Medical Chronology - Disability Case Review

EXHIBIT REF	DATE	PROVIDER	OCCURRENCE/TREATMENT
1F pg. 40-43, 44-46, 47-48, 65-97, 98	12/DD/2023	ABCD Health Care AAAA Hospital MMMM DDDD, M.D.	**Hospital Admission Note** Admission: MM/DD/YYYY Discharge: MM/DD/YYYY Diagnosis/visit problems: Atrial fibrillation with rapid ventricular response Chest pain Hospital course: History of hypertension, atrial fibrillation with ablation YYYY and mobile AAAA, GERD, hyperlipidemia, medical noncompliance presenting MM/DD/YYYY with palpitations workup demonstrating rapid atrial fibrillation with mildly elevated troponins, subsequent left heart catheterization performed MM/DD/YYYY showing mild diffuse disease. Hospitalization was complicated by uncontrolled hypertension, medications being addressed, patient did spontaneous cardioverted with Cardizem. Lab showing elevated creatinine, the patient has been previously referred to nephrology in YYYY for kidney stones and renal insufficiency but never did make an appointment. Renal ultrasound was performed showing enlarged polycystic kidneys commensurate with polycystic kidney disease and kidney stones without ureteral involvement. The patient feels improved, and reviewed precautions regarding Eliquis and the importance of medical compliance. Patient voices understanding. **Also suspect the patient has underlying sleep apnea recommending an outpatient sleep study.** **Labs:** **MM/DD/YYYY: BUN – 24 (High), creatinine 2.1 (High), eGFR AA – 43 (low), eGFR nonAA – 36 (low), troponin I cardiac – 0.05 (high), creatinine kinase MB – 10.8 (High), CKMB percent index – 9 (High)** **MM/DD/YYYY: BUN – 22 (High), creatinine 1.8 (High), eGFR AA – 51 (low), eGFR nonAA – 42 (low), creatinine kinase MB – 11.1 (High), CKMB percent index – 9 (High)** **MM/DD/YYYY: BUN – 23 (High), creatinine 2.0 (High), eGFR AA – 46 (low), eGFR nonAA – 38 (low), ProBNP – 3466 (high), urine protein – trace (Abnormal), urine blood – trace (Abnormal), urine RBC – 6 (high)** **MM/DD/YYYY: BUN – 29 (High), creatinine 2.0 (High), eGFR AA – 46 (low), eGFR nonAA – 38 (low), urine protein/creatinine ratio - 0.3 (High), urine, random, protein – 21.6 (High).** **Electrocardiogram**: **MM/DD/YYYY: Atrial fibrillation. ST depression, consider ischemia, inferior leads. Prolonged QT interval. Abnormal EKG. HR 143 bpm.** **MM/DD/YYYY: Atrial fibrillation. Probable left ventricular hypertrophy. Abnormal EKG. HR 85 bpm.** **Procedures**:

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			X-ray of the chest (MM/DD/YYYY, *Read by XZZZ YYYY, M.D.)* Impression: No radiographic evidence of acute disease. No edema, infiltrate, effusion or pneumothorax. **Ultrasound renal (MM/DD/YYYY, *Read by XZZZ YYYY, M.D.)*** **Impression: Polycystic kidney disease. No hydronephrosis. Bilateral nephrolithiasis. No perinephric fluid collection.** **Transthoracic Echocardiogram (MM/DD/YYYY, *Read by ZZZZ YYYY, M.D.*):** **Findings: Left ventricle – Mild global hypokinesis.** **Impression: Left Ventricle: Normal left ventricular size per gender. Severely abnormal left ventricle mass when indexed for body surface area per gender. Severe increase in left ventricular wall thickness per gender, with concentric hypertrophy pattern. Global systolic function: Mildly abnormal left ventricular ejection fraction per gender, calculated LVEF by biplane is 50%, which may be rhythm induced. Regional systolic function: Wall motion: All segments contract normally. Right Ventricle: Normal right ventricle size, function, and wall thickness. Underlying rhythm is atrial fibrillation. This is a very thick ventricle. If appropriate, further imaging with strain could be done to exclude amyloid/ hypertension heart disease, or other.** Discharge: Patient's condition at discharge: Improved. Discharge disposition: Routine home or self-care. Discharge instructions: Discharge activity: Resume normal activity. Discharge diet: Low sodium (2gms) Additional discharge instructions: Patient has been specifically instructed to avoid all over-the-counter anti-inflammatories. Follow up care/appointments: Follow up primary care physician 1-2 weeks. Follow up nephrology 2-3 weeks. Discharge medications summary: Current medications: Lipitor, Verapamil, Metoprolol, Apixaban, Losartan, Prilosec.
1F pg. 49-55	MM/DD/YYYY	ABCD Health Care AAAA Hospital SSSS AAAA, D.O.	**Emergency Department note** HPI: Evaluation of moderate pressure discomfort in chest which started earlier today was relieved with Nitro the pain did not radiate to his back. He is a little short of breath. Vital signs: **BP 187/112mmHg, 208/149mmHg.** Medical decision making: Patient required my immediate attention continuous cardiopulmonary patient was started on Cardizem after a bolus emergent consultation made with the hospitalist for admission. Critical care: Indication: Patient was critically ill with a high probability of imminent or life-threatening deterioration. Critical care provided: Direct patient care (not related to procedure), additional history taking, interpretation of diagnostic studies, documentation, and consultation with other physicians. Diagnosis: Atrial fibrillation with RVR Chest pain

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2F pg. 1-6, 33, 34, 42-45, 46-48	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital SSSS HHHH, M.D.	**Hospital Admission Note** Admission: MM/DD/YYYY Discharge: MM/DD/YYYY Hospital course: Right upper quadrant to right posterior quadrant pain. **History of malignant hypertension with noncompliance**. History of atrial fibrillation on Eliquis. Follow-up with cardiology intermittently but not been compliant in that. He is known to our service to be non-compliant and not follow up routinely. Was admitted with malignant hypertension and placed in the ICU. Incidentally had a CT of the abdomen and pelvis, which showed polycystic kