. (6F 26)

Subjective: Patient age 28 noted; no specific complaints recorded on form. (6F 26)

Citation: 6F 26

2023-05-19 | Unknown Facility / Torres, Lisa CRNP

Summary: Patient with HbS/beta thalassemia status post splenectomy presents for routine follow-up with chronic low back/hip pain and medication nonadherence; hemoglobin 12.4 g/dL with microcytosis (MCV 74 fL), elevated reticulocyte count (2.8%), Hb fraction showing Hgb S 65.7% and low Hgb A, low ferritin (23 ng/mL), and vitamin D deficiency (25OH 15 ng/mL). Plan: encourage restarting hydroxyurea, hydration and pain action plan, begin/continue vitamin D supplementation with recheck, and address pain with conservative measures (ibuprofen, baclofen, PT) and follow-up for sickle cell management.

Diagnoses: Sickle cell disease (HbS/beta thalassemia), Anemia due to HbS/beta thalassemia, Chronic low back pain, Muscle pain, Post-splenectomy status, History of splenic sequestration, Vitamin D deficiency, ADHD

Procedures: History of splenectomy in 2019 documented. (10F 135)

Laboratory Results: 5/19/2023 labs: Sodium 137 mmol/L; Potassium 4.4 mmol/L; Chloride 102 mmol/L; Bicarbonate 27 mmol/L; Anion gap 8.0 mmol/L; Glucose 75 mg/dL; BUN 8 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.6 mg/dL; Adjusted calcium 9.1 mg/dL; Protein 8.1 g/dL; Albumin 4.6 g/dL; Total bilirubin 1.0 mg/dL; Alkaline phosphatase 69 U/L; ALT 11 U/L; AST 16 U/L; LDH 180 U/L. Vitamin D 25OH 15 ng/mL (low). Ferritin 23.0 ng/mL (low). Hemoglobin fractions: Hgb S 65.7%, Hgb A 16.1% (low), Hgb F 12.7% (high), Hgb A2 5.5% (high). CBC: WBC 5.91 x10^3/cmm; RBC 4.91 x10^6/cmm; Hemoglobin 12.4 g/dL (low); Hematocrit 36% (low); MCV 74 fL (low); MCH 25 pg (low); Platelets 322.7 x10^3/cmm; RDW 19.0% (high); Reticulocyte 2.8% (high). Urine: urine protein random 4 mg/dL; urine creatinine 91 mg/dL; urine albumin <7.0 mg/L. Urine drug screen negative. (3F 133-134, 136; 10F 123-124, 126, 134-135, 137)

Objective: Review of systems largely negative: no fever, no shortness of breath, no gastrointestinal symptoms; positive for sleep difficulty and anxiety. Alert and oriented x4 without confusion or headache. Vitals: temperature 98.3 F, heart rate 58 bpm, blood pressure 122/79 mmHg (mean arterial pressure documented 94 mmHg), oxygen saturation 98%. Exam: no acute distress, normal heart and lung sounds, soft non-tender abdomen, normal strength and gait; neurologic and psychiatric exams normal. History of HbS/Beta thalassemia with prior splenic sequestration and splenectomy in 2019. Laboratory data demonstrate anemia indices and elevated reticulocyte count. (3F 131-134; 10F 121-124, 132-135)

Subjective: The claimant reported not taking prescribed medications due to side effects, being inconsistent with the intended plan of care, and not liking to take medications except ADHD meds. Endorsed chronic lower back/hip pain, back pain and muscle pain, difficulty falling asleep, and anxiety. Stated he will try restarting hydroxyurea and be more consistent. Will accept OTC vitamin D supplementation. Given instructions for hydration and pain management; plan to recheck vitamin D level to determine need for supplementation. (3F 131-132, 134-135; 10F 121-122, 124-125, 132-133, 135-136)

Medications: Hydroxyurea 500 mg daily; Baclofen 5 mg 1 tablet TID; Dextroamphetamine-amphetamine 10 mg daily; Docusate 200 mg BID; Ergocalciferol 1.25 mg (50,000 IU) weekly; Gabapentin (start 1 cap nightly); Ibuprofen 800 mg TID PRN; Morphine 15 mg every 4 hours PRN; Naloxone 4 mg nasal as needed; Penicillin V potassium 250 mg BID. (3F 131-132, 135-136; 10F 121-122, 124-126, 132-133, 136-137)

Assessment and Plan: Anemia due to HbS/Beta thalassemia. Sickle cell disease (HbS/Beta thalassemia) patient post-splenectomy seen for routine follow-up. Vitamin D 25OH low at 15 ng/mL; OTC vitamin D 2000 IU daily recommended and plan to recheck vitamin D level. Advised increased hydration, encouraged restarting hydroxyurea, counseled on medication adherence. Pain action plan provided for mild and severe pain; continue ibuprofen, consider baclofen and physical therapy for low back pain. Continue follow-up for sickle cell management. (3F 131, 134-135; 10F 121, 124-125, 132-133, 135-136)

Citation: 3F 131-136; 10F 121-126, 132-137

2023-05-19 | Unknown Facility / Reynolds, Daniel D MD

Summary: CBC shows microcytic anemia (Hgb 12.4 g/dL, MCV 74 fL) with high RDW (19%) and reticulocytosis (2.8%), and peripheral smear findings (polychromasia, occasional schistocytes and target cells) consistent with hemolysis or an underlying hemoglobinopathy. Urine drug screen was negative and spot urine testing demonstrated low-level proteinuria.

Diagnoses: Microcytic anemia (MCV 74 fL), Elevated reticulocyte count (reticulocytosis), Laboratory evidence of hemolysis (polychromasia, schistocytes, increased retics), Peripheral smear with target cells/ovalocytes (suggests possible hemoglobinopathy/thalassemia trait), Low-level proteinuria (urine protein elevated on spot urine), Negative urine drug screen

Laboratory Results: 5/19/2023 12:58 CDT: CBC and differential — WBC 5.91 x10^3/cmm, RBC 4.91 x10^6/cmm, Hgb 12.4 g/dL, Hct 36%, MCV 74 fL, MCH 25 pg, MCHC 34 g/dL, Platelets 322.7 x10^3/cmm, RDW 19.0%, MPV 8 fL. Differential: Neutrophils 37% (abs neutrophils 2.17 x10^3/cmm), Lymphocytes 48% (abs lymphocytes 2.81 x10^3/cmm), Monocytes 12%, Eosinophils 2%. NRBC 4/100 WBC. Reticulocyte: 2.8% (high), retic absolute 0.1332 x10^6/cmm, RBC retic 4.84 x10^6/cmm. Peripheral smear/comments: Polychromasia 1+, Microcytosis 2+, Anisocytosis 1+, Hypochromia 1+, Ovalocytes occasional, Target cells occasional, Tear cells rare, Sickle cells rare, Schistocytes occasional, Burr cells rare, Stomatocytes rare. Urine studies: urine drug screen negative; urine drug screen cutoff values reported — Amphetamines 500 ng/mL, Barbiturates/Benzodiazepines 200 ng/mL, Buprenorphine 5 ng/mL. Urine protein/creatinine data: Calculated U Alb/Creat 4, Urine protein 44 mg/dL, Urine creatinine 91 mg/dL. Vitamin D 25-OH category definitions noted: deficient <20 ng/mL, insufficient 20–<30 ng/mL, sufficient 30–100 ng/mL. (3F 137-139; 10F 127-129, 138-140)

Citation: 3F 137-139; 10F 127-129, 138-140

2023-05-22 | Pinnacle Behavioral Health Hoover / Wagner, Jennifer

Summary: The claimant meets DSM-5 criteria for ADHD, combined type, with objective QbTest findings showing markedly elevated activity and impulsivity (QbActivity 3.1 and QbImpulsivity 3.4, both ~99th percentile) and moderate inattention on clinical history; GAD-7 (14) and PHQ-9 (12) indicate moderate anxiety and depression. Stimulant treatment with Focalin XR was initiated with plan for dose titration and reassessment in 2–3 weeks.

Diagnoses: Attention-deficit/hyperactivity disorder, combined type (F90.2), Generalized anxiety disorder, Depressive disorder

Procedures: QbTest (Ability Test) performed to assess motion, attention, and impulsivity and to assess validity and capability to complete testing; QbTest to be interpreted. (6F 23)

Objective: Temp 97.1 F, weight 188 lb, height 6'1", BMI 24.8. General: appears well-nourished. Psychiatric: alert, cooperative, good eye contact, speech normal, mood euthymic, affect congruent, attention normal. Neurological: no tics. Cardiovascular: BP and HR normal/expected. QbTest performed assessing motion, attention, and impulsivity; technician time 30 minutes, total provider testing time 32 minutes. QbTest measures: Time Active 31%, Distance 22.9 m, Area 99 cm², Microevents 10,200, Motion simpl. 50.1%. Attention/impulse metrics: Reaction time 558 ms, Reaction time variability 210 ms, Omission error 18.6%, Commission 9.8%, Error rate 12.0%. QbTest results: QbActivity 3.1 (99% more active than controls), QbInattention 0.8, QbImpulsivity 3.4 (99% more impulsive than controls). (6F 23-24, 27, 29)

Subjective: Reported combined inattentive/hyperactive/impulsive ADHD symptoms. Intake forms, rating scales, and a structured interview were reviewed; the claimant reported a prior ADHD diagnosis but prior evaluation not available. Screening measures: GAD-7 score 14 (moderately elevated) and PHQ-9 score 12 (moderately elevated). Social history: married, lives with partner, no children, full-time employment in cyber security, recent relocation. The claimant reported attention and impulsivity symptoms present for >6 months with onset before age 12 and impairment across settings. Will reassess once ADHD symptoms are under control. (6F 19, 21, 24-25)

Medications: Hydroxyurea 500 mg capsule, listed 05/22/2023, 30 tablets, active. Focalin XR 20 mg capsule, extended release, 1 daily for 30 days. (6F 21, 24, 27, 29)

Assessment and Plan: Attention-deficit hyperactivity disorder, combined type (F90.2). The claimant meets DSM-5 criteria for ADHD; prior ADHD diagnosis reported but prior evaluation not available. Plan: start stimulant titration with Focalin XR and reassess in approximately 2–3 weeks; follow-up with Wagner. Discussed legal aspects, risks, benefits, and monitoring of stimulant medication; instructed the claimant on prescription handling and to report acute changes or side effects; will reassess ADHD symptoms. (6F 19, 23-25, 29)

Citation: 6F 19, 21, 23-25, 27, 29-36

2023-05-22 | Pinnacle Behavioral Health Hoover / Grant, Ashley

Summary: Neurobehavioral testing showed markedly elevated impulsivity and activity scores (Q-scores 3.4 and 3.1, both at the 99th percentile) with attention above average (Q-score 0.8, 80th percentile); no medications or interpretation/follow-up documented. These findings indicate significant hyperactivity and impulsivity on objective testing which may contribute to functional impairment.

Diagnoses: Severely elevated impulsivity (Impulsivity Q-score 3.4, 99th percentile), Severely elevated hyperactivity/activity (Activity Q-score 3.1, 99th percentile), Elevated attention (Attention Q-score 0.8, 80th percentile)

Objective: Neurobehavioral test results with Q-scores reported: Activity Q-score 3.1 (99th percentile), Attention Q-score 0.8 (80th percentile), Impulsivity Q-score 3.4 (99th percentile). (6F 28)

Medications: None specified (6F 28)

Assessment and Plan: Detailed assessment report documenting objective test scores for activity, attention, and impulsivity with high impulsivity and activity scores; follow-up or interpretation not shown on page. (6F 28)

Citation: 6F 28

2023-05-22 | Pinnacle Behavioral Health Hoover (1200 Riverchase Dr, Hoover, AL) / Unknown Provider

Summary: Patient meets DSM-5 criteria for ADHD, combined type, with prior poor tolerance to stimulants (palpitations, increased anxiety) and prior ineffective Intuniv ER. Current plan: continue Qelbree 100 mg, add Starterra 25 mg, discontinue the current stimulant and initiate Focalin XR 20 mg with forced titration over 1–2 weeks while considering Qelbree as a non-stimulant alternative, with close monitoring and follow-up in ~2 months; vitals documented and stable.

Diagnoses: Attention-deficit hyperactivity disorder, combined type

Objective: Vital signs documented on multiple dates: 12/14/2023 — BP 124/86 mmHg, BMI 23.9, Temp 97.4°F, HR 70/min; 11/16/2023 — BP 132/84 mmHg, BMI 24.2, Temp 97.6°F, HR 68/min. (11F 6)

Subjective: The claimant and/or parent reported prior poor tolerance of stimulant medications with palpitations and increased anxiety, and prior use/failure of Intuniv ER. Discussion held about medication changes and follow-up via portal. (11F 4-5)

Medications: Continue Qelbree 100 mg. Intuniv ER 1 mg daily noted. Add Starterra 25 mg (low dose). Plan to discontinue current stimulant; consider Qelbree (viloxazine ER) as a non-stimulant alternative and start Focalin XR 20 mg with forced titration over approximately 1–2 weeks. (11F 4-5)

Assessment and Plan: ADHD, combined type. The claimant meets DSM-5 criteria. Current regimen is not optimally controlled. Plan: continue current medication regimen, add new agent, start Focalin XR with close monitoring for side effects, consider Qelbree as non-stimulant alternative, and follow up in approximately 2 months with portal check-ins. (11F 4-5, 7)

Citation: 11F 4-7

2023-06-14 | Unknown Facility / Douglas, Tanya L CRNP

Summary: Patient with sickle cell disease presented for vaso-occlusive pain in legs and lower back and was treated in clinic with IV analgesia and IV fluids; he remains on hydroxyurea. Labs consistent with hemolysis (elevated total bilirubin and LDH, reticulocytosis) with mild anemia and microcytosis, plus hyperkalemia (K 5.7) and borderline hypoglycemia (glucose 64); patient reports third-shift work with inadequate sleep and requested an employer letter.

Diagnoses: Sickle cell crisis (vaso-occlusive pain), Left upper quadrant (LUQ) abdominal pain

Procedures: Sickle cell infusion visit with administration of IV pain medication and IV fluids for vaso-occlusive crisis. (3F 43; 10F 109)

Functional Assessment: Works third shift and reports insufficient sleep that is interfering with health and work; requests a letter for employer explaining SCD and importance of sleep. | Patient reports working third shift and inability to get enough sleep which is interfering with his health and requests a letter for his employer explaining his SCD and need for sleep. (3F 43; 10F 109)

Laboratory Results: Comprehensive labs 6/14/2023: Sodium 133 mmol/L; Potassium 5.7 mmol/L (high); Chloride 100 mmol/L; Bicarbonate 24 mmol/L; Glucose 64 mg/dL (low); BUN 10 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73 m²; Calcium 9.6 mg/dL; Adjusted calcium 8.9 mg/dL; Protein 8.2 g/dL; Albumin 4.9 g/dL; Total bilirubin 1.7 mg/dL (high); AST 43 U/L (high); ALT 16 U/L; LDH 448 U/L (high). CBC: WBC 7.56 x10^3/µL; RBC 4.95 x10^6/µL; Hgb 12.8 g/dL (low); Hct 37% (low); MCV 75 fL (low); MCH 26 pg (low); RDW 19.5% (high); Platelets 298.4 x10^3/µL; Reticulocyte 2.6% (high). (3F 45; 10F 111)

Objective: Denies recent ER visits or hospitalization. Reports adequate hydration (>64 oz/day), regular bowel movements, and good appetite. Reports adherence to hydroxyurea 1 tab daily. Vitals 6/14/2023 14:30 CDT: Temp 98 F, HR 70 bpm, RR 18/min, SpO2 99%, BP 120/71 mmHg, weight 187.9 lb, height 71 in. Exam: alert and oriented, no acute distress, normal gait; lungs clear to auscultation; cardiovascular regular rate and rhythm; abdomen soft, non-tender; neuro alert and oriented; speech with a stutter. (3F 43-44; 10F 109-110)

Subjective: The claimant reported vaso-occlusive pain that began last Thursday, usually manages at home, with limited relief from ibuprofen and cyclobenzaprine. Also endorsed cough and nasal congestion, negative COVID test, denies shortness of breath, fever, chills, abdominal pain, nausea, vomiting, diarrhea, or loss of taste/smell. (3F 43; 10F 109)

Medications: Hydroxyurea 500 mg PO daily (reports adherence); Ibuprofen 800 mg PO TID; Baclofen 5 mg PO TID; Ergocalciferol 1.25 mg (50,000 IU) PO weekly; Naloxone 4 mg nasal spray once PRN; Morphine 15 mg PO every 4 hours PRN for pain; Cyclobenzaprine (patient has used; dose not specified). (3F 43-44; 10F 109-110)

Assessment and Plan: Sickle cell crisis (vaso-occlusive pain) treated during infusion visit with IV fluids and IV analgesia; continue home hydroxyurea and pain management. Provide supportive care and follow-up as needed; employer letter requested and to be provided. (3F 43; 10F 109)

Citation: 3F 43-45; 10F 109-111

2023-06-14 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: CBC differential shows neutrophils 54% (absolute 4.08 x10^3/µL) and lymphocytes 33% (absolute 2.52 x10^3/µL), with other differential percentages within expected ranges. Reticulocyte percentage was mildly elevated at 2.6% (retic absolute 0.1309 x10^6/µL), suggesting a mild increase in erythropoietic activity; no other significant abnormalities reported.

Diagnoses: Reticulocytosis (elevated reticulocyte count)

Laboratory Results: Collected 6/14/2023 14:55 CDT: the claimant's Neutrophils 54%; Absolute neutrophils 4.08 x10^3/cmm; Lymphocytes 33%; Absolute lymphocytes 2.52 x10^3/cmm; Monocytes 10%; Eosinophils 1%; Basophils 1%; Reticulocyte 2.6% (H); Retic absolute 0.1309 x10^6/cmm; RBC/Retic 4.94 x10^6/cmm. (3F 60; 10F 107)

Citation: 3F 60-61; 10F 107-108

2023-06-15 | Unknown Facility / Douglas, Tanya L CRNP

Summary: The patient with HbS/Beta thalassemia and prior splenectomy presented for a vaso-occlusive pain crisis with low back and bilateral leg pain and received a Dilaudid PCA load/bolus regimen and 4 hours of D5W IV fluids with reported pain improvement prior to discharge. Labs showed mild anemia (Hgb 12.4 g/dL) with elevated reticulocyte count and preserved renal function (Cr 1.0 mg/dL, eGFR >90); he was discharged with oral pain medications, hydration precautions, and return precautions.

Diagnoses: Sickle cell disease with vaso-occlusive crisis, HbS/Beta thalassemia, History of splenectomy, Low back pain, Bilateral leg pain

Procedures: Sickle cell infusion visit with PCA analgesia: Dilaudid 2 mg load then 0.3 mg q15 min PCA; IV fluids with D5W infusion administered over 4 hours. (3F 71; 10F 115, 118)

Laboratory Results: Albuminuria/proteinuria 12/19/2022: interpretation none. 6/15/2023 08:27 CDT: Sodium 138 mmol/L, Potassium 4.5 mmol/L, Glucose 97 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m². CBC: Hgb 12.4 g/dL (low), Hct 38% (low), MCV 76 fL (low), MCH 25 pg (low), RDW 19.1% (high), Platelets 296.5 x10^3/µL, Reticulocyte 2.6% (high). (3F 69-70; 10F 116-117)

Objective: Constitutional: no fever, no sweats, no weakness. Respiratory: cough and nasal congestion; lungs clear to auscultation. Cardiovascular: no chest pain. Vitals: T 97.7 F, HR 67 bpm, RR 18, SpO2 98%, BP 118/79 mmHg, pain score 8. Exam: alert and oriented, moves all extremities well. Genotype HbS/Beta thalassemia positive; history of splenic sequestration with prior splenectomy. Sickle cell disease with vaso-occlusive crisis documented; PCA analgesia administered. Review of systems notable for cough and nasal congestion, no fever or chest pain. (3F 68-69, 71; 10F 115-116, 118)

Subjective: The claimant reported a history of HbS/Beta thalassemia and prior splenectomy. The claimant reported lower back pain and bilateral leg pain, and that he was very drowsy and slept during a prior infusion when he received Dilaudid 2 mg. The claimant and his wife reported that an ADHD medication caused dehydration. The claimant was reassessed several times during the current infusion and reported pain improvement; he stated he is able to manage at home with oral pain medication. He was instructed to drink at least 64 oz of water, rest, and take oral pain medications. (3F 68-69, 71; 10F 115-116, 118)

Medications: Dilaudid PCA: 2 mg load then 0.3 mg q15 min; D5W IV infusion. Hydroxyurea 500 mg 1 capsule daily. Ibuprofen 800 mg 1 tablet TID. Baclofen 5 mg TID. Ergocalciferol 1.25 mg weekly. Fluticasone nasal (Flonase 50 mcg/inh) 2 sprays every AM. Morphine 15 mg PO 1 tablet q4h PRN. Naloxone 4 mg/0.1 mL nasal spray once, 2 EA. (3F 68-69, 71-72; 10F 115-116, 118-119)

Assessment and Plan: Sickle cell vaso-occlusive pain related to sickle cell disease with lower back and bilateral leg pain; patient improved with IV PCA Dilaudid and IV fluids and was discharged with oral pain regimen and symptomatic management. Plan: continue home medications, hydration, rest, and oral pain medications; instructed to drink at least 64 oz water and call clinic if further assistance needed. (3F 68-71; 10F 115-118)

Citation: 3F 68-73; 10F 115-120

2023-06-15 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Lab review for a sickle cell crisis showed a hemolyzed specimen; findings consistent with hemolysis included an elevated reticulocyte percentage (2.6%) and absolute retic, with elevated LDH (448 U/L) and total bilirubin (1.7 mg/dL), though hemolysis may artifactually affect LDH and AST. Additional abnormalities included mild hyponatremia (Na 133 mmol/L), hyperkalemia (K 5.7 mmol/L), and low glucose (64 mg/dL); renal function and hemoglobin were near baseline (Cr 1.0 mg/dL, eGFR >90, Hgb 12.8 g/dL).

Diagnoses: Sickle cell crisis

Laboratory Results: Collected 06/15/2023 08:27 CDT: Eosinophils 4%, Basophils 1%, Reticulocyte 2.6% (H), Retic absolute 0.1271 x10^6/cmm, RBC Retic 4.92 x10^6/cmm. Collected 06/14/2023 14:55 CDT: Sodium 133 mmol/L, Potassium 5.7 mmol/L (H), Chloride 100 mmol/L, Bicarbonate 24 mmol/L, Glucose 64 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.6 mg/dL, Albumin 4.9 g/dL, Bilirubin total 1.7 mg/dL, Alk Phos 62 U/L, ALT 16 U/L, AST 43 U/L, LDH 448 U/L (H), WBC 7.56 x10^3/cmm, RBC 4.95 x10^6/cmm, Hgb 12.8 g/dL, Platelet 298 x10^3/cmm. Specimen noted as hemolyzed which may affect some results. (3F 23; 10F 104, 106)

Assessment and Plan: Sickle cell crisis with lab review; specimen hemolyzed may affect protein, albumin, AST, LDH results. (10F 106)

Citation: 3F 23-24; 10F 104-106

2023-06-16 | Unknown Facility / Douglas, Tanya L CRNP

Summary: Patient with HbS/β-thalassemia and prior splenectomy presented for vaso-occlusive crisis and received IV PCA Dilaudid (1 mg load then 1 mg q30 min, total 2 mg administered) and D5W 500 mL over 4 hours; he was very drowsy and slept during the infusion. Plan: continue IV opioids and fluids with follow-up/return for additional management and discussion with hematology.

Diagnoses: Sickle cell disease with vaso-occlusive crisis, HbS/Beta thalassemia, History of splenic sequestration/splenectomy

Procedures: Dilaudid PCA: 1 mg load then 1 mg q30 minutes; D5W 500 mL infused over 4 hours. (10F 112)

Objective: Orders/notes list PCA Dilaudid 1 mg load then 1 mg q30 minutes and D5W 500 mL infused over 4 hours; total 2 mg Dilaudid given during visit. (3F 46)

Subjective: The claimant reported receiving treatment in ITU, was very drowsy and slept during the infusion, and will return tomorrow for additional management. The claimant reported he received a total of 2 mg of Dilaudid during his visit. (3F 46; 10F 112)

Medications: Received total 2 mg Dilaudid during visit. Medication history: baclofen 5 mg PO TID; ergocalciferol 1.25 mg (50,000 IU) 1 cap PO weekly; fluticasone nasal (Flonase) 50 mcg, 2 sprays every AM; hydroxyurea 500 mg cap PO daily;

ibuprofen 800 mg tab PO TID; morphine 15 mg tab PO every 4 hours PRN; naloxone 4 mg/0.1 mL nasal spray, 2 devices, once. (3F 46; 10F 112-113)

Assessment and Plan: Sickle cell plan for VOC in a patient with HbS/Beta thalassemia and prior splenectomy: continue IV opioids and fluids for VOC pain; care discussed with covering physician; will follow up/return for additional management and discussion with Dr. Collins. (3F 46; 10F 112)

Citation: 3F 46-48; 10F 112-114

2023-06-22 | Pinnacle Behavioral Health Hoover / Wagner, Jennifer

Summary: Patient with ADHD, combined type reported worsening symptoms and intolerance of stimulants (palpitations, tachycardia, increased anxiety) leading to discontinuation of Focalin XR and initiation of viloxazine ER (Qelbree) 200 mg daily; guanfacine (Intuniv) reportedly caused decreased erections. Follow-up arranged in one week for medication management; musculoskeletal pain and long-term drug therapy were also noted.

Diagnoses: ADHD, combined type, Generalized Anxiety Disorder, Adverse effect of amphetamines, Long term drug therapy, Musculoskeletal pain

Functional Assessment: Patient intolerant of stimulants due to palpitations and increased anxiety affecting medication tolerance. (6F 14)

Objective: Vitals: BP 128/78, Pulse 75 regular, Temp 97.7 F, Weight 182 lb, Height 6'1", BMI 24.1. Physical exam: general well-nourished. Psychiatric: alert, cooperative, normal speech, euthymic mood, normal attention. Neurologic: no tics or tremor. Cardiovascular: BP and HR normal/expected. (6F 13)

Subjective: The claimant presented for medication management and follow up of ADHD and reported ADHD symptoms are worse since the last encounter. The claimant reported palpitations, tachycardia, feeling edgy or nervous, recent dehydration requiring an ER visit, intolerance of stimulants with excessive side effects including palpitations and increased anxiety, MSK pain, and that Intuniv resulted in decreased erections. (6F 12, 14-15)

Medications: Focalin XR 20 mg capsule, 1 capsule by mouth daily (discontinued). hydroxyurea 500 mg capsule listed. Qelbree (viloxazine ER) 200 mg capsule daily prescribed. Intuniv reported as causing decreased erections. (6F 12, 14-15)

Assessment and Plan: ADHD with worsening symptoms and medication side effects; prior stimulant (Focalin XR 20 mg) was discontinued due to side effects. Plan to discontinue stimulant medication and initiate Qelbree (viloxazine ER) 200 mg daily with follow-up in 1 week with Jennifer Wagner. MSK pain noted with reported medication side effect from Intuniv; plan/follow-up for MSK pain not shown. (6F 12, 14-15)

Citation: 6F 12-15

2023-06-23 | Grandview Medicine / Research Organization / Unknown Provider

Summary: Hospital visit for a sickle-cell crisis; laboratory evaluation showed largely normal metabolic, hepatic, renal, and lipid panels with creatinine 1.0 mg/dL and eGFR >90 mL/min/1.73m2. CBC demonstrated hemoglobin 12.4 g/dL, hematocrit 38%, WBC 5.16 x10^3/mm3 and platelets 296.5 x10^3/mm3, with no laboratory evidence of acute organ dysfunction.

Diagnoses: Sickle-cell crisis

Laboratory Results: Lipid panel: Chol 124 mg/dL, Tg 100 mg/dL, HDL 42 mg/dL, LDL 77 mg/dL. Glycemic markers: Hgb A1C 4.3%, eAG 77 mg/dL. 6/15/2023 08:27 CDT basic/metabolic and hepatic panel and CBC: Sodium 138 mmol/L, Potassium 4.5 mmol/L, Chloride 104 mmol/L, Bicarbonate 27 mmol/L, AGAP 7.0 mmol/L, Glucose 97 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.0 mg/dL, Adjusted calcium 8.8 mg/dL, Albumin 4.3 g/dL, Total bilirubin 1.3 mg/dL, Alk Phos 65 U/L, ALT 12 U/L, AST 19 U/L, LDH 204 U/L; CBC: WBC 5.16 x10^3/mm3, RBC 4.99 x10^6/mm3, Hgb 12.4 g/dL, Hct 38%, Platelets 296.5 x10^3/mm3, Neutrophils 44% (absolute 2.27 x10^3/mm3), Lymphocytes 40% (absolute 2.05 x10^3/mm3). (3F 19, 22)

Citation: 3F 18-22

2023-06-23 | Grandview Medicine / Unknown Provider

Summary: Hospitalized for a sickle-cell crisis. Laboratory evaluation showed overall normal metabolic and liver panels, eGFR >90 mL/min/1.73 m2, Hgb A1c 4.3% (eAG ~77 mg/dL), hemoglobin 12.4 g/dL, WBC 5.16 x10^3/µL and platelets 296 x10^3/µL, with no acute laboratory evidence of renal or hepatic failure.

Diagnoses: Sickle-cell crisis

Laboratory Results: Cholesterol 124 mg/dL, Triglycerides 100 mg/dL, HDL 42 mg/dL, LDL 77 mg/dL. Hgb A1c 4.3% with eAG 77 mg/dL; interpretive data referencing eAG and the A1C-Derived Average Glucose (ADAG) study (no additional numeric values provided). 6/15/2023 08:27 CDT - Basic metabolic panel: Sodium 138 mMol/L, Potassium 4.5 mMol/L, Chloride 104 mMol/L, Bicarbonate 27 mMol/L, Anion gap 7.0 mMol/L, Glucose 97 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73 m2, Calcium 9.0 mg/dL, Adjusted calcium 8.8 mg/dL, Albumin 4.3 g/dL. Liver tests: Total bilirubin

1.3 mg/dL, Alkaline phosphatase 65 U/L, ALT 12 U/L, AST 19 U/L, LDH 204 U/L. CBC: WBC 5.16 x10^3/cmm, RBC 4.99 x10^6/cmm, Hgb 12.4 g/dL, Hct 38%, Platelet 296.5 x10^3/cmm. (10F 100-101, 103)

Citation: 10F 99-103

2023-06-28 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Follow-up for right knee pain (recent knee spasms, largely resolved since recent admission) and known lumbar intervertebral disc degeneration/chronic low back pain; patient has sickle cell disease (history of SS on hydroxyurea with a recent flare and hospitalization). Vitals notable for tachycardia (pulse 112); routine labs plus STI/HIV/HCV screening were ordered and no acute distress or neurologic deficit was found on exam.

Diagnoses: Right knee pain, Degeneration of lumbar intervertebral disc, Chronic low back pain, Attention-deficit hyperactivity disorder, Sickle cell-hemoglobin SS disease, Sickle cell-beta-thalassemia, Sickle cell disease, Anxiety, Fatigue

Laboratory Results: CBC with differential/platelet; comprehensive metabolic panel; TSH reflex to free T4; HIV AB/P24 Ag with reflex; HCV antibody reflex to quantitative PCR; NAAT for Chlamydia trachomatis/Neisseria gonorrhoeae/Trichomonas. (9F 26)

Objective: Height 6 ft, weight 178 lbs with clothes, BMI 24.1. Blood pressure 117/84 sitting, pulse 112 regular, respiratory rate 18, O2 saturation 99% on room air. Review of systems: no fever or night sweats; no dry eyes; no hearing difficulty; no sore throat. General: healthy-appearing, well-nourished, no acute distress. HEENT normal. Lungs without dyspnea. Heart regular rate and rhythm. Abdomen soft, non-tender. Motor strength and tone normal. Gait normal. Skin without rash. (9F 22, 25-26)

Subjective: The claimant reported right knee pain and knee spasms and was unsure if sickle cell was contributing; stated back pain is better. The claimant reported starting ADHD medication and that they have a history of sickle cell disease (SS) with the last flare last week; they are on hydroxyurea and were admitted to Grandview. The claimant noted having had right knee pain during that admission that has since resolved. The claimant denied chest pain, cough, muscle aches, rashes, weakness, numbness, or fatigue and reported feeling safe in their relationship. (9F 22, 25-26)

Medications: Baclofen 5 mg one tablet three times daily; bupropion HCL SR 100 mg (titration described) each morning; ergocalciferol (vitamin D2) 1,250 mcg weekly; fluticasone propionate nasal 50 mcg, 2 sprays each nostril every morning; hydrocodone 5 mg/acetaminophen 325 mg one tablet every 4 hours as needed for pain; hydroxyurea 500 mg daily; meloxicam 15 mg daily; morphine 15 mg immediate release one tablet every 4 hours as needed for pain; Qelbree one tablet daily (recently started ADHD medication). (9F 23, 25)

Assessment and Plan: Follow-up visit for right knee pain and lumbar intervertebral disc degeneration. Adult health examination with plan for routine labs and STD/HIV/HCV screening. Problem list includes lumbar disc degeneration, ADHD, sickle cell disease, and fatigue. No specific treatment plan documented. (9F 22, 26)

Citation: 9F 22-26

2023-06-28 | Regional Laboratory Birmingham / Graham, Kenneth DO

Summary: CBC shows microcytic, hypochromic indices with an elevated RDW and presence of nucleated red blood cells despite a hemoglobin of 13.0 g/dL; platelets are mildly elevated at 419 x10^3/µL. These findings suggest red cell size variability and early/occult red cell pathology (commonly iron deficiency or evolving anemia) and warrant correlation with iron studies and clinical evaluation.

Diagnoses: Microcytosis (low MCV), Hypochromia (low MCH), Elevated RDW (anisocytosis), Nucleated red blood cells (NRBCs) present, Mild thrombocytosis (platelets 419 x10^3/µL)

Laboratory Results: Specimen collected 06/28/2023 14:49; specimen reported 06/29/2023 06:10; accession ID 1877638CE9069. CBC: WBC 6.1 x10^3/µL, RBC 5.09 x10^6/µL, Hemoglobin 13.0 g/dL, Hematocrit 39.6%, MCV 78 fL (below normal), MCH 25.5 pg (below normal), RDW 19.4% (above normal), Platelets 419 x10^3/µL; differential/absolute: Neutrophils 40% (absolute 2.5 x10^3/µL), Lymphs 47% (absolute 2.9 x10^3/µL), Monocytes 9% (absolute 0.5 x10^3/µL), EOS 2% (absolute 0.1 x10^3/µL); NRBC 2% (above high normal). (9F 62-63)

Citation: 9F 62-63

2023-06-29 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Office visit for lipid/hyperlipidemia screening; encounter performed and signed off by Kenneth Graham, DO. Patient instructed to return to the office as needed.

Diagnoses: Hyperlipidemia screening (Encounter for screening for lipoid disorders, Z13.220)

Assessment and Plan: Encounter for lipid disorder screening; patient to return to office as needed. Encounter performed and signed off by Kenneth Graham, DO. (9F 27)

Citation: 9F 27

2023-06-29 | Regional Laboratory Birmingham / Graham, Kenneth DO

Summary: Routine lab work showed no laboratory evidence of HIV infection (HIV Ag/Ab non-reactive) and HCV antibody non-reactive; RPR was non-reactive. Thyroid-stimulating hormone and lipid panel (total cholesterol 150 mg/dL, LDL 84 mg/dL, HDL 56 mg/dL, triglycerides 48 mg/dL) were within normal limits and the claimant was advised to follow up as scheduled.

Diagnoses: HIV antigen/antibody test non-reactive (no laboratory evidence of HIV infection), HCV antibody (anti-HCV) non-reactive

Laboratory Results: HIV AB/P24 AG SCREEN: NON REACTIVE; HIV-1/HIV-2 antibodies and HIV-1 p24 antigen not detected, no laboratory evidence of HIV infection. HCV AB: NON REACTIVE; Specimen collected 06/28/2023 14:49, reported 06/29/2023 08:15. RPR: Non-reactive. TSH 1.570 UIU/mL (ref 0.450-4.500). Cholesterol total 150 mg/dL; Triglycerides 48 mg/dL; HDL 56 mg/dL; VLDL 10 mg/dL; LDL 84 mg/dL. (9F 57-60)

Assessment and Plan: Lab results within normal limits. HIV antigen/antibody testing nonreactive with no laboratory evidence of HIV infection. HCV antibody non-reactive; interpretation states not infected with HCV unless early/acute infection is suspected or other evidence indicates infection. The claimant was notified that recent lab tests are within normal limits and to follow up at next appointment. (9F 57-58, 60)

Citation: 9F 57-60

2023-06-29 | Heritage Physician Services (Pelham, 450 Oak Mountain Blvd Ste 105) / Unknown Provider

Summary: Basic metabolic panel and liver tests are overall within normal limits: glucose 92 mg/dL, BUN 8 mg/dL, creatinine 1.09 mg/dL with eGFR 95 mL/min/1.73m2, electrolytes and liver enzymes normal. The only notable abnormality is a mildly low total CO2 (19 mmol/L), which may reflect a mild acid–base disturbance and could warrant clinical correlation if symptomatic or persistent.

Laboratory Results: Glucose 92 mg/dL; BUN 8 mg/dL; Creatinine 1.09 mg/dL; eGFR 95 mL/min/1.73m2; BUN/Creatinine ratio 7; Sodium 137 mmol/L; Potassium 4.1 mmol/L; Chloride 100 mmol/L; Carbon dioxide (total) 19 mmol/L (below low normal); Calcium 9.8 mg/dL; Total protein 8.1 g/dL; Albumin 4.9 g/dL; Globulin 3.2 g/dL; A/G ratio 1.5; Bilirubin total 1.0 mg/dL; Alkaline phosphatase 66 IU/L; AST (SGOT) 30 IU/L; ALT (SGPT) 24 IU/L. (9F 61)

Citation: 9F 61

2023-06-30 | Regional Laboratory Birmingham / Graham, Kenneth DO

Summary: Nucleic acid amplification tests for chlamydia, gonorrhea, and Trichomonas were negative. Urinalysis was otherwise unremarkable (no leukocyte esterase, nitrite, protein, blood; WBC/RBC minimal) with only trace ketones and urobilinogen at the upper reference limit.

Diagnoses: Negative NAAT for Chlamydia, Gonorrhea, and Trichomonas, Urinalysis within normal limits with trace ketones

Laboratory Results: Chlamydia by NAA: NEGATIVE; Gonococcus by NAA: NEGATIVE; Trich vag by NAA: NEGATIVE. UA: Specific gravity 1.015, pH 6.0, Urine color YELLOW, Appearance CLEAR, WBC esterase NEGATIVE. Urinalysis: Protein negative; Glucose negative; Ketones trace (abnormal); Occult blood negative; Bilirubin negative; Urobilinogen 1.0 mg/dL (ref 0.2-1.0); Nitrite negative. Microscopy: WBC none seen (0-5/HPF), RBC 0-2/HPF, epithelial cells (non renal) none seen (0-10/HPF), casts none seen (/LPF), bacteria none seen/none seen-few. (9F 64-65)

Citation: 9F 64-65

2023-08-16 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Patient presented for an anal bump and bleeding with wiping; exam identified small external hemorrhoidal tissue at the anal verge without active bleeding, abscess, or fluctuance. Topical Anusol-HC was recommended and surgical referral was advised if there is no improvement in 2–3 weeks.

Diagnoses: Sickle cell-beta-thalassemia, Sickle cell hemoglobin SS disease, Attention deficit hyperactivity disorder, External hemorrhoids, Degeneration of lumbar intervertebral disc

Objective: Vitals: BP 122/78 sitting, Pulse 102 bpm regular, RR 17, Temp 98.2°F oral, O2 sat 99% on room air, Weight 177 lbs, BMI 24. Rectal exam: small hemorrhoidal tissue at the anal verge; no bleeding, no abscess, not fluctuant. (9F 17, 20)

Subjective: The claimant reported a bump in the anal area, an anal lump, and blood on stool when wiping with slight discomfort; noted that his wife has similar lesions. (9F 17, 20)

Medications: Anusol-HC 2.5% topical cream; Baclofen 5 mg tablet TID; bupropion HCL SR 100 mg daily; ergocalciferol 1,250 mcg weekly; fluticasone nasal spray; hydrocodone-acetaminophen 5/325 mg PRN; hydroxyurea 500 mg daily; meloxicam 15 mg daily; morphine 15 mg PRN; Qelbree 1 tablet daily. Recommend Anusol cream; consider referral to surgery if no improvement in 2–3 weeks. (9F 18, 20)

Assessment and Plan: External hemorrhoids. Recommend topical Anusol cream and consider surgical referral if no improvement in 2–3 weeks. (9F 20)

Citation: 9F 17-20

2023-08-16 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient presented for hemorrhoids/residual hemorrhoidal skin tags; exam consistent with residual hemorrhoidal skin tags. Provided hemorrhoid care instructions, prescribed Anusol-HC 2.5% topical cream with perineal applicator (apply thin layer 2–4 times daily) and advised return to clinic as needed.

Diagnoses: Residual hemorrhoidal skin tags

Medications: Anusol-HC 2.5% topical cream with perineal applicator, apply a thin layer to affected area 2-4 times daily; 30 gram tube. (9F 21)

Assessment and Plan: Residual hemorrhoidal skin tags; provided hemorrhoid care instructions, prescribed topical Anusol-HC, return to office as needed. (9F 21)

Citation: 9F 21

2023-08-17 | Regional Laboratory Birmingham / Graham, Kenneth DO

Summary: HSV-1 and HSV-2 type-specific IgG indices were reported at <0.91 (reference 0.00–0.90), noted by the lab report as within normal limits; no active diagnosis was recorded. Patient to be seen at next appointment for follow-up.

Laboratory Results: HSV-1 IgG (TYPE SPEC) <0.91 INDEX (ref 0.00-0.90); HSV-2 IgG (TYPE SPEC) <0.91 INDEX (ref 0.00-0.90). (9F 56)

Assessment and Plan: Laboratory results within normal limits per report; patient to be seen at next appointment. (9F 56)

Citation: 9F 56

2023-08-21 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Imaging of the hips showed patchy lucency and sclerosis in the left acetabulum and the intertrochanteric region of the proximal right femur consistent with stable bone infarcts; joint spaces were normal and there was no acute fracture. The claimant reported hip pain without injury; basic metabolic panel results were unremarkable.

Diagnoses: Sickle cell disease, Bone infarct

Imaging: Patchy areas of lucency and sclerosis in the left acetabulum and intertrochanteric proximal right femur suggesting bone infarcts, stable; joint spaces normal and no acute fracture. (3F 5)

Laboratory Results: Sodium 137 mmol/L, Potassium 4.5 mmol/L, Chloride 106 mmol/L, Bicarbonate 25 mmol/L, AGAP 6.0 mmol/L, Glucose 78 mg/dL, BUN 6 mg/dL (collected 08/21/2023 12:11 CDT). 8/21/2023 BMP: Sodium 137 mmol/L, Potassium 4.5 mmol/L, Chloride 106 mmol/L, Bicarbonate 25 mmol/L; AGAP 6.0 mmol/L; Glucose 78 mg/dL; BUN 6 mg/dL. (3F 124; 10F 93)

Subjective: The claimant reported hip pain without injury. (3F 5)

Medications: Baclofen 5 mg oral tablet (1 tab TID); ergocalciferol 1.25 mg (50,000 IU) oral capsule (1 cap weekly); fluticasone nasal spray 50 mcg, 2 sprays every AM; hydroxyurea 500 mg capsule daily; ibuprofen 800 mg oral tablet as prescribed; morphine 15 mg oral tablet PRN every 4 hours; naloxone 4 mg nasal spray. (3F 124; 10F 93)

Assessment and Plan: Imaging consistent with stable bone infarcts in the hips with no acute fracture. (3F 5)

Citation: 3F 5-6, 124; 10F 93

2023-08-21 | Hematology Clinic / Curtis, Ashley M CRNP

Summary: Established patient with sickle cell disease reporting recent ED/ICU visits, suboptimal adherence to hydroxyurea, and current back and muscle pain; exam and vitals were normal. Labs show Hgb 12.9 g/dL with Hgb S 65.8% and elevated Hgb F 13.2%, low ferritin (23 ng/mL); plan to consider starting Adakveo and repeat pelvic X-ray for prior bone infarct with routine follow-up.

Diagnoses: Sickle cell disease, Back pain, Muscle pain

Imaging: Will repeat pelvic X-ray today due to prior bone infarct. (3F 119; 10F 88)

Laboratory Results: 8/21/2023 labs: Sodium 137 mmol/L; Potassium 4.5 mmol/L; Chloride 106 mmol/L; Bicarbonate 25 mmol/L; Glucose 78 mg/dL; BUN 6 mg/dL; Creatinine 1.1 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.5 mg/dL; Albumin 4.4 g/dL; ALT 13 U/L; AST 16 U/L; LDH 183 U/L; Ferritin 23.0 ng/mL (LOW). Hemoglobin fractions: Hgb A 15.3% (LOW), Hgb F 13.2% (HI), Hgb S 65.8%. CBC: WBC 4.76 x10^3/cmm; RBC 4.97 x10^6/cmm; Hgb 12.9 g/dL (LOW); Hct 38% (LOW); MCV

77 fL (LOW); MCH 26 pg (LOW); MCHC 34 g/dL; Platelets 331.7 x10^3/cmm; RDW 18.6% (HI); Reticulocyte 2.0%; Basophils 4% (HI). Urine drug screen negative for buprenorphine, cannabis, cocaine, fentanyl, heroin, hydrocodone, opiates, oxycodone. (3F 121-122; 10F 90-91)

Objective: Review of systems negative for fever, sweats, weakness, weight change, visual disturbance, respiratory or cardiac symptoms; sleep disturbance due to night shift noted; dilated eye exam up to date. Vitals: Temp 98.6 F, HR 73 bpm, SpO2 96%, BP 119/79 mmHg, weight 177.1 lb. Exam: alert and oriented; lungs clear to auscultation; regular cardiac rhythm; abdomen soft, non-tender; normal range of motion, normal strength, normal gait, able to move all extremities. Neurologic: alert, oriented, normal sensory and motor function, no focal deficits; cognition/speech clear and coherent. Psychiatric: cooperative, appropriate mood and affect, normal judgment. Interval update notes no ER visits/hospitalizations since last update; reports low water intake and poor sleep due to night shift. (3F 119-121; 10F 88-91)

Subjective: The claimant reported feeling pretty good but concerned about two ICU/ED visits in June and admitted to not taking prescribed medications regularly; considering initiation of Adakveo. The claimant complained of back pain and muscle pain. (3F 119-120; 10F 88-89)

Medications: Hydroxyurea 500 mg PO daily; ibuprofen 800 mg PO TID PRN; morphine 15 mg PO every 4 hr PRN for pain; baclofen 5 mg PO TID; ergocalciferol 50,000 IU (1.25 mg) PO weekly; fluticasone nasal 2 sprays each nare AM; naloxone nasal 4 mg once. Previously tried bupropion and Strattera for ADHD (stopped). (3F 119-120; 10F 88-89)

Assessment and Plan: Sickle cell disease with suboptimal medication adherence. Musculoskeletal back pain and muscle pain. Continue hydroxyurea and current medications; consider initiation of Adakveo. Plan to repeat pelvic X-ray due to prior bone infarct and continue routine follow-up in clinic. Transition of care documented with updated care and emergency plans; no subspecialty referrals at this time. (3F 119-120, 122; 10F 88, 91)

Citation: 3F 119-122; 10F 88-91

2023-08-21 | Grandview Medicine / Curtis, Ashley M CRNP

Summary: Patient is prescribed baclofen (5 mg TID) for spasticity, hydroxyurea 500 mg daily (suggesting treatment for a hematologic disorder such as sickle cell disease), and morphine 15 mg for pain control. Additional meds include intranasal fluticasone for nasal symptoms/allergic rhinitis, ibuprofen 800 mg as needed for analgesia/anti-inflammatory use, and high-dose ergocalciferol (50,000 IU weekly) for vitamin D repletion.

Medications: Baclofen 5 mg oral tablet, 1 tab three times daily; Hydroxyurea 500 mg oral capsule, 1 cap daily. Morphine 15 mg oral tablet; Flonase (fluticasone) 50 mcg/inh nasal spray 2 sprays daily; Ibuprofen 800 mg oral tablet; Ergocalciferol 1.25 mg (50,000 IU) oral capsule weekly. (4F 3, 5)

Citation: 4F 3-5

2023-08-21 | Unknown Facility / Brooks, William S MD

Summary: Pelvic radiographs show patchy lucency and sclerosis in the left acetabulum and the intertrochanteric region of the proximal right femur consistent with bone infarcts; joint spaces are preserved and there is no acute fracture. Findings were interpreted as stable; patient presented with pain without injury.

Diagnoses: Sickle cell disease, Bone infarcts

Imaging: XR pelvis/hips 08/21/2023: Patchy areas of lucency and sclerosis in the left acetabulum and intertrochanteric proximal right femur suggesting bone infarcts; no acute fracture. (10F 86)

Objective: Radiograph interpretation notes patchy lucency and sclerosis in left acetabulum and intertrochanteric proximal right femur; joint spaces normal, no acute fracture. (10F 86)

Subjective: Patient reported pain without injury. (10F 86)

Assessment and Plan: Imaging suggests bone infarcts in the left acetabulum and proximal right femur, stable; no acute fracture identified. (10F 86)

Citation: 10F 86-87

2023-08-21 | Unknown Facility / Chakraborty, Priya MD

Summary: Hemoglobin electrophoresis shows Hgb S 65.8%, Hgb A 15.3%, Hgb F 13.2%, a pattern interpreted as presence of hemoglobin S with findings suggestive of coexisting beta-thalassemia; transfusion or treatment effects could not be excluded. CBC shows mild microcytosis (MCV 77 fL) and elevated RDW (18.6%) with Hgb 12.9 g/dL; renal function and calcium were normal and urine drug screen was negative for fentanyl/heroin/hydrocodone/opiates/oxycodone.

Diagnoses: Hemoglobin S (sickle hemoglobin) predominance on electrophoresis, Findings suggestive of beta-thalassemia

Laboratory Results: 8/21/2023 labs: Creatinine 1.1 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.5 mg/dL; Adjusted Calcium 9.2 mg/dL; Albumin 4.4 g/dL; LDH 183 U/L; Ferritin 23.0 ng/mL; Hgb A 15.3%; Hgb F 13.2%; Hgb S 65.8%; Urine

protein (random) 5 mg/dL; Urine creatinine 136 mg/dL. Urine drug screen: fentanyl, heroin, hydrocodone, opiates, oxycodone all negative. CBC: WBC 4.76 x10^3/cmm; RBC 4.97 x10^6/cmm; Hgb 12.9 g/dL; Hct 38%; MCV 77 fL; Platelets 331.7 x10^3/cmm; RDW 18.6% (H); Neutrophils 40% (absolute neutrophils 1.91 x10^3/cmm); Lymphocytes 45% (absolute lymphocytes 2.14 x10^3/cmm); Retic% 2.0; Retic absolute 0.0979 x10^6/cmm; RBC retic 4.88 x10^6/cmm. Reference/interpretive data included: GFR categories (G1 ≥90; G2 60-89; G3a 45-59; G3b 30-44; G4 15-29; G5 <15); ACR and P/C ratio ranges; notes on adjusted calcium/ALT/AST; U Ampheta cutoff 500 ng/mL. Urine drug screen interpretive data with cutoff values: U Barb/U Benz 200 ng/mL; U Buprenorphine 5 ng/mL; U Cannabin 50 ng/mL; U Cocain Meta 150 ng/mL; U Fentanyl 1 ng/mL; U Heroin 10 ng/mL; U Hydrocodone 300 ng/mL; U Opiates 300 ng/mL; screening assay only, results not confirmed. (3F 125-128; 10F 94-97)

Assessment and Plan: The claimant's hemoglobin electrophoresis shows Hemoglobin A and S with findings suggestive of beta-thalassemia; cannot exclude blood transfusion or treatment effect. (3F 125)

Citation: 3F 125-128; 10F 94-97

2023-10-03 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient with HbS/β-thalassemia status-post splenectomy received first crizanlizumab (Adakveo) IV infusion which was well tolerated without complications; plan is repeat infusion in 2 weeks then every 4 weeks and to continue hydroxyurea. Labs show mild chronic anemia (Hgb ~11.9–12.4 g/dL), elevated RDW, and reticulocyte 2.4%; patient reported recent brief back/leg pain that has since improved.

Diagnoses: Sickle cell disease (HbS/β-thalassemia), Status post splenectomy, History of splenic sequestration

Procedures: Adakveo (crizanlizumab) IV infusion administered (first infusion) and tolerated without complications. Plan: next infusion in 2 weeks then every 4 weeks (documented as monthly thereafter). (3F 79, 82; 10F 80, 83)

Laboratory Results: 10/03/2023: Sodium 136 mmol/L, Potassium 4.3 mmol/L, Chloride 103 mmol/L, Bicarbonate 25 mmol/L, Glucose 76 mg/dL, BUN 11 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.5 mg/dL, Albumin 4.7 g/dL, ALT 15 U/L, AST 21 U/L, WBC 5.51 x10^3/µL, Hgb 12.4 g/dL (low), Hct 37% (low), RDW 18.2% (high). Reticulocyte 2.4%; Retic absolute 0.1186 x10^6/µL; RBC retic 4.98 x10^6/µL. 10/16/2023: Sodium 139 mmol/L, Potassium 4.2 mmol/L, Chloride 104 mmol/L, Bicarbonate 25 mmol/L, Glucose 50 mg/dL, BUN 7 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.3 mg/dL, Albumin 4.5 g/dL, Total bilirubin 0.9 mg/dL, Alk Phos 63 U/L, ALT 16 U/L, AST 18 U/L, LDH 201 U/L; WBC 5.37 x10^3/mm3, RBC 4.54 x10^6/mm3, Hgb 11.9 g/dL, Hct 35%, MCV 76 fL, Platelet 305.9 x10^3/mm3; Neutrophils 41% (absolute 2.20 x10^3/mm3), Lymphocytes 42% (absolute 2.28 x10^3/mm3), Monocytes 10%. (3F 81-82, 85; 10F 82-83)

Objective: Review of systems largely negative. Musculoskeletal: mild back and leg pain; normal range of motion and strength, moves all extremities well. Neurologic/cognitive: alert and oriented x4, normal sensory, speech noted stutter. Vitals: Temp 97.3–97.5 F, HR 63–66 bpm, RR 14–16/min, SpO2 99–100%, BP 123/67–127/69 mmHg. HEENT/oral mucosa moist. Respiratory: lungs clear to auscultation, respirations non-labored, breath sounds equal. Abdomen soft, non-tender. Integumentary warm, dry. Psychiatric: cooperative, appropriate mood and affect. Laboratory cell morphology: anisocytosis 1+, rare ovalocytes, rare target/tear/burr cells, occasional schistocyte; reticulocyte 2.4%. (3F 79-82; 10F 80-83)

Subjective: The claimant with a history of HbS/Beta thalassemia and prior splenectomy reported some crisis pain in his back and legs on Friday that improved over the weekend and is much better now. He feels well overall, has no acute concerns today, and tolerated his first Adakveo (crizanlizumab) infusion without complications. Patient education provided to the claimant and spouse covering disease plan of care, hydroxyurea mechanism and indication, nutrition education, and pain management. (3F 79, 82-83; 10F 80, 83-84)

Medications: Hydroxyurea 500 mg daily (continue hydroxyurea 1 cap daily); Adakveo (crizanlizumab) infusion given. Ibuprofen 800 mg TID (also documented as ibuprofen 600 mg PRN); morphine 15 mg PRN q4h as needed for severe pain. Outpatient meds listed: baclofen 5 mg TID (also PRN for mild pain), ergocalciferol 1.25 mg weekly (50,000 IU), fluticasone nasal spray 2 sprays each nares daily, naloxone 4 mg nasal once. (3F 79-80, 82-83; 10F 80-81, 83)

Assessment and Plan: Sickle cell disease (HbS/Beta thalassemia) status-post splenectomy presenting for first crizanlizumab (Adakveo) infusion; infusion tolerated well. Continue hydroxyurea and current pain regimen; monitor during infusion. Return to clinic in 2 weeks for next infusion then every 4 weeks and follow-up as directed. Care plan and education reviewed; covering physician agrees with the plan of care. (3F 79, 82-83; 10F 80, 83-84)

Citation: 3F 79-85; 10F 80-85

2023-10-16 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient received education on disease plan of care including hydroxyurea mechanism/indication, nutrition, and pain management; current meds include hydroxyurea 500 mg daily and PRN opioids (morphine) with naloxone available. Care plan was discussed with and agreed upon by the covering physician, and the patient acknowledged understanding of the education and plan.

Diagnoses: Sickle cell disease

Subjective: Patient education provided; reported education topics included disease plan of care, hydroxyurea mechanism/indication, nutrition education, and pain management. (3F 66)

Medications: Baclofen 5 mg oral tab; Hydroxyurea 500 mg oral capsule; Ibuprofen 800 mg oral tablet; Morphine 15 mg oral tablet PRN; Naloxone 4 mg/0.1 mL nasal spray. (3F 66)

Assessment and Plan: Care discussed with covering physician who agrees with the plan of care; patient acknowledged understanding of education provided. (3F 66)

Citation: 3F 66-67

2023-10-16 | Unknown Facility / Torres, Lisa CRNP

Summary: Patient with HbS/β-thalassemia received second/loading Adakveo (crizanlizumab) IV infusion and experienced mild mid–to–low back pain during the infusion that improved after slowing the infusion rate and giving diphenhydramine; infusion to continue monthly at a slower rate. Labs notable for low glucose (50 mg/dL), microcytic indices with Hgb 11.9 g/dL, MCV 76 fL, elevated RDW 18.9% and reticulocyte 2.9%, and otherwise stable vitals and exam.

Diagnoses: LUQ pain, HbS/Beta thalassemia, Sickle cell crisis, Status post splenectomy, Low back pain, Infusion-related reaction, Anemia

Procedures: Adakveo (crizanlizumab) IV infusion administered as the second/loading dose. Plan to continue monthly infusions at a slower rate. (3F 62, 65; 10F 70, 73)

Laboratory Results: BMP 10/16/2023: Sodium 139 mmol/L, Potassium 4.2 mmol/L, Chloride 104 mmol/L, Bicarbonate 25 mmol/L, Glucose 50 mg/dL (low), BUN 7 mg/dL, Creatinine 1.0 mg/dL, Calcium 9.3 mg/dL, Albumin 4.5 g/dL, ALT 16 U/L, AST 18 U/L. CBC: WBC 5.37 x10^3/cmm; Hgb 11.9 g/dL (low); Hct 35% (low); MCV 76 fL (low); MCH 26 pg (low); RBC 4.54 x10^6/µL; Platelet 305.9 x10^3/µL; RDW 18.9% (high); Retic 2.9% (high); Absolute lymphocytes 2.28 x10^3/cmm. (3F 64-65; 10F 72-73)

Objective: Review of systems notable for mild back and leg pain. Vitals 10/16/2023 13:25: Temp 97.5 F, HR 65 bpm, RR 14/min, SpO2 100%, BP 126/72 mmHg. Alert and oriented, no acute distress. Lungs clear. Cardiovascular: regular, S1, S2. Musculoskeletal: normal range of motion, normal strength, normal gait, able to move all extremities. Clinic CBC: Hgb 11.9 g/dL (low), Hct 35% (low), MCV 76 fL (low), MCH 26 pg (low), RBC 4.54 x10^6/µL, Platelets 305.9 x10^3/µL, RDW 18.9% (high), Reticulocyte 2.9% (high). WBC 5.37 x10^3/cmm; Absolute lymphocytes 2.28 x10^3/cmm. (3F 63-65; 10F 71-73)

Subjective: The claimant reported unusual pain on top of his foot after his first Adakveo infusion that resolved with rest, hydration, and pain medication. The claimant reported mild mid to mid-low back pain rated 6/10 about 15 minutes into his Adakveo infusion that improved after the infusion rate was slowed and Benadryl was given. The claimant denies other associated symptoms and endorses no other acute complaints. (3F 62-65; 10F 70-73)

Medications: Adakveo (crizanlizumab) monthly IV infusion; hydroxyurea 500 mg daily (HU) described as 1 tab/cap daily. Home/clinic meds: ibuprofen 800 mg TID, morphine 15 mg PO q4h PRN, baclofen 5 mg TID, ergocalciferol 50,000 IU (1.25 mg) weekly, fluticasone nasal, naloxone nasal spray. Symptomatic pain plan: mild pain—ibuprofen 600 mg PRN and baclofen PRN; severe pain—morphine 15 mg every 4 hours PRN. Benadryl was given with the infusion. (3F 62-63, 65; 10F 70-71, 73)

Assessment and Plan: Sickle cell disease; receiving Adakveo infusions with first two infusions as loading doses 2 weeks apart then transition to monthly dosing. Infusion-associated mild mid to mid-low back pain during Adakveo infusion; infusion rate was slowed and Benadryl administered with reported symptomatic improvement. Exam largely normal aside from reported mild back/leg pain. Labs notable for low glucose (50 mg/dL) and chronic microcytic indices (Hgb 11.9 g/dL, Hct 35%, MCV 76 fL) with elevated RDW 18.9% and reticulocyte 2.9%. Continue monthly Adakveo infusions at a slower rate with Benadryl and continue hydroxyurea and the symptomatic pain plan. (3F 62-65; 10F 70-73)

Citation: 3F 62-65; 10F 70-73

2023-10-16 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Nelson, Victoria L CRNP

Summary: Outpatient lab monitoring for a patient with sickle cell disease on hydroxyurea showed stable hemoglobin 12.3 g/dL with mild microcytosis (MCV 76 fL) and elevated RDW 19.4%, and mildly increased reticulocyte count (~2.7–2.9%) consistent with ongoing hemolysis/compensation. Basic chemistry, renal function (eGFR >90) and liver tests were within normal limits, though a single glucose was low at 59 mg/dL and WBC rose to 10.5 x10^3/cmm on 04/10/2024.

Diagnoses: LUQ pain, Sickle cell crisis, Sickle cell disease

Laboratory Results: CBC/Chemistry and related labs: Eosinophils 5%; Basophils 2%; Reticulocyte 2.9% (H), Retic Absolute 0.1334 x10^6/cmm; RBC 4.75 x10^6/cmm; RBC Retic 4.62 x10^6/cmm; Sodium 140 mmol/L; Potassium 4.0 mmol/L; Chloride 109 mmol/L; Bicarbonate 23 mmol/L; Anion gap 8.0 mmol/L; Glucose 71 mg/dL; BUN 8 mg/dL; Creatinine 0.9 mg/dL; eGFR >90 mL/min/1.73 m2; Calcium 8.8 mg/dL; Adjusted calcium 8.6 mg/dL; Protein 7.0 g/dL; Albumin 4.2 g/dL; Total bilirubin 0.9 mg/dL; Alkaline phosphatase 57 U/L; ALT 12 U/L; AST 18 U/L; LDH 199 U/L; WBC 6.54 x10^3/cmm; Hemoglobin 12.3 g/dL; Hematocrit 36%; MCV 76 fL; MCH 26 pg; MCHC 34 g/dL; Platelet 327 x10^3/cmm; RDW 19.4%. 01/30/2024 08:01 CST differential and retic: Neutrophils 41% (Absolute neutrophils 2.68 x10^3/cmm); Lymphocytes 45% (Absolute lymphocytes

2.97 x10^3/cmm); Monocytes 8%; Eosinophils 4%; Basophils 2%; Reticulocyte 2.7%, Retic absolute 0.1244 x10^6/cmm; RBC/Retic 4.58 x10^6/cmm. 04/10/2024 09:41 CDT basic/metabolic and CBC: Sodium 139 mmol/L; Potassium 4.0 mmol/L; Chloride 104 mmol/L; HCO3 23 mmol/L; Glucose 59 mg/dL; BUN 12 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73 m2; Hemoglobin 12.3 g/dL; Hematocrit 35%; WBC 10.51 x10^3/cmm; Platelet 362.9 x10^3/cmm; Total bilirubin 0.7 mg/dL; AST 16 U/L; ALT 10 U/L. (3F 86, 92-93, 96-97; 10F 68)

Medications: cyclobenzaprine 5 mg nightly; dextroamphetamine-amphetamine 10 mg BID; docusate 100 mg BID; ergocalciferol 1.25 mg weekly; hydroxyurea 500 mg daily (capsule); ibuprofen 600 mg QID PRN (tablet); morphine 15 mg q4h PRN (tablet); naloxone 4 mg nasal (spray) as needed; penicillin V potassium 250 mg BID (tablet); HYDROcodone-acetaminophen (Norco) 5 mg/325 mg tablet. (3F 88-89)

Citation: 3F 86-97; 10F 68-69

2023-10-17 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Curtis, Ashley M CRNP

Summary: Patient with known sickle cell disease presented in a vaso-occlusive pain crisis affecting shoulders and right hip with nausea/vomiting and transient, resolved right-sided numbness; treated with IV fluids, IV analgesia including ketorolac, and received Adakveo infusion with diphenhydramine premedication for pruritus. Labs showed mild anemia (Hgb ~11.9 g/dL), elevated reticulocyte percentage, low glucose (50 mg/dL on 10/17/2023), and otherwise stable vitals with no focal neurologic deficits on exam.

Diagnoses: Sickle cell crisis, Sickle cell disease

Procedures: Adakveo infusion administered; infusion plan updated to run over 1 hour with premedication diphenhydramine (Benadryl). Plan documented to premedicate with diphenhydramine and extend infusion to 1 hour. (3F 25; 10F 56)

Laboratory Results: 10/17/2023: Sodium 137 mmol/L, Potassium 3.7 mmol/L, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, WBC 10.99 x10^3/cmm, Hgb 11.9 g/dL (low), Hct 35% (low), MCV 75 fL (low), RDW 18.6% (high), Glucose 50 mg/dL (low), Reticulocyte 2.9% (high). 10/03/2023: Hgb 12.4 g/dL, Hct 37%, WBC 5.51 x10^3/cmm, Platelet 281.7 x10^3/cmm, Neutrophils 54%, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, BUN 11 mg/dL, Sodium 136 mmol/L, Potassium 4.3 mmol/L, Glucose 76 mg/dL, Total bilirubin 0.6 mg/dL, LDH 211 U/L, Reticulocyte 2.4% (retic absolute 0.1186 x10^6/cmm). Peripheral smear/morphology: Eosinophils 1%, Basophils 0%, NRBC 1/100 WBC, Micro 1+, Anisocytosis 1+, Ovalocytes rare, Target cells rare, Tear cells rare, Schistocytes occasional, Burr cells rare. Additional values: WBC 5.37 x10^3/cmm, Platelet 305.9 x10^3/cmm, RDW 18.9% (high) noted in record. (3F 27-28, 32-33, 77; 10F 57-58)

Objective: Itching/pruritus noted after medication administration. Hydration and bowel/apetite: water intake >64 oz daily, regular bowel movements, appetite good. Medication adherence variable. No focal neurologic deficits documented on exam. Vitals: Temp 97.3 F, HR 107 bpm, RR 14, SpO2 95%, BP 125/66. Exam: alert and oriented, lungs clear, cardiovascular normal, abdomen soft, musculoskeletal exam notable for pain in right arm and hip, cognition/speech: stutter. Psychiatric: cooperative with appropriate mood and affect. (2F 7; 3F 25-27; 10F 56)

Subjective: The claimant reported a sickle cell vaso-occlusive crisis with acute pain in the shoulders and right hip, associated nausea and vomiting requiring antiemetic therapy, and receipt of IV pain medication and IV fluids today. The claimant reported a prior ER visit earlier and transient right arm and leg numbness that resolved. The claimant took ibuprofen the prior night. (18F 16, 21-22; 3F 25-26; 10F 56)

Medications: Heparin flush 50 units/5 mL, IV flush once day of treatment PRN/line flush; Diphenhydramine 25 mg PO given 10/17/2023 09:39 (diphenhydramine 25 mg capsule PO PRN for itching/pruritus, 1 dose noted); Ketorolac (Toradol) 15 mg (0.5 mL) IV, once (order dated 10/17/2023); Dextrose 5% in Water IV bolus 500 mL, rate 125 mL/hr, infuse over 4 hours (single day of treatment). (18F 15-17, 19-22; 2F 7-9, 11-12, 14; 3F 25-26, 30; 10F 56, 60)

Assessment and Plan: Medication orders placed for line flushes and heparin flushes for IV/PICC management. Diagnosis: sickle cell crisis (vaso-occlusive crisis) treated with IV pain medication, ketorolac order for pain, IV dextrose 5% per medication orders, and Adakveo infusion with diphenhydramine premedication for itching/pruritus. Continue routine inpatient management and monitoring; order/nurse/pharmacist verifications documented. (18F 15-17, 20-22; 2F 7-8, 11-12, 14; 3F 25, 28; 10F 56, 58)

Citation: 18F 15-17, 19-22; 2F 7-9, 11-12, 14; 3F 25-28, 30-35, 77-78; 10F 56-58, 60-61

2023-10-17 | Grandview ED / Warren, Michael P MD

Summary: About 30 minutes after an Adakveko infusion the patient developed burning posterior right shoulder pain, right hip pain, and right arm numbness consistent with an infusion reaction triggering a sickle cell pain crisis; pain improved with IV opioids (Dilaudid) but persisted. Vitals were stable, labs showed Hgb 11.9 g/dL with elevated reticulocyte 3.0%, and the patient was treated with IV fluids and analgesia and discharged with hematology/sickle cell follow-up.

Diagnoses: Infusion reaction, Sickle cell pain crisis, HbS/Beta thalassemia

Laboratory Results: Sodium 137 mmol/L, Potassium 3.7 mmol/L, Glucose 90 mg/dL, Creatinine 1.0 mg/dL, Hgb 11.9 g/dL (low), Reticulocyte 3.0% (high), Platelet 292.6 K/µL. (10F 63)

Objective: Vitals: T 98 F, HR 74 bpm, RR 16, SpO2 100%, BP 125/71 mmHg. Exam: alert, moderate distress; chest wall severe pain over posterior right shoulder and right hip with light touch to skin; lungs clear, no murmurs. Vitals/labs reviewed with reticulocyte stable; Hgb 11.9 (low), retic 3.0% (high); creatinine 1.0; exam otherwise not detailed. (10F 62-63)

Subjective: Patient reported burning right shoulder, hip pain, and right arm numbness beginning ~30 minutes after infusion; pain has persisted despite morphine, ibuprofen, and baclofen. Patient reports ongoing pain that improved with Dilaudid but remains present. (10F 62-63)

Medications: Patient had taken morphine 15 mg and used ibuprofen and baclofen prior to presentation. Dilaudid given for pain (dose not specified). (10F 62-63)

Assessment and Plan: Likely infusion reaction with pain crisis; plan to obtain CBC and retic, treat with IV fluids and pain regimen, and re-evaluate. Final diagnosis: Sickle Cell Pain Crisis; plan to discharge with follow-up in sickle cell clinic and transition care to hematology providers. (10F 62-63)

Citation: 10F 62-63

2023-10-17 | Grandview ED / Griffin, Thomas R MD

Summary: Patient with HbS/Beta-thalassemia developed burning severe right shoulder and hip pain with right arm numbness about 30 minutes after Adakveko infusion; exam showed allodynia and moderate distress but vitals and relevant labs (CBC/retic, chemistries) were stable. Pain improved after IV Dilaudid, the event was managed as a sickle cell pain crisis possibly related to an infusion reaction, and the patient was discharged with sickle cell clinic follow-up.

Diagnoses: Infusion reaction (possible), Right shoulder pain, Right hip pain, Right arm numbness, HbS/Beta-thalassemia (HbS/B-Thal), Sickle cell pain crisis

Functional Assessment: Will discharge with plan to follow up in sickle cell clinic; patient amenable to plan. (3F 75)

Laboratory Results: (10/17/2023 04:44 CDT) Sodium 137 mmol/L, Potassium 3.7 mmol/L, Chloride 104 mmol/L, Bicarbonate 25 mmol/L, Anion gap 8, Glucose 90 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Magnesium 1.8 mg/dL, Calcium 9.0 mg/dL; CK 81 U/L; WBC 10.99 x10^3/µL, RBC 4.61 x10^6/µL, Hgb 11.9 g/dL (low), Hct 35% (low), Platelets 292.6 x10^3/µL, RDW 18.6% (high), Reticulocyte 3.0% (high). (3F 75-76; 10F 64)

Objective: Vitals: T 98 F, HR 74 bpm, RR 16/min, SpO2 100%, BP 125/71 mmHg. The claimant was alert, in moderate distress. Severe pain localized over the posterior right shoulder and right hip with allodynia to light touch. Hemoglobin/hematocrit and reticulocyte count appeared stable on reexamination. Pain improved after Dilaudid administration. (3F 74-75)

Subjective: The claimant reported burning right shoulder, hip pain, and right arm numbness beginning approximately 30 minutes after infusion and persistent since that time. The claimant stated pain remained present but improved with Dilaudid and was amenable to the discharge plan. (3F 74-75)

Medications: Dilaudid administered for pain. (3F 75)

Assessment and Plan: Possible infusion reaction in a patient with HbS/B-Thal presenting with localized severe pain. Plan to obtain CBC and reticulocyte count, administer IV fluids, treat pain per recommended regimen and re-evaluate. Final diagnosis: sickle cell pain crisis. Plan discharge with follow-up in the sickle cell clinic, transition of care to Dr. Owens, and contact with Dr. Collins. (3F 74-75)

Citation: 3F 74-76; 10F 64

2023-10-17 | Unknown Facility / Dawson, Tyler G RN

Summary: The claimant presented with acute, generalized radiating sharp pain with initial pain score 9 that decreased to 7–5 after analgesic treatments and nonpharmacologic measures; plan to continue analgesia with hydromorphone PCA, ketorolac, and supportive therapies. Peripheral IV (22G) placed in left forearm without complications, vitals overall stable and oxygenation adequate on room air (SpO2 95%).

Diagnoses: Acute generalized radiating sharp pain

Procedures: Peripheral IV insertion in left forearm with 22 gauge catheter; device patent with blood return and no complications. (18F 10; 2F 2)

Objective: Height 73 in (185.42 cm), weight 80.739 kg, BMI 23.48. Oxygen saturation 95% on room air. Peripheral IV in left forearm 22 gauge, patent with blood return, no complications; IV dressing dry and intact. Serial 0–10 pain scores documented, ranging from 9 (primary pain score) down to 7 and 5 during the day; primary acceptable pain score documented as 4. Multiple vital sign sets: heart rate ranged 67–107 bpm (values documented: 67, 71, 96, 97, 107), respiratory rate 10–16 br/min, temperatures approximately 96.9–97.3°F (36.1°C), oxygen saturations 95–99%, blood pressures systolic 112–128 mmHg and diastolic 64–81 mmHg, mean arterial pressure approximately 77–82 mmHg. (18F 10-14; 2F 2-5)

Subjective: The claimant reported acute, generalized radiating sharp pain, endorsed alleviation with heat therapy, medications, and rest, and denied aggravating factors. (18F 11; 2F 3)

Medications: Hydromorphone PCA admixture 30 mg (diluent for PCA noted); Hydromorphone PCA documented (dose noted in admixture). Ondansetron ODT 8 mg PO. Ketorolac (Toradol) 15 mg IV; Ketorolac trometh inj 30 mg IV. Dextrose 5% in water IV 500 mL. (18F 10, 14; 2F 2, 6)

Assessment and Plan: Peripheral IV functioning and patent with no complications; IV dressing dry and intact. The claimant is on room air with adequate oxygenation (SpO2 95%). Pain assessment documents generalized radiating sharp pain with primary pain score 9, acceptable pain score 4, and decreasing scores to 7–5 during the day; plan to continue analgesic measures and nonpharmacologic therapies. Vitals overall stable per nursing documentation. (18F 10; 2F 2-4)

Citation: 18F 10-14; 2F 2-6

2023-10-17 | Emergency Department / Price, Morgan E RN

Summary: The claimant presented to the ED with acute right arm pain rated 10/10, arrived by wheelchair but was alert, moving all extremities, and hemodynamically stable with normal vitals and oxygenation. Clinicians noted a possible infusion reaction after recent Adakveo with numbness and sharp right-sided pains; ED evaluation, monitoring, and further workup were planned.

Diagnoses: Acute right arm pain, Possible infusion reaction, Sickle cell disease

Functional Assessment: Mode of arrival: wheelchair; no other functional limitations documented. (18F 24)

Objective: Vitals: Temp 98 F, HR 74 bpm, RR 16/min, BP 125/71 mmHg, SpO2 100% on room air; measurements taken with the claimant seated. Primary pain location right arm, described as aching. The claimant was alert and oriented to person and place, arrived by wheelchair, respirations unlabored and regular, moves all extremities well; ID band verified, side rails up, call light present. (18F 23-24; 2F 15-16)

Subjective: The claimant reported acute aching right arm pain with a primary pain score of 10/10, denied alleviating or associated symptoms, and reported a possible infusion reaction after Adakveo on 10/16 with numbness and sharp pains on the right side of the body. The claimant denied chest pain or shortness of breath. (18F 23-24; 2F 15-16)

Assessment and Plan: Primary assessment: acute right arm pain (primary ED pain) with high pain score and stable vital signs. Secondary concern for possible infusion reaction related to recent Adakveo infusion with neurologic symptoms (numbness and sharp right-sided pains). ED nursing assessment and plan documented; ED evaluation, monitoring, and further workup planned. (18F 23-24; 2F 15-16)

Citation: 18F 23-24; 2F 15-16

2023-10-17 | Grandview ED Lab / Unknown Provider

Summary: Lab testing 10/16–10/17/2023 showed mild anemia (Hgb 11.9 g/dL, Hct 35%) with elevated RDW (18.6%) and reticulocyte percentage 3.0%, findings consistent with increased RBC turnover/hemolysis in the setting of sickle cell disease. Metabolic panel otherwise unremarkable (normal renal/hepatic values, eGFR >90), but there was a low glucose 50 mg/dL and a transient neutrophilia on 10/17 (79%, absolute neutrophils 8.68 x10^3/µL).

Diagnoses: Sickle cell disease

Laboratory Results: Collected 10/17/2023 04:44 CDT: RDW 18.6%, MPV 8 fL, Neutrophils 79%, Absolute neutrophils 8.68 x10^3/cmm, Lymphocytes 11%, Absolute lymphocytes 1.16 x10^3/cmm, Reticulocyte % 3.0, Retic absolute 0.1408 x10^6/cmm, RBC retic 4.63 x10^6/cmm. 10/16/2023 labs: Sodium 139 mMol/L, Potassium 4.2 mMol/L, Chloride 104 mMol/L, Bicarbonate 25 mMol/L, AGAP 10.0 mMol/L, Glucose 50 mg/dL, BUN 7 mg/dL; Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.3 mg/dL, Adjusted calcium 8.9 mg/dL, Albumin 4.5 g/dL, Total bilirubin 0.9 mg/dL, Alk Phos 63 U/L, ALT 16 U/L, AST 18 U/L, LDH 201 U/L; WBC 5.37 x10^3/cmm, RBC 4.54 x10^6/cmm, Hgb 11.9 g/dL, Hct 35%, Platelet 305.9 x10^3/cmm, Neutrophils 41%, Absolute neutrophils 2.20 x10^3/cmm, Lymphocytes 42%. (10F 65, 67)

Citation: 10F 65-67

2023-10-17 | Unknown Facility / Collins, Sarah E MD

Summary: Hospitalized for a sickle-cell vaso-occlusive pain crisis requiring inpatient opioid patient-controlled analgesia. Hydromorphone PCA initiated with a 2 mg loading dose, 0.3 mg demand dose, 15-minute lockout, hourly limit ~1 mg (max 1.2 mg), and no continuous infusion.

Diagnoses: Sickle-cell crisis

Medications: Diluent for Premix PCA 30 mL with hydromorphone additive PCA 30 mg; loading dose 2 mg, PCA dose 0.3 mg, lockout interval 15 min, hour limit 1, continuous dose 0. Diluent for Premix PCA 30 mL with Hydromorphone PCA 30 mg; PCA settings listed: loading dose 2 mg, PCA dose 0.3 mg, lockout 15 min, hourly limit 1 mg, max limit 1.2 mg, continuous dose 0 mg. (18F 18; 2F 10)

Citation: 18F 18; 2F 10

2023-10-18 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient with sickle cell disease presenting for management of a sickle cell crisis; education provided about disease plan, hydroxyurea, nutrition, and pain management, and naloxone ordered as opioid rescue criteria with Adakveo infusion scheduled. Labs on 10/03/2023 showed stable renal function and electrolytes, hemoglobin 12.4 g/dL with reticulocyte 2.4% and occasional schistocytes/NRBCs consistent with ongoing hemolysis but no acute renal or metabolic derangement.

Diagnoses: Sickle cell disease, Sickle cell crisis

Laboratory Results: 10/03/2023 10:26 CDT — BMP: Sodium 136 mmol/L, Potassium 4.3 mmol/L, Chloride 103 mmol/L, Bicarbonate 25 mmol/L, Glucose 76 mg/dL, BUN 11 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73 m2, Calcium 9.5 mg/dL, Albumin 4.7 g/dL. CBC: WBC 5.51 x10^3/cmm, Hgb 12.4 g/dL, Hct 37%, Platelets 281.7 x10^3/cmm. 10/03/2023 10:26 CDT — CBC/morphology: Eosinophils 1%, Basophils 0%, NRBC 1/100 WBC; Micro 1+, Anisocytosis 1+, Ovalocytes Rare, Target Cell Rare. Red cell morphology and retics: Tear Cell Rare, Schistocyte Occasional, Burr Cells Rare; Reticulocyte 2.4%, Retic Absolute 0.1186 x10^6/cmm, RBC Retic 4.98 x10^6/cmm. (10F 76-77)

Subjective: Patient education provided; reported education topics included disease plan of care, hydroxyurea mechanism and indication, nutrition education, and pain management. (10F 74)

Medications: Naloxone 0.4 mg/mL injectable solution; 0.2 mg (0.5 mL) IV every 5 minutes PRN, up to 3 doses (stop date/time listed). Naloxone 4 mg nasal spray as prescribed. Baclofen 5 mg oral tablet TID. Hydroxyurea 500 mg capsule daily. Ibuprofen 800 mg oral tablet TID. Morphine 15 mg oral tablet every 4 hours PRN. (2F 13; 10F 74)

Assessment and Plan: Medication order for naloxone for sickle cell crisis with administration criteria: give for respiratory rate <6 or RASS -3. Care and plan discussed and agreed upon by covering physician. Next Adakveo infusion scheduled for Nov 13 with clinic visit on Nov 21. Clinical diagnosis: sickle cell disease; labs reviewed on 10/03/2023. (2F 13; 10F 74, 76)

Citation: 2F 13; 10F 74-79

2023-11-06 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Psychiatric assessment completed with symptom questionnaires showing prominent anxiety, depressed mood, obsessive-compulsive symptoms, and oppositional/defiant behaviors reported for several hours daily. Findings indicate clinically significant symptoms across anxiety, mood, OCD, and behavioral domains warranting further evaluation and treatment planning.

Diagnoses: Anxiety disorder, unspecified, Depressive disorder, unspecified, Obsessive-compulsive disorder (OCD), Oppositional defiant disorder (ODD)

Subjective: Patient completed symptom questionnaires endorsing anxiety, depressed mood, OCD symptoms, and ODD behaviors; reported several hours per day symptom duration. (6F 9)

Citation: 6F 9

2023-11-07 | Behavioral Neuropsychology Associates LLC / Harrison, Richard B PhD

Summary: Psychological testing showed low-average general intellectual functioning (FSIQ 84) with severe auditory inattention, visual vigilance deficits, and moderate impulsivity, supporting clinically significant ADHD predominantly inattentive type and longstanding specific learning disorders that cause marked academic and occupational impairment. The evaluation also documents stuttering, insomnia, anxiety and adjustment-related depressive features, recommends accommodations and vocational rehabilitation supports, and notes medical comorbidities including sickle cell disease with prior splenectomy and related complications.

Diagnoses: ADHD, predominantly inattentive presentation, Specific Learning Disorders (reading fluency, written expression, and mathematics), Childhood-Onset Fluency Disorder (stuttering), Generalized Anxiety Disorder, Adjustment Disorder with mixed anxiety and depressed mood, Insomnia Disorder, Low-average intellectual functioning (Full Scale IQ 84), Sickle cell disease (post-splenectomy), Avascular necrosis (related to sickle cell disease), Sickle cell retinopathy, left eye, Chronic pain, Vision impairment (congenital cataracts)

Procedures: History of splenectomy. (15F 3)

Functional Assessment: Endorsed significant impairment from ADHD and learning difficulties affecting academic and occupational functioning. | Provider recommended vocational rehabilitation supports and accommodations including 1.5x test time, distraction-reduced testing environment, preferential seating, use of a note-taker/technology, tutoring, job readiness training, and job coaching. | Will require supervision for executive functioning and assistance with housing stability; condition described as chronic. | Marked limitations documented: deficits in remembering work-like procedures, understanding and carrying out short/simple instructions, maintaining attention and regular attendance, working with others, handling work stress, and awareness of hazards; multiple items rated as seriously limited or unable to meet competitive standards. (24F 1, 3; 25F 2, 4-6; 7F 1; 15F 3-4, 7; 12F 2; 4F 9)

Objective: 29-year-old, right-handed, clean and neatly groomed, alert and oriented, cooperative, stuttering, neutral affect with dull mood, passive presentation, and reported low motivation. Psychological testing (WAIS-IV) indices: Verbal

Comprehension 87, Perceptual Reasoning 84, Working Memory 89, Processing Speed 89, Full-Scale IQ 84, General Ability Index 83. Testing demonstrated visual vigilance deficit, severe auditory inattentiveness, and moderate impulsivity to auditory stimuli. Findings indicate low-average general intellectual functioning with commensurate written expression and mathematical functioning, and confirm symptoms of ADHD, stuttering, and insomnia while not confirming ASD. Barkley Adult ADHD Rating Scale–IV percentiles reported for childhood and current symptoms (inattention, hyperactive-impulsive, total) from self-report and third-party informants. (24F 1-4; 25F 2; 7F 1; 15F 3-5; 12F 2-3; 4F 9)

Subjective: Reported history of specific learning disorders in all academic areas, childhood ADHD, anxiety and depression beginning in adolescence, stuttering, sickle cell disease, and insomnia; referred for psychological evaluation. Endorsed four symptoms of Autism Spectrum Disorder but denied most hallmark ASD symptoms. Self-report and informant reports documented clinically significant inattention and hyperactivity-impulsivity beginning prior to age 12 and persisting presently. Spouse indicated he does not exhibit symptoms consistent with high-functioning ASD and reported overall low-average adaptive behavior functioning. Reported follow-up visits since 10/24 (1–2 months), attended appointments, and was compliant with treatment. (24F 1-3; 25F 2-3, 5; 7F 1; 15F 3-4)

Medications: Qelbree; hydroxyurea; ibuprofen; cyclobenzaprine; Wellbutrin 100 mg HS; Risperidone 2 mg BID; Trazodone 100 mg HS PRN; Buspirone 5 mg BID PRN. (24F 1; 25F 2)

Assessment and Plan: Psychological evaluation indicating adjustment-related depression, generalized anxiety features, ADHD inattentive symptoms, and longstanding specific learning disorders with stuttering. Testing considered reliable and valid and documents clinically significant ADHD symptoms, low-average intellectual functioning, academic skill weaknesses, and severe cognitive/executive impairment with functional impact. Recommendations: accommodations, vocational rehabilitation, social/adaptive skills training, and speech therapy. Continue current medications and follow-up care as indicated. (24F 1-3; 25F 2, 5-6; 7F 1; 15F 3-5, 7; 12F 2-3; 4F 9)

Citation: 24F 1-6; 25F 1-6; 7F 1; 15F 3-8; 12F 1-3; 4F 9; 6F 1-3

2023-11-16 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Patient followed for medication management of ADHD and anxiety; ADHD symptoms have improved but continue to impair attention and executive function per symptom questionnaire. Recent dose escalation of viloxazine (Qelbree) caused significant side effects (excessive fatigue/carefreeness, decreased motivation, headache, decreased appetite, flattened affect), prompting reduction to 100–200 mg nightly, and patient had a sickle cell crisis about 3 weeks ago.}

Diagnoses: Attention-deficit hyperactivity disorder, Anxiety, Sickle cell disease

Functional Assessment: The patient appears to be compliant with the current stimulant medication plan; no specific work limitations documented. (8F 11)

Subjective: The claimant reported ADHD symptoms have improved but continue to negatively affect attention and executive function. The claimant reported anxiety symptoms and presented for medication management and follow-up. The claimant reported a sickle cell crisis approximately 3 weeks ago triggered by a clinic trial. The claimant described medication side effects including headache, decreased appetite, flattened affect, decreased motivation and excessive fatigue/carefreeness when dose increased. The claimant completed an ADHD symptom and side-effect questionnaire/checklist on 11/16/23, endorsing ongoing ADHD symptoms, multiple symptom ratings and side-effect items; the form also noted medication as at goal. (8F 11, 16; 6F 5, 10)

Medications: Qelbree 200 mg started; prior trial increase to 400 mg caused excessive fatigue, carefreeness and decreased motivation. Qelbree 100 mg capsule ER 1 nightly for 30 days. Qelbree 200 mg capsule listed at 1-2 daily on various dates. Focalin XR 20 mg capsule 1 daily. Intuniv ER 1 mg tablet 1 daily for 30 days. Hydroxyurea 500 mg capsule (listed). (8F 11; 6F 4-5)

Assessment and Plan: Ongoing medication management for ADHD with Qelbree, monitoring symptoms and side effects after recent dose adjustments and a prior trial increase to 400 mg that caused excessive fatigue and decreased motivation. Follow-up planned per clinic protocol after ADHD symptom review and questionnaire indicating ongoing symptoms despite improvement. (8F 11, 16; 6F 5)

Citation: 8F 11, 16; 6F 4-5, 10

2023-11-20 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Provider adjusted psychiatric medications for executive function concerns, reducing Qelbree 100 mg and adding Intuniv (guanfacine) 1 mg daily while continuing Qelbree 200 mg ER BID previously completed/changed. They discussed avoiding stimulants because of sickle cell disease and planned follow-up in one month for reassessment.

Diagnoses: Executive function disorder, Sickle cell disease

Medications: Qelbree 200 mg capsule ER 2 daily x30 days (completed); Qelbree 100 mg capsule ER 1 nightly x30 days; Intuniv ER 1 mg tablet 1 daily x30 days. (6F 8)

Assessment and Plan: Decrease Qelbree 100 mg and add Intuniv ER 1 mg for executive function concerns; discussed stimulant concerns due to sickle cell and plan follow-up in 1 month. (6F 8)

Citation: 6F 8

2023-11-20 | Pinnacle Behavioral Health Hoover / Wagner, Jennifer

Summary: Evaluation documents longstanding ADHD symptoms (ASRS 6/11) with functional impairment at school, work, and home and reports that current medication does not last the full day; claimant also endorses increased anxiety, depressed mood, OCD and ODD symptoms per questionnaires. Notable medical history includes prior splenectomy for sickle cell disease and a resting pulse of 54 bpm; plan centers on medication management and follow-up for ADHD and comorbid psychiatric symptoms.

Diagnoses: Attention-deficit/hyperactivity disorder (ADHD), Generalized anxiety disorder (anxiety), Depression, Obsessive-compulsive disorder (OCD), Oppositional defiant disorder (ODD), Sickle cell disease

Procedures: Prior splenectomy listed in surgical history. (6F 22)

Functional Assessment: Problems completing work, executive function deficits, behavior and relationship problems, low frustration tolerance, and significant time management issues. (6F 20)

Objective: GAD-7 and PHQ-9 questionnaires completed with scores recorded on the form. ASRS score 6/11; documentation of problematic academic performance, difficulty completing work, executive function deficits, behavior problems, and anxiety/depressed mood. Vital signs: blood pressure 112/59 mmHg (left brachial, sitting), pulse 54 bpm (left radial, regular, normal quality). (6F 18, 20, 22)

Subjective: The claimant completed an ADHD symptom questionnaire and endorsed trouble sleeping, irritability, fatigue, anxiety, and episodes of rapid heartbeat; indicated concerns that medication does not last long enough / is not effective for the full day. The claimant reported increased anxiety, depressed mood, obsessive-compulsive symptoms, and oppositional defiant behaviors, noting these symptoms are occurring more often and lasting all day. The claimant reported symptom onset by middle school and endorsed inattentive and hyperactive/impulsive symptoms present for at least 6 months with functional problems at school, work, and home. The claimant denied prior formal ADHD diagnosis and denied current ADHD care. The claimant also denied sleep problems and daytime tiredness in another portion of the record. Prior participation in speech therapy was reported. (6F 16, 18, 20, 22)

Medications: Foxallin listed as current medication (handwritten), no dose recorded. Previous ADHD treatments listed: amphetamine, atomoxetine, bupropion. (6F 18, 20)

Assessment and Plan: Self-report ADHD symptom assessment completed; the claimant reports residual ADHD symptoms and that current medication does not last long enough, indicating follow-up or medication adjustment may be needed. Anxiety, depression, OCD, and ODD symptoms documented with questionnaire scores; plan for medication management and monitoring noted. Findings consistent with DSM-5 ADHD symptoms with functional impairment; treatment planning recommended. Provider reviewed past medical and surgical history and ROS; notes attached for the encounter. (6F 16, 18, 20, 22)

Citation: 6F 16, 18, 20, 22

2023-11-20 | Pinnacle Behavioral Health Hoover / Unknown Provider

Summary: Patient is compliant with stimulant therapy (Qelbree) and reports >75% improvement in anxiety and depression, but endorses marked worsening of inattention and hyperactivity/impulsivity on the ASRS consistent with ADHD, combined type not optimally controlled. Vitals and exam unremarkable; patient has sickle cell disease currently without crisis and is on hydroxyurea, and long-term medication therapy is documented.

Diagnoses: Attention-deficit hyperactivity disorder, combined type, Generalized Anxiety Disorder, Depression, Sickle-cell disease without crisis, Long-term (current) drug therapy

Procedures: Office O/P established, moderate complexity 30–39 minute encounter; brief emotional/behavioral assessment performed. (6F 7)

Objective: Vital signs: BP 132/84 mmHg, Pulse 68 regular, O2 99% on room air, Temperature 97.6 F. Review of systems: denied fatigue/weakness and denied dizziness; neurologic exam limited to reported headaches. General: appears stated age, well-nourished. Psychiatric: alert, cooperative, good eye contact, normal speech, euthymic mood, congruent affect, attention normal, no hyperactivity. Neurological: no tics or tremor. Cardiovascular: BP and HR within expected/normal limits. (6F 6-7)

Subjective: The claimant reported feeling too carefree with lack of motivation and headaches. The claimant appears compliant with the current stimulant medication plan and reports improvement in anxiety and depression of greater than 75%. The claimant endorsed frequent problems over the past 6 months with organization, remembering appointments, difficulty sustaining attention, fidgeting/restlessness, talking too much, interrupting, and finishing others' sentences; symptoms were marked as worsening. Adult ADHD Self-Report Scale (ASRS) completed, endorsing frequent problems with inattention and hyperactivity/impulsivity and marked worsening of symptoms. (6F 6, 11, 17)

Medications: Qelbree 200 mg capsule, extended release, 2 capsules by mouth daily; hydroxyurea 500 mg capsule. (6F 6)

Assessment and Plan: Anxiety and depression improved by greater than 75%; the claimant is compliant with the medication plan. ADHD, combined type, not optimally controlled; symptoms persistent/worsening per ASRS and require clinical

correlation. Generalized anxiety disorder. Sickle cell disease without crisis; on hydroxyurea. Long-term (current) drug therapy noted. (6F 6-7, 11)

Citation: 6F 6-7, 11, 17

2023-11-21 | Hematology Clinic / Douglas, Tanya L CRNP

Summary: Patient with HbS/Beta thalassemia and prior splenectomy presented for routine sickle cell follow-up with chronic pain; CBC shows mild anemia (Hgb 12.1 g/dL) with elevated RDW (19.3%) and reticulocyte count (2.6%) consistent with hemolysis, and hemoglobin electrophoresis demonstrating Hgb S 64.5%, Hgb F 13.7%, Hgb A2 5.4%. Patient declined further Adakveo after an infusion-related vaso-occlusive crisis, continues hydroxyurea and PRN pain regimen (ibuprofen, baclofen, morphine), naloxone prescribed, and is currently not working full time.

Diagnoses: HbS/Beta thalassemia, Chronic low back pain, Post-splenectomy status, History of splenic sequestration

Functional Assessment: Patient is no longer working full time and was laid off; not currently working or on a routine schedule. | No longer working full time; was laid off and does not have a regular work routine. | Follow-up in 3 months; no specific work restrictions documented. (3F 104; 10F 45, 48)

Laboratory Results: 11/21/2023 12:50 CST: Sodium 137 mmol/L; Potassium 4.8 mmol/L; Chloride 103 mmol/L; Bicarbonate 26 mmol/L; AGAP 8.0 mmol/L; Glucose 68 mg/dL (LOW); BUN 7 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.5 mg/dL (adjusted 9.0 mg/dL); Protein 7.4 g/dL; Albumin 4.6 g/dL; Bilirubin total 0.7 mg/dL; Alkaline phosphatase 66 U/L; ALT 11 U/L; AST 14 U/L; LDH 146 U/L; Vitamin D 25OH 15 ng/mL (LOW); Ferritin 18.0 ng/mL (LOW). Hemoglobin electrophoresis: Hgb A 16.4% (LOW), Hgb F 13.7% (HIGH), Hgb S 64.5%, Hgb A2 5.4% (HIGH). Urine protein 4 mg/dL. Urine drug screen negative for amphetamines, barbiturates, benzodiazepines, buprenorphine, cannabinoids, cocaine, fentanyl, heroin, hydrocodone, methadone, opiates, oxycodone. (3F 106-107; 10F 47-48)

Objective: Review of systems largely negative; no fever, no visual changes, nasal congestion only. Vitals: Temp 98.1 F, HR 59 bpm, SpO2 99%, BP 121/74 mmHg, MAP 90 mmHg, pain 4/10, weight 185.5 lb, height 73 in. Exam: alert and oriented x4, no acute distress, lungs clear to auscultation, heart regular rate and rhythm, non-tender abdomen, moves all extremities, speech stutter noted, mood and affect appropriate. Clinic CBC/retic panel shows mild anemia with Hgb 12.1 g/dL, Hct 36%, MCV 76 fL, MCH 26 pg, RDW 19.3% high, reticulocyte 2.6% high; WBC 5.18 x10^3/cmm, RBC 4.74 x10^6/cmm, platelets 255.1 x10^3/cmm. (3F 104-105, 107; 10F 45-46, 48)

Subjective: The claimant reports HbS/Beta thalassemia with prior splenectomy and history of splenic sequestration; started Adakveo but had a crisis after the second infusion and declines further Adakveo infusions. Endorses chronic low back pain, rates pain today 4/10, previously tried gabapentin which caused memory loss, currently takes ibuprofen and morphine. Psychiatric review: denies anxiety and depression. Endorsed routine follow-up care and transition plan items and wishes to discontinue Adakveo. (3F 104-105, 107; 10F 45, 48)

Medications: Hydroxyurea 500 mg PO daily (documented as one capsule/one tab daily and continued); Ibuprofen 800 mg PO TID (also documented as PRN q8h for mild pain); Morphine 15 mg PO every 4 hours as needed for crisis/severe pain; Baclofen 5 mg PO TID (also documented as PRN q8h); Naloxone 4 mg nasal once. (3F 104-105, 107; 10F 45-46, 48)

Assessment and Plan: Sickle cell disease (HbS/Beta thalassemia) with chronic pain and prior splenectomy/splenic sequestration; mild anemia with evidence of hemolysis (elevated RDW and reticulocyte count) and hemoglobin electrophoresis consistent with HbS/Beta thalassemia (Hgb S 64.5%, Hgb F 13.7%, Hgb A2 5.4%). Continue hydroxyurea, hydration and pain action plan, continue outpatient pain regimen (ibuprofen, baclofen, morphine PRN), naloxone prescribed, patient counseled regarding infusion-related VOC pain and declines further Adakveo infusions. Plan: routine sickle cell clinic care and follow-up in 3 months. (3F 104, 107; 10F 45-46, 48)

Citation: 3F 104-107; 10F 45-48

2023-11-21 | Unknown Facility / Chakraborty, Priya MD

Summary: Labs show iron-deficiency microcytic anemia (low MCV, low ferritin) with reticulocytosis and a hemoglobinopathy pattern consistent with sickle cell/beta-thalassemia (predominant HbS, elevated HbF and HbA2). Additional findings include vitamin D deficiency (25-OH 15 ng/mL) and mildly-to-moderately increased urine protein/albumin (calculated protein/creatinine ~49 mg/g); basic metabolic and liver tests otherwise unremarkable and urine drug screen negative.

Diagnoses: Iron-deficiency microcytic anemia, Hemoglobinopathy consistent with sickle cell/beta-thalassemia (HbS 64.5%, HbA 16.4%, HbF 13.7%, HbA2 5.4%), Vitamin D deficiency (25-OH 15 ng/mL), Moderately increased urine albumin/protein (calculated urine protein/creatinine ~49 mg/g)

Laboratory Results: Collected 11/21/2023 12:50 CST: Bilirubin total 0.7 mg/dL, Bilirubin direct 0.2 mg/dL; Alkaline phosphatase 66 U/L; ALT 11 U/L; AST 14 U/L; LDH 146 U/L; Vitamin D 25-OH 15 ng/mL (deficient); Ferritin 18.0 ng/mL (low); Hemoglobin A 16.4%, Hemoglobin F 13.7% (high), Hemoglobin S 64.5%, Hemoglobin A2 5.4% (high); Urine albumin <7.0 mg/L; Urine protein random 4 mg/dL; Calculated urine protein/creatinine 49.4; Urine creatinine 81 mg/dL; Urine drug screen negative for amphetamines, barbiturates, benzodiazepines, buprenorphine, cannabinoids, cocaine metabolites, fentanyl, heroin, hydrocodone, methadone, oxycodone, opiates (cutoffs: amphetamines 500 ng/mL; barbiturates/benzodiazepines 200

ng/mL; buprenorphine 5 ng/mL); WBC 5.18 x10^3/µL; RBC 4.74 x10^6/µL; Hemoglobin 12.1 g/dL; Hematocrit 36%; MCV 76 fL (low); MCH 26 pg (low); MCHC 34 g/dL; Platelets 255.1 x10^3/cmm; RDW 19.3% (high); MPV 8 fL; Neutrophils 38%, Absolute neutrophils 1.97 x10^3/cmm; Lymphocytes 46%, Absolute lymphocytes 2.38 x10^3/cmm; Monocytes 10%; Eosinophils 3%; Basophils 2%; Reticulocyte 2.6% (high), Retic absolute 0.1205 x10^6/cmm, RBC retic 4.56 x10^6/cmm. Interpretive ranges provided: Vitamin D 25-OH — deficient <20 ng/mL, insufficient 20-<30 ng/mL, sufficient 30-100 ng/mL; Albumin-to-creatinine ratio (ACR) — A1 <30 mg/g, A2 30-300 mg/g, A3 >300 mg/g. (3F 109-111; 10F 50-52)

Citation: 3F 109-111; 10F 50-52

2023-12-14 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Patient presented for ADHD medication follow-up with only partial symptom improvement, reporting morning sluggishness, low motivation, and limited improvement in focus. Intuniv ER was discontinued after adverse effects, atomoxetine previously caused tachycardia, Qelbree dose was decreased and Focalin XR is on board; neuropsychological results will be added to the chart and medication management/follow-up planned (patient has comorbid sickle cell disease on hydroxyurea).

Diagnoses: Attention-deficit/hyperactivity disorder (ADHD), Sickle cell disease

Subjective: Patient reported stopping Intuniv ER due to adverse effects, has history of sickle cell, previously tried Strattera which caused tachycardia, and brings neuropsychologist results; reports continued morning sluggishness, low motivation and limited improvement in focus. (8F 7)

Medications: Medication list includes Strattera 25 mg capsule 1 daily, Qelbree 100 mg capsule nightly, hydroxyurea 500 mg capsule, Intuniv ER 1 mg tablet (discontinued), and Focalin XR 20 mg capsule. Intuniv ER was added then stopped after 2 weeks; Qelbree dose was decreased; history of Strattera use with tachycardia. (8F 6-7)

Assessment and Plan: Medication management for ADHD with partial symptom improvement; plan documented medication changes and follow-up, add results to chart. (8F 7)

Citation: 8F 6-7

2024-01-02 | Faith Community Health Clinic / Unknown Provider

Summary: Patient completed PHQ-9 and endorsed multiple depressive symptoms over the past 2 weeks; total score was 14, consistent with moderate depression. Follow-up and further evaluation were recommended to assess treatment needs and safety.

Diagnoses: Depression

Subjective: Completed PHQ-9 screening and endorsed multiple depressive symptoms over the past 2 weeks. (22F 42)

Assessment and Plan: PHQ-9 total score 14 consistent with moderate depression; follow-up and further evaluation recommended. (22F 42)

Citation: 22F 42-43

2024-01-30 | Unknown Facility / Carson, Mitchell PA-C

Summary: 29-year-old man with HbS/β-thalassemia presented with 2–3 days of vaso-occlusive pain in the lower back, arms, and legs and was treated in infusion with IV fluids, IV Dilaudid (with PCA loading) and IV ketorolac with pain reduced to a tolerable level. Labs showed mild microcytic anemia (Hgb 12.3 g/dL, MCV 76 fL) with elevated RDW and reticulocyte count, consistent with his hemoglobinopathy and recent hemolysis; discharged with outpatient hydroxyurea, oral analgesics, and follow-up.

Diagnoses: HbS/Beta thalassemia, Vaso-occlusive crisis, History of splenectomy

Procedures: Sickle cell infusion visit with IV fluids and IV analgesia: D5W 500 mL IV infused over 4 hours; IV Dilaudid bolus with PCA loading/placement; Toradol 15 mg IV x1 administered. (3F 49, 52; 10F 39, 42)

Laboratory Results: 1/30/2024 08:01 CST: Sodium 140 mmol/L, Potassium 4.0 mmol/L, Chloride 109 mmol/L (high), Bicarbonate 23 mmol/L, Glucose 71 mg/dL, BUN 8 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 8.8 mg/dL, Albumin 4.2 g/dL. CBC: Hgb 12.3 g/dL (low), Hct 36% (low), MCV 76 fL (low), MCH 26 pg (low), RDW 19.4% (high), WBC 6.54 x10^3/µL, Platelets 327 x10^3/µL, Reticulocyte 2.7% (high). (3F 51; 10F 41)

Objective: Vitals: HR 62–64 bpm, RR 12–16 br/min, BP 115/70 and 128/75 mmHg, SpO2 97–99%, Temp 97.7°F. General: alert and oriented, no acute distress. HEENT: moist oral mucosa, extraocular movements intact. Cardiac: normal rate and rhythm. Lungs: clear to auscultation. Abdomen: soft, non-tender. Musculoskeletal: normal range of motion with reported pain in arms, legs, and lower back. Neurologic/cognition: speech with stutter. Psychiatric: cooperative, appropriate mood and affect. Treatments given in ED/infusion visit included Dilaudid bolus with PCA loading dose, Toradol 15 mg IV x1, and D5W 500 mL IV infused over 4 hours. Pain reduced to a tolerable level on reassessment. (3F 50, 52; 10F 40-42)

Subjective: The claimant is a 29-year-old male with sickle cell disease presenting with 2–3 days of vaso-occlusive (VOC) pain in the lower back, arms, and legs similar to prior episodes, worse with colder weather. He reports minimal relief from ibuprofen and morphine taken the prior night, denies chest pain, tachycardia, shortness of breath, cough, congestion, abdominal pain, nausea/vomiting/diarrhea, dizziness, or visual changes. The claimant documents ongoing disease treatment with hydroxyurea and has received prior treatment in the infusion unit; he reported improvement after an infusion previously but declined ongoing infusion therapy at that time. (3F 49-50, 52; 10F 39-40, 42-43)

Medications: Hydroxyurea 500 mg capsule, 1 cap (1 tablet/capsule stated as HU 1 cap daily). Ibuprofen 800 mg oral tablet, 1 tab TID. Morphine 15 mg oral tablet, 1 tab every 4 hours PRN for pain. Baclofen 5 mg oral tablet, 1 tab TID. Naloxone 4 mg/0.1 mL nasal spray, once each nare (listed as naloxone 4 mg nasal once). Toradol 15 mg IV x1. Instructions: continue hydroxyurea (HU 1 cap daily), use morphine 15 mg every 4 hours PRN for severe pain, ibuprofen and baclofen for mild pain. (3F 49-50, 52-53; 10F 39-40, 42-43)

Assessment and Plan: Sickle cell vaso-occlusive crisis treated with IV fluids and IV opioids (Dilaudid bolus with PCA load) and Toradol 15 mg IV; pain improved to a tolerable level. No acute distress on exam; musculoskeletal pain in arms, legs, and lower back noted. Continue current outpatient medications and hydration; instructed to use oral pain medications at home. Teaching evaluation completed; plan of care discussed with covering physician who agrees. Follow-up in clinic on 02/20/2024. (3F 49-50, 52-53; 10F 39, 42-43)

Citation: 3F 49-54; 10F 39-44

2024-01-30 | Unknown Facility / Douglas, Tanya L CRNP

Summary: Basic metabolic panel and chemistries collected 11/21/2023 were within reference limits (Na 137, K 4.8, Cl 103, HCO3 26, AGAP 8, Glucose 68, BUN 7, Cr 1.0, eGFR >90, Ca 9.5, albumin 4.6). Patient and spouse received education and acknowledged understanding of the disease plan of care including hydroxyurea mechanism/indication, nutrition counseling, and pain management.

Laboratory Results: 11/21/2023 collected: Sodium 137 mmol/L; Potassium 4.8 mmol/L; Chloride 103 mmol/L; Bicarbonate 26 mmol/L; AGAP 8.0 mmol/L; Glucose 68 mg/dL; BUN 7 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.5 mg/dL; Adjusted calcium 9.0 mg/dL; Protein 7.4 g/dL; Albumin 4.6 g/dL. Sodium 137 mmol/L, Potassium 4.8 mmol/L, Chloride 103 mmol/L, Bicarbonate 26 mMol/L, AGAP 8.0 mMol/L, Glucose 68 mg/dL, BUN 7 mg/dL; Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.5 mg/dL, Adjusted Calcium 9.0 mg/dL, Protein 7.4 g/dL, Albumin 4.6 g/dL. (3F 108; 10F 49)

Assessment and Plan: Patient education provided regarding disease plan of care, hydroxyurea mechanism/indication, nutrition education, and pain management; patient and spouse taught and acknowledged understanding. (3F 108)

Citation: 3F 108; 10F 49

2024-02-20 | Hematology Clinic / Douglas, Tanya L CRNP

Summary: Patient with HbS/beta thalassemia presented for routine sickle cell follow-up after a vaso-occlusive crisis with upper back/shoulder pain; he remains on hydroxyurea, declined restarting Adakveo due to prior infusion reaction, and uses home opioids with a negative urine drug screen. Labs show mild microcytic anemia (Hgb 12.0 g/dL, MCV 76 fL) with reticulocytosis and elevated Hgb F, low ferritin (24 ng/mL) and low vitamin D (12 ng/mL).

Diagnoses: Sickle cell disease (HbS/beta thalassemia), Chronic low back pain

Functional Assessment: Patient stated he is working on getting disability. | Patient is working on obtaining disability; no other specific lifting/sitting/standing limits documented. (3F 142; 10F 24)

Laboratory Results: 02/20/2024 comprehensive labs: Sodium 136 mmol/L, Potassium 4.3 mmol/L, Chloride 103 mmol/L, Bicarbonate 25 mmol/L, Glucose 98 mg/dL, BUN 11 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.4 mg/dL, Albumin 4.5 g/dL, Alk Phos 74 U/L, ALT 12 U/L, AST 15 U/L, LDH 175 U/L, Vitamin D 25OH 12 ng/mL (low), Ferritin 24 ng/mL, Hgb A 16.1% (low), Hgb F 13.6% (high). CBC: WBC 5.17 x10^3/cmm, RBC 4.58 x10^6/cmm, Hgb 12.0 g/dL (low), Hct 35% (low), MCV 76 fL (low), MCH 26 pg (low), Platelets 267.2 x10^3/cmm, RDW 19.0% (high), Absolute neutrophils 2.22 x10^3/cmm, Absolute lymphocytes 2.27 x10^3/cmm, Reticulocyte 2.5% (high), Retic absolute 0.1151 x10^6/cmm (RBC Retic 4.55 x10^6/cmm reported in one source). (3F 144-145; 10F 26-27)

Objective: Review of systems: no fever, no sweats, no weakness, no visual disturbances, nasal congestion, no cough. Vitals: weight 172.2 lb, temperature 98.7 F, heart rate 69 bpm, blood pressure 129/78 mmHg, SpO2 97%. Exam: alert and oriented x4, no acute distress, lungs clear to auscultation, non-tender abdomen, moves all extremities well, neck supple. Urine drug screen negative for amphetamines, barbiturates, benzodiazepines, buprenorphine, cannabinoids, cocaine, fentanyl, heroin, hydrocodone, methadone, opiates, and oxycodone. (3F 142-143, 145; 10F 24-26)

Subjective: The claimant reported doing fair and that he experienced a crisis yesterday with upper back and shoulder pain; he used home pain medications, stated morphine is not as helpful, and declined restarting Adakveo after a prior infusion reaction. The claimant reported chronic lower back pain, has HbS/Beta Thalassemia, and is working on obtaining disability. (3F 142-143; 10F 24-25)

Medications: Hydroxyurea 500 mg PO daily (hydroxyurea one tab daily reported adherent); ibuprofen 800 mg PO TID; morphine 15 mg PO every 4 hours PRN for pain; baclofen 5 mg PO TID; naloxone 4 mg intranasal spray once. (3F 142-143; 10F 24-25)

Assessment and Plan: Sickle cell disease/HbS-Beta Thalassemia with recent vaso-occlusive crisis (upper back and shoulder pain yesterday); continue hydroxyurea and current pain regimen. The claimant declines restarting Adakveo after prior infusion reaction. Transition care completed (transition policy, updated care and emergency plans, self-assessment done). Chronic lower back pain (musculoskeletal). Follow-up in clinic as needed; PCP not due and no subspecialist referrals at this time. (3F 142, 145; 10F 24-25, 27)

Citation: 3F 142-145; 10F 24-27

2024-02-20 | Unknown Facility / Chakraborty, Priya MD

Summary: Lab work showed low ferritin (24 ng/mL) consistent with iron depletion despite near-normal hemoglobin (12.0 g/dL) and hematocrit (35%). Urine albumin/creatinine and protein/creatinine ratios were within reference ranges and a comprehensive urine drug screen was negative.

Diagnoses: Low ferritin indicating iron depletion (ferritin 24 ng/mL)

Laboratory Results: Ferritin 24.0 ng/mL; Hemoglobin 12.0 g/dL, Hct 35%; WBC 5.17 x10^3/cmm, RBC 4.58 x10^6/cmm; urine albumin 7.3 mg/L, calculated U Alb/Creat 9.4, U Prot Random 4 mg/dL, calculated U Prot/Creat 51.3, U Creatinine 78 mg/dL; comprehensive urine drug screen negative for amphetamines, barbiturates, benzodiazepines, buprenorphine, cannabinoids, cocaine, fentanyl, heroin, hydrocodone, methadone, opiates, oxycodone. Abs. neutrophils 2.22 x10^3/cmm; lymphocytes 44%; absolute lymphocytes 2.27 x10^3/cmm; monocytes 9%; eosinophils 2%; basophils 2%; reticulocyte 2.5%; retic absolute 0.1151 x10^6/cmm; RBC retic 4.55 x10^6/cmm. Interpretive ranges: VitD 25OH: Deficient <20 ng/mL, Insufficient 20-<30 ng/mL, Sufficient 30-100 ng/mL; ACR and P/C ratio reference ranges provided. Urine drug screen cutoffs: Amphetamines 500 ng/mL, Barbiturates/Benzodiazepines 200 ng/mL, Buprenorphine 5 ng/mL, Cannabin 50 ng/mL. (3F 148-150)

Citation: 3F 148-150

2024-02-26 | Unknown Facility / Douglas, Tanya L CRNP

Summary: Patient with HbS/Beta thalassemia status post splenectomy reports recurrent vaso-occlusive pain crises, has stopped Adakveo and prefers hydrocodone/acetaminophen for breakthrough pain; ongoing hydroxyurea was continued. Labs notable for hemoglobin 12.0 g/dL, reticulocyte 2.5%, and vitamin D deficiency (25-OH vitamin D 12 ng/mL); plan: start weekly ergocalciferol, maintain hydration and pain action plan, follow up in 3 months.

Diagnoses: HbS/Beta thalassemia, History of splenectomy/splenic sequestration, Vitamin D deficiency

Laboratory Results: 2/20/2024 labs: Sodium 136 mmol/L; Potassium 4.3 mmol/L; Chloride 103 mmol/L; Bicarbonate 25 mmol/L; AGAP 8.0 mmol/L; Glucose 98 mg/dL; BUN 11 mg/dL; Creatinine 0.9 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.4 mg/dL; Adjusted calcium 9.0 mg/dL; Protein 7.3 g/dL; Albumin 4.5 g/dL; Bilirubin total 0.8 mg/dL; Bilirubin direct 0.2 mg/dL; Alk Phos 74 U/L; ALT 12 U/L; AST 15 U/L; LDH 175 U/L; Vit D 25OH 12 ng/mL; Ferritin 24.0 ng/mL. CBC: Hemoglobin 12.0 g/dL; Hematocrit 35%; WBC 5.17 x10^3/cmm; RBC 4.58 x10^6/cmm; MCV 76 fL; MCH 26 pg; MCHC 35 g/dL; Absolute neutrophils 2.22 x10^3/cmm; Lymphocytes 44% (Absolute lymphocytes 2.27 x10^3/cmm); Monocytes 9%; Eosinophils 2%; Basophils 2%; Reticulocyte 2.5% (Retic absolute 0.1151 x10^6/cmm; RBC retic 4.55 x10^6/cmm). Urine: albumin/creatinine ~9.4 mg/g; urine protein random 4 mg/dL. Multiple urine drug screens negative. (3F 147; 10F 29-32)

Subjective: The claimant with HbS/Beta Thalassemia and history of splenic sequestration status post splenectomy reports having crisis pain. The claimant stopped Adakveo, states he has morphine for crisis pain but prefers hydrocodone-acetaminophen (Norco) which helped more than morphine, and is no longer receiving Adakveo. (3F 146; 10F 28)

Medications: Hydroxyurea 500 mg daily; hydrocodone-acetaminophen (Norco) 5 mg/325 mg every 4 hours PRN for severe pain; morphine 15 mg PRN; baclofen 5 mg TID; ibuprofen 800 mg TID; ergocalciferol (vitamin D) 50,000 IU (1.25 mg) capsule weekly; naloxone 4 mg nasal spray. (3F 146-147; 10F 28-29)

Assessment and Plan: Sickle cell disease care plan reviewed: continue hydroxyurea, maintain hydration, follow pain action plan, start weekly vitamin D supplements (ergocalciferol 50,000 IU weekly), and follow up in 3 months with Dr. Collins. (3F 146; 10F 28)

Citation: 3F 146-147; 10F 28-32

2024-03-08 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: The patient with known sickle cell disease presented 10–14 days after a COVID-19 diagnosis with cough, fatigue, myalgias and mild dyspnea; vital signs were normal (SpO2 100% RA) and CBC was unremarkable. Chest x-ray showed no acute cardiopulmonary disease; clinician provided reassurance, cough care instructions, and conservative management.

Diagnoses: Sickle cell-beta-thalassemia, Sickle cell hemoglobin SS disease, Attention deficit hyperactivity disorder, Degeneration of lumbar intervertebral disc, Chronic low back pain, Cough, COVID-19, Streptococcal pharyngitis

Imaging: Chest x-ray PA and lateral (03/08/2024): no active pulmonary disease, no cardiomegaly, no lymphadenopathy, no diaphragm abnormalities; study quality good. Chest x-ray was ordered (XR, CHEST, 2 VIEW) to rule out pneumonia. (9F 16, 68)

Laboratory Results: WBC 6.1 x10^3/µL; RBC 5.24 x10^6/µL; Hemoglobin 13.2 g/dL; Hematocrit 40.9%; Platelets 411 x10^3/µL; Absolute lymphocytes 3.6 x10^3/µL. (9F 68)

Objective: Height 6 ft (stated); weight 184 lbs with clothes; BMI 25. Vitals: BP 109/70 sitting, pulse 70 bpm regular, RR 17, O2 sat 100% on room air, oral temperature 98.7°F, pain scale 4. General: healthy-appearing, well-nourished, no acute distress, ambulating normally. Lungs: respiratory effort without dyspnea, percussion without dullness. HEENT and remainder of exam normal: normocephalic, tympanic membranes clear, extraocular movements intact, normal heart exam, abdomen soft, neurologic gait normal. (9F 12, 16)

Subjective: The claimant reported cough and endorsed new symptoms including fatigue, aches, and trouble breathing; denied fever, diarrhea, nasal congestion/runny nose, and rash. The claimant reported a COVID diagnosis two weeks ago, was prescribed paxlovid and amoxicillin, has been taking ibuprofen, reports strep-like symptoms, and about 10 days of ongoing symptoms. The claimant has a known history of sickle cell disease and follows with a sickle cell clinic. (9F 12, 15-16)

Medications: Atomoxetine 25 mg capsule daily; baclofen 5 mg TID; bupropion HCl SR 100 mg daily (with titration described); ergocalciferol (vitamin D2) 1,250 mcg weekly; fluticasone nasal spray 50 mcg, 2 sprays qAM; guanfacine ER 1 mg daily; hydrocodone/acetaminophen 5/325 mg PRN q4h; hydrocortisone 2.5% topical BID–TID; hydroxyurea 500 mg daily; ibuprofen 800 mg q6h PRN (patient reported taking ibuprofen); meloxicam 15 mg daily; morphine 15 mg q4h PRN; Qelbree 100 mg nightly (and 200 mg formulation noted). Paxlovid and amoxicillin were prescribed previously. (9F 13, 16)

Assessment and Plan: The claimant with sickle cell disease has cough and strep-like symptoms following a recent COVID diagnosis (~2 weeks prior) with approximately 10 days of ongoing symptoms including fatigue, aches, and dyspnea. Provider offered reassurance, provided cough care instructions, ordered chest x-ray to rule out pneumonia (no acute cardiopulmonary disease on imaging), and reviewed CBC results as documented. (9F 16, 68)

Citation: 9F 12-16, 68

2024-03-15 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient presented for ADHD follow-up and medication management requesting refills; current ADHD meds reviewed and continued (atomoxetine 25 mg daily, Qelbree 100 mg nightly) with plan for return office follow-up. Active comorbidities include sickle cell disorders and chronic low back pain with degenerative lumbar disc disease and multiple analgesics listed on the medication list.

Diagnoses: Attention deficit hyperactivity disorder, predominantly inattentive type, Sickle cell-beta-thalassemia, Sickle cell - hemoglobin SS disease, Degeneration of lumbar intervertebral disc, Chronic low back pain

Laboratory Results: STATUS COVID-19/FLU A-B ANTIGEN TST listed with date 02/22/24; no numeric results shown. (9F 50)

Subjective: Patient requested ongoing management of ADHD and medication refill; history and problems reviewed. (9F 49)

Medications: Atomoxetine 25 mg capsule - take 1 capsule every day by oral route; qty 30. Reviewed medications include atomoxetine 25 mg daily; baclofen 5 mg TID; ergocalciferol 1,250 mcg weekly; fluticasone propionate nasal spray 50 mcg two sprays each nostril daily; guanfacine ER 1 mg daily; hydrocodone/acetaminophen 5/325 mg PRN q4h; hydrocortisone 2.5% topical; hydroxyurea 500 mg daily; ibuprofen 800 mg PRN q6h; meloxicam 15 mg daily; morphine 15 mg PRN q4h; Qelbree 100 mg nightly. (9F 49-50)

Assessment and Plan: Attention deficit hyperactivity disorder, predominantly inattentive type documented with plan for return to office follow-up. (9F 49)

Citation: 9F 49-50

2024-04-01 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Patient with ADHD and two distinct sickle cell genotypes (HbS/β-thalassemia and HbSS) is maintained on hydroxyurea and multiple analgesics; chronic low back pain is attributed to lumbar intervertebral disc degeneration. Current meds include ADHD agents (atomoxetine, guanfacine, viloxazine), hydroxyurea, opioids and NSAIDs, baclofen, and weekly high-dose vitamin D.

Diagnoses: Attention deficit hyperactivity disorder, Sickle cell-beta-thalassemia, Sickle cell hemoglobin SS disease, Degeneration of lumbar intervertebral disc (chronic low back pain)

Medications: Reviewed medication list includes: atomoxetine 25 mg daily; baclofen 5 mg three times daily; ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) weekly; fluticasone propionate nasal spray 50 mcg, 2 sprays each nostril daily; guanfacine ER 1 mg daily; hydrocodone 5 mg/acetaminophen 325 mg as needed q4h; hydrocortisone 2.5% topical 2–4 times

daily; hydroxyurea 500 mg daily; ibuprofen 800 mg q6h as needed; meloxicam 15 mg daily; morphine 15 mg q4h as needed; Qelbree (viloxazine) 100 mg nightly/1 tablet daily. (9F 48)

Citation: 9F 47-48

2024-04-10 | Unknown Facility / Carson, Mitchell PA-C

Summary: The patient with HbS/β-thalassemia presented with 2 days of lower-back vaso-occlusive pain and was treated with IV fluids (D5W), IV hydromorphone PCA, and IV ketorolac with clinical improvement allowing discharge on oral analgesics and continuation of hydroxyurea. Point-of-care glucose was 59 mg/dL (corrected by eating); labs showed mild anemia (Hgb 12.3 g/dL) with microcytosis (MCV 76 fL), elevated RDW and reticulocyte count, and he was reassessed repeatedly with pain reduced to a tolerable level.

Diagnoses: Sickle cell disease with vaso-occlusive crisis, Post-splenectomy status

Procedures: D5W 500 mL infusion over 4 hours; IV Dilaudid 2 mg load with 0.3 mg q15 min PCA; Toradol 15 mg IV x1 dose. IV fluids and IV analgesia administered for sickle cell vaso-occlusive pain (infusion visit). (3F 36, 39; 10F 13, 16)

Laboratory Results: 4/10/2024 labs: Sodium 139 mmol/L; Potassium 4.0 mmol/L; Chloride 104 mmol/L; Bicarbonate 23 mmol/L; Anion gap 12 mmol/L; Glucose 59 mg/dL (LOW) (point-of-care glucose 59); BUN 12 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.0 mg/dL; Albumin 4.2 g/dL; ALT 10 U/L; AST 16 U/L; LDH 198 U/L; WBC 10.51 x10^3/cmm; RBC 4.64 x10^6/cmm; Hgb 12.3 g/dL (LOW); Hct 35% (LOW); MCV 76 fL (LOW); RDW 18.9% (HI); Reticulocyte 2.8% (HI); Platelet 362.9 x10^3/cmm. (3F 38-39; 10F 15-16, 20-21)

Objective: Review of systems negative except as in HPI. Genotype: HbS/Beta Thalassemia +. Vitals: 4/10/2024 12:21 – pulse 60 bpm, RR 14, SpO2 94%, BP 125/73 mmHg, pain score 6; 4/10/2024 9:30 – temp 97.8 F (temporal), HR 75, RR 16, SpO2 99%, BP 121/63 mmHg, weight 172 lb, height 73 in. Exam: alert and oriented, extraocular movements intact, normocephalic, moist oral mucosa, cardiovascular regular rate and rhythm without edema, lungs clear and non-labored, abdomen soft non-tender with normal bowel sounds, normal range of motion with focal lower back pain, integument warm and dry, neck supple, neurologic alert and oriented, cognition and speech noted stutter, psychiatric cooperative with appropriate mood and affect. The claimant was reassessed multiple times during infusion with pain reduced to a tolerable range for discharge on oral pain medications. (3F 36-39; 10F 13-16)

Subjective: The claimant reported 2 days of lower back vaso-occlusive pain similar to prior sickle cell pain, denied injury, chest pain, shortness of breath, wheezing, cough, congestion, or abdominal pain. He reported minimal relief with ibuprofen and morphine taken since last night. He felt a little nauseated and lightheaded and had not had time to eat prior to arrival; point-of-care glucose was 59 mg/dL, after which he was able to eat and had symptom improvement. He was able to eat after treatment in clinic. (3F 36, 39; 10F 13, 16)

Medications: Hydroxyurea 500 mg PO daily; Ibuprofen 800 mg PO TID; Morphine 15 mg PO every 4 hours PRN; Baclofen 5 mg PO TID; Ergocalciferol 1.25 mg (50,000 IU) PO weekly; Naloxone 4 mg nasal spray once; Hydrocodone-acetaminophen (Norco) 5 mg-325 mg 1 tab PO every 4 hours PRN. (3F 36-37, 39-41; 10F 13-14, 16-18)

Assessment and Plan: Sickle cell vaso-occlusive pain managed with IV fluids and analgesia with clinical improvement. Continue hydroxyurea and outpatient pain regimen. Discussed slowing infusion rate and adding diphenhydramine if needed. Advised hydration, rest, and use of PO pain medications. Follow-up with Dr. Collins on 05/22/2024. (3F 36, 39; 10F 13, 16)

Citation: 3F 36-42; 10F 13-21

2024-04-24 | Grandview Medicine / Unknown Provider

Summary: Patient with sickle cell disease complicated by sickle cell retinopathy is post-splenectomy (laparoscopic splenectomy 12/04/2019) and noted to be at risk for venous thromboembolus; patient presented with sleep concerns and significant work-related stress. No new procedures reported at this visit; key issues are asplenia with associated risks and current psychosocial symptoms affecting sleep.

Diagnoses: Attention deficit hyperactivity disorder (ADHD), At risk of venous thromboembolus, Post-splenectomy (asplenia), Sickle cell disease, Sickle cell retinopathy

Procedures: Procedure history: laparoscopic splenectomy and robotic surgical system procedures listed with procedure date 12/04/2019. Splenectomy on 12/04/2019. (3F 99-100)

Subjective: Patient reported sleeping concerns and feeling highly stressed related to work; employment noted as Grandview graduate working in IT for a security company. (3F 100)

Citation: 3F 99-100

2024-04-24 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Patient underwent a laparoscopic (robot-assisted) splenectomy on 12/04/2019 and is noted as post-splenectomy. History includes sickle cell disease with sickle cell retinopathy, ADHD, and documented risk for venous thromboembolism; patient reports sleep disturbances and significant work-related stress.

Diagnoses: ADHD, At risk of venous thromboembolism, Post-splenectomy status, Sickle cell disease, Sickle cell retinopathy

Procedures: Laparoscopic splenectomy (Procedure Date 12/04/2019) and robotic surgical system listed for same date. Splenectomy listed with procedure date 12/04/2019. (10F 3-4)

Subjective: Patient reported sleeping concerns and feeling highly stressed due to work; noted student and works in IT for a security company. (10F 4)

Citation: 10F 3-4

2024-04-29 | Pinnacle Behavioral Health Hoover / Riley, Amanda

Summary: Patient endorsed executive function concerns and discussion about stimulant therapy was deferred due to comorbid sickle cell disease and potential need for pain medications. Plan: decrease Qelbree (viloxazine) dose and start Intuniv ER (guanfacine) 1 mg daily, notify Dr. Nolan, and reassess stimulant consideration after Qelbree reduction.

Diagnoses: Executive function difficulties, Sickle cell disease

Subjective: Patient endorsed executive function concerns and discussion about adding stimulants; concerns raised about stimulants due to sickle cell disease and need for pain medication. (8F 14)

Medications: Decrease Qelbree 100 mg; Intuniv ER 1 mg daily added. (8F 14)

Assessment and Plan: Care plan: decrease Qelbree dose and start Intuniv ER 1 mg daily for executive function concerns; will notify Dr. Nolan and revisit stimulant consideration after Qelbree reduction. (8F 14)

Citation: 8F 14

2024-04-29 | Pinnacle Behavioral Health Hoover / Unknown Provider

Summary: Patient with ADHD, combined type currently controlled on medication with anxiety and depression improved >75%, but reports persistent decreased motivation and headaches and a history of intolerance to stimulants with prior failures of Intuniv ER and higher-dose Qelbree. Plan is continued medication management, portal monitoring, and follow-up in ~2 months.

Diagnoses: ADHD, combined type, Generalized Anxiety Disorder, Social anxiety disorder, Depression, Sickle cell disease, Adverse effect of medication, Long term drug therapy

Procedures: Office visit (20 minutes) CPT 99213. (8F 9)

Objective: Vitals: BP 124/86, Pulse 70 regular, Temp 97.4 F, Weight 181 lb, Height 6'1", BMI 23.9. Additional vitals noted: BP 132/84, Pulse 68, SpO2 99% on room air, Temp 97.6 F, Weight 183 lb, Height 6'1", BMI 24.2. General: appears well-nourished; weight change expected. Psychiatric: alert, cooperative, good eye contact, speech normal, mood euthymic, affect congruent, attention normal, no hyperactivity. Neurological: no tics or tremor. Cardiovascular: blood pressure and heart rate within reported ranges. No other physical exam findings documented. (8F 8-9, 12-13)

Subjective: Reported nervousness and social anxiety; reported being more calm but still lacking some motivation. Reported not tolerating stimulants and failing Intuniv ER and higher doses of Qelbree. Reported feeling too carefree, lack of motivation, and endorsed headaches. Reported anxiety and depression have improved >75%. Patient completed Adult ADHD Self-Report Scale endorsing multiple symptoms as Often/Very Often and indicated symptoms are worsening. Plan to message via portal and return in approximately 2 months with portal check-ins. (8F 8, 10, 12, 17)

Medications: Intuniv ER 1 mg tablet 1 tablet by mouth daily; Intuniv ER 1 mg daily x30 days (discontinued). Qelbree 100 mg capsule 1 capsule by mouth nightly; Qelbree 100 mg capsule ER 1 nightly x30 days; Continue Qelbree 100 mg. Oelbree 200 mg capsule (extended release) 2 capsules PO daily. Strattera 25 mg capsule 1 daily x30 days. Hydroxyurea 500 mg capsule. (8F 8-10, 12-13)

Assessment and Plan: The claimant appears compliant with current medication plan. ADHD symptoms currently controlled on medication; diagnosis listed as ADHD, combined type. Anxiety and depression improved (>75%) though decreased motivation persists. Adverse medication effect noted and history of intolerance to stimulants; prior failures of Intuniv ER and higher doses of Qelbree documented. History of sickle cell disease managed with hydroxyurea. Plan: medication management, continue current therapy, portal monitoring, and follow-up in approximately 2 months with Riley, Amanda. (8F 8-10, 12-13, 17)

Citation: 8F 5, 8-10, 12-13, 17; 4F 1-2

2024-05-08 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient with HbS/beta thalassemia presented for IV fluids and opioid analgesia for a vaso-occlusive crisis after an Adakveo loading dose; pain improved to a tolerable level with D5W infusion, IV dilaudid PCA and ketorolac, and labs were not alarming. Discharge plan included continued hydroxyurea, a multimodal pain plan (including PRN morphine), hydration, sleep-hygiene with increased melatonin, and follow-up for future Adakveo infusions.

Diagnoses: HbS/Beta thalassemia (sickle cell disease variant), Vaso-occlusive crisis, Post-splenectomy state, Insomnia

Procedures: IV D5W 500 mL infusion over 4 hours, Dilaudid 2 mg load with 0.3 mg q15min PCA, Toradol 15 mg IV x1 dose. (10F 59)

Objective: Patient reassessed several times during infusion with pain reduced to a tolerable range; labs were reported as not alarming. (10F 59)

Subjective: Patient reported VOC pain after 2nd loading dose of Adakveo and earlier numbness that prompted an ER visit which resolved; he desired to continue Adakveo. Patient reported history of HbS/Beta Thalassemia and prior splenic sequestration with splenectomy, had a couple of recent ITU visits for VOC, and endorsed insomnia. (10F 59, 92)

Medications: Continue hydroxyurea 1 capsule daily; severe pain plan includes morphine 15 mg every 4 hours PRN; ibuprofen and baclofen recommended for mild pain. Continue hydroxyurea 1 cap daily; pain plan includes ibuprofen 600 mg PRN, baclofen PRN, continue morphine 15 mg every 4 hours PRN; melatonin increased to 10 mg for sleep. (10F 59, 92)

Assessment and Plan: Sickle cell disease with VOC improved after IV therapy; advised hydration, pain plan, and follow-up in 1 month for next Adakveo infusion. Sickle cell disease management: continue hydroxyurea, hydrate, follow pain plan, consider starting monthly Adakveo infusions; advised sleep hygiene and short trial of higher-dose melatonin; follow up in 3 months or sooner PRN. (10F 59, 92)

Citation: 10F 59, 92

2024-05-08 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Nelson, Victoria L CRNP

Summary: Patient presented for lab work with tachycardia (HR 107) and exam notable for pain in right arm and hip and a speech stutter; urine drug screen was performed as a screening immunoassay (positives unconfirmed). Laboratory data include a documented eGFRcr G5 <15 (noted as kidney failure) but contemporaneous BMP from 01/30/2024 showed Cr 0.9 mg/dL with eGFR >90 mL/min/1.73m2; otherwise electrolytes, LFTs, CBC, and calcium were within expected ranges.

Diagnoses: CKD G5, Sickle cell disease, Sickle cell crisis, LUQ pain

Laboratory Results: Urine drug screen: immunoassay cutoffs and interpretive data — Fentanyl cutoff 1 ng/mL; Heroin cutoff 10 ng/mL (detects 6-AM); Hydrocodone cutoff 300 ng/mL; Opiates cutoff 300 ng/mL (measures hydromorphone, codeine, hydrocodone, morphine); Oxycodone cutoff 300 ng/mL; Cocaine/Methadone cutoff 150 ng/mL; Cannabin screening noted. Assays are screening only and positive results are not confirmed; interpretive statement that these immunoassays are screening tests for medical use only and positive results are not confirmed or for legal use. Additional lab data: eGFRcr G5 <15 indicating kidney failure (note also an eGFR >90 mL/min/1.73m2 with Cr 0.9 mg/dL on 01/30/2024). Collected 01/30/2024 08:01 CST: Na 140 mMol/L, K 4.0 mMol/L, Cl 109 H mMol/L, HCO3 23 mmol/L, AGAP 8.0 mMol/L, Glucose 71 mg/dL, BUN 8 mg/dL, Cr 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Ca 8.8 mg/dL, Adj Ca 8.6 mg/dL, Albumin 4.2 g/dL, Total bilirubin 0.9 mg/dL, Alk Phos 57 U/L, ALT 12 U/L, AST 18 U/L, LDH 199 U/L, WBC 6.54 x10^3/cmm, RBC 4.75 x10^6/cmm, Hgb 12.3 g/dL, Hct 36%, MCV 76 fL, Platelet 327 x10^3/cmm, RDW 19.4%. Notes regarding adjusted calcium and possible false low ALT/AST with sulfasalazine or vitamin B6 deficiency. (10F 11, 22, 33, 35-36, 53, 98, 130, 141)

Objective: Vitals 10/17/2023: Temp 97.3 F, HR 107 bpm, RR 14/min, SpO2 95%, BP 125/66 mmHg. Exam: alert and oriented; extraocular movements intact; oral mucosa moist; regular cardiac rhythm; lungs clear to auscultation; abdomen soft, non-tender; musculoskeletal: pain in right arm and hip; neck supple; neurologic: alert; speech: stutter. (10F 55)

Medications: Baclofen 5 mg PO TID; Cyclobenzaprine 5 mg nightly; Dextroamphetamine-amphetamine 10 mg BID; Hydroxyurea 500 mg PO daily; Baclofen listed once at 5 mg PO TID. Ibuprofen: 800 mg PO TID and 600 mg PO QID (both dosing regimens documented) and ibuprofen 600 mg 1 tab PO QID; Morphine 15 mg PO q4h PRN for pain; Naloxone 4 mg/0.1 mL nasal spray once (naloxone nasal spray 4 mg documented); Hydrocodone-acetaminophen (Norco) 5 mg-325 mg PRN; HYDROcodone-acetaminophen 325 mg/10 mg 1 tab PO every 4 hr PRN for pain (both hydrocodone-acetaminophen formulations documented); Codeine-acetaminophen (Tylenol with Codeine #3) 1 tab PO every 6 hr PRN; Penicillin V potassium 250 mg BID; Docusate 100 mg BID; Ergocalciferol 1.25 mg weekly; multiple Haemophilus B vaccines documented. (10F 55, 143-145)

Assessment and Plan: Interpretive statement: these immunoassays are screening tests for medical use only and positive results are not confirmed or for legal use. (10F 33)

Citation: 10F 11-12, 22-23, 33-38, 53-55, 98, 130-131, 141-145; 8F 1-2

2024-05-10 | Hillcrest Primary Care Vestavia / Unknown Provider

Summary: Patient with chronic sickle cell disease (both S-beta-thalassemia and HbSS) managed with hydroxyurea and multiple analgesics, and degenerative lumbar intervertebral disc disease causing chronic low back pain treated with NSAIDs

and opioids as needed. ADHD is being treated pharmacologically (atomoxetine, guanfacine, viloxazine) and the record notes anxiety; routine immunizations were updated and COVID/flu testing was ordered per protocol.

Diagnoses: Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Attention deficit hyperactivity disorder, Degeneration of lumbar intervertebral disc, Anxiety

Procedures: Immunizations recorded, including COVID-19 mRNA doses, multiple influenza vaccines, MMR, meningococcal, pneumococcal, Hepatitis B, Hib, DTaP/DTP series, and polio vaccines. (9F 9)

Laboratory Results: COVID-19/FLU A-B antigen test listed as 'TEST AS DIRECTED TODAY' dated 02/22/24. (9F 8)

Subjective: The claimant reports never smoking, no other tobacco or nicotine use, no illicit drug use, no alcohol use, occasional caffeine intake; exercises occasionally; married; has an advance directive. (9F 10)

Medications: Atomoxetine 25 mg daily; Baclofen 5 mg TID; Ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) weekly; Fluticasone propionate 50 mcg nasal spray, 2 sprays each nostril daily; Guanfacine ER 1 mg daily; Hydrocodone 5 mg/ acetaminophen 325 mg PRN; Hydrocortisone 2.5% topical; Hydroxyurea 500 mg daily; Ibuprofen 800 mg PRN q6h; Meloxicam 15 mg daily; Morphine 15 mg PRN q4h; Qelbree (viloxazine) 100 mg at bedtime. (9F 8)

Citation: 9F 4-10

2024-05-21 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Patient has ADHD, predominantly inattentive type, treated with atomoxetine 25 mg daily and viloxazine (Qelbree) 100 mg ER nightly; medication list also includes multiple analgesics (opioids, NSAIDs), baclofen, and meloxicam for chronic low back pain. The patient has sickle cell hemoglobin SS disease managed with hydroxyurea 500 mg daily and requires PRN opioids for vaso-occlusive pain.

Diagnoses: Attention deficit hyperactivity disorder, predominantly inattentive type, Sickle cell-hemoglobin SS disease, Degeneration of lumbar intervertebral disc, Chronic low back pain

Medications: Atomoxetine 25 mg capsule, take 1 capsule daily, qty 90; Qelbree 100 mg capsule (extended release), take 1 capsule nightly, qty 90. Reviewed medications list including atomoxetine 25 mg daily, baclofen 5 mg TID, ergocalciferol (vitamin D2) 1,250 mcg weekly, fluticasone propionate nasal spray 50 mcg (2 sprays each nostril daily), guanfacine ER 1 mg daily, hydrocodone/acetaminophen 5/325 mg PRN every 4 hours, hydrocortisone 2.5% topical, hydroxyurea 500 mg daily, ibuprofen 800 mg PRN every 6 hours, meloxicam 15 mg daily, morphine 15 mg PRN every 4 hours, Qelbree (viloxazine) listed daily and 100 mg ER at bedtime. (9F 43-44)

Citation: 9F 43-44

2024-06-11 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient with sickle cell disease presented for IV fluids and analgesia for a vaso-occlusive crisis; received D5W 500 mL over 4 hours, hydromorphone 2 mg load with 0.3 mg q15min PCA, ketorolac IV, and PRN morphine, with reassessments showing pain reduced to a tolerable level and labs without alarming findings. Plan: continue hydroxyurea, consider monthly Adakveo infusions, follow up in clinic, and manage insomnia (melatonin up to 10 mg short-term) with outpatient follow-up as needed.

Diagnoses: Sickle cell disease with vaso-occlusive crisis (VOC), Insomnia

Procedures: IV fluids infused (D5W 500 ml over 4 hours) and IV pain medication administration including PCA. (3F 29)

Objective: Patient reassessed several times during infusion with pain reduced to a tolerable range; labs reported as not alarming. (3F 29)

Subjective: Patient reported numbness earlier that resolved and endorsed ongoing pain managed with IV therapy; wants to continue Adakveo. Patient reported interest in starting Adakveo and stated he had a couple of ITU visits for VOC in the last 2 months; he also complained of insomnia and prior benefit from melatonin. (3F 29, 123)

Medications: Dilaudid 2 mg load with 0.3 mg q15min PCA, Toradol 15 mg IV x1, Morphine 15 mg q4h PRN for severe pain; Ibuprofen and Baclofen recommended for mild pain; continue hydroxyurea 1 capsule daily. Continue hydroxyurea 1 cap daily; melatonin may be increased to 10 mg short term; ibuprofen 600 mg PRN, baclofen PRN, morphine 15 mg every 4 hours PRN for severe pain. (3F 29, 123)

Assessment and Plan: Sickle cell disease with vaso-occlusive crisis treated with IV fluids and analgesia; pain improved and patient to follow up in 1 month for next Adakveo infusion and to call clinic if worsens. Sickle cell disease with ongoing management; continue HU and hydration, consider monthly Adakveo infusions, follow up in clinic in 3 months or sooner as needed. (3F 29, 123)

Citation: 3F 29, 123

2024-06-11 | Unknown Facility / Douglas, Tanya L CRNP

Summary: Patient with HbS/β-thalassemia (sickle cell disease) and prior splenectomy presents for telehealth follow-up of ongoing lower back pain; plan is to initiate and titrate gabapentin, continue cyclobenzaprine as needed, and follow up in 2 weeks. Recent labs show ferritin 25 ng/mL and no albuminuria/proteinuria; patient remains on hydroxyurea and PRN analgesics including ibuprofen and Dilaudid PCA as previously prescribed.

Diagnoses: HbS/Beta thalassemia (sickle cell disease), History of splenectomy, Lower back pain

Laboratory Results: Ferritin 25 ng/mL (12/19/2022); albuminuria/proteinuria: none (12/19/2022). (3F 9)

Objective: Psychiatric: cooperative with appropriate mood and affect; no other exam findings documented on this page. (3F 9)

Subjective: Patient presented for a telemedicine follow-up reporting ongoing lower back pain and has history of sickle cell disease with prior splenectomy. (3F 9)

Medications: Hydroxyurea 1 cap daily; Dilaudid PCA 1 mg load with 1 mg q30 minutes; ibuprofen 800 mg PRN; start gabapentin with titration; continue cyclobenzaprine PRN. (3F 9)

Assessment and Plan: Sickle cell disease with HbS/Beta thalassemia and history of splenic sequestration/splenectomy; allow initiation and titration of gabapentin and follow up in 2 weeks via telehealth. (3F 9)

Citation: 3F 9

2024-06-11 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Labs from 6/14/2023 show mild hyponatremia (Na 133 mmol/L), hyperkalemia (K 5.7 mmol/L), glucose 64 mg/dL, bilirubin 1.7 mg/dL, ALT 16 U/L (may be falsely low due to sulfasalazine), AST 43 U/L, markedly elevated LDH 448 U/L and high RDW 19.5%, findings suggestive of hemolysis in the setting of sickle cell disease/crisis. Kidney function reporting is conflicting (creatinine 1.0 mg/dL with eGFR >90 but also an eGFRcr flagged as G5 <15 indicating kidney failure); urine drug immunoassay was performed (screening only).

Diagnoses: Sickle cell disease, Sickle cell crisis, Kidney failure

Laboratory Results: Interpretive note: The claimant treated with Sulfasalazine may generate a false low result for ALT; performing locations listed (TKC LAB and Grandview Hosp Lab). 6/14/2023 labs: Sodium 133 mmol/L, Potassium 5.7 mmol/L, Chloride 100 mmol/L, Bicarbonate 24 mmol/L, AGAP 9.0 mmol/L, Glucose 64 mg/dL, BUN 10 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73 m2; Calcium 9.6 mg/dL, Adjusted calcium 8.9 mg/dL (notes regarding adjusted calcium), Albumin 4.9 g/dL, Protein 8.2 g/dL; Bilirubin total 1.7 mg/dL, Alk Phos 62 U/L, ALT 16 U/L, AST 43 U/L, LDH 448 U/L; WBC 7.56 x10^3/cmm, RBC 4.95 x10^6/cmm, Hgb 12.8 g/dL, Hct 37%, Platelet 298.4 x10^3/cmm, RDW 19.5%, MPV 8 fL. eGFRcr also reported as G5 <15 indicating kidney failure. Note that ALT/AST may be falsely low with sulfasalazine or vitamin B6 deficiency. Urine drug screen immunoassay panel with screening cutoffs: Buprenorphine (note tramadol cross-reacts), Cannabin 50 ng/mL, Cocaine/Metabolite & Methadone 150 ng/mL, Fentanyl 1 ng/mL, Heroin 10 ng/mL, Hydrocodone 300 ng/mL, Opiates 300 ng/mL, Oxycodone 300 ng/mL; all results screening only and not confirmed. (3F 57, 59, 98, 112, 114-117, 129, 140, 151)

Citation: 3F 57-59, 98, 112-118, 129-130, 140-141, 151; 10F 1-2

2024-06-13 | Unknown Facility / Fleming, Laura MD

Summary: Hemoglobin electrophoresis detected both HbA and HbS with increased HbA2 and elevated HbF (note that transfusion or hereditary persistence of HbF cannot be excluded); follow-up recommended. CBC shows mild microcytosis (MCV 74 fL) with Hgb 12.2 g/dL and elevated RDW, and point-of-care urine drug screen was positive for opiates only.

Diagnoses: Hemoglobin S

Laboratory Results: 6/13/2024 15:27 CDT: WBC 5.45 10^3/cmm; Hgb 12.2 g/dL; Hct 36%; Platelet 305.2 10^3/cmm; RBC 4.77 10^6/cmm; MCV 74 fL; MCH 26 pg; MCHC 34 g/dL; RDW 18.6%; MPV 8 fL; Neutrophils 44%; Abs Neutrophils 2.40 10^3/cmm; Lymphocytes 41%; Absolute Lymphocytes 2.23 10^3/cmm; Monocytes 10%; Eosinophils 3%; Basophils 2%; Retic 2.1%; Retic absolute 0.1029 10^6/cmm. Urine drug screen: U Opiates positive, all other tested drugs (amphetamines, benzodiazepines, buprenorphine, cannabis, cocaine metabolite, fentanyl, heroin, hydrocodone, methadone, oxycodone) negative. Urine drug screen cutoff values: Barbiturates/Benzodiazepines 200 ng/mL; Buprenorphine 5 ng/mL; Cannabin 50 ng/mL; Cocaine metabolite & Methadone 150 ng/mL; Fentanyl 1 ng/mL; Heroin 10 ng/mL; Hydrocodone 300 ng/mL; Opiates 300 ng/mL. (17F 44-45)

Assessment and Plan: Hemoglobin A and S detected with increased Hemoglobin A2 and elevated Hemoglobin F; cannot exclude blood transfusion or hereditary persistence of Hb F. Results reviewed by Laura Fleming, M.D.; recommends follow-up as indicated. (17F 44)

Citation: 17F 44-45

2024-06-13 | Unknown Facility / Kapoor, Arjun V MD

Summary: Follow-up for HbS/Beta thalassemia (sickle cell disease) with chronic anemia: Hgb S 65.2%, Hgb 12.2 g/dL (low), elevated RDW 18.6%, low Hgb A and elevated Hgb F; patient reports lower back pain and recent job loss pursuing disability. Discussed pain management and holding hydroxyurea given ANC changes; urine drug screen positive for opiates.

Diagnoses: HbS/Beta thalassemia (sickle cell disease), Anemia

Functional Assessment: Patient is pursuing disability due to health-related job loss; functional limits not otherwise specified. (17F 40)

Imaging: MRI brain: no history/findings of CVA. (17F 40)

Laboratory Results: Ferritin 24 (2/2024), Vitamin D 12 (2/2024), UPC 78 (2/2024), cardiac EF 60-65% (2/2021). Hgb S 65.2%, Hgb A2 5.4%, Hgb 12.2 g/dL (LOW), WBC 5.45 x10^3/cmm, RBC 4.77 x10^6/cmm, RDW 18.6% (HI). LDH 203 Units/L; Hgb A 16.3% (LOW); Hgb Fetal 13.1% (HI). (17F 40-42)

Objective: Review of systems completed and negative except as stated; lungs 97% on room air and no signs of CVA on prior MRI brain. Clinic notes with laboratory results showing Hgb S 65.2%, Hgb A2 5.4%, Hgb 12.2 g/dL (low), RDW 18.6% (high), and urine opiates positive. Vitals: T 98.3 F, HR 93 bpm, SpO2 97%, BP 121/79 mmHg, weight 184.6 lb, height 73 in; exam: alert and oriented, lungs clear, musculoskeletal normal range of motion with pain in lower back. (17F 40-42)

Subjective: Patient reported he is working on obtaining disability, lost his job due to health issues months ago, and denied adverse bleeding; appetite good. Patient complained of pain in lower back. (17F 40, 42)

Medications: Ibuprofen 800 mg TID, morphine 15 mg Q4 PRN, Baclofen 5 mg TID; discussed holding Hydroxyurea (Hydrea) after ANC changes. Baclofen 5 mg PO TID; ergocalciferol 1.25 mg PO weekly; hydroxyurea 500 mg PO daily; ibuprofen 800 mg PO TID; naloxone 4 mg nasal once; PRN: hydrocodone-acetaminophen (Norco) 5/325 1 tab q4h PRN and morphine 15 mg PO q4h PRN. (17F 40, 42)

Assessment and Plan: Sickle cell disease (HbS/Beta thalassemia genotype) follow-up in clinic; discussed holding hydroxyurea and pain management plan. Sickle Cell Plan documented with transition care completed (updated care plan, emergency plan, self-assessment) and no subspecialist referrals noted. (17F 40-41)

Citation: 17F 40-42

2024-06-21 | Unknown Facility / Kapoor, Arjun V MD

Summary: 29-year-old male with HbS/Beta thalassemia status post splenectomy; recent labs show Hgb S 65.2%, Hgb F 13.1%, Hgb A 16.3%, Hgb A2 5.4% and LDH 203 U/L. Management includes continued hydroxyurea 500 mg daily and folate, PRN opioid and adjunctive pain meds per pain plan, with APP follow-up in 2 weeks for hydroxyurea titration and MD follow-up in 4 weeks.

Diagnoses: HbS/Beta thalassemia, History of splenic sequestration, Asplenia

Laboratory Results: 6/13/2024 LDH 203 U/L; Hgb A 16.3%; Hgb F 13.1%; Hgb S 65.2%; Hgb A2 5.4%. (17F 43)

Subjective: Patient is a 29-year-old male with HbS/Beta Thal and history of splenic sequestration s/p splenectomy presenting for follow-up. (17F 43)

Medications: Continue folate 1 mg daily; continue hydroxyurea (hydroxyurea 500 mg capsule, 1 cap daily); ergocalciferol refilled; morphine 15 mg every 4 hours PRN for severe pain; baclofen and ibuprofen as needed per pain plan. (17F 43)

Assessment and Plan: Sickle cell disease management: continue folate and hydroxyurea, maintain hydration, follow pain action plan; follow-up in 2 weeks with APP to titrate hydroxyurea and in 4 weeks with MD. (17F 43)

Citation: 17F 43

2024-06-27 | Unknown Facility / Adams, Donna B CRNP

Summary: 29-year-old man with HbS/Beta Thal presented with a 2-day vaso-occlusive pain episode in bilateral arms, legs, and lower back; labs showed mild normocytic/microcytic anemia (Hgb 11.9 g/dL, Hct 35%, MCV 76 fL) and peripheral smear with target cells and occasional sickle cells. He received IV fluids, ketorolac, and IV opioids with hydromorphone PCA, with pain improving from 8/10 to 5/10 and able to eat/drink; discharged with continuation of hydroxyurea and outpatient follow-up.

Diagnoses: Sickle cell disease (HbS/Beta Thalassemia), Sickle cell vaso-occlusive crisis

Procedures: Received IV fluids (D5W 500 mL infusion) and IV analgesia for vaso-occlusive crisis, including Dilaudid 2 mg load with hydromorphone PCA 0.3 mg q15 min and Toradol 15 mg IV x1 dose. (17F 31, 34)

Laboratory Results: 6/27/2024 labs (14:02 CDT unless noted): Sodium 135 mmol/L; Potassium 4.6 mmol/L; Chloride 103 mmol/L; Bicarbonate 23 mmol/L; Anion gap 9.0 mmol/L; Glucose 72 mg/dL; BUN 8 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.5 mg/dL; Albumin 4.5 g/dL; Total bilirubin 0.7 mg/dL; Alk Phos 59 U/L; ALT 12 U/L; AST 17 U/L; LDH 204 U/L. CBC: WBC 5.26 x10^3/cmm; Neutrophils 30% (absolute 1.58 x10^3/cmm); Lymphocytes 56% (absolute 2.96 x10^3/cmm); Monocytes 9%; Eosinophils 4%; Basophils 1%; Hgb 11.9 g/dL (low); Hct 35% (low); RBC 4.68 x10^6/cmm; MCV

76 fL (low); RDW 18.8%; Platelet 334 x10^3/cmm; MPV 8 fL. Reticulocyte count 2.0%; Retic absolute 0.0930 x10^6/cmm; RBC retic 4.70 x10^6/cmm. Peripheral smear: moderate target cells, occasional tear cells, few sickle cells, rare schistocytes, occasional burr cells; anisocytosis 1+, hypochromia 1+. (17F 33, 36-37)

Objective: Vitals: T 98.1 F, HR 68 bpm, RR 15, SpO2 95%, BP 128/73 mmHg, weight 184.6 lb, height 73 in. Exam: alert and oriented, extraocular movements intact, non-tender abdomen, normal cardiovascular exam, lungs clear to auscultation, musculoskeletal normal range of motion and strength with reported lower back pain, neurologic alert and oriented, speech with stutter. Patient was reassessed several times during infusion with pain reduced to a tolerable range; able to eat and drink while receiving infusion; encouraged hydration. (17F 32, 34)

Subjective: The claimant, a 29-year-old man with HbS/Beta Thal and prior splenectomy on hydroxyurea 500 mg daily, complained of vaso-occlusive pain for 2 days in bilateral arms, legs, and lower back, worse in warmer weather. He endorsed lower back pain and nausea, denied chest pain, shortness of breath, fever, or recent injury. Reported pain decreased from 8/10 to 5/10 after infusion and was able to eat and drink. (17F 31-32, 34)

Medications: Home/acute medications: Hydroxyurea 500 mg daily (continue; '1 capsule daily' documented); Baclofen 5 mg TID; Ibuprofen 800 mg TID; Ergocalciferol 1.25 mg (50,000 IU) weekly; Morphine 15 mg q4h PRN; Norco (hydrocodone-acetaminophen) 5/325 mg as needed q4h; Naloxone 4 mg nasal once. ED/infusion analgesia: Dilaudid 2 mg load with PCA 0.3 mg q15 min; Toradol 15 mg IV x1. Instructed PO pain meds for home. (17F 31-32, 34)

Assessment and Plan: Sickle cell vaso-occlusive crisis in the setting of sickle cell disease (HbS/Beta Thal). Pain improved with IV fluids and analgesia. Plan: IV fluids and analgesia continued, consider Benadryl and slowing infusion rate if needed, encourage hydration, continue hydroxyurea. Sickle Cell transition care plan reviewed; claimant received transition policy, updated care and emergency plans, and completed self-assessment. No subspecialty referrals at this time. Follow-up with Dr. Kapoor 7/11/24. (17F 31, 33-34)

Citation: 17F 31-37

2024-06-27 | Unknown Facility / Collins, Sarah E MD

Summary: Patient with sickle cell disease experiences frequent pain crises requiring daily opioid/analgesic therapy; the condition is considered permanent and limits work capacity, notably reducing his ability to stand and lift. Provider documents ongoing need for daily pain medication to manage symptoms.

Diagnoses: Sickle cell disease

Functional Assessment: Provider indicates the condition reduces his ability to work and affects his ability to stand and lift. (14F 1)

Subjective: Patient is currently diagnosed with sickle cell disease and often experiences pain crises that affect his ability to stand and lift; patient is currently on daily pain medication. (14F 1)

Medications: Daily pain medication (unspecified). (14F 1)

Assessment and Plan: Sickle cell disease considered permanent and limits work capacity; patient requires daily pain medication. (14F 1)

Citation: 14F 1

2024-07-11 | Unknown Facility / Stone, Christopher K MD

Summary: Hemoglobin electrophoresis is consistent with a Hemoglobin S–predominant sickling disorder (HbS 65.4%, HbF 13.1%, HbA 16.1%, HbA2 5.4%). CBC shows mild anemia with microcytosis (Hgb 12.3 g/dL, MCV 76 fL), elevated RDW and reticulocyte count (2.2%), and the urine drug screen was positive for hydrocodone.

Diagnoses: Sickle cell disorder (Hemoglobin S–predominant; HbS 65.4%, HbF 13.1%), Microcytic anemia suggestive of thalassemia trait or iron deficiency (MCV 76 fL, RDW 19.6%), Positive urine drug screen for hydrocodone

Laboratory Results: 7/11/2024 10:46 CDT: LDH 196 U/L; Hgb A 16.1%, Hgb F 13.1%, Hgb S 65.4%, Hgb A2 5.4%; U drug screens mostly negative with Hydrocodone positive; WBC 6.07 x10^3/mm3, Hgb 12.3 g/dL, Hct 36%, Platelets 289.2 x10^3/mm3; RBC 4.83 x10^6/cmm, MCV 76 fL, MCH 25 pg, MCHC 34 g/dL, RDW 19.6%, Abs neutrophils 2.49 x10^3/cmm, Lymphocytes 44%, Reticulocyte 2.2%, RBC retic 4.76 x10^6/cmm. Urine drug screen cutoff values: Amphetamines 500 ng/mL; Barbiturates/Benzodiazepines 200 ng/mL; Buprenorphine 5 ng/mL; Cannabin 50 ng/mL; Cocaine metabolite and Methadone 150 ng/mL; Fentanyl 1 ng/mL; Heroin 10 ng/mL; Hydrocodone 300 ng/mL; Opiates 300 ng/mL. (17F 27-28)

Citation: 17F 27-28

2024-07-11 | Unknown Facility / Kapoor, Arjun V MD

Summary: Radiographs showed lumbar endplate anomalies consistent with sickle cell disease and patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts, with no fracture or femoral head osteonecrosis;

concern for sacroiliitis prompted recommendation for SI joint MRI. The patient received a sickle cell infusion for acute low back pain that is interrupting sleep and limiting independent ADLs and work.

Diagnoses: Sickle-cell thalassemia beta plus with crisis, unspecified, Bone infarcts, Low back pain, Possible sacroiliitis, Mild degenerative hip disease, Vitamin D deficiency, unspecified

Procedures: Sickle cell infusion performed for this acute visit. Prior infusion documented 6/27. (17F 20, 23)

Functional Assessment: Back pain makes it hard to complete independent ADLs though patient has not had falls. | Pain is prohibiting work and staff will complete paperwork for food assistance; limitations due to back pain affecting work capacity. (17F 20, 22-23)

Imaging: Lumbar spine radiographs: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease; no fracture, malalignment, degenerative or erosive changes. Hips/pelvis radiographs: patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis or fracture; mild degenerative change. SI joints: no fracture or erosive change on radiograph but concern for sacroiliitis; MRI of the SI joints recommended for further evaluation. MRI brain: no history or signs of cerebrovascular accident documented. (17F 18, 21, 23)

Laboratory Results: Vitamin D 12 (2/2024). Ferritin 24 (2/2024); prior ferritin 18 ng/mL (11/21/2023). Renal assessment UPC 78 (2/2024); prior albuminuria/proteinuria none (11/21/2023). LDH 196 Units/L. Hemoglobin A 16.1% (reported low). Cardiac EF 60–65% (2/2021). (17F 21-25)

Objective: Radiographs of the lumbar spine and bilateral hips/pelvis were performed and reviewed by radiology. General: alert and oriented, no acute distress. Vitals: lungs 98% on room air. HEENT: EOM intact, normocephalic, moist oral mucosa. Cardiovascular: normal rate and rhythm, no edema; prior cardiac EF 60–65% (2/2021). Respiratory: lungs clear to auscultation, respirations non-labored. Abdomen: soft, non-tender. Musculoskeletal/neurologic: normal range of motion and normal strength; pain with palpation of lower back noted. Integumentary warm and dry; neck supple. Neurologic: alert and oriented; articulation noted stutter. Cooperative mood and affect. (17F 18, 21-24)

Subjective: The claimant reported low back pain without trauma that improved with prior IV pain meds but persists and interrupts sleep. Pain not relieved by Norco 1 tablet or ibuprofen 800 mg at bedtime. Reports pain with palpation in the lower back. Presented for sickle cell follow-up and endorsed need for hydration and pain management. Reports water intake >64 oz/day, good appetite, regular bowel movements. Current outpatient pain regimen includes ibuprofen, Norco, and baclofen; lists medications and had no refills today. (17F 18, 20-23)

Medications: Hydroxyurea 500 mg daily (continue 1 capsule daily; adjust per labs). Baclofen 5 mg TID. Ibuprofen 800 mg TID (patient reported ibuprofen 800 mg at bedtime). Norco (hydrocodone-acetaminophen 5/325 mg) PRN; patient reported taking Norco 1 tablet at bedtime and PRN hydrocodone 5/325 mg every 4 hours for severe pain. Morphine 15 mg q4h PRN. Ergocalciferol 1.25 mg weekly. Naloxone 4 mg nasal once PRN. (17F 20-24)

Assessment and Plan: Acute low back pain in a patient with sickle cell disease; radiology impression of lumbar endplate abnormalities consistent with sickle cell disease and probable bone infarcts in the hips with mild degenerative changes. Concern for sacroiliitis—MRI of the SI joints recommended. Sickle cell disease with history of splenectomy and ongoing back pain; infusion visit provided for symptom management. Preventative care and medication review completed; eye exam overdue; renal and cardiac labs noted for follow-up. Plan: continue hydroxyurea, encourage hydration, obtain radiographs (completed today), refer to specialist, follow-up with APP in 2 weeks and MD in 4 weeks. (17F 18, 20-23, 25)

Citation: 17F 18-25

2024-07-11 | Hematology & Oncology (Grandview) / Kapoor, Arjun V MD

Summary: 29-year-old man with HbS/β-thalassemia and prior splenectomy presents with pain severe enough to prohibit work and profuse sweating when ill; chest and spine X-rays were obtained today without acute abnormalities and repeat labs are planned in 2 weeks. Management includes continuing/increasing hydroxyurea to 1000 mg daily, vitamin D supplementation, PRN hydrocodone for severe pain with ibuprofen/baclofen for mild pain, and follow-up with APP in 2 weeks and MD in 4 weeks.

Diagnoses: Sickle cell disease (HbS/Beta Thal), Post-splenectomy status, Vitamin D deficiency, Back pain

Procedures: Chest/spine XR obtained today (XR recommended and done). (17F 26)

Functional Assessment: Pain is prohibiting work; paperwork for food assistance being completed due to inability to work. (17F 26)

Imaging: XR reported without any acute abnormalities per addendum; XR recommended for back pain and obtained today. (17F 26)

Laboratory Results: Repeat labs planned in 2 weeks; no specific lab values documented on page. (17F 26)

Subjective: 29M with HbS/Beta Thal and prior splenectomy presents for follow-up and reports pain limiting work and profuse sweating when sick. (17F 26)

Medications: Continue hydroxyurea 1 cap daily (Hydrea increased to 1000 mg/day per addendum), ergocalciferol 50,000 units daily, hydrocodone 5/325 mg every 4 hours PRN for severe pain; ibuprofen and baclofen for mild pain. (17F 26)

Assessment and Plan: Sickle cell disease with pain; vitamin D deficiency; back pain. Continue medications, obtain XR, repeat labs in 2 weeks, follow-up with APP in 2 weeks and MD in 4 weeks. (17F 26)

Citation: 17F 26

2024-07-11 | The Jefferson Clinic at Grandview Health System / Collins, Sarah E MD

Summary: Hematology letter documents chronic sickle cell disease (HbS/β-thalassemia) with recurrent pain crises, infections, and chronic anemia; complications have required periods of crisis care or hospitalization. The patient may need homebound care during crises and has been unable to maintain stable employment due to these limitations.

Diagnoses: Sickle cell disease (HbS/β-thalassemia), Anemia (sickle cell–related)

Functional Assessment: Notes the patient may require homebound care or hospitalization during crises and has been unable to hold stable employment. (13F 1)

Subjective: Letter states the patient has sickle cell disease (HbS/Beta Thal) and that complications include pain, infection, and anemia with periods of crisis requiring care or hospitalization. (13F 1)

Assessment and Plan: Hematology letter documents chronic sickle cell disease with complications including pain crises and anemia and offers contact for further documentation or assistance. (13F 1)

Citation: 13F 1

2024-07-13 | Alabama Division of Disability Determination / Unknown Provider

Summary: The claimant underwent a psychological evaluation including mental status exam and clinical interview to assist Social Security disability determination; he was cooperative but a poor historian and his wife was present to corroborate. He arrived on time, engaged throughout testing, and is taking multiple medications including opioids (morphine, hydrocodone/Norco), stimulants/ADHD medication (atomoxetine/Strattera), and other agents that could affect cognition and functioning.

Procedures: Mental Status Exam, clinical interview, and clinical observations were performed. (15F 2)

Objective: Test session behavior: arrived on time, cooperative and engaged throughout the assessment; described as a poor historian. (15F 2)

Subjective: Claimant was referred for evaluation, his wife was present, he verbally acknowledged consent and was cooperative but a poor historian. (15F 2)

Medications: Hydroxyurea 500 mg daily; Morphine 15 mg daily; Hydrocodone 325 mg daily; Penicillin (dose not listed); Quelbree 100 mg daily; Stattera (Atomoxetine) 25 mg daily; Norco 325 mg daily; Baclofen 5 mg daily; Ibuprofen 800 mg twice daily. (15F 2)

Citation: 15F 2

2024-07-29 | Unknown Facility / Carson, Mitchell PA-C

Summary: Patient with HbS/beta+ thalassemia on hydroxyurea reports chronic low back pain rated 7/10 that disrupts sleep and ADLs; exam otherwise nonacute. Imaging shows patchy sclerosis of the left acetabulum and right intertrochanteric femur consistent with bone infarcts and lumbar endplate anomalies from sickle cell disease; labs notable for Hgb 12.0 g/dL, ferritin 24 ng/mL and vitamin D 12 ng/mL; MRI sacrum/SI joints recommended for further evaluation.

Diagnoses: Sickle cell disease (HbS/beta+ thalassemia), Low back pain, Bone infarcts, Lumbar endplate anomalies consistent with sickle cell disease, Hip sclerosis, Vitamin D deficiency

Functional Assessment: Back pain limits independent ADLs and interrupts sleep; no other specific work restrictions documented. (17F 9)

Imaging: Hip AP and pelvis radiographs: patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis, fracture, or malalignment. SI joints: no fracture; MRI recommended to evaluate for sacroiliitis. Lumbar spine AP and lateral radiographs: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease; no fracture or malalignment. MRI brain: No history of CVA documented. (17F 10, 12)

Laboratory Results: Ferritin 24 ng/mL (2/2024). Vitamin D 12 ng/mL (2/2024). 7/29/2024 labs: Sodium 138 mmol/L; Potassium 4.0 mmol/L; Chloride 104 mmol/L; Bicarbonate 25 mmol/L; Glucose 83 mg/dL; BUN 9 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.4 mg/dL; Albumin 4.3 g/dL. Hematology (7/29/2024): Hgb A 16.3% (low), Hgb F 12.8% (high), Hgb S 65.5%, Hgb A2 5.4% (high). CBC: WBC 6.26 x10^3/µL; RBC 4.62 x10^6/cmm; Hemoglobin 12.0 g/dL (low); Hematocrit 35% (low); MCV 75 fL (low); MCH 26 pg (low); RDW 19.5% (high); Platelets 333.6 x10^3/cmm; Reticulocyte 2.5% (high). (17F 10-12, 14)

Objective: Genotype documented as HbS/Beta Thalassemia +. Vitals: Temp 98.2 F, HR 62 bpm, O2 sat 98%, BP 123/73 mmHg, MAP 90 mmHg. Primary pain score 7. Alert and oriented, no acute distress. Cardiovascular and respiratory exams normal. Abdomen soft, non-tender. Musculoskeletal exam: normal strength and range of motion. Neurologic: alert;

cooperative with stutter noted in speech. Laboratory values were obtained and radiographs of hips and lumbar spine were performed with documented radiology observations. (17F 9-12)

Subjective: The claimant denied new acute complaints and reported tolerating the medication change. The claimant endorsed ongoing low back pain not relieved by Norco and ibuprofen 800 mg (noted as 1 tablet PRN or 800 mg at bedtime in some documentation); pain interrupts sleep and limits activities of daily living. Review of systems completed and otherwise negative. (17F 9-10)

Medications: Hydroxyurea 1000 mg daily; Norco (hydrocodone-acetaminophen) 5/325 mg PRN q4h; ibuprofen 800 mg TID; baclofen 5 mg TID; ergocalciferol 1.25 mg weekly; naloxone nasal 4 mg once; morphine 15 mg PRN q4h. (17F 9-10)

Assessment and Plan: Sickle cell disease (HbS/Beta Thalassemia) with ongoing low back pain. Continue hydroxyurea 1000 mg daily. Sickle cell plan with transition care noted. Recommend MRI sacrum/SI joints for further evaluation. Repeat labs and clinic follow-up as planned. (17F 9, 12)

Citation: 17F 9-12, 14

2024-07-29 | Unknown Facility / Stone, Christopher K MD

Summary: CBC shows microcytic anemia (MCV 75 fL) with marked anisocytosis (RDW 19.5%), target cells and rare sickle cells, and occasional nucleated RBCs; reticulocyte percentage is mildly elevated (2.5%), suggesting a marrow response and possible underlying hemoglobinopathy or mixed iron-deficiency/hemolytic process that warrants further evaluation (hemoglobin electrophoresis and iron studies).

Diagnoses: Microcytic anemia (low MCV), Elevated red cell distribution width (anisocytosis), Presence of target cells and rare sickle cells suggestive of hemoglobinopathy, Nucleated red blood cells (NRBCs) present, Mild reticulocytosis

Laboratory Results: 7/29/2024 CBC: Platelets 333.6 x10^3/µL, RBC 4.62 x10^6/µL, MCV 75 fL (L), MCH 26 pg (L), MCHC 34 g/dL, RDW 19.5%, MPV 8 fL; Neutrophils 39% (abs 2.45 x10^3/µL), Lymphocytes 46% (abs 2.91 x10^3/µL), Monocytes 8%, Eosinophils 4%, Basophils 2%, NRBC 2/100 WBC, Anisocytosis 1+, Target cells few, Sickle cells rare; Reticulocyte % 2.5%, Retic absolute 0.1174 x10^6/µL, RBC retic 4.71 x10^6/µL. (17F 15)

Citation: 17F 15

2024-08-09 | Unknown Facility / Stevens, Angela CRNP

Summary: Patient presented for an acute sickle cell infusion visit for pain related to sickle-cell thalassemia beta-plus with crisis and received infusion treatment. Basic labs were essentially normal (K+ 4.4 mmol/L, Cr 1.0 mg/dL, eGFR >90 mL/min/1.73m2, LFTs within normal limits); current meds include hydroxyurea and PRN opioids.

Diagnoses: Sickle-cell thalassemia beta plus with crisis, Low back pain, unspecified, Hyperkalemia

Procedures: Sickle cell infusion (acute infusion visit). (17F 48)

Laboratory Results: 8/19/2024 13:04 CDT: Sodium 140 mmol/L, Potassium 4.4 mmol/L, Chloride 108 mmol/L, Bicarbonate 23 mmol/L, AGAP 9.0 mmol/L, Glucose 87 mg/dL, BUN 11 mg/dL; Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.3 mg/dL, Adjusted Calcium 9.1 mg/dL, Protein 7.5 g/dL, Albumin 4.3 g/dL, Bilirubin total 0.6 mg/dL, Alk Phos 62 U/L, ALT 12 U/L, AST 17 U/L, LDH 188 U/L. (17F 56)

Medications: Baclofen 5 mg PO TID, diclofenac topical (Voltaren 1%) topical QID, ergocalciferol 1.25 mg (50,000 IU) oral weekly, hydrocodone-acetaminophen (Norco) 5 mg-325 mg PO PRN q4h, hydroxyurea 500 mg PO daily, ibuprofen 800 mg PO TID, morphine 15 mg PO PRN q4h, naloxone 4 mg nasal spray once (2 devices). (17F 54)

Assessment and Plan: Acute sickle cell infusion visit documented; signed by CRNP Angela Stevens with result date 08/09/2024. (17F 48)

Citation: 17F 48, 54-56

2024-08-29 | Unknown Facility / Lambert, Brian MD

Summary: 12-lead ECG was performed on 08/29/2024 at 16:46 CDT and reviewed by cardiologist Brian Lambert, MD (report attached to record); no ECG interpretation details are provided in this event. The visit is for a patient with sickle cell disease presenting with left upper quadrant pain in the setting of a documented sickle cell crisis.

Diagnoses: LUQ pain, Sickle cell crisis, Sickle cell disease

Procedures: ECG procedure (accession CV-24-0129069) performed 08/29/2024 at 16:46 CDT. (19F 25)

Imaging: ECG performed 08/29/2024 16:46 CDT (Accession CV-24-0129069); report reviewed by cardiologist Lambert, Brian MD. (19F 25; 17F 64)

Medications: Naloxone nasal spray 4 mg/0.1 mL, 4 mg, single dose prescribed 10/17/2023; naloxone 4 mg nasal administered nasally. Baclofen 5 mg TID. Ergocalciferol 1.25 mg PO weekly. Hydrocodone-acetaminophen (Norco) 5/325 1 tab PO q4h PRN. Hydroxyurea 500 mg PO daily. Ibuprofen 800 mg TID and ibuprofen 600 mg PO QID PRN. Morphine 15 mg

PO q4h PRN. Cyclobenzaprine 5 mg PO nightly. Dextroamphetamine-amphetamine 10 mg PO BID. Docusate sodium 100 mg PO BID (200 mg total daily). Penicillin V potassium 250 mg PO BID. Documented Haemophilus b conjugate vaccinations. (19F 25; 17F 64, 66-68)

Citation: 19F 25; 17F 64-68

2024-08-29 | Grandview / Lambert, Brian MD

Summary: 12-lead ECG demonstrated a normal tracing with sinus rhythm at a ventricular rate of 69 bpm and intervals RR 860 ms, PR 156 ms, QRS 83 ms, QT 340 ms, QTc Bazett 366 ms (QTc Hodges 337 ms); no acute ischemic changes were identified.

Diagnoses: Sinus rhythm, Attention-deficit hyperactivity disorder, Childhood Onset Fluency Disorder, Dorsalgia, unspecified, Headache, Sickle cell disease

Imaging: 12-lead ECG interpreted as normal; sinus rhythm. QTc Bazett 366 ms, QTc Hodges 337 ms. (19F 26; 17F 63)

Objective: 12-lead ECG: sinus rhythm. Ventricular heart rate 69 BPM. Intervals: RR 860 ms, PR 156 ms, QRS 83 ms, QT 340 ms, QTc Bazett 366 ms. (19F 26; 17F 63)

Assessment and Plan: Normal ECG interpretation with sinus rhythm and interval measurements as documented (RR 860 ms, PR 156 ms, QRS 83 ms, QT 340 ms, QTc Bazett 366 ms); no acute ischemic changes. Electronic signature dated 09/02/2024. (19F 26; 17F 63)

Citation: 19F 26-28; 17F 63

2024-08-29 | Unknown Facility / Kapoor, Arjun V MD

Summary: Patient was seen for sickle-cell thalassemia in crisis with associated hyperkalemia; an ECG was performed per orders and a 3-month follow-up was arranged. Naloxone nasal spray was prescribed and patient also reported dorsalgia; ADHD noted in problem list.

Diagnoses: Sickle-cell thalassemia, Hyperkalemia, Dorsalgia, Attention-deficit hyperactivity disorder

Procedures: ECG (EKG) ordered and completed per order details. (16F 7)

Medications: Naloxone nasal spray 4 mg (0.1 mL) nares-both, once, 2 EA, prescribed. Naloxone 4 mg/0.1 mL nasal spray (prescribed 10/17/2023) listed in medication history. (18F 7; 16F 7)

Assessment and Plan: Visit/orders for sickle cell disease with crisis and associated conditions including hyperkalemia; return-to-clinic follow-up ordered (3 months). (16F 7)

Citation: 18F 7; 16F 7

2024-08-29 | Grandview Medicine / Unknown Provider

Summary: Patient with sickle cell disease and sickle cell retinopathy has a history of laparoscopic/robotic splenectomy on 12/04/2019 and is noted to be at increased risk for venous thromboembolism; current complaints include sleep disturbance and high work-related stress. Surgical history (post-splenectomy) and thromboembolism risk are the primary clinical considerations given the underlying SCD.

Diagnoses: Attention deficit hyperactivity disorder (ADHD), At risk of venous thromboembolus, Post-splenectomy status, Sickle cell disease, Sickle cell retinopathy

Procedures: Laparoscopic splenectomy (procedure date 12/04/2019) and robotic surgical system documented for same date. Laparoscopy, surgical, splenectomy and robotic surgical system listed with procedure date 12/04/2019. Splenectomy on 12/04/2019. (18F 5; 17F 69-70)

Subjective: Reported sleeping concerns and feeling highly stressed due to work; reported being a student and working in IT for a security company and living with spouse. (17F 70)

Citation: 18F 5; 17F 69-70

2024-08-29 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Patient with sickle cell disease underwent laparoscopic robotic splenectomy on 12/04/2019 and is now post-splenectomy with an associated increased risk for venous thromboembolism. Additional comorbidities documented include sickle cell retinopathy and ADHD.

Diagnoses: Attention deficit hyperactivity disorder (ADHD), At risk of venous thromboembolus, Post-splenectomy, Sickle cell disease, Sickle cell retinopathy

Procedures: Laparoscopy with splenectomy and use of robotic surgical system, procedure date 12/04/2019. (16F 3)

Citation: 16F 3

2024-08-30 | Hematology Clinic / Kapoor, Arjun V MD

Summary: Follow-up for sickle-cell thalassemia beta-plus with crisis: patient tolerating hydroxyurea 1000 mg with improved low back pain, recalled a resolved chest pain episode, and was hemodynamically stable with O2 97% on room air; notable labs include vitamin D deficiency (12 ng/mL), ferritin 24 ng/mL, and urine protein/creatinine 78. Plan included pain management guidance, transition back to PCP, referral to psychiatry, and 3-month follow-up with Dr. Kapoor.

Diagnoses: Attention-deficit hyperactivity disorder, Dorsalgia, Hyperkalemia, Sickle cell disease, Sickle-cell thalassemia beta plus with crisis, Low back pain, Pain, Sickle-cell thalassemia beta-plus with crisis, Dorsalgia, unspecified, Sickle-cell thalassemia beta plus with crisis, unspecified, ADHD, Sickle-cell thalassemia beta plus

Imaging: MRI brain: no history of CVA noted. (19F 22; 17F 60)

Laboratory Results: Vitamin D 12 ng/mL (2/2024); Ferritin 24 ng/mL (2/2024); renal assessment UPC 78 (2/2024); cardiac ejection fraction 60–65% (2/2021); oxygen saturation 97% on room air. (19F 22; 17F 60)

Objective: The claimant was alert and oriented, in no acute distress. Extraocular movements intact. Lungs 97% on room air. Cardiovascular: normal rate and rhythm, no edema. Abdomen soft, non-tender, normal bowel sounds. Musculoskeletal: normal range of motion. (19F 22; 17F 60)

Subjective: The claimant presented for follow-up today with his wife and endorsed an acute issue. He reported low back pain improvement, recalled a chest pain episode several days ago but denied current chest pain, and was concerned about a prior elevated potassium. He stated he is tolerating Hydrea (hydroxyurea) 1000 mg without GI symptoms or nail discoloration. He reported pain ranging from mild to severe and was given instructions for heat, hydration, rest, and medication use. Genotype reported as HbS/Beta Thalassemia +. (19F 21-22, 24; 18F 6, 8; 17F 59-60, 62; 16F 6, 8)

Medications: Hydroxyurea 1000 mg daily; baclofen 5 mg TID; atomoxetine 25 mg daily AM; ergocalciferol 1.25 mg weekly; ibuprofen 800 mg TID; naloxone nasal spray 4 mg PRN; viloxazine 100 mg nightly; hydrocodone-acetaminophen (Norco) 5/325 mg every 4 hours PRN; morphine 15 mg PRN. (19F 22, 24; 18F 8; 17F 60, 62; 16F 8)

Assessment and Plan: Hematology Clinic visit for an acute issue and management of sickle cell disease; note documented and signed by Kapoor, Arjun Vikram, MD. Plan to transition back to PCP in SCD clinic and arrange PCP follow-up; referral to Psychiatry at Grandview. Aware of 9/30 Spine Clinic visit. No urgent eye evaluation needed despite history of retinal scar. Pain management plan provided with medication guidance. Follow-up with Dr. Kapoor in 3 months. (19F 21-22, 24; 18F 6, 8; 17F 60, 62; 16F 6, 8)

Citation: 19F 21-22, 24; 18F 6, 8; 17F 59-60, 62; 16F 6, 8; 1F 1-2

2024-09-09 | Heritage Physician Services (Vestavia) / Graham, Kenneth DO

Summary: Patient seen for ADHD follow-up; atomoxetine and Qelbree (100 mg ER) were prescribed. Patient has chronic low back pain with history of sickle cell disease and concern for possible avascular necrosis, with plan for CT lumbar spine and CT pelvis/hip and referral to orthopedics for further evaluation.

Diagnoses: Attention-deficit hyperactivity disorder, predominantly inattentive type, Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Degeneration of lumbar intervertebral disc, Chronic low back pain, Thoracic back pain

Imaging: Recommend CT lumbar spine and CT pelvis/hip to further evaluate low back pain and SI joint; prior CT/MRI/X-ray noted as Y. (9F 55)

Subjective: Established patient visit. The claimant reported persistent low back pain for over 1 year and a history of sickle cell disease; provider concerned about possible avascular necrosis. No other specific subjective complaints documented. (9F 45, 55)

Medications: Atomoxetine 25 mg capsule, take 1 capsule daily; Atomoxetine 25 mg daily (listed duplicate); Baclofen 5 mg tablet TID; Ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) capsule weekly; Fluticasone propionate nasal spray 50 mcg, 2 sprays each nostril daily (qAM documented); Guanfacine ER 1 mg daily; Hydrocodone-acetaminophen 5/325 mg tablet q4h PRN; Hydrocortisone 2.5% topical cream; Hydroxyurea 500 mg capsule daily; Ibuprofen 800 mg q6h PRN; Meloxicam 15 mg daily; Morphine 15 mg IR q4h PRN; Qelbree 100 mg capsule, extended release — take 1 capsule daily at bedtime; qty 30, refills 1. (9F 45-46, 51-52)

Assessment and Plan: Attention-deficit hyperactivity disorder, predominantly inattentive type; atomoxetine prescribed and follow-up scheduled; Qelbree (100 mg ER at bedtime) prescribed. Low back pain (M54.50); plan to obtain CT lumbar spine and CT pelvis/hip and refer to orthopedic surgeon for evaluation (concern for avascular necrosis related to sickle cell disease). (9F 45, 51, 55)

Citation: 9F 45-46, 51-52, 55

2024-09-09 | Heritage Physician Services (Pelham) / Graham, Kenneth DO

Summary: Patient presented for a skin lesion; care instructions were given, a return visit was scheduled, and HSV-1/2 IgG testing was ordered. Medical history noted sickle cell disease variants (on hydroxyurea) and ADHD, with chronic lumbar disc degeneration documented.

Diagnoses: Skin lesion, Sickle cell-beta-thalassemia, Sickle cell-hemoglobin SS disease, Attention deficit hyperactivity disorder, Degeneration of lumbar intervertebral disc

Laboratory Results: HSV 1 and 2 - SPEC AB, IGG W/RFX (test ordered) (9F 53)

Subjective: Patient reported a skin lesion and was scheduled for return visit. (9F 53)

Medications: Atomoxetine 25 mg daily; Baclofen 5 mg TID; Ergocalciferol (vitamin D2) 1,250 mcg weekly; Fluticasone propionate nasal spray 50 mcg, 2 sprays each nostril daily; Guanfacine ER 1 mg daily; Hydrocodone/acetaminophen 5/325 mg PRN q4h; Hydrocortisone 2.5% topical TID-QID; Hydroxyurea 500 mg daily; Ibuprofen 800 mg q6h PRN; Meloxicam 15 mg daily; Morphine 15 mg PRN q4h; Qelbree 100 mg nightly. (9F 54)

Assessment and Plan: Skin lesion (L98.9) with care instructions and plan for return to office. (9F 53)

Citation: 9F 53-54

2024-09-11 | Grandview / Unknown Provider

Summary: Follow-up for sickle cell disease with history of splenic sequestration; patient reports improved low back pain with normal strength and range of motion on exam. Labs notable for vitamin D deficiency (12 ng/mL) and low ferritin (24 ng/mL); prior elevated potassium was addressed with reassuring EKG, hydroxyurea continued, ADHD meds refilled, and referrals to psychiatry and Spine Clinic arranged.

Diagnoses: Sickle cell disease, History of splenic sequestration/splenectomy, Hyperkalemia (laboratory concern), Low back pain, ADHD

Imaging: MRI brain: no history of CVA noted. (16F 5)

Laboratory Results: Ferritin 18 ng/mL (11/21/2023); albuminuria/proteinuria none (11/21/2023). Vit D 12 (2/2024); Ferritin 24 (2/2024); Renal assessment UPC 78 (2/2024); Cardiac EF 60-65% (2/2021); Lungs O2 97% on RA. (16F 4-5)

Objective: Normal strength; integumentary warm and dry; neck supple; lungs clear to auscultation; neurologic alert and oriented; articulation and speech: stutter; psychiatric: cooperative with appropriate mood and affect. General: alert and oriented, no acute distress. Eye: extraocular movements intact. HENT: oral mucosa moist. Cardiovascular: normal rate and rhythm, no edema. GI: soft, non-tender, non-distended, normal bowel sounds. Musculoskeletal: normal range of motion. (16F 4-5)

Subjective: Reported pain with palpation in the lower back and follow-up for sickle cell disease and prior splenic sequestration. Patient reported low back pain has improved since last visit, recalled brief chest pain several days ago but none present, concerned about prior elevated potassium and wants referral to PCP/psychiatry; tolerating hydroxyurea 1000 mg well with no GI symptoms. (16F 4-5)

Medications: Continue Hydroxyurea 2 capsules daily; refills of Strattera and Qelbree planned. Hydroxyurea 1000 mg daily; Viloxazine 100 mg nightly; Baclofen 5 mg TID; Ibuprofen 800 mg TID; Naloxone 4 mg nasal once; Hydrocodone-acetaminophen PRN; Morphine 15 mg PRN. (16F 4-5)

Assessment and Plan: Sickle cell disease follow-up: continue hydroxyurea and hydration, EKG reassuring regarding hemolyzed samples affecting potassium, refer to psychiatry and refill ADHD medications, follow-up with Spine Clinic 09/30/2024. Low back pain improved; patient wants to transition to PCP and referral to psychiatry at Grandview; concerned about prior elevated potassium and follow-up planned with spine clinic as needed. (16F 4-5)

Citation: 16F 4-5

2024-10-03 | Unknown Facility / Curtis, Ashley M CRNP

Summary: The patient presented with an acute vaso-occlusive pain crisis causing severe low back and bilateral leg pain that required IV hydromorphone PCA and IV fluids, with reassessments showing pain reduced to a tolerable level for discharge on oral meds. Imaging revealed patchy sclerosis consistent with hip bone infarcts and lumbar vertebral endplate anomalies related to sickle cell disease; labs showed mild anemia (Hgb 12.1), low ferritin, and albuminuria (U Alb/Cr 9.4).

Diagnoses: Low back pain, Pain in left leg, Pain in right leg, Sickle-cell thalassemia beta plus with crisis, Vaso-occlusive crisis, Albuminuria/proteinuria, Bone infarcts (hips), Lumbar endplate anomalies

Procedures: IV analgesia and IV fluids administered for acute sickle cell vaso-occlusive pain. IV Dilaudid (hydromorphone) 2 mg loading dose with 0.3 mg q15 min PCA and D5W 500 mL over 4 hours administered. (19F 10, 14)

Functional Assessment: No specific work restrictions documented; follow-up recommended with Spine Clinic and specialists for back pain. (19F 14)

Imaging: Hip AP/Lateral: Patchy sclerosis involving the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis, fracture, or malalignment; mild degenerative disease. SI joints: no fracture or erosive changes; MRI with/without contrast suggested to evaluate for sacroiliitis. Lumbar spine AP/Lateral: Endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease; no fracture, malalignment, or erosive changes. (19F 13)

Laboratory Results: 10/03/2024: Sodium 138 mmol/L, Potassium 4.5 mmol/L, Chloride 107 mmol/L, Bicarbonate 22 mmol/L, Glucose 73 mg/dL, BUN 10 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.3 mg/dL, Albumin 4.3 g/dL, ALT 11 U/L, AST 16 U/L, LDH 193 U/L. CBC/hematology: Hgb 12.1 g/dL (low), Hct 35% (low), WBC 6.07 x10^3/µL, Platelets 327.4 x10^3/µL, RBC 4.47 x10^6/µL, MCV 78 fL (low), RDW 18.9% (high), Lymphocytes 53% (high), Absolute lymphocytes 3.22 x10^3/µL, Reticulocyte 2.4% (absolute 0.1001 x10^6/µL), RBC retic 4.25 x10^6/µL, Monocytes 6%, Eosinophils 3%, NRBC 1/100 WBC, Micro 1+, Anisocytosis 1+, Ovalocytes Rare. Ferritin 24 ng/mL (2/20/2024). Urine albumin/creatinine ratio: U Alb/Cr 9.4 (albuminuria/proteinuria noted). (19F 12-13, 17-18)

Objective: Denies shortness of breath, chest pain, fever, chills, cough, abdominal pain, nausea/vomiting/diarrhea, sore throat, runny nose, or loss of taste/smell. Notes sickle cell-related spine changes and prior hip bone infarcts. Vitals: 10/03/2024 12:00 CDT — HR 70 bpm, RR 16/min, O2 sat 98%, BP 135/74 mmHg, pain score 7; 10/03/2024 08:00 CDT — Temp 98.0°F, HR 60 bpm, RR 18/min, O2 sat 99%, BP 120/68 mmHg. Alert and oriented, normal cardiac rhythm, lungs clear, normal range of motion and strength, neurologic exam alert; speech with stutter noted. Patient reassessed several times during infusion with pain reduced to a tolerable range for home management with oral pain medication. (19F 10-12, 14)

Subjective: The claimant, a 30-year-old male with HbS/Beta Thal and prior splenectomy, reported progressive vaso-occlusive pain in the lower back and bilateral legs for approximately 2 weeks, causing difficulty with activities of daily living and endorsing need for IV pain medication and IV fluids. He reported current home analgesics and adjuncts of baclofen, ibuprofen, and Norco with little relief, using heat without benefit. He reported water intake >64 oz/day, regular bowel movements, good appetite, and listed current pain management regimen. Primary pain score reported as 10 on presentation; overall complaint of back and leg pain. (19F 10-12, 14)

Medications: Hydroxyurea 1000 mg daily (continue). Ibuprofen 800 mg TID (as stated; also advised PRN). Hydrocodone-acetaminophen (Norco) 5/325 mg PRN every 4 hours. Baclofen 5 mg TID (also documented as every 8 hours PRN). Diclofenac topical. Ergocalciferol. Naloxone nasal. Viloxazine 100 mg nightly. PRN morphine 15 mg every 4 hours as needed. IV Dilaudid per above. (19F 10-11, 14)

Assessment and Plan: Acute vaso-occlusive sickle cell pain crisis causing low back and bilateral leg pain; treated with IV hydromorphone and IV fluids. Imaging consistent with bone infarcts of the hips and lumbar endplate anomalies related to sickle cell disease; MRI recommended to evaluate possible sacroiliitis of the SI joints. Albuminuria/proteinuria noted (U Alb/Cr 9.4) and low ferritin. Sickle cell transition plan and updated care plan provided; follow-up with Spine Clinic and with Dr. Kapoor and Dr. Bennett on 12/12/2024 or sooner if needed. Continue hydroxyurea, IV fluids, and analgesia as above. (19F 10, 12-15)

Citation: 19F 10-18

2024-10-05 | Unknown Facility / Carson, Mitchell PA-C

Summary: Patient with sickle cell disease had hydroxyurea increased to 1000 mg daily with reassuring monitoring labs and plan for continued lab surveillance; prior X-ray (7/11) showed no acute abnormality. He reports worsening back pain possibly related to atomoxetine that is currently prohibiting work; pain management includes hydrocodone/acetaminophen PRN, ibuprofen and baclofen as needed, and possible specialist referral with follow-up in 2 weeks.

Diagnoses: Sickle cell disease, Vitamin D deficiency, Back pain

Functional Assessment: States pain is prohibiting work and will complete paperwork for food assistance; limitation described as inability to work due to pain. (17F 13)

Imaging: X-ray dated 7/11 per Dr. Kapoor showed no acute abnormality. (17F 13)

Laboratory Results: Labs described as reassuring; monitoring labs for HU continuation are planned. (17F 13)

Objective: Labs reported as reassuring with no acute complaints; prior XR 7/11 per Dr. Kapoor showed no acute abnormality. (17F 13)

Subjective: Reports increased hydroxyurea (HU) to 1000 mg daily that he is taking and possible worsening of back pain with atomoxetine; states pain is prohibiting work. (17F 13)

Medications: Continue hydroxyurea 1000 mg daily; ergocalciferol 50,000 units daily; hydrocodone/acetaminophen 5/325 mg every 4 hours PRN for severe pain; ibuprofen and baclofen for mild pain as needed. (17F 13)

Assessment and Plan: Sickle cell disease with plan to continue HU and monitor labs, follow-up in 2 weeks; back pain being evaluated with possible future referral to specialist. (17F 13)

Citation: 17F 13

2024-10-05 | Grandview / Stevens, Angela CRNP

Summary: 29-year-old man with HbS/Beta thalassemia presented with a vaso-occlusive episode causing severe lower back pain treated with IV analgesics and IV fluids, with pain improving from 8/10 to 5/10 on reassessment. Imaging demonstrated pelvic/hip bone infarcts and lumbar endplate anomalies consistent with sickle cell disease; labs notable for elevated LDH, hemoglobin 12.2 g/dL, potassium 5.4 mmol/L, and urine positive for hydrocodone.

Diagnoses: Sickle cell vaso-occlusive crisis, HbS/Beta thalassemia, Bone infarcts of the pelvis/hip, Hip sclerosis, Lumbar vertebral endplate anomalies consistent with sickle cell disease, Lower back pain (vaso-occlusive), History of splenic sequestration and splenectomy, Vitamin D deficiency, Hyperkalemia, ADHD

Procedures: IV analgesic medications administered and IV fluids given for vaso-occlusive pain episode; patient reassessed several times during infusion with pain reduced to a tolerable range. (17F 53)

Functional Assessment: Pain interrupts sleep and makes completion of independent ADLs difficult. | Patient stated pain is prohibiting work and paperwork for food assistance will be completed; follow-up and evaluation of work ability planned. (17F 49, 53)

Imaging: Hip AP: patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis, fracture, or malalignment; mild degenerative disease. SI joints: no fracture or erosive changes; MRI pelvis/SI recommended if concern for sacroiliitis. Lumbar spine AP/lateral: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease; no fracture or malalignment. XR on 7/11 per Dr. Kapoor showed no acute abnormality. MRI brain: no history of CVA noted. (17F 49, 52-53)

Laboratory Results: Ferritin 24 (2/2024); Vitamin D 12 (2/2024); urine protein/creatinine (UPC) 78 (2/2024). Basic metabolic and hematology: Sodium 135 mmol/L; Potassium 5.4 mmol/L; Chloride 103 mmol/L; Bicarbonate 21 mmol/L; Glucose 74 mg/dL; BUN 13 mg/dL; Creatinine 1.0 mg/dL; eGFR >90 mL/min/1.73m2; Calcium 9.6 mg/dL. Hemolysis markers/cell counts: LDH 443 U/L; Hgb 12.2 g/dL; Hct 36%; MCV 76 fL; MCH 26 pg; MCHC 34 g/dL; Platelets 314.4 x10^3/µL; RDW 20.3%; Absolute neutrophils 2.32 x10^3/µL; Lymphocytes 54%; Reticulocyte 2.0%; RBC 4.73 x10^6/µL. Urine drug screen: hydrocodone positive; opiates positive. Chart note: 2+ hemolysis. (17F 49, 51-53, 61)

Objective: Vitals (8/9/2024): Temp 96.9 F at 11:20 (also 96.0 F at 7:49); HR 68 bpm (low 55 bpm earlier); RR 16–17/min; SpO2 96–100% on room air; BP 118/71 and 106/68. Primary pain score 8 earlier, reduced to 5 on reassessment during infusion. General: alert and oriented, no acute distress. HEENT: moist. CV: normal rate and rhythm. Resp: lungs clear to auscultation, non-labored respirations, equal breath sounds, symmetrical chest wall expansion, no chest wall tenderness. GI: soft, non-tender. MSK: normal ROM and strength. Neuro: alert and oriented; speech/articulation: stutter. Psych: cooperative, appropriate mood and affect. Labs notable for K 5.4 mmol/L, bicarbonate 21 mmol/L, LDH 443 U/L, Hgb 12.2 g/dL, Hct 36%, MCV 76 fL, MCH 26 pg, RDW 20.3%, platelets 314.4 x10^3/µL, absolute neutrophils 2.32 x10^3/µL, lymphocytes 54%, reticulocyte 2.0%, RBC 4.73 x10^6/µL; urine positive for hydrocodone/opiate; chart note of 2+ hemolysis. Prior cardiac EF 60–65%. (17F 49-51, 53, 61)

Subjective: 29-year-old male with HbS/Beta Thal and history of splenic sequestration/splenectomy reported 2 days of lower back vaso-occlusive pain rated 8/10, achy and constant, worse with lying and walking and radiating to his right leg; history of prior similar sickle cell pain, difficulty sleeping due to pain, and follows a sickle cell plan. Presented for IV pain control and fluids and for sickle cell follow-up; reports drinking more water when symptomatic. (17F 49, 53, 61)

Medications: Hydroxyurea 1000 mg daily (also historical note of hydroxyurea 500 mg daily and record stating "continue hydroxyurea 2 capsules daily"); Ibuprofen 800 mg TID; Hydrocodone-acetaminophen (Norco) 5/325 mg every 4 hours PRN for severe pain; Baclofen 5 mg TID; Ergocalciferol listed as 1.25 mg oral weekly (and separately as ergocalciferol 50,000 units daily in other record entries); Naloxone 4 mg nasal once PRN; Morphine 15 mg PRN; PRN hydrocodone and other opioid options per pain action plan. Refill plans noted for Strattera and Qelbree until psychiatry visit. (17F 49-50, 53, 61)

Assessment and Plan: Vaso-occlusive crisis causing lower back pain consistent with the claimant's sickle cell disease; treated with IV analgesia and IV fluids. Imaging findings consistent with bone infarcts of the pelvis/hip and vertebral endplate anomalies related to sickle cell disease; MRI pelvis/SI recommended if concern for sacroiliitis; follow-up with Spine Clinic and with Dr. Kapoor next week. Continue hydroxyurea (current plan lists 1000 mg daily), hydration, and PRN pain regimen per sickle cell plan; encourage medication refills and transition care. Hyperkalemia (K 5.4) noted with reassuring EKG per chart; psychiatric referral and ADHD medication refills arranged. (17F 49, 52-53, 61)

Citation: 17F 49-53, 61

2024-10-05 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: An immunoassay urine drug screen was performed with screening cutoffs provided for cocaine/metabolite, methadone, fentanyl, heroin, hydrocodone, opiates, and oxycodone (results are screening only and not confirmed; cannabinoid cutoff not listed). eGFR interpretive categories (G2–G5) and lab cautions about adjusted calcium and ALT/AST interferences were noted, with the record listing kidney failure as a diagnosis but no specific numeric eGFR value reported.

Diagnoses: Kidney failure

Laboratory Results: Urine drug screen immunoassay screening cutoffs: Cocaine metabolite/methadone 150 ng/mL, Fentanyl 1 ng/mL, Heroin 10 ng/mL, Hydrocodone 300 ng/mL, Opiates 300 ng/mL, Oxycodone 300 ng/mL; cannabinoid cutoff not listed. Immunoassay urine drug screen notes that Opiates screening measures hydromorphone, codeine, hydrocodone, and morphine. Results are screening only and not confirmed. eGFR interpretive categories provided: G2 60–89 mL/min/1.73

m2, G3a 45–59, G3b 30–44, G4 15–29 (severely decreased), G5 <15 (kidney failure). Notes regarding adjusted calcium calculation and that sulfasalazine or vitamin B6 deficiency may affect ALT/AST results. (17F 7, 16, 29, 38, 46, 57)

Citation: 17F 7-8, 16-17, 29-30, 38-39, 46-47, 57-58

2024-10-24 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient presented for new adult psychiatric evaluation with a PHQ-9 score of 19 indicating moderately severe depression, endorsing low interest, depressed mood, sleep and concentration problems; denied substance use. Pharmacotherapy was initiated (viloxazine—Qelbree 100 mg nightly—and risperidone 0.25 mg twice daily) with follow-up and ongoing treatment recommended.

Diagnoses: Sickle cell-hemoglobin SS disease, Depression, Generalized Anxiety Disorder, Attention deficit hyperactivity disorder, combined type, Insomnia disorder related to another mental disorder

Objective: Vitals and measurements: none recorded; allergies reviewed (NKDA); medications reviewed. (22F 44)

Subjective: Patient presented for a new adult psychiatry evaluation and review of psychiatric symptoms and history. Patient reported sexually active; denied illicit/recreational drug use and reported never smoker status. Patient endorsed depressive symptoms on the PHQ-9 over the past 2 weeks, including low interest, depressed mood, sleep and concentration problems. (22F 44, 49-50)

Medications: Qelbree 100 mg capsule, extended release: take 1 capsule nightly for 30 days; risperidone 0.25 mg tablet: take 1 tablet twice daily for 30 days. (22F 44)

Assessment and Plan: Multiple psychiatric conditions reviewed with initiation of pharmacotherapy (Qelbree and risperidone) as part of treatment plan. PHQ-9 total score 19 indicating moderately severe depression per results interpretation; follow-up and treatment recommended. (22F 44, 50)

Citation: 22F 44, 49-50

2024-10-25 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient reported ongoing ADHD symptoms and negative side effects from atomoxetine (Strattera); clinician discontinued Strattera, continued Qelbree 100 mg nightly for ADHD, and initiated risperidone 0.25 mg nightly for mood disorder. Patient to return for medication management follow-up in one month.

Diagnoses: ADHD, Mood disorder

Subjective: Patient reported negative side effects from Strattera and ongoing ADHD symptoms; requested medication adjustments. (22F 48)

Medications: Stop Strattera 25 mg AM; continue Qelbree 100 mg at bedtime for ADHD; start Risperidone 0.25 mg at bedtime for mood disorder. (22F 48)

Assessment and Plan: Medication changes for ADHD and mood disorder with plan to return to clinic in one month for follow-up. (22F 48)

Citation: 22F 48

2024-10-29 | Unknown Facility / West, Emily M PA

Summary: 30-year-old male with 3 weeks of right ear pain and decreased hearing after an URI, with prior topical ofloxacin failure; exam notable for cerumen and intact tympanic membrane, pain score 9, no fever. Diagnosed with acute otitis media and started on amoxicillin-clavulanate 875/125 mg PO BID for 14 days plus fluticasone nasal spray and oral fexofenadine, with audiogram planned in 3 weeks.

Diagnoses: Acute otitis media, Sickle cell disease, Sickle cell retinopathy, Post-splenectomy, At risk of venous thromboembolus, ADHD

Procedures: Splenectomy 12/04/2019. (19F 5)

Objective: Alert and oriented x4, no acute distress. Review of systems otherwise negative with no fever or chills. Vital signs: HR 58 bpm, NIBP 128/76 mmHg, SpO2 100%, pain score 9. General: alert and oriented. HENT: right ear canal with cerumen, tympanic membrane intact. Neck supple. Respirations non-labored. Cranial nerves II–XII grossly intact. (19F 4, 6-7)

Subjective: The claimant is a 30-year-old male reporting 3 weeks of right ear pain with decreased hearing after a prior upper respiratory infection. He endorses tinnitus and denies ear drainage. Prior treatment with ofloxacin ear drops did not resolve symptoms. He reports feeling highly stressed and endorses sleeping concerns; appetite is good and he lives with his spouse. Sexual history: sexually active. Substance/alcohol/tobacco use: none, never smoker. (19F 4, 6-7)

Medications: Atomoxetine 25 mg AM; atomoxetine 25 mg daily (listed twice); viloxazine 100 mg nightly; baclofen 5 mg TID; hydroxyurea 500 mg capsules, 2 caps daily (1,000 mg total); ergocalciferol 1.25 mg (cap) weekly; ibuprofen 800 mg 1 tab TID; diclofenac topical 1 application QID PRN; naloxone nasal spray 4 mg once; hydrocodone-acetaminophen (Norco) 5/325

mg 1 tab PRN q4h; morphine 15 mg 1 tab PRN q4h; fexofenadine 180 mg 1 tab daily; fluticasone nasal 50 mcg 2 sprays BID; Amoxicillin-clavulanate (Augmentin) 875 mg-125 mg oral tablet 1 tab every 12 hours for 14 days; Flonase and oral antihistamine (fexofenadine 180 mg noted). (19F 5, 7-8)

Assessment and Plan: Impression: otalgia of the right ear and acute otitis media with persistent symptoms despite prior topical ofloxacin. Plan: oral Amoxicillin-clavulanate (Augmentin) 875/125 mg PO every 12 hours for 14 days, fluticasone nasal (Flonase) 50 mcg 2 sprays BID, oral antihistamine (fexofenadine 180 mg daily). Return in 3 weeks with audiogram. (19F 4, 7)

Citation: 19F 4-9

2024-11-21 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Follow-up psychiatric visit for multiple diagnoses including ADHD, generalized anxiety disorder, specific reading disorder, insomnia, and mood disorder with continuation of psychiatric medications (Qelbree 100 mg nightly and risperidone at current dosing). Vitals were stable and patient reported no changes in social/family situation and is currently unemployed.

Diagnoses: Mood disorder, Generalized anxiety disorder, Attention deficit hyperactivity disorder, Specific reading disorder, Insomnia disorder

Objective: Vitals recorded: RR 20, HR 77, BP 123/77, Wt 88 kg, BMI 25.6, Ht 6 ft 1 in on 11/21/2024. (22F 36)

Subjective: Patient reported follow-up care for specific reading disorder and generalized anxiety disorder. Patient reported no changes in family/social situation, stated not currently employed, and denied guns present in home. (22F 36, 41)

Medications: Qelbree 100 mg capsule ER: take 1 capsule nightly; risperidone 0.25 mg tablet: 1 tablet twice daily; risperidone 1 mg tablet: 0.5 tablet morning and 1 tablet at bedtime. (22F 36)

Assessment and Plan: Follow-up for multiple psychiatric diagnoses with medication prescriptions/continuation documented. (22F 36)

Citation: 22F 36, 41

2024-11-21 | Faith Community Health Center / Unknown Provider

Summary: Clinic received prior records documenting diagnoses of generalized anxiety disorder, ADHD (combined type), childhood-onset fluency disorder, insomnia, and an unspecified mood disorder; patient is on Quelbree 100 mg nightly and risperidone 0.5 mg morning/1 mg bedtime with prior adverse reaction to Strattera noted. Treatment was continued/initiated per records with medication management and follow-up planned in one month.

Diagnoses: Generalized Anxiety Disorder, ADHD, combined type, Insomnia Disorder, Mood disorder, Childhood-onset fluency disorder

Subjective: Received records from Live Oak's clinic documenting prior assessment and treatment including mood and anxiety symptoms and prior medications. (19F 34)

Medications: Quelbree 100 mg at bedtime; risperidone 0.5 mg in the morning and 1 mg at bedtime; prior Strattera noted with adverse effects. (19F 34)

Assessment and Plan: Records note diagnoses of generalized anxiety disorder, ADHD combined type, childhood-onset fluency disorder, insomnia, mood disorder and learning/speech disorders; treatment plan initiated with medications and follow-up in 1 month. (19F 34)

Citation: 19F 34

2024-12-12 | Hematology Clinic / Curtis, Ashley M CRNP

Summary: Patient with HbS/beta thalassemia is clinically stable on hydroxyurea 1000 mg daily but reports headaches, sleep apnea, and back pain; exam stable with SpO2 97% and prior EF 60–65%. Imaging shows patchy sclerosis consistent with bone infarcts of the left acetabulum and right intertrochanteric femur without osteonecrosis or fracture, labs notable for Hgb 12.1 g/dL, HbS 66%, HbF 11.5%, and vitamin D deficiency (12 ng/mL).

Diagnoses: Attention-deficit hyperactivity disorder, Childhood-onset fluency disorder (stuttering), Dorsalgia (back pain), Headache, HbS/beta thalassemia (sickle cell disease), Sleep apnea, Bone infarcts, Acetabular sclerosis, Degenerative joint disease

Imaging: MRI brain: no history of CVA noted. Hip bilateral AP/Lat with pelvis routine AP: patchy sclerosis involving the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no evidence of femoral head osteonecrosis, fracture, or malalignment; mild degenerative disease. SI joints: no fracture, malalignment, or erosive changes. Lumbar spine AP and lateral: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease and no acute fracture. (19F 40, 42-43)

Laboratory Results: Vitamin D 12 ng/mL (2/2024). Ferritin 24 ng/mL (2/2024). 12/12/2024: LDH 185 U/L; Hemoglobin A 17.0% (low), Hemoglobin F 11.5% (high), Hemoglobin S 66.0%, Hemoglobin A2 5.5% (high). Urine amphetamines negative;

urine barbiturates negative. Prior 2/20/2024 urine albumin/creatinine 9.4. CBC: WBC 6.68 x10^3/cmm; Hgb 12.1 g/dL (low); Hct 35% (low); Platelets 326 x10^3/cmm; RBC 4.75 x10^6/cmm; MCV 74 fL (low); MCH 25 pg (low); RDW 18.9% (high); Basophils 3% (high); Reticulocyte 2.5% (high). (19F 40-42)

Objective: Lungs clear, SpO2 97% on room air; cardiac exam regular rhythm, prior EF 60-65% with no signs of pulmonary hypertension. Vitals 12/12/2024 14:54 CST: Temp 98.3 F, HR 75 bpm, BP 118/79 mmHg, MAP 92 mmHg. Abdomen soft, non-tender; regular bowel movements, appetite good. Neurologic/musculoskeletal: alert and oriented, normal strength and range of motion, no acute distress. Skin warm and dry. Speech with stutter. Psychiatric: cooperative, appropriate mood and affect. (19F 40-41)

Subjective: The claimant reported feeling pretty well overall, wife assisting with answering due to stutter. Endorsed headaches and sleep apnea. Reported that hydroxyurea increase to 1000 mg daily may worsen his pain but also reported tolerating hydroxyurea 1000 mg daily and consistent use. Reported possible worsening of back pain with atomoxetine. No acute complaints. (19F 40, 43)

Medications: Hydroxyurea 1000 mg daily (continue two capsules daily). Ibuprofen 800 mg three times daily PRN for mild pain. Norco (hydrocodone-acetaminophen) 5 mg/325 mg 1 tab PO every 4 hours PRN for severe pain. Morphine 15 mg PO every 4 hours PRN. Baclofen 5 mg three times daily (every 8 hours as needed). Viloxazine 100 mg nightly. Amotoxetine 25 mg daily. Fexofenadine 180 mg daily. (19F 40-41, 43)

Assessment and Plan: Genotype HbS/beta thalassemia+. Sickle cell disease stable on hydroxyurea; plan to continue current therapy. Imaging consistent with patchy sclerosis likely representing bone infarcts with mild degenerative changes; no femoral head osteonecrosis or fracture identified. Back pain addressed conservatively with ibuprofen, baclofen, and opioids PRN; follow-up arranged with Dr. Barrett and sickle cell clinic (Dr. Kapoor) in 3 months. Eye exam overdue and needs follow-up. Continuing current medications and pain management regimen. (19F 40, 42-43)

Citation: 19F 39-43

2024-12-12 | Primary Care Sickle Cell (Grandview) / Bennett, Amanda K MD

Summary: Patient with known sickle-cell disease/β+-thalassemia on hydroxyurea and history of splenectomy presents after being lost to follow-up with ongoing vaso-occlusive pain (pain score 8), recurrent intermittent ED/IM analgesic treatments, and new right otitis treated with antibiotics. Labs confirm hemoglobin fractions (Hgb S 66.0%, Hgb F 11.5%, Hgb A2 5.5%); exam is largely nonfocal but notable for sleep-disordered breathing with witnessed apneas and daily headaches causing functional impairment, prompting referrals for sleep study, neurology/ophthalmology, and continuation of outpatient management.

Diagnoses: Sickle-cell thalassemia beta-plus with vaso-occlusive pain/crisis, Sickle-cell disease with pain, Status post splenectomy (asplenia), Sleep-disordered breathing/suspected obstructive sleep apnea, Chronic headaches, Chronic back pain, Attention-deficit hyperactivity disorder (ADHD), Anxiety and depression (stable), Sickle cell retinopathy (overdue follow-up), Stuttering, Elevated hemoglobin F, Elevated hemoglobin A2, Hemoglobin S detected

Functional Assessment: Reports difficulty walking/driving during headaches and feels unrefreshed in the morning due to disordered sleep; snoring and witnessed events may impair function. (19F 32)

Laboratory Results: Glucose 82 (11/2021); cholesterol normal (9/2022); Hepatitis C antibody negative (2015); ACR normal (2/2024). 12/12/2024 15:41 CST: LDH 185 U/L; Hemoglobin fractions: Hgb A 17.0%, Hgb F 11.5% (high), Hgb S 66.0%, Hgb A2 5.5% (high). CBC: WBC 6.68 x10^3/cmm, Hgb 12.1 g/dL, Hct 35%, Platelets 326 x10^3/cmm. RBC indices: RBC 4.75 x10^6/cmm, MCV 74 fL, MCH 25 pg, MCHC 34 g/dL, RDW 18.9% (high), MPV 8 fL. Differential: Neutrophils 36%, Lymphocytes 43%, Monocytes 11%, Eosinophils 5%, Basophils 3% (high), Atypical lymphs 2%, NRBC 1. Reticulocyte % 2.5% (high), Retic absolute 0.1175 x10^6/cmm, RBC retic 4.75 x10^6/cmm. (19F 33, 35-36)

Objective: Vitals: T 98.3 F, HR 75 bpm, SpO2 97%, BP 118/79 mmHg (mean NIBP 92 mmHg), pain score 8, weight 205.1 lb, BMI 27.06. General: alert and oriented, no acute distress, normocephalic. Lungs clear to auscultation, non-labored respirations. Cardiovascular: normal rate and regular rhythm. Musculoskeletal: moving all extremities. Neurologic: alert and oriented, grossly intact cranial nerves II–XII, normal sensory and motor exam, normal deep tendon reflexes, funduscopic exam with crisp disc margins, mildly impaired balance and heel-to-toe walking. (19F 31-32)

Subjective: The claimant reported being lost to follow-up since 9/2022 with ongoing sickle cell care, one ER visit in 2023, intermittent IV/IM pain medication treatments every few months, and rare pain med use. Recent right ear pain with decreased hearing and prior urgent care diagnosis of ear infection; prior left acute otitis treated with antibiotics and audiogram follow-up recommended but patient no-showed. Reports sleep-disordered breathing with nightly "sleep paralysis," snoring, witnessed apneic events, feeling unrefreshed, and history of nighttime shortness of breath after presumed pneumonia. Endorsed daily headaches since this summer with photophobia, no phonophobia, no nausea/vomiting, no vision changes but feels impaired for walking/driving during headaches; poor response to ibuprofen, acetaminophen, and migraine medications. Reports ADHD treated by a new provider with Qelbree (viloxazine) and risperidone for impulsivity and anxiety/depression; prior use of sertraline (Zoloft) noted. Longstanding stutter worse when tired. Low mood improved off night shift (PHQ-2 = 0). Married, not using contraception. (19F 29-30, 32-33)

Medications: Augmentin (2 weeks) recommended for ear infection; Flonase (fluticasone nasal spray) BID and antihistamine recommended. PenVK prophylaxis noted. Outpatient medications: atomoxetine 25 mg daily, baclofen 5 mg TID, diclofenac topical, ergocalciferol 1.25 mg weekly, fexofenadine 180 mg daily, fluticasone nasal spray BID, hydroxyurea 1000 mg daily,

ibuprofen 800 mg TID, naloxone nasal 4 mg once, viloxazine 100 mg nightly (Qelbree). PRN: HYDROcodone-acetaminophen and morphine listed. Risperidone noted for impulsivity/anxiety/depression; prior sertraline (Zoloft) use noted. Recommend considering magnesium, riboflavin, and coenzyme Q10 supplements. (19F 29-30, 32-33)

Assessment and Plan: Return visit for primary care sickle cell follow-up. Left acute otitis treated with antibiotics; audiogram follow-up recommended but patient no-showed. Chronic back pain with referral to PM&R and follow-up scheduled. Sleep-disordered breathing with nightly events and snoring; plan referral for sleep evaluation/total sleep study. Daily headaches with nonfocal neurologic exam; plan to evaluate for intracranial abnormality and venous sinus thrombosis with referral to Dr. Collins, consider neurology referral if uncontrolled, and provide handout with follow up in 6–8 weeks. Refer to ophthalmology (Parkview) for visual and retina evaluation given concerns and overdue diabetic/retina follow-up. Status post splenectomy with vaccinations noted. Will request records from new ADHD provider and continue to monitor mood and stutter. (19F 29-30, 32-33, 35)

Citation: 19F 29-33, 35-36

2024-12-18 | Unknown Facility / Duncan, Angela R MD

Summary: This consult evaluates suspected obstructive sleep apnea with loud snoring, frequent excessive daytime sleepiness limiting work, nightly sleep paralysis and parasomnias, and delayed sleep phase; exam noted Mallampati II with redundant soft palate and BMI ~27. Plan is diagnostic split/night polysomnography with parasomnia monitoring and consideration of PAP therapy if indicated; labs showed mild microcytic anemia (Hgb 12.1).

Diagnoses: Overweight (BMI 27.0-27.9), Delayed sleep phase syndrome, Excessive daytime sleepiness, Parasomnia, Obstructive sleep apnea, Snoring, Sickle cell disease, Post-splenectomy, Sickle cell retinopathy, At risk of venous thromboembolus, ADHD

Procedures: Plan for sleep studies including split/night polysomnogram (PSG) and parasomnia monitoring. (19F 52)

Functional Assessment: Not working since 10/2023 and applying for disability; reports excessive daytime sleepiness limiting function. (19F 50)

Laboratory Results: 10/3/24 normal CMP; mild microcytic anemia with Hgb 12.1. (19F 52)

Objective: Vitals 12/18/2024: HR 76 bpm, RR 18/min, O2 sat 97%, BP 116/59 mmHg (diastolic 59 LOW), weight 205 lb, height 73 in. General: alert and oriented, steady gait, behavior appropriate. HEENT: pupils equal and reactive, extraocular movements intact, oral mucosa moist, Mallampati II with redundant soft palate, no pharyngeal erythema. Lungs clear to auscultation. Cardiovascular: normal rate and rhythm. Neurologic: alert, oriented, normal motor function. Psychiatric: cooperative, normal mood and judgment. (19F 51-52)

Subjective: The claimant reported snoring, loud snoring that wakes his wife and occasional choking, frequent daytime sleepiness, episodes of sleep paralysis nearly every night, parasomnia events, morning headaches, jerking legs during sleep, and delayed sleep phase symptoms. The claimant has not worked since 10/2023 and is applying for disability. (19F 50, 52)

Medications: Baclofen 5 mg oral TID; fluticasone nasal (Flonase) 50 mcg 2 sprays BID; ibuprofen 800 mg oral TID; naloxone 4 mg nasal once; HYDROcodone-acetaminophen (Norco) 5/325 mg PRN for pain. (19F 50)

Assessment and Plan: Suspected obstructive sleep apnea with excessive daytime sleepiness, parasomnias, and delayed sleep phase. No prior sleep studies; plan diagnostic polysomnography (split/night PSG) with parasomnia monitoring, discuss positive airway pressure (PAP) therapy if indicated, and provide safety and behavioral recommendations. Disability documentation to be addressed as part of sleep evaluation. (19F 50, 52)

Citation: 19F 49-52

2024-12-19 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient attended an office visit for immunization, received education on nutrition, exercise, and pain management and acknowledged understanding; care plan was reviewed and agreed upon with the covering physician. Current medications include hydroxyurea, norco (hydrocodone-acetaminophen), ibuprofen, naloxone nasal spray, and viloxazine.

Diagnoses: Encounter for immunization

Subjective: The claimant received education on nutrition, exercise, and pain management and acknowledged understanding. (19F 44)

Medications: Hydroxyurea 500 mg, 2 caps PO daily; Hydrocodone-acetaminophen (Norco) 5-325 mg, 1 tab PO every 4 hrs PRN; Ibuprofen 800 mg, 1 tab PO TID; Naloxone nasal 4 mg spray; Viloxazine 100 mg oral capsule, 1 cap nightly (bedtime), 30 capsules prescribed on 08/30/2024. (19F 44-45)

Assessment and Plan: Care discussed with covering physician who agrees with the plan of care as noted. Encounter for immunization noted; diagnosis reviewed 12/17/2024. (19F 44, 47)

Citation: 19F 44-48

2024-12-23 | Unknown Facility / Bennett, Amanda K MD

Summary: Overnight polysomnography showed an initial AHI of 18.5 (consistent with moderate OSA); CPAP titration reduced AHI to 1.4 events/hour. CPAP titration was performed and APAP 5–15 cm H2O with a medium ResMed AirFit F40 full-face mask and humidification was recommended, with nursing to clarify DME/prescription location.

Diagnoses: Obstructive sleep apnea

Procedures: CPAP titration performed during overnight sleep study. (19F 162)

Imaging: Sleep study (polysomnography) on 12/23/2024: initial AHI 18.5, AHI 1.4 with CPAP titration. (19F 162)

Objective: Sleep study initial portion AHI 18.5 prompting initiation of CPAP; during CPAP portion AHI 1.4 events/hour. (19F 162)

Assessment and Plan: Recommendation for APAP therapy 5–15 cm H2O with a medium ResMed AirFit F40 fullface mask and humidification; nursing to clarify DME/ prescription location. (19F 162)

Citation: 19F 162-163

2024-12-23 | Valley Medical / Desai, Priti C MD

Summary: Patient with sickle cell anemia presented with left-sided pleuritic chest pain worse with deep breaths and focal chest wall tenderness; ECG was normal and troponin nondiagnostic. CTA chest and chest x-ray were obtained, D-dimer was elevated (1.75 FEU µg/mL), and IV analgesia/fluids and contrast for imaging were administered given concern for a sickle cell–related chest process.

Diagnoses: Pleuritic chest pain, Sickle cell anemia

Procedures: 12-lead ECG performed. (21F 5)

Imaging: 12-lead ECG: normal sinus rhythm/normal electrocardiogram. CT angiography chest for pulmonary embolus (stat) completed 12/23/24. Portable chest x-ray completed 12/23/24. (21F 5, 8)

Laboratory Results: Laboratory studies performed 12/23/24: CBC with diff — WBC 8.5 x10^3/µL; RBC 4.87 x10^6/µL; Hgb 12.2 g/dL (low); Hct 35.3% (low); RDW 19.4% (high); Plt 312 x10^3/µL; MPV 7.3 fL (low). CMP — Na 137 mmol/L; Cl 109 mmol/L (high); Anion gap 5.4 (low); Creatinine 0.90 mg/dL; Glucose 83 mg/dL; AST 26 U/L. Cardiac/other labs — CPK/CK-MB completed; D-dimer 1.75 FEU µg/mL (high); reticulocyte count completed; Troponin I 0.014 ng/mL. (21F 8-9)

Objective: ECG interpreted as normal sinus rhythm with a normal electrocardiogram. Nursing assessments and vital signs over the last 24 hours: Temp 98.3 F; Pulse 72–92 bpm; Respirations 8–20/min; BP 147–149/83–91 mmHg; SpO2 98–99%. Exam: alert and oriented x3, cooperative; normocephalic, atraumatic; PERRL, EOMI; full neck ROM, no JVD; left-sided chest wall tenderness; lungs clear to auscultation bilaterally; heart regular rate and rhythm, no gallops or murmurs; abdomen soft, nondistended, non-tender; no CVA tenderness; thoracic and lumbar spine normal to inspection with normal ROM; neuro: alert and oriented x3; extremities full ROM; skin without lesions or rashes. ROS otherwise negative except positives listed in HPI. (21F 5-8)

Subjective: The claimant reported left-sided chest pain radiating to his back that started yesterday, worse with deep breaths; he uses shallow breathing to decrease pain. Chest pain was the reason for ECG. He denied fever, chills, nausea, or vomiting. (21F 1, 5-6)

Medications: Naproxen sodium 550 mg PO q12H PRN pain, #14 tablets (recorded 12/23/24). 0.9% sodium chloride IV bolus 1,000 mL given then discontinued. Iohexol IV contrast administered for imaging. Ketorolac 30 mg IV once. (21F 7-8)

Assessment and Plan: Electrocardiogram normal with no acute ischemic changes; report signed by interpreting physician. Pleuritic chest pain (acute). Evaluation in the ED with concern for a sickle cell–related chest process given history of sickle cell anemia. (21F 5-6)

Citation: 21F 1, 5-9

2024-12-23 | Valley Medical Main Laboratory / Desai, Priti C MD

Summary: Labs show mild anemia (Hgb 12.2 g/dL, Hct 35.3%) with high RDW (19.4%) and elevated reticulocyte count/absolute retic, suggesting increased red cell turnover (hemolysis or recent blood loss). D-dimer is markedly elevated at 1.75 FEU µg/mL, which raises concern for thromboembolic disease; basic chemistry otherwise notable for mild hyperchloremia (Cl 109 mmol/L).

Diagnoses: Anemia with increased RDW and reticulocytosis, Elevated D-dimer

Laboratory Results: WBC 8.5 x10^3/µL; Hgb 12.2 g/dL (low); Hct 35.3% (low); Plt 312 x10^3/µL; RDW 19.4% (high). Retic Abs 0.150 H; Retic Pct 3.08 H (hematology panel continued). D-dimer 1.75 FEU µg/mL (reference 0.00–0.50). Chemistry: Na 137 mmol/L; K 4.6 mmol/L; Cl 109 mmol/L (high); CO2 23 mmol/L; Anion gap 5.4 (low); Glucose 83 mg/dL; Ca 9.1 mg/dL; Total bilirubin 0.7 mg/dL; AST 26 U/L; ALT 27 U/L; CK 105 U/L; eGFR >90 mL/min/1.73 m2. Troponin I 0.014 ng/mL. Total Protein 7.8 g/dL; Albumin 4.50 g/dL; Alkaline Phosphatase 79 U/L; CKMB <0.22 (units not specified). (21F 16-19)

Citation: 21F 16-19

2024-12-23 | Valley Medical / Dixon, Nathan MD

Summary: CT pulmonary angiography and portable chest radiograph performed for chest pain and shortness of breath showed no pulmonary embolism and no acute cardiopulmonary abnormality; lungs clear and heart size normal. No acute thoracic process identified on imaging; follow-up as clinically indicated.

Diagnoses: Chest pain, Shortness of breath, No pulmonary embolism on CT angiography

Procedures: CT angio chest for evaluation of pulmonary embolism performed. XR chest 1V portable performed. (21F 2, 4)

Imaging: CT angiography chest: no evidence of pulmonary thromboembolism or other acute thoracic abnormality. XR chest 1V portable: heart size normal and lungs clear without focal consolidation, pleural effusion, or pneumothorax. (21F 2, 4)

Objective: Pulmonary arterial system well-opacified with no intraluminal filling defect; lungs clear without focal consolidation, no pleural effusion or pneumothorax; heart and mediastinum without acute abnormality. Heart size is normal; lungs clear without focal consolidation, pleural effusion, or pneumothorax; osseous and soft tissue structures intact. (21F 2, 4)

Subjective: Patient presented reporting chest pain and shortness of breath. Indication: reported chest pain. (21F 2, 4)

Assessment and Plan: Impression: No evidence of pulmonary thromboembolism or other acute thoracic abnormality; study signed by radiologist. No acute cardiopulmonary disease on portable chest radiograph; follow-up as clinically indicated. (21F 2, 4)

Citation: 21F 2-4

2024-12-23 | Emergency Department / Dixon, Nathan MD

Summary: 30-year-old man with sickle cell disease presented with left pleuritic chest pain; he was hemodynamically stable with normal oxygenation, unremarkable EKG, chest x-ray and chest CTA showed no consolidation, effusion, pneumothorax, or pulmonary embolism. Labs showed mild anemia and an elevated D-dimer; he received IV ketorolac in the ED and was advised outpatient hematology follow-up and return precautions.

Diagnoses: Pleuritic chest pain (pleurisy), Sickle cell disease

Procedures: IV Toradol given in the ED (anti-inflammatory intervention). (21F 10)

Imaging: Chest X-ray 12/23/24: heart size normal, lungs clear without focal consolidation, pleural effusion, or pneumothorax; Chest CTA 12/23/24: no evidence of pulmonary thromboembolism or other acute thoracic abnormality. CT angiogram of the chest showed no evidence of pulmonary thromboembolism or acute abnormality. Chest X-ray 12/23/24: no evidence of acute infiltrate or consolidation; heart size normal and lungs clear. (21F 10-12)

Laboratory Results: Albumin 4.50 g/dL. WBC 8.5 10^3/uL, Hgb 12.2 g/dL (low), Hct 35.3% (low); elevated D-dimer 1.75 (units not specified); troponin normal. (21F 10-12)

Objective: Vital signs: T 98.3 F, pulse 72 then 92, RR 20, NIBP 149/83, pulse oximetry 98%; patient comfortable on exam. EKG unremarkable; chest x-ray showed no acute infiltrate or consolidation; vitals include NIBP 147/91 and pulse oximetry 99%. Chest X-ray: heart size normal; lungs clear without focal consolidation or pleural effusion. (21F 10-12)

Subjective: Patient resting comfortably, in no acute distress, reported pleuritic symptoms; normal oxygen saturation and not tachycardic. The patient, a 30-year-old male, reported left-sided chest pain worse with inspiration and endorsed a history of sickle cell disease. (21F 10-11)

Medications: Toradol IV administered (dose not specified). IV Toradol administered in the ED. (21F 10-11)

Assessment and Plan: Suspect pleurisy causing symptoms; treated with IV anti-inflammatories in ED, outpatient follow-up with hematology recommended and return precautions given. Suspected pleurisy causing symptoms; outpatient follow-up with hematology arranged and return precautions given. Radiologist impression: chest x-ray shows no acute cardiopulmonary disease or consolidation. (21F 10-12)

Citation: 21F 10-12

2024-12-23 | Valley Medical Emergency Department / Dixon, Nathan MD

Summary: Patient presented to the ED with pleuritic chest pain; ECG was normal (sinus rhythm, rate 74, QTc 392) and chest CTA showed no pulmonary embolism or acute thoracic abnormality (no effusion or pneumothorax). Patient was treated symptomatically with naproxen, discharged in good condition with PCP follow-up and return precautions for worsening symptoms.

Diagnoses: Pleuritic chest pain

Imaging: Chest CTA: no evidence of pulmonary thromboembolism or other acute thoracic abnormality; no effusion or pneumothorax. (21F 13)

Objective: ECG: normal sinus rhythm, rate 74, no ectopy, no ST changes, QTC 392. Chest CTA: no evidence of pulmonary thromboembolism or other acute thoracic abnormality; no effusion or pneumothorax. (21F 13)

Subjective: Patient reported chest pain described as pleuritic. (21F 13)

Medications: Naproxen sodium (Anaprox DS) 550 mg PO Q12H PRN, qty 14. (21F 13)

Assessment and Plan: Clinical impression: pleuritic chest pain; patient discharged home in good condition with PCP follow-up and return to ED for worsening symptoms. (21F 13)

Citation: 21F 13-15

2024-12-31 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient seen for psychiatric follow-up for generalized anxiety disorder and coexisting mood symptoms; reports no illicit drug use or tobacco. Vitals stable, medications (Qelbree 100 mg qHS, risperidone 1 mg BID, trazodone 50 mg PRN) continued, behavioral homework provided, and referral/appointment to outpatient psychiatry arranged for 01/28/2025.

Diagnoses: Sickle cell-hemoglobin SS disease, Mood disorder, Generalized anxiety disorder, Attention deficit hyperactivity disorder, combined type, Insomnia disorder related to another mental disorder

Objective: Vitals: RR 20, HR 73, BP 117/73, Wt 93.7 kg, BMI 27.3, Ht 6 ft 1 in (measurements dated 12/31/2024). (22F 25)

Subjective: Patient presented for follow-up of generalized anxiety disorder and related mood symptoms. Reported no illicit/recreational drug use and stated 'Never smoker.' (22F 25, 31)

Medications: Qelbree 100 mg capsule daily at bedtime; Risperidone 1 mg tablet twice daily; Trazodone 50 mg tablet as needed (all prescribed 12/31/24). (22F 25)

Assessment and Plan: Follow-up visit for generalized anxiety disorder and mood disorder; medications prescribed/continued and plan for ongoing psychiatric follow-up. Homework given including deep breathing, journaling, and exercise; return to clinic in 1 month and referral/appointment to Faith Community Psychiatry - Woodlawn on 01/28/2025. (22F 25, 29)

Citation: 22F 25, 29, 31

2025-01-02 | Unknown Facility / Curtis, Ashley M CRNP

Summary: 30-year-old man with HbS/Beta thalassemia and prior splenectomy presented with a 5-day worsening vaso-occlusive pain crisis of the lower back, arms, and legs and was treated with IV Dilaudid PCA and 500 mL D5W. Hip x-rays showed patchy sclerosis consistent with bone infarcts (left acetabulum, right intertrochanteric femur) and lumbar endplate anomalies consistent with sickle cell–related changes; labs notable for mild anemia (Hgb 12.4 g/dL) and low glucose (62 mg/dL).

Diagnoses: Sickle cell disease (HbS/Beta thalassemia), Vaso-occlusive crisis (sickle cell pain crisis), Bone infarcts of the hips (left acetabulum and right intertrochanteric femur), Chronic spinal pain, Endplate anomalies of lumbar vertebrae (sickle cell–related), Degenerative joint disease (mild)

Procedures: IV analgesia and IV fluids administered for sickle cell infusion visit: Dilaudid 2 mg IV load with Dilaudid PCA 0.3 mg q15 min; D5W 500 mL over 4 hours. (19F 83, 87)

Imaging: Hip AP and lateral: patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis, fracture, or malalignment; mild degenerative disease; sacroiliac joints without fracture or erosive changes. Lumbar spine AP and lateral: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease; no fracture, malalignment, or degenerative/erosive changes. (19F 84, 86)

Laboratory Results: 1/2/2025 — Sodium 135 mMol/L, Potassium 4.6 mMol/L, Chloride 102 mMol/L, Bicarbonate 24 mMol/L, AGAP 9.0 mMol/L, Glucose 62 mg/dL (low), BUN 11 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m², Calcium 9.7 mg/dL, Adjusted Calcium 9.3 mg/dL, Protein 7.8 g/dL, Albumin 4.5 g/dL, Total Bilirubin 0.7 mg/dL, Alk Phos 67 U/L, ALT 18 U/L, AST 19 U/L, LDH 232 U/L. CBC: WBC 6.73 x10^3/cmm, Hgb 12.4 g/dL (low), Hct 36% (low), Platelets 414.6 x10^3/cmm (high), RBC 4.96 x10^6/cmm, MCV 74 fL (low), MCH 25 pg (low), RDW 19.1% (high), Absolute neutrophils 4.04 x10^3/cmm, Absolute lymphocytes 1.78 x10^3/cmm. (19F 85-86)

Objective: Vitals: 1/2/2025 16:52 CST — HR 103 bpm, RR 16/min, SpO2 99%, BP 116 mmHg. Additional vitals recorded: Temp 97.8°F, HR 63 bpm, RR 16/min, SpO2 98%, BP 125/73 mmHg. Exam: alert and oriented, lungs clear to auscultation, regular cardiac rhythm with mild tachycardia, normal range of motion and strength, non-tender abdomen, stutter noted in speech. (19F 84-85)

Subjective: The claimant is a 30-year-old man with HbS/Beta Thal and history of splenectomy presenting for vaso-occlusive crisis (VOC) pain progressively worsening over 5 days with chronic pain exacerbation. He reports pain in the lower back, arms, and legs. He requests IV pain medication and IV fluids. At home he has been taking baclofen, ibuprofen, and Norco with little relief and uses heat and hydration. He reports taking hydroxyurea 1000 mg daily without issues. He denies shortness of breath, chest pain, fever, chills, cough, abdominal pain, nausea/vomiting/diarrhea, sore throat, runny nose, or loss of taste/smell. (19F 83-85, 87)

Medications: Home/continued medications and PRN orders: Hydroxyurea 1000 mg daily (continue 2 capsules daily), Hydrocodone-acetaminophen 5/325 mg PRN q4h for severe pain, Ibuprofen 800 mg TID (listed; also ibuprofen PRN per pain action plan), Baclofen 5 mg TID (listed; also baclofen PRN per pain action plan), Diclofenac topical, Fluticasone nasal, Naloxone nasal spray. In-clinic/acute: Dilaudid IV per PCA protocol. (19F 83-84, 87)

Assessment and Plan: Sickle cell infusion visit for acute vaso-occlusive pain; plan for IV analgesia and fluids and symptomatic management. SCD-related chronic spinal pain with hip bone infarcts, likely exacerbation of chronic pain; plan includes follow-up with spine doctor next month and continue current medications. Clinic note documents vitals, exam, and lab review; no explicit diagnosis or treatment plan listed on this page. Imaging findings consistent with bone infarcts in the hip region and endplate anomalies of the lumbar spine suggestive of sickle cell–related changes; mild degenerative disease noted and SI joints without fracture or ankylosis; consider MRI for further SI joint evaluation if concern for sacroiliitis. (19F 83-87)

Citation: 19F 83-87

2025-01-03 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient with sickle cell disease experienced chest discomfort and received an infusion with repeated reassessments showing pain reduced to a tolerable range; advised home management with oral pain medication, increased oral intake (≥64 oz/day), rest, and clinic contact if needed. A 3–7 day Holter monitor was performed (result dated 03/14/2025) to evaluate the noted sinus arrhythmia.

Diagnoses: Sickle cell disease, Chest discomfort, Sinus arrhythmia

Imaging: Holter Monitor (3 to 7 Days) performed; result date 03/14/2025 13:14 CDT. (19F 90)

Objective: Patient was reassessed several times throughout an infusion and pain was noted to be reduced to a tolerable range. (19F 88)

Subjective: Patient reported pain that was reduced to a tolerable range and was advised to manage at home with oral (PO) pain medication and hydration. (19F 88)

Medications: Oral (PO) pain medication prescribed/recommended (unspecified). (19F 88)

Assessment and Plan: Plan to manage pain at home with PO pain medication, increase oral intake to at least 64 oz/day, rest, and contact clinic if further assistance is needed. (19F 88)

Citation: 19F 88-90

2025-01-13 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Burke, Natalie A CRNP

Summary: Patient with sickle-cell/β-thalassemia presented in vaso-occlusive crisis with progressive back, arm, and leg pain and was treated with IV analgesia and IV fluids; patient reported nonadherence to home hydroxyurea. Pelvic and lumbar x-rays showed patchy sclerosis of the acetabulum/intertrochanteric region and lumbar endplate anomalies consistent with sickle cell disease with no fracture, and labs demonstrated Hgb 12.2 g/dL, reticulocyte 2.4%, ferritin 24 ng/mL.

Diagnoses: Low back pain, Pain in left arm, Pain in left leg, Pain in right arm, Sickle-cell thalassemia beta plus with crisis, Sickle cell disease, Degenerative lumbar disease, Sickle cell crisis

Imaging: Hip AP/Lat and pelvis: patchy sclerosis involving left acetabulum and right intertrochanteric femur, mild degenerative disease. Lumbar AP and lateral: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease. No fracture or malalignment. (19F 75)

Laboratory Results: Urine albumin/creatinine ratio 9.4 (2/20/2024). Ferritin 24 ng/mL (2/20/2024). Chemistry and hematology collected 01/13/2025 13:09 CST: Sodium 136 mMol/L, Potassium 4.3 mMol/L, Chloride 103 mMol/L, Bicarbonate 25 mMol/L, AGAP 8.0 mMol/L, Glucose 71 mg/dL, BUN 14 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.4 mg/dL, Adjusted Calcium 9.2 mg/dL, Albumin 4.3 g/dL, Bilirubin total 0.7 mg/dL, Alkaline phosphatase 62 U/L, ALT 13 U/L, AST 15 U/L, LDH 196 U/L. CBC: WBC 7.35 x10^3/cmm, Hgb 12.2 g/dL, Hct 36%, Platelet 356.4 x10^3/cmm, RBC 4.98 x10^6/cmm, MCV 73 fL, RDW 18.7%. Differential: Monocytes 7%, Eosinophils 4%, Basophils 2%, NRBC 1/100 WBC. Peripheral smear/interp: Anisocytosis 1+, Hypochromia 1+, Ovalocytes rare, Target cells occasional, Schistocytes rare, Spherocytes rare. Reticulocyte % 2.4, Retic absolute 0.1195 x10^6/cmm, RBC retic 4.95 x10^6/cmm. Interpretive notes: adjusted calcium calculation described; notes that sulfasalazine may cause false low ALT and that vitamin B6 deficiency may decrease aminotransferase activity (ALT, AST). (19F 75, 79-81)

Objective: General: alert and oriented, no acute distress. Eye: extraocular movements intact. HENT: normocephalic, oral mucosa moist. Cardiovascular: regular rhythm with mild tachycardia. Respiratory: lungs clear to auscultation. GI: abdomen soft, non-tender, non-distended, normal bowel sounds. Musculoskeletal: normal range of motion and strength. Neurologic: alert and oriented; speech: stutter. (19F 74-75)

Subjective: The claimant reported progressively worsening vaso-occlusive (VOC) pain over the prior 2 days with pain in the back, arms, and legs, and presented for IV pain medication and IV fluids. The claimant stated he has been taking baclofen, ibuprofen, and Norco at home and hydrating, and reported cold weather worsened pain. The claimant stated he is not taking

hydroxyurea 1000 mg daily, which he feels is causing increased pain. Denied shortness of breath, chest pain, fever, chills, cough, abdominal pain, nausea/vomiting/diarrhea, sore throat, rhinorrhea, or loss of taste/smell. (19F 73-75)

Medications: Home/active medications: hydroxyurea 1000 mg daily (patient reported not taking), ibuprofen 800 mg PO TID, Norco (hydrocodone-acetaminophen) 5/325 mg PRN q4h, baclofen 5 mg TID. Additional listed agents: topical diclofenac, fluticasone nasal, naloxone nasal spray. (19F 73-74)

Assessment and Plan: Vaso-occlusive sickle cell pain crisis treated with IV pain medication and IV fluids; symptomatic management and infusion visit care to continue. Acute update notes the claimant was noncompliant with hydroxyurea, contributing to pain; advised to restart hydroxyurea and continue current pain regimen with follow-up as needed. Sickle cell plan with transition care documented. Concern for sacroiliitis; recommendation that MRI pelvis/SI joints with and without contrast could be performed for more sensitive evaluation. Labs obtained 01/13/2025. (19F 73-75, 79)

Citation: 19F 73-75, 77-82

2025-01-28 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient seen for follow-up and medication management of generalized anxiety disorder; vitals stable (BP 134/79, HR 75) and prescriptions (Qelbree 100 mg nightly, risperidone 1 mg 1.5 tabs twice daily, trazodone 100 mg nightly) provided. Encounter documented by NP with return to clinic in one month and a psychiatry appointment scheduled.

Diagnoses: Generalized anxiety disorder, Mood disorder, Attention-deficit/hyperactivity disorder, Sickle cell disease (SS), Insomnia disorder

Objective: Vitals: RR 20, HR 75, BP 134/79, Wt 97.4 kg, BMI 28.3, Ht 6 ft 1 in. (22F 18)

Subjective: The claimant presented for follow-up for generalized anxiety disorder and medication management. (22F 18)

Medications: Qelbree 100 mg capsule extended release: 1 capsule nightly; Risperidone 1 mg: 1.5 tablets twice daily; Trazodone 100 mg: 1 tablet nightly. (22F 18)

Assessment and Plan: Follow-up for generalized anxiety disorder with ongoing medication management and prescriptions provided. Encounter performed and documented by Danielle Ramsey, NP with sign-off on 01/28/2025; return to clinic in one month and scheduled psychiatry appointment noted. (22F 18, 22)

Citation: 22F 18, 22-24

2025-02-02 | Unknown Facility / Maxwell, Sharon DO

Summary: Emergency visit for chest pain and palpitations with a HEART score of 1. Chest radiograph was normal (no consolidation, effusion, or pneumothorax); patient was diagnosed with sinus arrhythmia and palpitations, had microcytic indices on CBC (MCV 74 fL, RDW 19.2%) noted, and was discharged home.

Diagnoses: Sinus arrhythmia, Palpitations

Imaging: Chest AP portable 02/02/2025: cardiomediastinal silhouette within normal limits; no focal consolidation, pleural effusion, or pneumothorax. (19F 62, 66)

Laboratory Results: RBC 5.03 10^6/cmm; MCV 74 fL low; MCH 25 pg low; MCHC 33 g/dL; RDW 19.2% high; Neutrophils 57%, Abs Neutrophils 4.03 10^3/cmm; Lymphocytes 27%, Absolute Lymphocytes 1.93 10^3/cmm; Monocytes 10%, Eosinophils 4%, Basophils 2%. (19F 62)

Objective: HEART score 1; chest exam/imaging interpreted with no focal consolidation, pleural effusion, or pneumothorax and cardiomediastinal silhouette within normal limits. The cardiomediastinal silhouette is within normal limits with no focal consolidation, pleural effusion, or pneumothorax. (19F 62, 66)

Subjective: Patient reported chest pain and palpitations. (19F 62)

Assessment and Plan: Final diagnosis listed as sinus arrhythmia and palpitations; patient discharged home; medical emergency noted. Final radiology report signed 02/02/2025 noting reviewed images and agreement with findings. (19F 62, 66)

Citation: 19F 62, 66

2025-02-02 | Unknown Facility / Murray, Kevin L MD

Summary: 12-lead ECG was performed on 02/02/2025 at 18:04 CST (accession CV-25-0017974). No interpretation or results are included in this event record; cardiology report is referenced but not provided here.

Imaging: ECG performed (accession CV-25-0017974) on 02/02/2025 at 18:04 CST; cardiology report follows. (19F 69)

Citation: 19F 69

2025-02-02 | Grandview Highlands / Murray, Kevin L MD

Summary: 12-lead ECG at 60 BPM showed sinus rhythm with PR 150 ms, QRS 98 ms, QTc (Bazett) 356 ms, and findings of possible right ventricular conduction delay with nonspecific ST changes; overall interpreted as a borderline ECG. No acute ischemic changes or frank arrhythmia were identified.

Diagnoses: Sinus rhythm, Right ventricular conduction delay, Nonspecific ST changes

Imaging: 12-lead ECG: sinus rhythm with possible right ventricular conduction delay and nonspecific ST changes; interpreted as borderline ECG. (19F 70)

Objective: ECG measurements: PR 150 ms, QRS 98 ms, QT 334 ms, QTc Bazett 356 ms, ventricular heart rate 60 BPM. (19F 70)

Assessment and Plan: Sinus rhythm with possible right ventricular conduction delay and nonspecific ST changes; ECG considered borderline. (19F 70)

Citation: 19F 70-72

2025-02-02 | Unknown Facility / Tucker, Ryan A MD

Summary: 30-year-old man with sickle cell disease presented with palpitations and intermittent left-sided chest pain; vitals were reassuring, chest wall was tender to palpation, ECG showed normal sinus rhythm with sinus arrhythmia, chest x-ray was unremarkable, and hs-troponin I (15 ng/L) did not suggest acute coronary syndrome. Labs showed mild microcytic anemia and peripheral smear with occasional sickle cells; cardiology referral was recommended and ED assessment deemed low suspicion for ACS.

Diagnoses: Chest pain, Palpitations, Sinus arrhythmia, Sickle cell disease

Imaging: Chest x-ray reported as unremarkable. (19F 61)

Laboratory Results: 02/02/2025 20:10 CST: Sodium 134 mmol/L, Potassium 4.3 mmol/L, Chloride 100 mmol/L, Bicarbonate 24 mmol/L, Glucose 72 mg/dL, BUN 12 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Magnesium 1.8 mg/dL, Calcium 9.3 mg/dL, Free T4 0.85 ng/dL, TSH 0.736 mIU/L. hs Troponin-I 15 ng/L. CBC: WBC 7.07 x10^3/cmm, RBC 5.03 x10^6/cmm, Hgb 12.4 g/dL (low), Hct 37% (low), Platelets 330 x10^3/cmm, MCV 74 fL, MCH 25 pg, MCHC 33 g/dL, RDW 19.2%, Neutrophils 57% (absolute 4.03 x10^3/cmm), Lymphocytes 27% (absolute 1.93 x10^3/cmm), Monocytes 10%, Eosinophils 4%, Basophils 2%. Peripheral smear/comments: Polychromasia 1+, Microcytosis 2+, Anisocytosis 1+, Hypochromia 1+, Target cells few, Occasional sickle cells. CDC HIV Non-Reactive; CDC Hep C Antibody Non-Reactive. (19F 61, 63-64)

Objective: Vitals: T 98.3 F, HR 66 bpm, RR 16/min, SpO2 98%, BP 108/58 mmHg. General: alert, no acute distress, skin warm and dry. HEENT/neck: EOMI, oral mucosa moist, neck supple. Lungs clear to auscultation. Cardiac: regular rhythm, no edema. Chest wall: left upper parasternal tender to palpation. ECG: rate 60, normal sinus rhythm with sinus arrhythmia. (19F 60-61)

Subjective: 30-year-old male with sickle cell disease reported palpitations and left-sided chest pain since 2 AM; pain intermittent, dull, localized to the left inframammary area, nonradiating. Denies diaphoresis, paresthesias, nausea/vomiting, lightheadedness, or fever. Vitals described as reassuring. (19F 60-61)

Assessment and Plan: ED assessment: chest pain in a patient with sickle cell disease with sinus arrhythmia on ECG. Low suspicion for acute coronary syndrome. Cardiology referral recommended. Patient given return precautions; ED evaluation ongoing per physician note. (19F 60-61)

Citation: 19F 60-61, 63-64

2025-02-02 | Grandview Highlands Laboratory / Tucker, Ryan A MD

Summary: Portable AP chest radiograph was performed for chest pain with comparison to prior study from 02/13/2019; no interpretation or impression was provided on the report page. Imaging was obtained to evaluate chest pain but no radiologic findings are documented in this record.

Diagnoses: Chest pain

Imaging: Chest AP portable radiograph performed; no interpretation or impression printed on this page. (19F 65)

Objective: Chest AP portable exam was performed with comparison to 02/13/2019 noted. (19F 65)

Subjective: Patient reported chest pain per clinical information on the radiology request. (19F 65)

Citation: 19F 65

2025-02-06 | PM&R Clinic / Barrett, Lisa M MD

Summary: The claimant with known sickle cell disease presented with severe, chronic low back pain with associated leg and arm pain and neuropathic features that significantly limit activities of daily living (requires assistance with showering and dressing) despite prior analgesics. Exam was nonfocal; treatment started with duloxetine and increased baclofen, topical diclofenac and continued hydroxyurea/analgesics, with referrals to PM&R and outpatient/ aquatic physical therapy.

Diagnoses: Chronic low back pain (mechanical), Myofascial pain, Sickle cell disease, Neuropathic pain, Chronic headache

Procedures: Splenectomy 12/04/2019; Robotic adrenalectomy 12/04/2019. (19F 110)

Functional Assessment: Activities significantly impacted by pain; requires assistance with personal care (showering and dressing) and is not working due to symptoms. (19F 109)

Objective: Vitals: T 97.3 F, HR 65 bpm, BP 113/69 mmHg, SpO2 97%, Pain score 8, Weight 205 lb, Height 73 in, BMI 27.05. The claimant is alert and oriented, no acute distress. Pupils equal, extraocular movements intact, normal oral mucosa. No focal neuropathic features or balance issues on exam. The claimant states he is hydrated. (19F 109, 111)

Subjective: The claimant reported low back pain with associated leg pain and arm pain. History of sickle cell disease with ongoing sickle cell-related pain. Low back pain described as throbbing, sharp, constant, worsened with movement. Prior medications (ibuprofen, hydrocodone-acetaminophen, baclofen) provided partial relief; pain rated 10/10 without medications and 6/10 with medications. Reports drowsiness from Norco, weakness in extremities, and limited activities of daily living requiring assistance with showering and dressing. Endorsed feeling highly stressed and sleeping concerns; appetite good. Sexual activity variably documented. Reports never using substances and never smoker. Review of systems otherwise negative. (19F 108-111)

Medications: Start duloxetine 30 mg PO daily; baclofen increased to 10 mg PO TID (previously 5 mg PO TID); diclofenac topical gel; fluticasone nasal spray 50 mcg 2 sprays BID; hydroxyurea 1000 mg daily; ibuprofen 800 mg TID; naloxone nasal spray 4 mg once; hydrocodone-acetaminophen (Norco) 5/325 mg PRN. (19F 109-110)

Assessment and Plan: Diagnoses: low back pain, sickle cell-related pain, and neuropathic pain. Plan: start duloxetine 30 mg daily and increase baclofen to 10 mg TID; consider outpatient physical therapy and aquatic therapy; referral to PM&R for evaluation and management. Follow up in 3 months or sooner as needed. (19F 108-109)

Citation: 19F 108-111

2025-02-07 | Unknown Facility / Spencer, Andrea N MD

Summary: MRI demonstrates mildly dilated optic nerve sheaths concerning for possible raised intracranial pressure; radiologist recommends clinical correlation and consideration of a dedicated temporal bone CT as indicated.

Diagnoses: Mildly dilated optic nerve sheaths, Raised intracranial pressure (possible/differential)

Imaging: Report notes mildly dilated optic nerve sheaths with differential consideration for raised intracranial pressure and recommends clinical correlation and dedicated temporal bone CT as indicated. (19F 117)

Objective: MRI safety screen: no implants, pacemaker, defibrillator, deep brain stimulator, aneurysm clips, or other metallic contraindications documented; history of anemia noted. (19F 117)

Subjective: Patient completed MRI safety screening and endorsed a history of anemia/blood diseases. (19F 117)

Assessment and Plan: Radiologist recommends clinical correlation for possible raised intracranial pressure and consideration of dedicated temporal bone CT. (19F 117)

Citation: 19F 117-119

2025-02-09 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Duncan, Angela R MD

Summary: Patient presented with insomnia and concerns about sleep; clinician provided education on sleep hygiene, CBT/I Coach app, and follow-up for insomnia and sleep apnea. Labs largely within normal limits aside from a glucose of 62 mg/dL and hematologic findings (moderate target cells, mild microcytosis, reticulocyte 2.4%) consistent with underlying hemoglobinopathy/sickle cell disease; medications include opioid analgesic with naloxone prescribed.

Diagnoses: Insomnia, Sleep apnea, Sickle cell crisis

Laboratory Results: 01/02/2025 12:04 CST: Sodium 135 mmol/L, Potassium 4.6 mmol/L, Chloride 102 mmol/L, Bicarbonate 24 mmol/L, AGAP 9.0 mmol/L, Glucose 62 mg/dL, BUN 11 mg/dL; Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73 m2, Calcium 9.7 mg/dL, Adjusted Calcium 9.3 mg/dL, Albumin 4.5 g/dL; Bilirubin total 0.7 mg/dL, Alk Phos 67 U/L, ALT 18 U/L, AST 19 U/L, LDH 232 U/L; WBC 6.73 x10^3/cmm, Hgb 12.4 g/dL, Hct 36%, Platelet 414.6 x10^3/cmm, Neutrophils 60%, Lymphocytes 26%. Collected 01/02/2025 12:04 CST: Eosinophils 3%, Basophils 1%, Polychromasia 1+, Microcytosis 2+, Anisocytosis 1+, Hypochromia 1+, Target cells: moderate; Stomatocytes: few; Reticulocyte 2.4%, Retic absolute 0.1180 x10^6/cmm, RBC retic 5.02 x10^6/cmm. AST: note states in patients with vitamin B6 deficiency, serum/plasma aminotransferase activity may be decreased. (19F 56-58)

Subjective: The claimant reported insomnia and concerns about sleep; education topics included insomnia and sleep apnea. (19F 53)

Medications: baclofen 5 mg 1 tab PO TID; diclofenac topical 1% gel topical QID; fluticasone nasal 50 mcg 2 sprays BID; hydrocodone-acetaminophen (Norco) 5/325 mg 1 tab PO q4h PRN (30 tabs); ibuprofen 800 mg 1 tab PO TID; naloxone nasal spray 4 mg/0.1 mL PRN; atomoxetine 25 mg 1 cap PO daily. (19F 53-54)

Assessment and Plan: Provided education on insomnia and sleep apnea; advised sleep hygiene and CBT/I Coach app; documented counseling and follow-up as appropriate. (19F 53)

Citation: 19F 53-59

2025-02-10 | Unknown Facility / Bennett, Amanda K MD

Summary: MRV performed to evaluate daily headache and possible venous sinus thrombus showed no venous sinus thrombosis or stenosis and no acute intracranial hemorrhage or infarct; hypoplastic right transverse/sigmoid sinus and jugular bulb were identified and deemed likely developmental. Additional findings included mild prominence of the optic nerve sheaths, bilateral maxillary sinus mucous retention cysts, and a moderate right mastoid effusion; follow-up per ordering clinician was recommended.

Diagnoses: Headache, Sickle cell disease

Imaging: MR Angio Venous Head without contrast; MRV shows no venous sinus stenosis or thrombosis and hypoplastic right transverse and sigmoid sinuses and jugular bulb, likely developmental. (19F 115)

Objective: No acute infarct or hemorrhage, no mass effect or herniation; ventricles and extra-axial spaces normal; flow voids intact; mild prominence of optic nerve sheaths, mucous retention cysts in bilateral maxillary sinuses, and moderate right mastoid effusion. (19F 115)

Subjective: Patient reported daily headache and history of sickle cell disease; exam ordered to evaluate venous sinus thrombus and other vascular causes. (19F 115)

Assessment and Plan: No acute intracranial hemorrhage or infarct and no venous sinus thrombosis identified; hypoplastic right transverse/sigmoid sinus likely developmental. Follow-up as indicated by ordering clinician. (19F 115)

Citation: 19F 115

2025-02-10 | Unknown Facility / Spencer, Andrea N MD

Summary: MR brain and MRV show no acute intracranial process and no venous sinus thrombosis or stenosis; there is mild prominence of the optic nerve sheaths and a moderate right mastoid effusion. The mastoid effusion may reflect otomastoiditis—clinical correlation and a dedicated temporal bone CT are recommended.

Diagnoses: Right mastoid effusion, Prominent optic nerve sheaths, Headache

Imaging: MR Brain w/o contrast/MR Angio Venous Head: no acute intracranial process, no venous sinus thrombosis or stenosis, mild optic nerve sheath prominence, moderate right mastoid effusion. (19F 116)

Objective: No acute infarct or hemorrhage, no mass effect or herniation; mild prominence of the optic nerve sheaths; moderate right mastoid effusion; MRV shows no venous sinus stenosis or thrombosis. (19F 116)

Subjective: Reported daily headache and history of sickle cell disease. (19F 116)

Assessment and Plan: No acute intracranial process and no venous sinus thrombosis; moderate right mastoid effusion possibly secondary to otomastoiditis; recommend clinical correlation and dedicated temporal bone CT. (19F 116)

Citation: 19F 116

2025-02-11 | Unknown Facility / West, Emily M PA

Summary: Patient with 3 weeks of right ear pain and decreased hearing after an URI; exam and audiology show right middle ear effusion with Type B tympanogram, intact tympanic membrane with middle ear fluid, SRT 20 dB right vs 10 dB left and word recognition 100% at a higher presentation level on the right. ENT/otology referral recommended for possible tympanostomy tube placement and observation.

Diagnoses: Decreased hearing right ear, Middle ear effusion, Sickle cell disease, Post-splenectomy, Splenomegaly, ADHD, Sickle cell retinopathy

Procedures: Prior splenectomy on 12/04/2019 documented. (19F 125)

Objective: Audiology: SRT left ear 10 dB, right ear 20 dB; WRS left 100% at 50 dB, right 100% at 60 dB. Tympanometry: Type B right ear (1.6 ecv), Type A left ear. Vitals stable. Right ear canal clear; tympanic membrane intact with fluid in the middle ear. Left ear clear. Neurologic and general exam benign. (19F 123, 126)

Subjective: The claimant reported 3 weeks of right ear pain and decreased hearing following a recent upper respiratory infection and acute otitis media. He stated he was previously treated with ofloxacin otic drops, denies ear drainage, and

endorses tinnitus. He reported feeling highly stressed with sleeping concerns, good appetite, and lives with his spouse. (19F 123, 125-126)

Medications: Ofloxacin otic drops (prior treatment); baclofen 5 mg TID; baclofen 10 mg TID; diclofenac topical (Voltaren 1% gel) topical QID; duloxetine (Cymbalta) 30 mg daily; fluticasone nasal spray 50 mcg 2 sprays BID; hydroxyurea 1000 mg daily; hydroxyurea 500 mg 2 caps daily; ibuprofen 800 mg TID; naloxone nasal spray 4 mg once; hydrocodone-acetaminophen (Norco) 5 mg-325 mg 1 tab every 4 hours PRN. (19F 123-124, 127)

Assessment and Plan: Decreased hearing of the right ear with right middle ear effusion. Plan: ENT/otology referral for possible tympanostomy tube placement and observation. (19F 123, 126)

Citation: 19F 123-128

2025-02-11 | Unknown Facility / Keller, Jennifer L CCC-A

Summary: Audiology/audiogram document dated 02/11/2025 is on file but this page provides no specific test results; the record lists sensorineural hearing loss of the right ear, indicating a unilateral hearing impairment. No audiometric values or degree of loss are reported here to quantify functional limitation.

Diagnoses: Sensorineural hearing loss, right ear

Imaging: Audiology/audiogram document dated 02/11/2025 (no specific results reported on this page). (19F 120)

Citation: 19F 120

2025-02-11 | Grandview Medicine Hoover ENT & Facial Plastic Surgery, 820 Lakeshore Drive, Hoover, AL / Keller, Jennifer L CCC-A

Summary: Audiogram and tympanometry show mild right hearing threshold elevation (AC PTA 25 dB, BC PTA 20 dB, SII 87%) with a Type B tympanogram (1.6 ECV), consistent with a right middle ear effusion causing mild conductive hearing loss; left ear demonstrates normal hearing (AC PTA 10 dB, BC PTA 8 dB, SII 96%, Type A tympanogram).

Diagnoses: Right middle ear effusion, Right mild conductive hearing loss, Normal left hearing

Imaging: Audiogram with plotted thresholds for both ears showing mild right hearing threshold elevation and normal left thresholds; tympanometry tracings included. (19F 121)

Objective: Audiogram: Right AC PTA 25 dB, BC PTA 20 dB, SII 87%. Left AC PTA 10 dB, BC PTA 8 dB, SII 96%. (19F 121)

Assessment and Plan: Tympanograms: Right ear Type B (1.6 ECV), Left ear Type A; audiometric results consistent with right middle ear process and normal left ear function. (19F 121)

Citation: 19F 121-122

2025-02-12 | Primary Care Sickle Cell (Grandview) / Bennett, Amanda K MD

Summary: Patient with sickle cell disease and chronic back pain presented with increased extremity/back pain and frequent headaches; brain MRI showed a moderate right mastoid effusion (possible otomastoiditis) and mildly dilated optic nerve sheaths, prompting ENT referral and consideration of dedicated temporal bone CT. Sleep study recommended CPAP for suspected obstructive sleep apnea and care was coordinated for CPAP supplies, ophthalmology for SCD retinopathy, and cardiology for palpitations.

Diagnoses: Attention-deficit hyperactivity disorder, unspecified, Childhood Onset Fluency Disorder, Chronic back pain, Headache, unspecified, Nonproliferative sickle-cell retinopathy, unspecified eye, Right mastoid effusion, Otomastoiditis, Obstructive sleep apnea, Sinus arrhythmia, Sickle cell disease, Splenomegaly, History of splenectomy

Imaging: MRI: No acute intracranial process or venous sinus thrombosis; moderate right mastoid effusion possibly secondary to otomastoiditis; mildly dilated optic nerve sheaths. Recommendation for dedicated temporal bone CT as indicated. (MRI obtained 2 days prior showed moderate right mastoid effusion possibly secondary to otomastoiditis.) (19F 157, 159)

Objective: Temperature 98.3 F, heart rate 77 bpm (02/12 timestamp), SpO2 97%, blood pressure 120/76 mmHg, pain score 8, weight 205.9 lb, BMI 27.17. General: alert and oriented. Lungs clear to auscultation. Cardiac: normal rate and rhythm. Neurologic and speech: intact. (19F 158-159)

Subjective: The claimant reported increased pain in arms, legs, and back, ongoing chronic back pain and current sickle cell disease (SCD) pain episodes, and was having headaches; stated he did not take any opiates today and stopped flonase which he felt did not help. He complained of frequent headaches despite not daily, reported an MRI 2 days prior showing moderate right mastoid effusion and ENT referral. He endorsed fatigue, poor sleep, snoring, nocturnal sleep paralysis consistent with obstructive sleep apnea (OSA) symptoms, reported having a sleep study in December with CPAP recommended, and has follow-up to obtain CPAP supplies. He reported worse stuttering when in pain and when tired. Ongoing follow-up items include headache diary review, CPAP use, ensuring eye exam for SCD retinopathy, and routine follow-up coordinated with sickle cell care. (19F 157, 159-161)

Medications: Stopped flonase. The claimant is not taking hydroxyurea because it causes back pain. Outpatient medications listed: baclofen 5 mg TID and baclofen 10 mg TID, duloxetine (Cymbalta) 30 mg daily, fluticasone nasal spray 50 mcg BID, hydroxyurea 1000 mg daily, ibuprofen 800 mg TID, naloxone nasal spray 4 mg PRN, hydrocodone-acetaminophen (Norco) 5 mg/325 mg every 4 hrs PRN. Risperidone and Qelbree (for ADHD) documented. Vaccines listed: Tdap, Menveo, MenB, Prevnar, Pneumovax. (19F 157-158, 160)

Assessment and Plan: Headaches with MRI showing moderate right mastoid effusion possibly related to otomastoiditis; clinical correlation recommended and dedicated temporal bone CT and ENT consideration/referral. Impression: ongoing headaches possibly related to right mastoid effusion/otomastoiditis. Sleep apnea with CPAP recommended; follow-up to obtain supplies. Chronic back pain with PMNR recommending duloxetine pending psychiatrist approval. Overdue ophthalmology follow-up for SCD retinopathy; referral planned. Referred cardiology for palpitations/arrhythmia follow-up. Plan: contact otologist/assist scheduling ENT and dedicated temporal bone CT as indicated, encourage headache diary, headache follow-up in 3 weeks via telehealth, review HA diary, CPAP follow-up, ensure comprehensive eye exam, follow up on mood with PHQ-9/GAD-7 and whether duloxetine was started for back pain, and routine visit in 3–4 months coordinated with sickle cell care. (19F 157, 159-161)

Citation: 19F 156-161

2025-02-18 | Unknown Facility / Barrett, Lisa M MD

Summary: Patient presents with lumbar/thoracic back pain worsened by extension and lateral bending with tenderness over thoracic and lumbar paraspinal muscles and bilateral shin/quad musculature. Neurologic exam intact with 5/5 strength throughout, grossly intact sensation, normal patellar and Achilles reflexes, and negative bilateral straight leg raise.}

Diagnoses: Lumbar/thoracic pain, Paraspinal muscle tenderness

Objective: Respirations non-labored, symmetrical chest expansion; 5/5 strength in bilateral upper and lower extremities, sensation grossly intact, reflexes normal at patellar and Achilles; negative SLR bilaterally; tenderness to palpation over thoracic and lumbar spine and paraspinal muscles. (19F 112)

Subjective: Patient reported pain with flexion and extension of the lumbar spine, worse with extension and with lateral side bending bilaterally, and tenderness over thoracic and lumbar paraspinal muscles and bilateral shins/quad musculature. (19F 112)

Medications: Medication list includes baclofen 5-10 mg TID, diclofenac topical gel, duloxetine 30 mg daily, hydrocodone-acetaminophen PRN, fluticasone nasal spray among others. Medication list includes: Hydrocodone-acetaminophen (Norco) 5 mg/325 mg tablets PRN q4h, Hydroxyurea 500 mg capsules 2 caps daily (1,000 mg total), Ibuprofen 800 mg tablets TID, Naloxone 4 mg/0.1 mL nasal spray, Baclofen 5 mg tablets TID, Diclofenac topical 1% gel, Fluticasone nasal spray 50 mcg 2 sprays BID. (19F 112-113)

Assessment and Plan: Lumbar/thoracic pain with paraspinal muscle tenderness and normal strength/sensation; evaluated and plan documented by clinician with follow-up as indicated. (19F 112)

Citation: 19F 112-114

2025-02-24 | Unknown Facility / Carson, Mitchell PA-C

Summary: The patient with HbS/beta-thalassemia and prior splenectomy presented with a vaso-occlusive crisis causing lower back and bilateral leg pain and received IV opioids and IV fluids. Imaging showed patchy sclerosis consistent with bone infarcts and lumbar endplate changes from sickle cell disease; labs notable for mild anemia (Hgb 11.2 g/dL) and elevated reticulocyte count (3.1%).

Diagnoses: Hemoglobin S/beta-thalassemia with vaso-occlusive crisis, Pain in lower back and legs (dorsalgia and bilateral leg pain), Chronic pain, Post-splenectomy status, Bone infarcts

Procedures: IV pain medication and IV fluid infusion administered for acute sickle cell vaso-occlusive pain. (19F 149)

Imaging: Hip AP: patchy sclerosis of the left acetabulum and right intertrochanteric femur suggesting bone infarcts; no femoral head osteonecrosis or fracture. Lumbar AP/lateral: endplate anomalies of several lumbar vertebral bodies consistent with sickle cell disease. (19F 152)

Laboratory Results: 2/24/2025 labs: Sodium 135 mMol/L, Potassium 4.1 mMol/L, Glucose 79 mg/dL, Creatinine 0.8 mg/dL, eGFR >90 mL/min/1.73m2, Hemoglobin 11.2 g/dL (low), Hematocrit 33% (low), MCV 73 fL (low), RDW 19.6% (high). Absolute lymphocytes 3.57 x10^3/cmm; Monocytes 3% (low); Reticulocyte 3.1% (high). (19F 151-152)

Objective: Vitals documented with two sets: heart rate 80 and 69 bpm; respiratory rate 16 and 18 br/min; SpO2 98%; blood pressure readings recorded as 127/124/124/86/62 mmHg. Exam: alert and oriented, extraocular movements intact, normocephalic, oral mucosa moist. Cardiovascular: regular rhythm, mild tachycardia. Lungs clear to auscultation, respirations non-labored. Musculoskeletal: normal range of motion and strength but reports pain in back, arms, and legs. Neurologic: alert and oriented; speech noted as stutter. Peripheral smear: lymphocytes 50%, absolute lymphocytes 3.57 x10^3/cmm, monocytes 3% (low), reticulocyte 3.1% (high) with other smear abnormalities. Radiographs reviewed (see imaging). (19F 150-152)

Subjective: The claimant, a 30-year-old male with HbS/Beta Thalassemia status post splenectomy, reported 3 days of lower back and leg pain attributed to a vaso-occlusive crisis. The claimant reported taking baclofen, ibuprofen, and Norco at home with little relief; endorses hydrating and using heat. Denies shortness of breath, chest pain, fever, chills, cough, abdominal pain, nausea, vomiting, diarrhea, sore throat, runny nose, or loss of taste/smell. Reports ongoing pain management needs and current medication regimen for pain control. (19F 149-150, 152)

Medications: Hydroxyurea 1000 mg daily; Ibuprofen 800 mg TID; Norco (hydrocodone-acetaminophen) 5/325 mg Q4h PRN; Baclofen 5-10 mg oral TID; Duloxetine 30 mg daily; Fluticasone nasal spray 50 mcg 2 sprays BID; Diclofenac topical 1% gel PRN; Naloxone 4 mg nasal once. (19F 149-150)

Assessment and Plan: Acute sickle cell vaso-occlusive episode affecting lower back and legs treated with IV pain medication and IV fluids. Continue home medications and hydration. Pain management regimen reviewed; no medication refills provided today. Follow-up per clinic as needed. Sickle cell plan for vaso-occlusive pain documented with treatment in ITU today and transition of care/updated plans noted. (19F 149-150, 152)

Citation: 19F 149-152

2025-03-06 | Unknown Facility / Bennett, Amanda K MD

Summary: Patient reports marked improvement in headaches (only one since last visit) and ongoing palpitations/fluttering; a Holter monitor worn by the patient captured episodes and results will be reviewed. Noted inconsistent risperidone use and active medical issues including sickle cell disease, VTE risk, and history of splenectomy/splenomegaly.

Diagnoses: Headache, unspecified, Palpitations, At risk of venous thromboembolus, Sickle cell disease (hemoglobin S), Splenomegaly, History of splenectomy, Stuttering

Objective: General: Alert and oriented, no acute distress. Eye: Extraocular movements intact. HENT: Normocephalic. (19F 141)

Subjective: Patient reported headaches improved with only one headache since last visit and inconsistent risperidone use; endorsed fluttering/chest palpitations and wore a Holter monitor with episodes noted. (19F 140)

Medications: Risperidone mentioned with inconsistent use (no dose listed). Baclofen 5 mg and 10 mg oral TID, diclofenac topical 1% gel topical QID, duloxetine 30 mg daily, fluticasone nasal spray 50 mcg 2 sprays BID, hydroxyurea 1000 mg daily, ibuprofen 800 mg TID, naloxone 4 mg nasal once; PRN hydrocodone-acetaminophen (Norco) 5 mg-325 mg 1 tab every 4 hrs PRN. (19F 140-141)

Assessment and Plan: Follow-up for improved headaches and ongoing evaluation of palpitations with Holter monitoring; plan to review Holter results. (19F 140)

Citation: 19F 140-141

2025-03-06 | Grandview / Bennett, Amanda K MD

Summary: Telehealth visit for sickle cell crisis with labs showing mild microcytic anemia (Hgb 11.2 g/dL, Hct 33%, MCV 73 fL), marked RDW elevation (19.6%), reticulocytosis (3.1%) and presence of NRBCs and RBC morphological abnormalities consistent with hemolysis. Basic metabolic panel and liver tests were within normal limits (creatinine 0.8 mg/dL, eGFR >90, normal bilirubin/ALT/AST), and the patient is on hydroxyurea and as-needed opioids among other medications.

Diagnoses: Sickle cell crisis

Laboratory Results: 2/24/2025 10:29 CST: Sodium 135 mmol/L, Potassium 4.1 mmol/L, Chloride 103 mmol/L, Bicarbonate 23 mmol/L, AGAP 9.0 mmol/L, Glucose 79 mg/dL, BUN 8 mg/dL; Creatinine 0.8 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 8.8 mg/dL, Adjusted Calcium 8.8 mg/dL, Protein 7.0 g/dL, Albumin 4.0 g/dL; Bilirubin total 0.6 mg/dL, Alk Phos 63 U/L, ALT 13 U/L, AST 16 U/L, LDH 184 U/L, WBC 7.15 x10^3/cmm, Hgb 11.2 g/dL; Hct 33%, Platelet 291 x10^3/cmm, RBC 4.49 x10^6/cmm, MCV 73 fL, MCH 25 pg, MCHC 34 g/dL, RDW 19.6%, MPV 8 fL, Neutrophils 40%, Absolute Neutrophils 2.86 x10^3/cmm, Lymphocytes 50%, Absolute Lymphocytes 3.57 x10^3/cmm. Collected 2/24/2025 10:29 CST: Monocytes 3%, Eosinophils 5%, Basophils 0%, Atypical lymphs 2%, NRBC 4/100 WBC, Micro 2+, Anisocytosis 1+; Ovalocytes rare, Target cells few, Burr cells occasional, Acanthocytes rare; Reticulocyte % 3.1%, Retic absolute 0.1462 x10^6/cmm, RBC retic 4.68 x10^6/cmm. (19F 145-146)

Medications: baclofen 5 mg and 10 mg oral TID; diclofenac (Voltaren) topical 1% QID; duloxetine 30 mg daily; fluticasone nasal 50 mcg 2 sprays BID; hydrocodone-acetaminophen (Norco) 5/325 PRN q4h; hydroxyurea 500 mg oral twice daily; ibuprofen 800 mg TID; naloxone 4 mg nasal once; risperidone 2 mg BID. (19F 143)

Assessment and Plan: Sickle cell crisis noted on 2/24/2025. (19F 145)

Citation: 19F 143-146

2025-03-10 | Unknown Facility / Walsh, Maria C MD

Summary: CT petrous temporal bones shows extensive right mastoid air cell effusions with right middle ear cavity opacification and only mild left tympanic membrane thickening with otherwise normally aerated left mastoid air cells. Imaging demonstrates findings consistent with Eustachian tube dysfunction and a right mastoid effusion; a clinical concern for possible CSF leak was noted but not definitively identified on the study.

Diagnoses: Eustachian tube dysfunction, Mastoid effusion

Imaging: CT petrous temporal bones (CT orbit w/o contrast) showing right mastoid effusion with middle ear opacification and left tympanic membrane thickening with otherwise expected appearance. (19F 136)

Objective: Right: extensive mastoid air cell effusions and middle ear cavity opacification; left: slight tympanic membrane thickening, mastoid air cells normally aerated and no middle ear opacification. (19F 136)

Subjective: Presented for CT orbit/petrous temporal bones for mastoid effusion and possible CSF leak as clinical concern. (19F 136)

Assessment and Plan: Clinical diagnosis: Eustachian tube dysfunction; imaging demonstrates right mastoid effusion and findings concerning for possible CSF leak per clinical indication. (19F 136)

Citation: 19F 136

2025-03-10 | Unknown Facility / Hawkins, Gregory H MD

Summary: CT temporal bones demonstrates a right mastoid effusion with right middle ear opacification; no acute osseous abnormality, tegmen tympani thinning, or superior semicircular canal dehiscence identified to suggest a CSF leak. Left external auditory canal was normal with mild tympanic membrane thickening.

Diagnoses: Right mastoid effusion, Right middle ear opacification, Left tympanic membrane thickening

Imaging: CT temporal bones (Stenver and Poschl reformats): right mastoid effusions; otherwise essentially negative petrous temporal bones without thinning of the tegmen tympani or superior semicircular canal dehiscence. CT temporal bones/orbits without contrast: right mastoid effusions; otherwise essentially negative CT scans of the petrous temporal bones with no thinning of tegmen tympani or superior semicircular canal dehiscence. (19F 137-138)

Objective: Right: external auditory canal and tympanic membrane normal; extensive mastoid air cell effusions and middle ear opacification. Left: external auditory canal normal with slight tympanic membrane thickening. Mastoid air cells normally aerated, middle ear cavity no opacification, tegmen tympani normal without thinning or dehiscence, ossicles normal, labyrinthine structures expected appearance. (19F 137-138)

Subjective: Reported mastoid effusion and concern for possible CSF leak. (19F 137)

Assessment and Plan: Radiology impression: right mastoid effusions; otherwise no acute osseous abnormality or dehiscence identified on CT temporal bones. Right mastoid effusions on CT of the temporal bones; otherwise no acute osseous abnormality identified. (19F 137-138)

Citation: 19F 137-139

2025-03-12 | Unknown Facility / Walsh, Maria C MD

Summary: Patient with right-sided hearing loss and tinnitus after an URI was found to have impacted cerumen obscuring the tympanic membrane, middle turbinate edema, and signs of eustachian tube dysfunction/negative middle ear pressure; impacted cerumen was removed under microscopy without complications. Management included fluticasone nasal spray, autoinflation exercises, tinnitus counseling, and plan for repeat audiogram in 3 months.

Diagnoses: Impacted cerumen, Eustachian tube dysfunction, Inferior turbinate hypertrophy, Middle turbinate edema, Negative middle ear pressure (right), Right sensorineural hearing loss, Attention deficit hyperactivity disorder (ADHD), HbS/beta thalassemia, Post-splenectomy status, At risk of venous thromboembolus

Procedures: History of splenectomy 12/04/2019 and robotic adrenalectomy 12/04/2019. Nasal endoscopy. Debridement/removal of impacted cerumen from the right ear using operating microscope and micro-instruments; procedure tolerated without complications and provided good visualization of the tympanic membrane. (19F 130, 132)

Imaging: none. (19F 132)

Laboratory Results: 02/24/25 CBC: HGB 11.2, WBC 7.15, HCT 33, MCV 73, PLT 291. BMP/chemistry: Albumin 4.0, Na 135, K 4.1, BUN 8, Creatinine 0.8. Thyroid: TSH 0.736, Free T4 0.85. (Values dated 02/24/25 or 02/02/25.) (19F 132-133)

Objective: Constitutional: No fever, no chills, no sweats, no fatigue. Vital signs: Temp 98.0 F, O2 sat 97%, BP 121/30 mmHg, weight 210.4 lb, height 73 in. General: Well developed, well nourished. HEENT: No recent visual problems, no double vision; conjunctivae and sclerae without lesions; ears with patent external auditory canals and translucent, mobile tympanic membranes when visualized; tympanic membrane not visualized pre-procedure due to copious cerumen; nasal endoscopy: middle turbinate edematous, middle meatus left with active drainage/obstruction, nasopharynx clear. Neck without lymphadenopathy. Respiratory: symmetric respiratory effort, no shortness of breath or cough. Cardiovascular: no palpitations. Gastrointestinal: no abdominal pain. Neuro/psychiatric: alert and oriented x4; elsewhere documented oriented x3; normal

mood and affect; cranial nerves II–XII intact; no spontaneous or gaze nystagmus; no abnormal balance or confusion noted. Patient tolerated procedure without complications. (19F 129-133)

Subjective: The claimant reported right-sided hearing loss, right ear pressure, hearing difficulty on the right, and concerns about tinnitus since September 2024 following an upper respiratory infection; left ear hearing reported as normal. Symptoms did not improve after ofloxacin ear drops. Prior treatments included Augmentin x14 days, fluticasone nasal spray (Flonase), and an oral antihistamine. Denied respiratory, cardiovascular, gastrointestinal symptoms and denied neurologic symptoms including numbness, tingling, or headache. During an unrelated encounter the clinician observed impacted cerumen in the right ear and the claimant agreed to debridement. Past medical history notable for HbS/beta thalassemia. (19F 129-130, 132-133)

Medications: Previously prescribed: Augmentin x14 days; ofloxacin ear drops. Current/other medications documented: Baclofen 5 mg PO TID; Duloxetine (Cymbalta) 30 mg PO daily; Fluticasone nasal 50 mcg/inh, 2 sprays BID; Hydrocodone-acetaminophen (Norco) 5/325, 1 tab PRN q4h for pain; oral antihistamine. (19F 129, 134)

Assessment and Plan: Right sensorineural hearing loss with chronic eustachian tube dysfunction, inferior turbinate hypertrophy, and impacted cerumen. Evaluation included consideration of middle ear effusion and eustachian tube dysfunction. Impacted right ear cerumen removed under microscopy without complication; claimant tolerated procedure well. Management included fluticasone nasal spray BID, autoinflation exercises, discussion of hearing conservation and tinnitus management, and plan to return in 3 months with repeat audiogram. Education provided; evaluated by APP and MD; follow-up as needed. (19F 129, 132-134)

Citation: 19F 129-135

2025-03-12 | The Piedmont Clinic of Grandview / Walsh, Maria C MD

Summary: Audiometry with insert earphones shows normal to near-normal hearing bilaterally (AC PTA R 18 dB/BC 12 dB, AC PTA L 10 dB/BC 5 dB; SII R 89%, L 95%). Tympanometry demonstrated right middle ear negative pressure (Type C, -260 daPa) with a left Type A tympanogram, suggesting right Eustachian tube dysfunction despite preserved hearing.

Diagnoses: Normal hearing, Right middle ear negative pressure (Type C tympanogram)

Objective: Audiogram: AC PTA R 18 dB, BC PTA R 12 dB, SII R 89%; AC PTA L 10 dB, BC PTA L 5 dB, SII L 95%. Tympanometry: Right Type C (-260 daPa), Left Type A. (19F 165)

Assessment and Plan: Audiometric testing demonstrates normal to near-normal hearing thresholds bilaterally with right middle ear negative pressure (Type C tympanogram); inserts were used. (19F 165)

Citation: 19F 165-166

2025-03-12 | Unknown Facility / Ross, Amy CCC-A

Summary: Audiogram performed on 03/12/2025 confirmed and documented sensorineural hearing loss (SNHL); results were reviewed with the patient. No additional findings or severity/ laterality details are provided in the record.

Diagnoses: Sensorineural hearing loss (SNHL)

Imaging: Audiology-audiogram performed 03/12/2025 at 14:40 CDT (Audiology-Audiogram-Walsh, MD). (19F 164)

Assessment and Plan: SNHL (sensorineural hearing loss) documented and reviewed on 03/12/2025. (19F 164)

Citation: 19F 164

2025-03-13 | Hematology Clinic / Kapoor, Arjun V MD

Summary: Patient with known sickle-cell thalassemia beta-plus in crisis presented with several days of acute low back pain that prohibits ambulation and function; exam notable for lower back tenderness and pain with external rotation of the left lower extremity. Ferritin was low at 18 ng/mL; disability paperwork is being pursued and symptom management/follow-up arranged.}

Diagnoses: Attention-deficit hyperactivity disorder, Acute low back pain, Sickle-cell thalassemia beta-plus with crisis, Iron deficiency (low ferritin)

Functional Assessment: Pain has prohibited ambulation and normal function; unable to participate in interview and wife is pursuing disability paperwork. (19F 167)

Laboratory Results: Ferritin 18 ng/mL (11/21/2023); albuminuria/proteinuria 11/21/2023 interpretation: none. (19F 168)

Objective: General: alert and oriented; extraocular movements intact; HENT moist; cardiovascular regular; abdomen soft non-tender; musculoskeletal: pain with palpation in lower back and pain with external rotation of LLE; lungs clear to auscultation; neurologic alert; speech: stutter. (19F 168)

Subjective: Patient reported several days of acute low back pain that has prohibited his ability to ambulate and function; has not taken opioids and only used ibuprofen. Reported pain with palpation in the lower back and pain elicited with external rotation of the left lower extremity. (19F 167-168)

Medications: Ibuprofen (patient-reported use), no opioids taken today. Baclofen 5 mg TID and 10 mg TID, diclofenac topical (Voltaren 1%), duloxetine 30 mg daily, fluticasone nasal 50 mcg 2 sprays BID, hydroxyurea 1000 mg daily, ibuprofen 800 mg TID, naloxone 4 mg nasal once, risperidone 2 mg BID; PRN hydrocodone-acetaminophen (Norco) 5/325 1 tab q4h PRN. (19F 167-168)

Assessment and Plan: Acute low back pain in a patient with sickle cell disease; follow-up and disability paperwork being pursued. Sickle Cell Plan documented; follow-up and management per clinic notes. (19F 167-168)

Citation: 19F 167-168

2025-03-14 | Grandview / Collins, Sarah E MD

Summary: Nine-day Holter monitoring showed predominant sinus rhythm (average HR 79 bpm, range 44–87) with rare PACs (<1%, including 9 short SVT runs, longest 4 beats) and rare PVCs (<1% burden); no atrial fibrillation, ventricular tachycardia, or significant pauses were observed. A Mobitz I (Wenckebach) second-degree AV block was detected; outpatient follow-up recommended as indicated.

Diagnoses: Sinus rhythm, Premature atrial contractions, Premature ventricular contractions, 2nd-degree AV block Mobitz I

Imaging: Holter report: analyzed duration 9 days; predominant sinus rhythm with average rate 79 bpm (range 44-87); rare PACs (<1%, 9 runs of SVT, longest 4 beats); rare PVCs with burden <1%; no VT detected; 2nd degree AV block Mobitz I (Wenckebach) detected; no significant pauses. (19F 91)

Assessment and Plan: Holter monitoring demonstrates predominant sinus rhythm with rare PACs and PVCs, presence of Mobitz I second-degree AV block, and no atrial fibrillation or VT; outpatient follow-up as indicated. (19F 91)

Citation: 19F 91

2025-03-18 | Comprehensive Sickle Cell Center, Grandview / Kapoor, Arjun V MD

Summary: Claimant experiences weekly vaso-occlusive pain crises from chronic sickle cell disease leading to frequent unpredictable missed days of work or school, sometimes manageable at home with prescribed narcotic/analgesic medications that cause drowsiness but at times requiring homebound care or hospitalization. Follow-up is recommended at least every three months, often monthly, with ongoing clinic documentation available.

Diagnoses: Sickle cell disease with recurrent vaso-occlusive pain crises

Functional Assessment: May require homebound care or hospitalization during crises and needs clinic follow-up at least every three months, sometimes once or twice monthly; frequent unpredictable missed work days. (20F 1)

Subjective: Reports the claimant experiences weekly pain crises with frequent recurrences causing missed days of work or school and difficulty maintaining employment; sometimes manageable at home with prescribed medications that may cause drowsiness. (20F 1)

Medications: Prescribed medications for sickle cell pain are referenced but specific drug names/doses are not listed. (20F 1)

Assessment and Plan: Chronic sickle cell disease with frequent vaso-occlusive pain crises impacting function and employment; follow-up and further documentation available via clinic contact. (20F 1)

Citation: 20F 1; 19F 1-3

2025-03-24 | Unknown Facility / Carson, Mitchell PA-C

Summary: Patient with Sickle cell disease (HbS/β-thalassemia), post-splenectomy, reports overall clinical improvement but ongoing hip pain with ambulation; plans were made to initiate monthly exchange transfusions and pursue MRI for the acute low back/hip pain. Recent labs show low ferritin (18 ng/mL); no new functional limitations documented and patient able to proceed with scheduled treatments.

Diagnoses: Sickle cell disease (HbS/β-thalassemia), Status post splenectomy, Acute low back and hip pain, ADHD, Obstructive sleep apnea, Iron deficiency (low ferritin)

Functional Assessment: No new functional limitations documented; patient ambulatory and able to pursue MRI and transfusion scheduling. | Reported difficulty ambulating initially but improved and now able to ambulate though still with hip pain. (19F 172-173)

Imaging: Plan to pursue MRI per Dr. Kapoor. (19F 173)

Laboratory Results: Ferritin 18 ng/mL (11/21/2023); albuminuria/proteinuria interpretation none (11/21/2023). (19F 173)

Objective: General: alert and oriented, no acute distress; respirations non-labored; neurologic exam alert and oriented; cognition and speech: stutter; psychiatric: cooperative with appropriate mood and affect. (19F 173)

Subjective: Patient reported feeling much better overall, still has hip pain but is able to ambulate and wants to proceed with monthly transfusions; denies chest pain, SOB, cough, fever, chills, abdominal pain, N/V/D. Patient reported acute onset low back pain about 2 weeks ago with difficulty ambulating; improved but still having hip pain. (19F 172-173)

Medications: Baclofen 5 mg oral TID and 10 mg oral TID, diclofenac topical gel, duloxetine (Cymbalta) 30 mg daily, fluticasone nasal spray 2 sprays BID, hydroxyurea 1000 mg daily, ibuprofen 800 mg oral TID, naloxone nasal 4 mg once. Risperidone 2 mg PO BID; Hydrocodone-acetaminophen (Norco) 5 mg/325 mg 1 tab PO every 4 hours PRN for pain. (19F 172-173)

Assessment and Plan: Plan to proceed with/schedule monthly exchange transfusions, reviewed expectations and risks, patient acknowledged understanding and follow-up arranged. Sickle cell disease (HbS/Beta Thal) follow-up, status post splenectomy; continue monthly exchange transfusion plan, pursuing MRI, no other changes. (19F 172-173)

Citation: 19F 172-173

2025-03-24 | Grandview Medicine / Unknown Provider

Summary: The record documents a robotic splenectomy on 12/04/2019 with post-splenectomy status and documented subsequent vaccinations (Haemophilus b conjugate, multiple influenza and meningococcal immunizations). Clinically the patient has sickle cell disease, SNHL, and ADHD, is considered at increased risk for VTE, and reports sleep disturbance with significant work-related stress.

Diagnoses: Sickle cell disease, Post-splenectomy status, Attention-deficit/hyperactivity disorder (ADHD), Sensorineural hearing loss (SNHL), At risk for venous thromboembolism (VTE)

Procedures: Laparoscopy, surgical, splenectomy (Procedure Date 12/04/2019); Robotic surgical system (Procedure Date 12/04/2019) noted in procedure history. Splenectomy documented 12/04/2019. Haemophilus b conjugate (PRP-T) vaccine given 11/12/2019; Lot 3P252, expiration 1/10/2021. Immunizations documented include influenza vaccinations on 12/05/2019, 12/08/2022, and 12/12/2024, and meningococcal vaccinations on 03/23/2022 and 09/15/2022. (19F 179-182)

Subjective: The claimant reported sleeping concerns and feeling highly stressed related to work; diet regular with good appetite. Family history: mother positive for depression; father positive for high blood pressure and depression; other relative positive for stroke. (19F 180-181)

Citation: 19F 179-183; 18F 1

2025-03-25 | Unknown Facility / Carson, Mitchell PA-C

Summary: Claimant presented for back pain and endorsed intermittent mild to severe pain episodes requiring multiple PRN analgesics (opioids and NSAIDs) with a pain action plan in place; hydroxyurea is continued. Plan includes coordinating exchange transfusions, recommending lumbar vs pelvic MRI, and follow-up with Dr. Kapoor in 2–3 months.

Diagnoses: Back pain, LUQ pain, ADHD, Sickle cell disease, Sickle cell crisis

Imaging: Recommend lumbar vs pelvic MRI. (19F 174)

Subjective: The claimant reported back pain, agreed to scheduling exchange transfusions, and endorsed episodes of mild and severe pain requiring PRN analgesic medications. (19F 174)

Medications: Hydroxyurea 500 mg daily (also documented as 2 capsules daily); hydrocodone-acetaminophen 5/325 mg every 4 hours PRN (Norco) and hydrocodone-acetaminophen 325 mg/10 mg 1 tab PO every 4 hours PRN; Percocet (oxycodone-acetaminophen 10/325) 1 tab PO every 6 hours PRN (60 tabs documented 12/07/2018); Tylenol with Codeine #3 (codeine-acetaminophen) 1 tab PO every 6 hours PRN; morphine 15 mg PRN q4h; ibuprofen 600 mg PO 1 tab QID and ibuprofen 800 mg PRN; baclofen 5 mg PO TID; cyclobenzaprine 5 mg nightly; naloxone 4 mg nasal spray; ergocalciferol 1.25 mg weekly; penicillin V potassium 250 mg BID; dextroamphetamine-amphetamine 10 mg BID; docusate 100 mg BID. (19F 174, 176-178)

Assessment and Plan: Pain action plan in place with continuation of medications; coordinate exchange transfusions; follow up with Dr. Kapoor in 2-3 months. (19F 174)

Citation: 19F 174-178

2025-03-26 | Unknown Facility / Carson, Mitchell PA-C

Summary: Patient with sickle cell vaso-occlusive crisis and back pain received IV Dilaudid (2 mg load with 0.3 mg Q15min PCA), D5W 500 mL infusion, ondansetron and diphenhydramine; pain improved to 5/10 and labs were described as reassuring. Patient was advised to hydrate, rest, continue hydroxyurea and PRN oral analgesics, and follow up with the Spine Clinic.

Diagnoses: Sickle cell disease with vaso-occlusive crisis, Back pain

Procedures: Dilaudid 2 mg IV load with 0.3 mg Q15min PCA and D5W 500 mL over 4 hours infusion. (19F 153)

Objective: Labs described as reassuring and patient was reassessed several times throughout the infusion. (19F 153)

Subjective: Patient reported improvement in pain to 5/10 after infusion and endorsed back pain; instructed to drink at least 64 oz water daily, rest, and take PO pain medication as needed. (19F 153)

Medications: Dilaudid IV load and PCA (0.3 mg Q15min), Ondansetron 8 mg PO once, Diphenhydramine 25 mg PO once, Continue Hydroxyurea 2 capsules daily; Hydrocodone 5/325 mg every 4 hours PRN; ibuprofen and baclofen as needed. (19F 153)

Assessment and Plan: Sickle cell disease with VOC and back pain; continue hydroxyurea, follow pain action plan, and arrange follow-up with Spine Clinic and listed providers. (19F 153)

Citation: 19F 153-155

2025-03-26 | Unknown Facility / Burke, Natalie A CRNP

Summary: 30-year-old man with HbS/β-thalassemia and prior splenectomy presented with a vaso-occlusive crisis causing lower back, arm, and leg pain and was treated with IV Dilaudid (2 mg load with 0.3 mg PCA q15min) and D5W 500 mL over 4 hours; pain improved to a tolerable range. Continue home hydroxyurea, oral analgesics as needed, and follow-up with spine clinic and specialists.

Diagnoses: Sickle cell disease (HbS/Beta Thal), Vaso-occlusive crisis, Back pain

Procedures: IV analgesia and infusion: Dilaudid 2 mg IV load with 0.3 mg PCA q15min and D5W 500 mL over 4 hours. (19F 76)

Objective: Patient reassessed several times during infusion with pain reduced to a tolerable range; no other exam findings documented. (19F 76)

Subjective: Patient is a 30M with HbS/Beta Thal and prior splenectomy who reported VOC pain in his lower back, arms, and legs and presented for IV treatment. (19F 76)

Medications: Continue Hydroxyurea 2 capsules daily; severe pain: Hydrocodone 5/325 mg q4h PRN; mild pain: ibuprofen and baclofen q8h as needed; IV Dilaudid per above. (19F 76)

Assessment and Plan: Sickle cell disease with vaso-occlusive crisis treated with IV opioids and fluids with improvement in pain; continue home hydroxyurea and follow up with spine clinic and specialists as instructed. (19F 76)

Citation: 19F 76

2025-03-26 | Hematology & Oncology (Grandview) / Kapoor, Arjun V MD

Summary: 30-year-old man with HbS/β-thalassemia presented with acute sickle cell–related pain predominantly in the back; he received IV hydromorphone (Dilaudid 1 mg) and ketorolac (15 mg) in clinic and continues hydroxyurea. Lumbar spine MRI and spine clinic referral were arranged to evaluate his back pain, exchange transfusion was discussed, and an outpatient pain plan and follow-up with APP in 1 week and physician in 2–3 months were planned.

Diagnoses: Sickle cell disease (HbS/β-thalassemia), Back pain, ADHD

Procedures: Received Dilaudid 1 mg IV and Toradol 15 mg IV in clinic today. (19F 169)

Imaging: Plan to obtain lumbar spine MRI to assess for any lesion contributing to his back pain. (19F 169)

Subjective: Patient is a 30-year-old man with HbS/Beta Thal presenting with acute pain and reports back pain; endorsed profuse sweating when symptomatic. (19F 169)

Medications: Continue Hydroxyurea 2 capsules daily; mild pain: ibuprofen and baclofen as needed; severe pain: hydrocodone 5/325 mg every 4 hours as needed. (19F 169)

Assessment and Plan: Sickle cell disease with acute pain and back pain; exchange transfusion discussed, referral to spine clinic placed, follow up with APP in 1 week and physician in 2-3 months. (19F 169)

Citation: 19F 169

2025-03-26 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Laboratory interpretive comments note that serum aminotransferase (AST/ALT) activity may be decreased with vitamin B6 deficiency and can be falsely low with sulfasalazine; an adjusted calcium calculation is also referenced. Urine drug screen assay cutoffs were reported (fentanyl 1 ng/mL; heroin 10 ng/mL; hydrocodone/oxycodone 300 ng/mL; opiates 300 ng/mL).

Diagnoses: Vitamin B6 deficiency, Possible false-low AST/ALT due to vitamin B6 deficiency or sulfasalazine

Laboratory Results: AST noted with interpretive comment: in patients with vitamin B6 deficiency, serum/plasma aminotransferase activity may be decreased. Interpretive data: U Fentanyl cutoff 1 ng/mL; U Heroin (6-AM) cutoff 10 ng/mL; U Hydrocodone/U Oxycodone cutoff 300 ng/mL; U Opiates cutoff 300 ng/mL. Interpretive notes: adjusted calcium calculation explained; ALT and AST notes regarding possible false low results with sulfasalazine and decreased aminotransferase activity with vitamin B6 deficiency. (19F 19, 37, 147)

Citation: 19F 19-20, 37-38, 147-148

2025-03-26 | Grandview / Unknown Provider

Summary: Sickle cell follow-up with plan for hydration and continued hydroxyurea; patient reports lower back pain with spine clinic follow-up arranged and headache burden significantly improved on current meds. Nine-day Holter showed predominant sinus rhythm with rare PACs/PVCs, nine short runs of SVT (longest 4 beats) and Mobitz I 2nd-degree AV block; cardiology follow-up arranged, and possible hyperkalemia noted but may reflect hemolyzed sample.

Diagnoses: Sickle cell disease with history of splenectomy (asplenia), Hyperkalemia (possible hemolyzed sample), Back pain, Attention-deficit/hyperactivity disorder (ADHD), Headache (improved on current medications), Palpitations, Mobitz I (Wenckebach) second-degree AV block, Supraventricular tachycardia (brief runs), Premature atrial and ventricular complexes (rare PACs/PVCs)

Imaging: Holter monitoring (9 days): predominant sinus rhythm average 79 bpm (range 44–87), rare PACs and PVCs burden <1%, 9 runs of SVT (longest 4 beats); no VT or atrial fibrillation; 2nd degree AV block Mobitz I detected. (19F 142)

Laboratory Results: Ferritin 18 ng/mL (11/21/2023); albuminuria/proteinuria: none (11/21/2023). (19F 23)

Objective: Normal strength; integumentary warm and dry; neck supple; lungs clear to auscultation, non-labored respirations; neurologic alert and oriented; cognition/speech with stutter; psychiatric cooperative with appropriate mood and affect. Respirations non-labored; moving all extremities; alert and oriented; speech clear and coherent; cooperative with appropriate mood and affect. (19F 23, 142)

Subjective: Patient complained of lower back pain with palpation and reports symptoms related to sickle cell disease and history of splenectomy. Patient reported significantly decreased headache burden since last visit and more consistent with meds; discussed possible med side effects and supplements. Patient complained of palpitations and went to ED; completed a 2-week Holter and returned it early. (19F 23, 142)

Medications: Continue Hydroxyurea two capsules daily; will refill Strattera and Qelbree until psychiatry visit. Continue current headache medications as prescribed; discussed trial of magnesium, riboflavin, and CoQ10 if headache burden increases. (19F 23, 142)

Assessment and Plan: Sickle cell follow-up with sickle cell plan and hydration instructions; EKG reassuring regarding potassium, noted possible hemolyzed samples affecting potassium; back pain—follow-up with Spine Clinic on 09/30/2024; refer to psychiatry for ADHD and med refills. Headache with improved burden; continue meds and headache diary, consider supplements and preventive options if frequent. Palpitations with Holter showing rare ectopy, runs of SVT and Mobitz I AV block; cardiology follow-up arranged. (19F 23, 142)

Citation: 19F 23, 142

2025-03-26 | The Piedmont Clinic of Grandview / Collins, Sarah E MD

Summary: Ambulatory patch monitoring was abnormal, showing supraventricular ectopy (SVE count 40, isolated 11), ventricular ectopy including couplets and bigeminy, intermittent second-degree AV block (Mobitz I and II), sinus arrhythmia with episodes of bradycardia (min HR 44 bpm) and tachycardia (max HR 161 bpm); no atrial fibrillation/flutter detected. Findings warrant clinical correlation and cardiology follow-up.

Diagnoses: Supraventricular arrhythmia, Second-degree AV block (Mobitz I and Mobitz II), Ventricular ectopy (including couplet and bigeminy), Sinus arrhythmia, Sinus bradycardia, Tachycardia (max HR 161 bpm), Accelerated junctional rhythm, Sickle cell disease

Imaging: Ambulatory patch monitoring detected SV arrhythmia (≥3 beats), ventricular arrhythmia events with ECG strips attached, and second-degree AV block (Mobitz I and Mobitz II noted). Ambulatory heart rate trend report: Min HR 44 bpm, Max HR 161 bpm, Avg HR 79 bpm, with documented bradycardia and tachycardia episodes across multiple days. Cardiac rhythm monitoring graphs show heart rate and ectopy trends over multiple days, including dates in Feb 2025 (examples 02/13/2025–02/19/2025). (19F 92-105)

Objective: Patch monitoring report: max HR 161 bpm, average HR 79 bpm, min HR 44 bpm. Documented supraventricular (SV) arrhythmia (≥3 beats). SVE hourly burden reported; SVE count 40 with isolated SVE count 11. Ventricular ectopy (VE) counts and VE hourly burden documented. Episodes of second-degree AV block recorded. Heart rate variability metric reported (mean 720 ms). ECG tracings displayed with rhythm noted as sinus arrhythmia; overall ambulatory cardiac monitoring data include bradycardia and tachycardia episodes across multiple days. (19F 92, 94, 97, 100-104)

Subjective: No patient symptoms provided in this study. (19F 97)

Assessment and Plan: Preliminary interpretation: abnormal ambulatory rhythm monitoring with supraventricular arrhythmias, quantified SVE burden (count 40, isolated 11), ventricular ectopy, and episodes of second-degree AV block (Mobitz I and Mobitz II noted). No atrial fibrillation/flutter detected on the monitoring study. Electrocardiographic tracings demonstrate sinus arrhythmia and sinus bradycardia with intermittent second-degree AV block (Mobitz I). No acute ischemic changes noted. Recommended clinical correlation and cardiology follow-up. (19F 92, 94, 100-104)

Citation: 19F 92-107

2025-03-27 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Follow-up psychiatric visit for generalized anxiety disorder with medication management and >15 minutes of psychotherapy; PHQ-9 score 10 indicating moderate depressive symptoms. Medications include Qelbree, risperidone PRN, and trazodone for sleep; plan includes monthly infusions starting 04/03/2025 and follow-up visits in 3 months and with psychiatry around 06/27/2025.

Diagnoses: Sickle cell disease SS, Mood disorder, Generalized anxiety disorder, Attention deficit hyperactivity disorder, combined type, Insomnia disorder related to another mental disorder

Objective: Vitals (03/27/2025): RR 20, HR 74, BP 127/76, Weight 97.2 kg, Height 6 ft 1 in, BMI 28.3. (22F 10)

Subjective: Presented for follow-up of generalized anxiety disorder and medication management. The claimant reported life stressors, chronic illnesses, and coping difficulties during brief psychotherapy, and completed a medical history patient report form listing past and current medical conditions and surgeries. The claimant endorsed depressive symptoms on the PHQ-9 over the past 2 weeks with a total score of 10. (22F 10, 14-16)

Medications: Qelbree 100 mg capsule nightly; risperidone 2 mg tablet one tablet twice daily as needed; trazodone 100 mg tablet at bedtime. (22F 10)

Assessment and Plan: Follow-up visit for generalized anxiety disorder with medication prescriptions and ongoing management. Provided brief psychotherapy (>15 minutes). PHQ-9 total score 10, indicating moderate depressive symptoms. Plan: return to clinic in 3 months; monthly infusions to start 04/03/2025; referral/return to psychiatry around 06/27/2025. (22F 10, 14, 16)

Citation: 22F 10, 14-16

2025-04-03 | Interventional Cardiology Clinic / Chen, David K MD

Summary: Holter monitoring showed predominant sinus rhythm with rare PACs/PVCs (<1% burden), nine short runs of SVT (longest 4 beats), and second-degree AV block Mobitz I (Wenckebach) without significant pauses; no VT or atrial fibrillation. The claimant remains active without exertional chest pain; plan is continued monitoring and cardiology follow-up.

Diagnoses: Second-degree AV block, Mobitz I (Wenckebach), Palpitations, Supraventricular tachycardia (SVT), Obstructive sleep apnea, Attention deficit hyperactivity disorder, Sickle cell disease, Sickle cell retinopathy, Sensorineural hearing loss, Stutter, History of splenectomy

Procedures: History of splenectomy on 12/04/2019 documented. (23F 3)

Functional Assessment: Remains active exercising without limitations and denies exertional chest pain. (23F 2)

Laboratory Results: Sodium 135 mMol/L; Potassium 4.0 mMol/L; Chloride 104 mMol/L; Bicarbonate 26 mMol/L; AGAP 5.0 mMol/L; Glucose 84 mg/dL; BUN 10 mg/dL (collected 04/03/2025 10:06 CDT). (23F 6)

Objective: Holter monitor (03/14/2025): predominant sinus rhythm, average rate 79 bpm; rare PACs and PVCs with burden <1%; 9 runs of SVT (longest 4 beats); no VT; 2nd-degree AV block Mobitz I (Wenckebach) without significant pauses. NYHA Class II. Review of systems negative for Constitutional, Respiratory, Cardiovascular, Musculoskeletal, Integumentary findings except as in HPI. Neurologic: alert and oriented x4. (23F 2, 4)

Subjective: The claimant reported left-sided chest pain and palpitations, with palpitations occurring at night. The claimant was recently started on CPAP for sleep apnea, reported feeling highly stressed, and endorsed sleeping concerns. Social history reviewed: alcohol use never, sexual activity status reviewed. (23F 2-3)

Medications: baclofen 5 mg oral TID; baclofen 10 mg oral TID; duloxetine 30 mg daily; hydroxyurea 1000 mg daily; ibuprofen 800 mg TID; hydrocodone-acetaminophen (Norco) 5 mg-325 mg oral tablet every 4 hours PRN; naloxone 4 mg nasal (nasal spray); risperidone 2 mg BID; diclofenac topical gel; fluticasone nasal spray 50 mcg; nortriptyline 10 mg. (23F 4, 6)

Assessment and Plan: ER follow-up for palpitations. Holter demonstrated Mobitz I AV block without dangerous pauses and no atrial fibrillation or VT. Continue monitoring and arrange cardiology follow-up. (23F 2)

Citation: 23F 2-4, 6

2025-04-03 | Unknown Facility / Reeves, Courtney CRNP

Summary: 30-year-old man with sickle cell disease and prior splenectomy presented for ER follow-up for chest pain and nocturnal palpitations; ambulatory Holter monitoring demonstrated 2nd-degree AV block Mobitz I. Exam notable for bradycardia (HR 56 bpm); plan includes echocardiogram and follow-up, and metoprolol was offered but declined.

Diagnoses: Sickle cell disease, Attention deficit hyperactivity disorder (ADHD), Obstructive sleep apnea, 2nd-degree AV block (Mobitz I), Chest pain

Objective: Vitals 4/3/2025 10:36 CDT: HR 56 bpm (low), O2 100%, BP 113/67 mmHg, weight 210 lb, height 73 in; exam—alert and oriented, pupils equal and reactive, normocephalic, lungs and abdomen non-tender, musculoskeletal normal range of motion, psychiatric cooperative with appropriate mood and affect. (23F 5)

Subjective: 30-year-old male with PMH of sickle cell, ADHD, OSA and prior splenectomy presents for ER follow-up for chest pain and reports palpitations at night when lying flat; recent Holter showed 2nd degree type I block. (23F 5)

Medications: Metoprolol offered as needed but patient declined at this time. (23F 5)

Assessment and Plan: ER follow-up for chest pain in patient with known sickle cell disease; recent Holter showed Mobitz I (2nd-degree type I) AV block with palpitations; plan to obtain echocardiogram and follow up. (23F 5)

Citation: 23F 5

2025-04-03 | Unknown Facility / Fleming, Laura MD

Summary: Labs show normal serum creatinine (1.0 mg/dL) and eGFR reported >90 mL/min/1.73m2 with only minimal urine protein (albumin/creatinine ~62 mg/g, A1 range). CBC demonstrates microcytic anemia (Hgb 12.4 g/dL, MCV 73 fL) with elevated RDW and reticulocyte percentage and low ferritin (26 ng/mL), and hemoglobin electrophoresis (Hb S 65.8%, Hb F 12.0%, Hb A 16.8%, Hb A2 5.4%) consistent with a sickle-related hemoglobinopathy (possible HbS/β-thalassemia or related variant).

Diagnoses: Kidney failure, CKD stage G4

Laboratory Results: Collected 04/03/2025: Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2; Calcium 9.4 mg/dL, Adjusted Calcium 9.0 mg/dL; Protein 7.9 g/dL, Albumin 4.5 g/dL; Bili total 0.6 mg/dL, Alk Phos 76 U/L, ALT 12 U/L, AST 16 U/L, LDH 193 U/L, Ferritin 26.0 ng/mL; Hgb A 16.8%, Hgb F 12.0%, Hgb S 65.8%, Hgb A2 5.4%; Calc U Prot/Creat 61.7 mg/g, U Prot Random 5 mg/dL, U Creat 81 mg/dL; multiple urine drug screens negative. 4/03/2025 CBC: Hgb 12.4 g/dL (low), Hct 37% (low), WBC 6.20 x10^3/µL, Platelets 354 x10^3/µL, RBC 5.04 x10^6/µL; indices: MCV 73 fL (low), MCH 25 pg (low), MCHC 34 g/dL, RDW 18.8% (high); differential: Neutrophils 56%, Abs neutrophils 3.47 x10^3/µL, Lymphocytes 30%, Absolute lymphocytes 1.89 x10^3/µL; reticulocytes: 2.7% (high), retic absolute 0.1328 x10^6/µL, RBC retic 4.93 x10^6/µL. eGFRcr: G4 15-29 mL/min/1.73m2 (severely decreased); G5 <15 mL/min/1.73m2 (kidney failure). ACR ranges: A1 <30 mg/g, A2 30-300 mg/g, A3 >300 mg/g; P/C ratio reference ranges provided. (23F 7-9)

Citation: 23F 7-9

2025-04-03 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Type and screen confirmed patient blood type A negative; antibody screen was negative and crossmatch with units (W183625094153 and W181925097941) was compatible, indicating suitable transfusion compatibility. Collected 04/03/2025 with crossmatch verified same day.

Diagnoses: ABO/Rh: A negative (blood type A−), Antibody screen: negative, Crossmatch: compatible

Laboratory Results: Collected 04/03/2025 10:06 CDT; crossmatch verified 04/03/2025 16:35 CDT: crossmatch compatible; ABO/Rh A NEG; Type and screen: A (pos) with antibody screen negative; product numbers W183625094153 and W181925097941. (23F 11)

Citation: 23F 11-12

2025-04-04 | Unknown Facility / Wade, Rachel B RN

Summary: Hospital record documents transfusion of two leukoreduced A-negative RBC units for a patient with sickle cell disease on 04/04/2025 (units given at 15:59 and 17:33 CDT), with transfusion history entered and performed by RN Rachel B. Wade. The event reflects blood product administration for management of sickle cell disease.

Diagnoses: Sickle cell disease

Procedures: Transfusion of two LR RBC units on 04/04/2025. (23F 13)

Objective: Transfusion history notes blood product: 'Sickle Cell patient.' Two large RBC units transfused (4/4/2025 15:59 and 17:33 CDT, A NEG). (23F 13)

Assessment and Plan: Transfusion history entered and performed by Wade, Rachel B RN on 04/03/2025-04/04/2025 documenting sickle cell patient blood product use and transfusions. (23F 13)

Citation: 23F 13-14

2025-04-10 | PM&R Clinic / Barrett, Lisa M MD

Summary: The patient has ongoing constant throbbing low back pain attributed mainly to sickle cell disease with lumbar and bilateral SIJ tenderness, negative straight leg raise, and a positive left FABER; MRI pelvis was ordered to evaluate SIJ pathology and suspected hip avascular necrosis. Management includes referral to PM&R/SpineNet, initiation of physical and aquatic therapy, trial of topical Luminis patches, medication adjustments (stop nortriptyline, start viloxazine, continue baclofen/analgesics), and follow-up after MRI.

Diagnoses: Low back pain, Sickle cell disease, Neuropathic pain, SI joint pain, Hip arthropathy/avascular necrosis (suspected), Arthritis

Procedures: History of splenectomy 12/04/2019 and robotic adrenalectomy 12/04/2019. (23F 17)

Functional Assessment: Referred to physical therapy for core strengthening and lumbosacral stabilization; encouraged walking on treadmill and aquatic therapy to help with pain. (23F 16)

Imaging: MRI pelvis ordered for 05/01/2025 to evaluate sacroiliac joint pathology and possible hip avascular necrosis; prior discussion documented regarding lumbar versus pelvic MRI. Radiology results reviewed: X-ray and computed tomography. (23F 15-16, 18)

Objective: Vitals: T 97.8 F, HR 82 bpm, SpO2 98%, BP 115/56 mmHg, weight 215.8 lb, BMI 28.47. Exam: alert and oriented, normocephalic, no rash, cranial nerves II–XII intact, cooperative mood; lumbar tenderness to palpation, bilateral SI joint tenderness, negative straight leg raise, left FABER positive with hamstring tightness. (23F 18)

Subjective: The claimant reported ongoing throbbing, constant, persistent low back pain, attributing pain to sickle cell rather than classic neuropathic pain; denied burning, numbness, tingling, or radiculopathy. Reported prior acute flare treated with Dilaudid and Toradol with variable benefit. Endorsed SI joint pain and hip pain, with history of sickle cell contributing to symptoms. Encouraged to start physical therapy and aquatic therapy while awaiting MRI pelvis. On 04/03/2025 the claimant reported feeling highly stressed, endorsed sleeping concerns, stated appetite is good, lives with spouse and works in IT. (23F 15-17)

Medications: Previously started duloxetine then discontinued. Baclofen 10 mg TID reported. Viloxazine (Qelbree) 100 mg capsule at bedtime was ordered; Qelbree 100 mg daily also reported. Trial of nortriptyline in history; outpatient list includes nortriptyline 10 mg BID (plan to stop due to jaw pain). Outpatient med list also includes hydroxyurea 1000 mg daily, ibuprofen 800 mg TID, risperidone 2 mg BID, naloxone nasal 4 mg PRN, diclofenac topical, fluticasone nasal. HYDROcodone-acetaminophen (Norco) 5 mg/325 mg oral tablet, 1 tab PO every 4 hours PRN for pain. Plan includes trial topical Luminis patches and continue/adjust Tylenol arthritis as needed. (23F 15-17)

Assessment and Plan: Problems: low back pain, sickle cell–related pain, and neuropathic pain. Plan: obtain MRI pelvis (05/01/2025), refer/follow up with SpineNet through PM&R, start physical therapy and pursue aquatic therapy, trial topical Luminis patches, continue/adjust medications (including Tylenol arthritis and baclofen adjustments), stop nortriptyline due to jaw pain, and follow up after MRI to consider injections or further imaging. (23F 15-16)

Citation: 23F 15-18

2025-04-15 | Unknown Facility / Stevens, Angela CRNP

Summary: 30-year-old man with HbS/Beta thalassemia presented with generalized vaso-occlusive crisis and received IV fluids (NS 500 mL over 4 hr) and IV opioid (hydromorphone 2 mg load then 0.3 mg PCA) plus adjuncts, with pain improving to ~5/10 and becoming manageable at home. Labs notable for mild anemia with microcytosis (Hgb 12.7 g/dL, MCV 75 fL, RDW 19.4%), low bicarbonate (21 mmol/L), and vitamin D deficiency (25-OH vitamin D 15 ng/mL); plan includes continue hydroxyurea, vitamin D repletion, conservative care for back pain, and possible lumbar/pelvic MRI.

Diagnoses: Vaso-occlusive crisis, HbS/Beta thalassemia, Chronic pain, Back pain, Status-post splenectomy, ADHD

Procedures: IV pain medication and IV fluids administered for acute sickle cell infusion visit. IV fluids: normal saline 500 mL over 4 hours. IV opioid PCA: hydromorphone (Dilaudid) 2 mg IV loading dose then 0.3 mg Q15 min PCA. Additional administered meds during visit: ondansetron 8 mg PO once, diphenhydramine 25 mg PO once, ketorolac 15 mg IV. (23F 26, 29)

Functional Assessment: Pain reduced to tolerable range to manage at home with PO pain medications and advised to drink at least 64 oz (closer to 80–96 oz) of water daily; no specific work restrictions noted. | Follow-up monthly; no specific work or lifting limits documented on this page. (23F 29-30)

Imaging: Recommend lumbar vs pelvic MRI. (23F 30)

Laboratory Results: 4/15/2025 13:08 CDT labs: Sodium 138 mmol/L, Potassium 4.1 mmol/L, Chloride 106 mmol/L, Bicarbonate 21 mmol/L (LOW), Glucose 84 mg/dL, BUN 10 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.0 mg/dL, VitD 25OH 15 ng/mL (LOW), WBC 6.60 x10^3/cmm, Hgb 12.7 g/dL (LOW), Hct 37% (LOW), Platelet 322.9 x10^3/cmm, RBC 4.93 x10^6/cmm, MCV 75 fL (LOW), MCH 26 pg (LOW), RDW 19.4% (HI). Differential: Lymphocytes

37%, Absolute lymphocytes 2.44 x10^3/cmm, Monocytes 9%, Eosinophils 4%, Basophils 1%. Reticulocyte 1.9%, Retic absolute 0.0933 x10^6/cmm, RBC Retic 5.02 x10^6/cmm. (23F 28-29)

Objective: Denies shortness of breath, chest pain, fever, chills, cough, abdominal pain, nausea/vomiting/diarrhea, sore throat, runny nose, or loss of taste/smell. Uses CPAP at night. Vitals on 04/15/2025: temperature 97.9–98.4 F, heart rate 65–76 bpm, respiratory rate 13–16 br/min, O2 sat 98%, blood pressure 117/59 to 125/66 mmHg. Exam: alert and oriented, extraocular movements intact, moist oral mucosa, regular rhythm with mild tachycardia, lungs clear to auscultation, soft non-tender abdomen, normal range of motion and strength, warm dry skin, supple neck, neurologically alert with a stutter, cooperative affect. Labs reported as reassuring. The claimant was reassessed several times during infusion and pain reduced to a tolerable range to manage at home. (23F 26-27, 29)

Subjective: The claimant reported generalized, aching vaso-occlusive (VOC) pain since Friday, had tried ibuprofen without help, took baclofen last night, has not taken Norco and states IV medications help when severe. The claimant is a 30-year-old male with HbS/Beta Thal presenting for IV pain medication and IV fluids for generalized VOC pain. Pain improved to 5/10 after treatment. The claimant reported back pain and was advised to continue home stretching, heat, and hydration; instructions given for mild versus severe pain management. (23F 26, 29-30)

Medications: Hydroxyurea 1000 mg daily (2 capsules daily listed), ibuprofen 800 mg TID, Norco (hydrocodone/acetaminophen) 5/325 mg one tablet every 4 hours PRN, baclofen 10 mg oral 1 tablet TID (listed also as 5–10 mg TID), diclofenac topical 1% one application PRN, fluticasone nasal 50 mcg 2 sprays BID, naloxone 4 mg nasal spray once, nortriptyline 10 mg BID, risperidone 2 mg BID, viloxazine 100 mg nightly, hydromorphone (Dilaudid) 2 mg IV load then 0.3 mg PCA, ondansetron 8 mg PO once, diphenhydramine 25 mg PO once, ketorolac 15 mg IV, cholecalciferol 1250 mcg oral weekly. (23F 26-27, 29-32)

Assessment and Plan: Acute vaso-occlusive pain in a patient with HbS/Beta thalassemia; treated with IV opioids and IV fluids. Continue home medications including hydroxyurea. Vitamin D deficiency noted (25OH 15 ng/mL) — plan to check and replace vitamin D. Back pain managed with conservative measures (stretching, heat, hydration) and pain plan. ADHD noted — follows with psychiatry. Follow-up arranged with infusion team/Dr. Kapoor as needed and monthly follow-up with provider per plan. (23F 26, 29-30)

Citation: 23F 26-33

2025-04-25 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient seen for psychiatric follow-up and medication management for generalized anxiety; PHQ-9 score was 19, consistent with moderately severe depressive symptoms. Current regimen reviewed (buspirone, Qelbree, risperidone PRN, trazodone) with recommendation for continued mental health follow-up and treatment as appropriate.

Diagnoses: Sickle cell-hemoglobin SS disease, Depression, Generalized anxiety disorder, Attention deficit hyperactivity disorder, Specific reading disorder

Objective: Vitals: RR 20, HR 81, BP 128/60, Wt 98.3 kg, BMI 28.6, Ht 6 ft 1 in. PHQ-9 total score documented as 19 indicating moderately severe depressive symptoms. (22F 2, 8)

Subjective: Patient presented for psychiatric follow-up for generalized anxiety and medication management; medications reviewed. Patient completed PHQ-9 and endorsed depressive symptoms over the past 2 weeks; reported various items consistent with depression. (22F 2, 8)

Medications: Buspirone 5 mg tablet: 1 tablet twice daily; Qelbree 100 mg capsule ER: 1 capsule nightly; Risperidone 2 mg tablet: 1 tablet twice daily PRN; Trazodone 100 mg tablet: 1 tablet nightly. (22F 2)

Assessment and Plan: Follow-up for generalized anxiety disorder with medication review and continued pharmacologic management. PHQ-9 score 19 consistent with moderately severe depression; recommends mental health follow-up or treatment as appropriate. (22F 2, 8)

Citation: 22F 2, 7-8

2025-04-28 | Hematology Clinic / Curtis, Ashley M CRNP

Summary: 30-year-old man with HbS/Beta thalassemia on hydroxyurea and monthly transfusions presented for follow-up of a generalized vaso-occlusive pain crisis (pain score 8) with predominant arm/leg/back pain that is improving; exam notable for normal vitals and ROM/strength with pain on use and a persistent stutter. Plan: continue current medications and transfusion schedule, arrange MRI for back pain, follow up with hematology/pain clinic (Dr. Barrett), and refer for speech therapy; no new labs or ER visits reported.

Diagnoses: HbS/Beta thalassemia, Vaso-occlusive pain, Chronic transfusion therapy, Obstructive sleep apnea, Back pain, ADHD

Procedures: Monthly transfusions noted, next scheduled on 05/09. (23F 36)

Functional Assessment: Patient requested information about seeing a speech therapist; no specific work restrictions documented. (23F 34)

Imaging: MRI scheduled for 05/01/2025. MRI scheduled on 05/01/2025 (noted for back pain). (23F 34, 36)

Laboratory Results: General labs: no new labs today. (23F 36)

Objective: Review of systems completed and negative except as stated in HPI; appetite good and regular bowel movements; no ER visits since 10/17/23 per chart. Document notes upcoming MRI on 5/1 and follow-up with Dr. Barrett on 5/8. Vitals: T 98.1 F, HR 64 bpm, SpO2 97%, BP 119/61 mmHg, weight 213.5 lb; exam: alert and oriented, normal extraocular movements, moist mucosa, normal cardiovascular and respiratory exam, soft non-tender abdomen, normal ROM and strength with pain in arms, legs, and back, speech: stutter. (23F 34-35)

Subjective: Patient reported generalized, aching VOC pain since Friday that is more manageable now and worse at night; denies SOB, chest pain, fever, chills, cough, abdominal pain, N/V/D, sore throat, runny nose or loss of taste/smell. He stated he uses CPAP at night and is on chronic transfusions. Patient complained of pain in arms, legs, and back; primary pain score 8. Patient is a 30M with HbS/Beta Thal presenting for follow-up (F/U), reports doing okay but is seeing Dr. Barrett for pain and requests speech therapy for stutter. (23F 34-36)

Medications: Hydroxyurea (HU) 1000 mg daily; ibuprofen 800 mg TID; Norco (hydrocodone/acetaminophen) 5/325 mg Q4 hours PRN; baclofen 5 mg TID. Baclofen 10 mg PO TID; cholecalciferol 1250 mcg weekly; diclofenac topical 1% apply up to 1 app; fluticasone nasal 50 mcg 2 sprays BID; hydroxyurea 500 mg PO daily (1000 mg listed under disease treatment); ibuprofen 800 mg PO TID; naloxone nasal 4 mg PRN; risperidone 2 mg PO BID; viloxazine 100 mg PO QHS; hydrocodone-acetaminophen (Norco) 5/325 mg PRN every 4 hr as needed. Continue Hydroxyurea two capsules daily; Baclofen recently increased to 10 mg TID; Hydrocodone 5/325 mg every 4 hours PRN for severe pain; ibuprofen PRN for mild pain. (23F 34-36)

Assessment and Plan: Sickle cell disease with HbS/Beta thalassemia presenting for follow-up of vaso-occlusive pain; continue current medications, arrange MRI and follow-up with Dr. Barrett, RN to submit disability paperwork, refer for speech therapy as requested. Sickle cell disease management plan: continue hydroxyurea, ensure hydration, monthly transfusions, address back pain with home stretching/heat/hydration and MRI follow-up, follow-up appointments with psychiatry and hematology noted. (23F 34, 36)

Citation: 23F 34-36

2025-04-30 | Unknown Facility / Russell, Nicole

Summary: MRI safety screening was completed and documented on 04/30/2025 with the patient denying implants, pacemaker/ICD, DBS, aneurysm clips, and body piercings; the patient reported drug allergies and a history of anemia. Screening by Russell, Nicole indicates the patient was cleared to proceed with MRI.

Diagnoses: Drug allergy, Anemia

Objective: MRI safety screen: implant items and devices marked 'No', drug allergies 'Yes', history of anemia 'Yes'; documented height 6'1" and weight 210#. (23F 40)

Subjective: Patient denied implants, pacemaker, defibrillator, deep brain stimulator, aneurysm clips, and body piercings; reported drug allergies and history of anemia. (23F 40)

Assessment and Plan: MRI safety screening completed and entered on 04/30/2025; screening performed by Russell, Nicole and documentation indicates clearance to proceed. (23F 40)

Citation: 23F 40-42

2025-04-30 | Unknown Facility / Ramsey, Danielle NP

Summary: Consultative exam documents chronic neurodevelopmental/psychiatric conditions (reading disorder, language disorder, ADHD, and mood disorder) with functional impact: provider expects >4 work absences per month, impairments lasting at least 12 months, and the claimant is unable to manage benefits independently. No specific treatment plan is listed on the visit note.

Diagnoses: ADHD, Mood disorder, Language disorder, Reading disorder, Chronic medical condition

Functional Assessment: Provider indicated more than four days per month absent from work, impairments expected to last at least 12 months, and patient cannot manage benefits independently. (25F 7)

Subjective: Provider noted the patient has chronic conditions including reading disorder, language disorder, ADHD, and mood disorder and difficulty sustaining regular work. (25F 7)

Assessment and Plan: Provider stated the patient's impairments are reasonably consistent with the evaluation and are long-lasting; no specific treatment plan listed on this page. (25F 7)

Citation: 25F 7; 23F 1

2025-05-01 | Unknown Facility / Pearson, Andrew J MD

Summary: MRI sacrum/pelvis demonstrated multifocal bone infarcts involving the acetabulum and iliac wing left greater than right with no bone marrow edema, fracture, or osseous lesion and no evidence of sacroiliitis; there are degenerative changes in the lower lumbar spine. Findings are consistent with complications of the patient's sickle cell disease and lumbar spondylosis.

Diagnoses: Multifocal bone infarcts (left > right acetabulum and iliac wing), Degenerative lumbar spine, Sickle cell disease

Imaging: MRI sacrum/pelvis with and without contrast: multifocal bone infarcts left > right acetabulum and iliac wing; no evidence of sacroiliitis; degenerative changes in the lower lumbar spine. (23F 39)

Objective: No significant bone marrow edema, no fracture, no osseous lesion; multifocal areas of bone infarct involving left greater than right acetabulum and iliac wing; sacroiliac joints without narrowing, erosion, capsulitis, synovitis, or ankylosis with a small degenerative cyst at the right anterior inferior SI joint. (23F 39)

Subjective: Reported low back pain; indication also notes sickle-cell disease and evaluation of SI joints for inflammation. (23F 39)

Assessment and Plan: 1) No evidence of sacroiliitis. 2) Multifocal areas of bone infarct involving the left greater than right acetabulum and iliac wing; note degenerative changes in the lower lumbar spine. (23F 39)

Citation: 23F 39

2025-05-01 | Grandview Highlands / Pearson, Andrew J MD

Summary: MRI of the sacrum/pelvis (MR Bone Pelvis) was performed to evaluate the SI joints for inflammation in a patient with sickle-cell disease; the exam was documented as multiplanar multisequence and was completed without contrast. Vitals were stable (SpO2 96%, BP 106/64) with pain score 8, and neuro/motor exam was intact with normal gait; a final imaging report was generated.

Diagnoses: Low back pain, Sickle-cell disease

Procedures: MRI of pelvis/sacrum (MR Bone Pelvis) performed. (23F 47)

Imaging: MRI sacrum/pelvis with and without contrast performed (documented as MR Bone Pelvis wo+w contrast); technique noted as multiplanar multisequence, no contrast used. (23F 47)

Objective: SpO2 96%, BP 106/64, pain score 8; neuro: cranial nerves II-XII grossly intact, MMT 5/5 for UE and LE, gait normal. (23F 47)

Subjective: Indication: sickle-cell disease without crisis and evaluation of SI joints for inflammation; patient reported low back pain. (23F 47)

Assessment and Plan: Imaging performed for low back pain and SI joint evaluation in setting of sickle-cell disease; final report generated. (23F 47)

Citation: 23F 47

2025-05-02 | Unknown Facility / Pearson, Andrew J MD

Summary: MRI pelvis shows multifocal bone infarcts predominantly on the left involving the acetabulum and iliac wing, with no acute bone marrow edema or fracture and no sacroiliitis; a small cyst at the right anterior inferior SI joint is likely degenerative. Degenerative changes were also noted in the lower lumbar spine.

Diagnoses: Multifocal bone infarcts involving the acetabula and iliac wings (left greater than right), Degenerative changes of the lower lumbar spine

Imaging: MRI pelvis: multifocal bone infarcts left greater than right involving acetabulum and iliac wing; degenerative changes in the lower lumbar spine; no sacroiliitis. (23F 48)

Objective: No significant bone marrow edema or fracture; multifocal areas of bone infarct involving the left greater than right acetabulum and iliac wing; small cyst at right anterior inferior SI joint likely degenerative and no evidence of sacroiliitis. (23F 48)

Assessment and Plan: No evidence of sacroiliitis; multifocal bone infarct involving the left greater than right acetabulum and iliac wing; noted degenerative changes in the lower lumbar spine. (23F 48)

Citation: 23F 48

2025-05-05 | Unknown Facility / Curtis, Ashley M CRNP

Summary: Patient received education on nutrition, exercise, and pain management; the care plan was discussed and agreed upon with the covering physician. No procedures or test results documented.

Assessment and Plan: Patient education provided on nutrition, exercise, and pain management; care and plan discussed and agreed upon with covering physician. (23F 37)

Citation: 23F 37-38

2025-05-08 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Barrett, Lisa M MD

Summary: The claimant reports persistent, diffuse musculoskeletal and neuropathic pain worse than baseline without an acute sickle cell crisis; MRI pelvis shows multifocal bone infarcts (left > right acetabulum and iliac wing) with no sacroiliitis and routine labs/CBC essentially within normal limits. Urine drug screen presumptively detected opiates (heroin/hydrocodone/oxycodone/opiates) pending confirmatory testing; plan includes discontinuing baclofen, continuing current pain regimen, and referrals to hematology/infusion clinic and ENT with follow-up in 3 months.

Diagnoses: Mechanical back pain, Sickle cell disease, Neuropathic pain, Jaw pain, Chronic pain

Procedures: The claimant receives monthly cellular exchange procedures for management of sickle cell disease. Venipuncture performed for blood draw (COMPUTER XM) on 05/08/2025. Prior surgeries: splenectomy 12/04/2019; robotic adrenalectomy 12/04/2019. (23F 43-45)

Imaging: MRI pelvis 05/01/2025: no evidence of sacroiliitis and multifocal areas of bone infarct involving the left greater than right acetabulum and iliac wing. (23F 43)

Laboratory Results: Collected 04/15/2025 13:08 CDT and basic/metabolic/hepatic/hematologic results: Sodium 138 mmol/L, Potassium 4.1 mmol/L, Chloride 106 mmol/L, Bicarbonate 21 mmol/L, AGAP 11 mmol/L, Glucose 84 mg/dL, BUN 10 mg/dL, Creatinine 0.9 mg/dL, eGFR >90 mL/min/1.73m2, Calcium 9.0 mg/dL, Albumin 4.2 g/dL, Total bilirubin 0.6 mg/dL, Alkaline phosphatase 64 U/L, ALT 27 U/L, AST 34 U/L. CBC: WBC 6.60 x10^3/cmm, Hgb 12.7 g/dL, Hct 37%, Platelet 322.9 x10^3/cmm. Differential/reticulocyte: Lymphocytes 37%, Absolute lymphocytes 2.44 x10^3/µL, Monocytes 9%, Eosinophils 4%, Basophils 1%; Reticulocyte 1.9%, Retic absolute 0.0933 x10^6/µL, RBC 5.02 x10^6/µL. Urine drug screen: interpretive data lists cutoffs (amphetamine 500 ng/mL; barbiturates/benzodiazepines 200 ng/mL; buprenorphine 5 ng/mL; cannabinoids 50 ng/mL; cocaine/metabolite and methadone 150 ng/mL; fentanyl 1 ng/mL; heroin 10 ng/mL) and notes: U Heroin, U Hydrocodone, U Oxycodone, U Opiates detected with assay cutoff 300 ng/mL and that assay is presumptive requiring confirmatory mass spectrometry. Vitamin D (25-OH) interpretive ranges provided: deficient <20 ng/mL, insufficient 20-<30 ng/mL, sufficient 30-100 ng/mL, upper safety limit >100 ng/mL. (23F 21-24, 55)

Objective: Reviewed symptoms and prior reports and reconciled medication list. No bowel or bladder concerns; claimant remains hydrated. Vital signs: temperature 98.0 F, heart rate 69 bpm, respiratory rate 18 br/min. (23F 43, 46)

Subjective: The claimant reported persistent, diffuse musculoskeletal pain affecting back, arms, jaw, head and generalized body aches worse than his usual baseline and possibly approaching a sickle cell crisis; he denied an acute crisis currently. He reported back pain and jaw pain and concerns about effectiveness of his current pain regimen. Review of systems otherwise negative. The claimant reported feeling highly stressed with sleeping concerns, good appetite, lives with spouse, does not exercise, is a student and works in IT for a security company. (23F 43-46)

Medications: Medications listed with doses: hydroxyurea 1000 mg daily; hydroxyurea 500 mg capsules (also listed); baclofen 10 mg three times daily (also noted baclofen 5 mg and 10 mg oral tablets and baclofen discontinued due to side effects); diclofenac topical 1% gel PRN; fluticasone nasal spray; hydrocodone-acetaminophen (Norco) 5 mg-325 mg tablets PRN; ibuprofen 800 mg three times daily (also listed ibuprofen 800 mg TID); naproxen 550 mg PRN (listed as 550 mg BID PRN in one entry); methocarbamol 750 mg TID PRN; naloxone nasal spray 4 mg once; nortriptyline 10 mg twice daily; risperidone 2 mg twice daily; viloxazine (Qelbree) 100 mg nightly; trazodone 100 mg nightly/at bedtime; buspirone 5 mg twice daily; duloxetine 30 mg daily; cholecalciferol (vitamin D) 1250 mcg weekly. (23F 19, 43-45)

Assessment and Plan: Impression: mechanical back pain and sickle cell–related pain with neuropathic features. Plan: discontinue baclofen (noted adverse effects), continue current regimen, MRI obtained. Follow-up and referrals: Sickle Cell Infusion Clinic appointment scheduled; follow with hematologist; ENT referral for jaw pain; consider physical therapy. Return to clinic in 3 months or sooner if needed. (23F 43-44)

Citation: 23F 19-25, 43-46, 55-56

2025-05-09 | Unknown Facility / Wade, Rachel B RN

Summary: Patient identified as having sickle cell disease with transfusion history entered and two leukoreduced RBC units transfused on 05/09/2025. Current meds include disease-modifying hydroxyurea and multiple analgesics/adjuncts; blood bank resident documentation noted as not charted.

Diagnoses: Sickle cell disease

Procedures: Transfusion of leukoreduced RBC units (two LR RBC units recorded on 05/09/2025). (23F 57)

Objective: Blood product history notes: 'Sickle Cell patient' and 'Blood Bank Resident: Not Charted.' (23F 57)

Medications: Medication list includes amoxicillin 500 mg PO TID for 7 days, baclofen 10 mg PO TID, buspirone 5 mg PO twice daily, duloxetine 30 mg PO daily, hydrocodone-acetaminophen (Norco) 5/325 mg PRN, hydroxyurea 500–1000 mg PO daily, ibuprofen 800 mg PO TID, methocarbamol 750 mg PO TID PRN, and multiple others (topical chlorhexidine, cholecalciferol, fluticasone nasal). (23F 59)

Assessment and Plan: Transfusion history entered and performed; patient identified as a sickle cell patient with transfusions documented on 05/09/2025. (23F 57)

Citation: 23F 57-59

2025-05-14 | Unknown Facility / Barrett, Lisa M MD

Summary: Labs show hemoglobin 12.3 g/dL with microcytosis (MCV 76 fL) and hemoglobin fractions notable for Hgb S 57.3% and Hgb F 9.7%, consistent with a sickle cell hemoglobinopathy in a patient on hydroxyurea; renal function is normal (creatinine 1.0 mg/dL, eGFR >90). Urine drug screen was positive for opiates, reflecting current opioid use while the patient is being treated for chronic pain.

Diagnoses: Sickle cell hemoglobinopathy (on hydroxyurea), Microcytic anemia (MCV 76 fL) — consider iron deficiency vs thalassemia trait, Opioid use (urine drug screen positive for opiates), Chronic pain managed with opioid analgesics

Laboratory Results: Collected 5/8/2025: BMP: Sodium 137 mMol/L, Potassium 4.7 mMol/L, Chloride 103 mMol/L, Bicarbonate 26 mMol/L, Glucose 79 mg/dL, BUN 12 mg/dL, Creatinine 1.0 mg/dL, eGFR >90 mL/min/1.73m2. Calcium 9.7 mg/dL, Adjusted Calcium 9.1 mg/dL, Albumin 4.7 g/dL. LFTs/enzymes: Alk Phos 80 U/L, ALT 11 U/L, AST 18 U/L, LDH 265 U/L. Ferritin 44 ng/mL. Hemoglobin fractions: Hgb F 9.7%, Hgb S 57.3%, Hgb A2 5.0%. CBC (5/8/2025 10:20 CDT): WBC 7.39 x10^3/cmm, Hgb 12.3 g/dL, Hct 36%, Platelets 285.6 x10^3/cmm, RBC 4.79 x10^6/cmm, MCV 76 fL, MCH 26 pg, MCHC 34 g/dL, RDW 19.6%, Absolute lymphocytes 2.14 x10^3/cmm, Retic absolute 0.1387 x10^6/cmm, RBC retic 4.82 x10^6/cmm. Urinalysis: color Yellow, clarity Clear, specific gravity 1.012, pH 6.0; Urine protein random 5 mg/dL, U Prot/Creat 60.2, U Creat 83 mg/dL. Urine drug screen: opiates positive; benzodiazepines, buprenorphine, cannabinoid, cocaine metabolite, fentanyl, heroin, hydrocodone, methadone, oxycodone negative. Additional notes in source: glucose fasting 70–100 mg/dL; glucose non-fasting 70–200 mg/dL. (Reference/eGFR categories and urine drug screen cutoff values provided in source.) (23F 51-54)

Medications: baclofen 10 mg TID; buspirone 5 mg twice daily; cholecalciferol 1250 mcg weekly; diclofenac topical; duloxetine 30 mg daily; fluticasone nasal spray; hydrocodone-acetaminophen 5/325 mg PRN; hydroxyurea 500 mg BID; hydroxyurea 1000 mg daily; ibuprofen 800 mg TID; methocarbamol 750 mg TID PRN; naloxone 4 mg nasal PRN; naproxen 550 mg BID PRN; nortriptyline 10 mg BID; risperidone 2 mg BID; trazodone 100 mg at bedtime; viloxazine 100 mg at bedtime. (23F 49-50)

Citation: 23F 49-54

2025-05-15 | Department of Oral Surgery / Caldwell, Jonathan Scott DMD

Summary: A panoramic (ORS Panorex) radiograph was obtained on 05/15/2025 to evaluate chronic periodontitis and other lesions of the oral mucosa; images were acquired by Oral Surgery and interpreted by radiology. The event record documents the imaging was performed but does not include specific imaging findings or reported abnormalities.

Diagnoses: Chronic periodontitis, Other lesions of oral mucosa

Imaging: ORS Panorex performed 05/15/2025; images obtained by the department of Oral Surgery with final report interpreted by radiology. (23F 60)

Medications: Naproxen 550 mg 1 tab PO BID PRN; Nortriptyline 10 mg 1 cap PO twice daily; Baclofen 10 mg one tablet three times daily; Risperidone 2 mg PO BID; Trazodone 100 mg 1 tab at bedtime; Viloxazine 100 mg capsule at bedtime. (23F 60)

Citation: 23F 60

2025-05-15 | Crestwood / Unknown Provider

Summary: Patient was scheduled for dentoalveolar (tooth) extractions with extraction procedure codes indicated; this was a surgical visit for planned removal of specified teeth. No operative details or intraoperative findings documented in the event.

Diagnoses: Dentoalveolar extractions scheduled

Procedures: Dentoalveolar extractions scheduled for the claimant (extraction procedure codes indicated). (23F 61)

Citation: 23F 61-65

2025-05-16 | Unknown Facility / Whitfield, Daniel P DDS, MD

Summary: Under ASA class III care with planned deep IV sedation, the patient underwent successful extraction of an impacted third molar (#17) for pericoronitis without complications and tolerated the procedure well. Notable medical history that affected perioperative risk includes prior splenectomy and hematologic disorders (sickle cell disease and beta thalassemia); perioperative antibiotics and steroids were administered.

Diagnoses: Beta thalassemia, Sickle cell disease, ADHD, At risk of venous thromboembolus, Post-splenectomy, Sensorineural hearing loss, Pericoronitis, Impacted third molar (tooth #17)

Procedures: Planned and performed: extraction of impacted third molar (tooth #17), 3rd molar extract class III. History of splenectomy 12/04/2019. (23F 66, 68, 70)

Imaging: X-ray obtained prior to the procedure (no additional findings documented). (23F 70)

Objective: Vital signs: HR 65 bpm, RR 15 br/min, SpO2 100%, BP 137/78 mmHg, pain score 8; weight 214 lb, BMI 28.23. Tooth #17 lateral flap elevated; tooth exposed, bone removed, tooth sectioned, elevated and extracted without complications; procedure tolerated well. (23F 66, 70)

Subjective: Reviewed H&P from 5/16/2025; reviewed 05/15/2025. The claimant examined today and no change has occurred in the claimant's condition since the H&P was completed. The claimant works in IT, lives with spouse, reports good appetite, feels highly stressed, and endorses sleeping concerns. (23F 66, 68)

Medications: Outpatient meds: amoxicillin 500 mg TID; baclofen 10 mg TID; busPIRone 5 mg BID; cholecalciferol 1250 mcg weekly; duloxetine 30 mg daily; hydroxyurea 1000 mg daily; ibuprofen 800 mg TID; naloxone nasal 4 mg PRN; risperidone 2 mg BID; trazodone 100 mg at bedtime; viloxazine 100 mg at bedtime. PRN: hydrocodone-acetaminophen and methocarbamol. Pre-procedure: Ancef 1 g and Decadron 8 mg. (23F 67, 70)

Assessment and Plan: Pre-sedation assessment: intravenous sedation yes; ASA class 3 (severe systemic disease); planned level of sedation/analgesia 3 (deep); patient NPO. Impacted third molar with pericoronitis extracted without complications. Return to clinic in 3-4 months for follow-up. (23F 66, 70)

Citation: 23F 66-68, 70

2025-05-21 | Unknown Facility / Carson, Mitchell PA-C

Summary: 30-year-old man with HbS/Beta thalassemia on hydroxyurea reporting increased sickle-cell–related pain despite hydrocodone; plan to change home opioid regimen with a short course of oral hydromorphone, continue PT and increase baclofen. MRI (5/1/25) showed multifocal bone infarcts of the acetabula and iliac wings (L>R); patient recently underwent tooth extraction and has additional extractions deferred for cost.

Diagnoses: HbS/Beta thalassemia, Chronic pain, Back pain, Multifocal bone infarcts, Postoperative tooth extraction, ADHD

Procedures: Recent tooth extraction by OMFS last week; has three additional recommended extractions deferred due to cost. (23F 76)

Imaging: MRI performed on 05/01/2025 (no results documented on this page). MRI sacrum/pelvis with and without contrast (5/1/25): no evidence of sacroiliitis; multifocal areas of bone infarct involving the left greater than right acetabulum and iliac wing. (23F 76-77)

Objective: General: Alert and oriented, no acute distress. HENT: Normocephalic; Respiratory: respirations non-labored; Neurologic: alert and oriented; Cognition and speech: articulation and speech: stutter; Psychiatric: cooperative with appropriate mood and affect. (23F 77)

Subjective: Patient reported increased pain in the last week despite Norco 5/325 mg, requests change; denies acute concerns otherwise and reports stretching/PT and baclofen helping; significant stutter noted making communication harder. Patient is a 30M with history of splenic sequestration s/p splenectomy who presented for video telehealth stating his main concern is switching his home pain medication and that he receives IV dilaudid in infusion when needed. (23F 76, 78)

Medications: Amoxicillin 500 mg TID x7 days; baclofen 10 mg TID; buspirone 5 mg BID as directed; chlorhexidine 0.12% oral rinse; cholecalciferol 1250 mcg weekly. Multiple medications listed including diclofenac topical 1% gel, duloxetine 30 mg daily, hydroxyurea 500 mg oral capsule 1000 mg daily, ibuprofen 800 mg TID, naloxone nasal spray 4 mg, nortriptyline 10 mg BID, baclofen 10 mg TID, risperidone 2 mg BID, trazodone 100 mg at bedtime, viloxazine 100 mg at bedtime; PRN: hydrocodone-acetaminophen (Norco) 5 mg/325 mg q4h PRN, methocarbamol 750 mg TID PRN, naproxen 550 mg BID PRN. Continue Hydroxyurea 2 capsules daily; Baclofen increased to 10 mg TID; Hydrocodone 5/325 mg every 4 hours PRN severe pain; hydromorphone 2 mg 1-2 tabs q4 PRN severe (short course). (23F 76-78)

Assessment and Plan: Follow-up for HbS/Beta thalassemia with chronic pain; plan to consider changing opioid regimen and trial oral dilaudid, continue PT and baclofen. Sickle cell plan documented with transition care completed; patient has updated care and emergency plans. No new labs today. Plan to switch home pain regimen with approval for short-course hydromorphone for severe pain, continue monthly MANX, complete amoxicillin and follow up with OMFS and clinic per schedule. (23F 76-78)

Citation: 23F 76-78

2025-05-27 | Unknown Facility / Carson, Mitchell PA-C

Summary: Medication reconciliation performed and care plan discussed in a 20-minute office visit; patient remains on multiple chronic medications including hydroxyurea for sickle cell disease, baclofen for spasticity, duloxetine, risperidone, viloxazine, and PRN opioids with naloxone available. Plan agreed with covering physician and visit was electronically signed.

Diagnoses: Sickle cell disease (on hydroxyurea), Attention-deficit hyperactivity disorder, Major depressive disorder (on duloxetine), Anxiety disorder (on buspirone), Psychotic disorder (treated with risperidone), Chronic pain with chronic opioid therapy, Spasticity (on baclofen), Vitamin D deficiency (on high-dose cholecalciferol), Allergic rhinitis

Medications: Medication list includes baclofen 10 mg oral TID, buspirone 5 mg BID, duloxetine 30 mg daily, hydromorphone 2 mg PRN, hydrocodone-acetaminophen as needed, ibuprofen 800 mg PRN, naproxen 550 mg PRN, cholecalciferol 1250 mcg weekly and other chronic meds. Medication list includes baclofen 10 mg oral TID, cholecalciferol 1250 mcg (50,000 IU) weekly, diclofenac topical 1% gel PRN, fluticasone nasal 50 mcg/inh 2 sprays BID, hydrocodone-acetaminophen (Norco) 5 mg-325 mg 1 tab PRN, hydroxyurea 500 mg 1,000 mg daily (2 caps), ibuprofen 800 mg TID, naloxone 4 mg nasal PRN, risperidone 2 mg BID, and viloxazine 100 mg nightly. (23F 79, 81)

Assessment and Plan: Care discussed and plan agreed with covering physician; time spent on visit 20 minutes and visit electronically signed. (23F 79)

Citation: 23F 79-81

2025-05-27 | Unknown Facility / Whitfield, Daniel P DDS, MD

Summary: The patient underwent a procedure under deep sedation (level 3) with Versed 5 mg and Propofol 100 mg, achieving analgesia while remaining alert and oriented. The procedure had minimal estimated blood loss, no complications or specimens removed, and the patient tolerated it well with pain controlled.

Procedures: Procedure performed as documented in procedure note with minimal estimated blood loss and no specimens removed. (23F 71)

Objective: Achieved level of sedation/analgesia: 3 (Deep); mental status alert and oriented; pain controlled; no complications noted. (23F 71)

Subjective: The claimant remained a candidate for sedation; the claimant and guardian were informed of the sedation plan, risks, benefits, and alternatives. (23F 71)

Medications: Versed 5 mg and Propofol 100 mg administered for sedation. (23F 71)

Assessment and Plan: Post-operative diagnosis consistent with pre-operative diagnosis; the claimant tolerated the procedure well with no complications and pain controlled. (23F 71)

Citation: 23F 71-75

2025-05-28 | Unknown Facility / Whitfield, Daniel P DDS, MD

Summary: Surgical record documents a robotic adrenalectomy performed on 12/04/2019; no other new diagnoses or exam findings are documented in this office visit. Home medications are listed (including analgesics, muscle relaxants, psychotropics, an antibiotic, antihypertensive, and vitamin D), which may reflect ongoing pain and psychiatric management but no additional procedures or test results are reported.

Diagnoses: Status post robotic adrenalectomy (12/04/2019)

Procedures: Robotic adrenalectomy (12/04/2019) documented in surgical records. (23F 69)

Medications: Home meds include amoxicillin 500 mg PO TID, baclofen 10 mg PO TID, busPIRone 5 mg PO TID, cholecalciferol 1250 mcg weekly, duloxetine 30 mg daily, fluticasone nasal spray 50 mcg 2 sprays BID, hydrocodone-acetaminophen (Norco) PRN, hydralazine 500 mg noted, ibuprofen 800 mg PRN, methocarbamol 750 mg TID, risperidone 2 mg BID. (23F 69)

Citation: 23F 69

2025-05-29 | Grandview Hospital Lab, 2300 University Boulevard, Birmingham, AL / Unknown Provider

Summary: Urine drug screen was performed with interpretive cutoff values specified: buprenorphine 5 ng/mL, cannabinoid 50 ng/mL, cocaine/metabolite 150 ng/mL, fentanyl 1 ng/mL, heroin 10 ng/mL, hydrocodone/oxycodone 300 ng/mL, and opiates 300 ng/mL. Individual patient test results are not provided, only the assay cutoff thresholds.

Laboratory Results: Urine drug screen interpretive data: Buprenorphine cutoff 5 ng/mL; Cannabin cutoff 50 ng/mL; Cocaine/Metadone cutoff 150 ng/mL; Fentanyl cutoff 1 ng/mL; Heroin cutoff 10 ng/mL; Hydrocodone/Oxycodone cutoff 300 ng/mL; Opiates cutoff 300 ng/mL. (23F 10)

Citation: 23F 10

2025-06-05 | Faith Community Health Clinic / Ramsey, Danielle NP

Summary: Patient presented with life stressors, chronic illnesses, difficulty coping, and high psychosocial needs on SDOH screening (disabled, Medicaid, low income, limited access to food/phone) and received >15 minutes of psychotherapy.

Medication plan continued Qelbree 100 mg nightly and risperidone was adjusted to 0.5 mg AM / 1 mg PM with follow-up in 1 and 2 months and referral to EST Psychiatry.

Diagnoses: Generalized Anxiety Disorder, Attention-deficit hyperactivity disorder, combined type, Childhood Onset Fluency Disorder, Insomnia Disorder, Mood disorder

Subjective: The claimant reported life stressors, chronic illnesses, difficulty with coping, mood symptoms including anger and aggression, and ongoing ADHD symptoms requiring medication management. Engaged in brief psychotherapy for >15 minutes and discussed disability paperwork (partially completed) and follow-up. Completed SDOH PRAPARE screening and reported being disabled, having CHFP Medicaid, a household of 2 with total combined income $20,000 for the past year, lacking access to food/phone/other necessities, and feeling very much stressed. The claimant reported feeling physically and emotionally safe where they currently live and denied being afraid of a partner or ex-partner in the past year. (22F 6, 32-33, 40)

Medications: Qelbree 100 mg capsule nightly for ADHD; Risperidone adjusted to 0.5 mg in AM and 1 mg at bedtime (per plan). (22F 40)

Assessment and Plan: Provided brief psychotherapy (>15 min) and brief supportive therapy; disability paperwork partially completed. Psychiatric diagnoses include ADHD and anxiety. Continue Qelbree 100 mg nightly; risperidone adjusted to 0.5 mg AM and 1 mg at bedtime with consideration of increasing risperidone as needed. Follow-up: return to clinic in 1 month and again in 2 months; referral/appointment for EST Psychiatry around 06/25/2025. (22F 6, 40)

Citation: 22F 6, 32-33, 40

2025-06-05 | Faith Community Health Clinic / Unknown Provider

Summary: Psychiatric visit for management of ADHD and mood/anxiety with PHQ-9 scores documented at 19 and 10; exam notable for severe stuttering causing marked communication impairment, intact orientation and memory but impaired organization, and no current suicidal ideation. Treatment includes risperidone, atomoxetine and Qelbree, trazodone/buspirone PRN, CPAP for sleep apnea, and initiation of monthly blood transfusions for sickle cell disease (HbS ~66%).

Diagnoses: ADHD, Mood disorder, Generalized Anxiety Disorder, Insomnia Disorder, Sickle cell anemia, GAD/OCD behaviors, Mood disorder secondary to anxiety, Insomnia / sleep apnea (on CPAP), Attention deficit hyperactivity disorder, combined type, Childhood Onset Fluency Disorder, Insomnia disorder related to another mental disorder, Stuttering, GAD, Insomnia, Attention-deficit hyperactivity disorder, combined type, Insomnia related to other mental disorder, Mood disorder, unspecified, Depression, Fluency disorder (stuttering), Mood disorder (secondary to anxiety), Insomnia due to other mental disorder, Unspecified mood disorder, PTSD, Childhood-onset fluency disorder (stuttering), Insomnia disorder due to another mental disorder, ADHD, combined presentation, Posttraumatic Stress Disorder, Disorder of speech, Adjustment Disorder with Mixed Anxiety and Depressed Mood, Major depression

Procedures: Monthly blood transfusions initiated starting 04/03/2025. (22F 12)

Functional Assessment: Severe impairments with communication (stutters) and memory/organization; requires being followed behind for doors and a dry erase board to express himself. | Unemployed; previously worked in cybersecurity and has goal of returning to work in 2025. | Unemployed; previously worked in cybersecurity and has goal of returning to work in 2025; disability applied and appealing. | Safety assessment: low imminent risk; notes prior passive suicidal ideation at age 26 and modifiable risk factors of ADHD and stuttering; no work limitations specified. (22F 4, 11, 19, 26-27, 38-39, 45-46)

Laboratory Results: Blood sickle cell percentage 66%. Monthly blood transfusions initiated starting 04/03/2025. (22F 4, 12)

Objective: Mental status exam: the claimant well-groomed; behavior active and agitated; speech normal volume with prominent stutter and severe communication impairment; oriented to person/place/time; memory intact; mood euthymic with anxious affect; thought content unremarkable; perception without hallucinations; insight and judgment intact; motor activity intact. No formal physical exam documented. (22F 3-4, 11, 19-20, 26-27, 38, 46)

Subjective: The claimant reported management needs for ADHD and mood; endorsed depressive symptoms on PHQ-9 with scores documented as 19 and 10 on a screening form. History of sickle cell anemia. Reports unemployment and financial stress, increased anxiety with outbursts, teeth grinding, interrupted sleep, difficulty concentrating, forgetfulness requiring reminders, and brought paperwork for a disability appeal. Described medication effects: some medications improved focus and mood; reported side effects including grogginess, increased sickle cell pain, worsened anxiety, and jitteriness. Prior/current diagnoses reported include generalized anxiety disorder, ADHD, mood disorder, and disorders of speech/language/reading. (22F 3-5, 11-13, 19-21, 26-28, 37-39, 45-47)

Medications: Risperdal (risperidone) current dose 2 mg BID; risperidone dosing ranges/instructions also documented (0.25–2 mg BID, earlier 0.25–1 mg BID, and 2 mg tablet instruction). Qelbree 100 mg nightly (at bedtime). Strattera (atomoxetine) 25 mg AM. Buspirone 5 mg BID PRN. Trazodone 100 mg PRN for sleep. Cymbalta (duloxetine) started 02/2025. CPAP started 02/2025 for sleep apnea. Historical stimulants: Adderall, Focalin, Vyvanse. Prior sertraline noted. (22F 4-5, 12-13, 20-21, 27-28, 39, 46-47)

Assessment and Plan: Safety: low imminent risk; no current suicidal or homicidal ideation; history of passive suicidal ideation at age 26; safety plan in place and protective factors noted. Clinical course: anxiety and mood symptoms reported improving with risperidone. Plan: routine psychiatric care with follow-up for mental health and sleep; build coping strategies;

consider/continue buspirone (noted as 5 mg twice daily and PRN use documented); trazodone PRN for sleep; medication review with plan to increase risperidone if needed for anxiety/mood. (22F 3-5, 11-13, 19-21, 26-28, 37-39, 45-47)

Citation: 22F 1, 3-5, 9, 11-13, 17, 19-21, 26-28, 37-39, 45-47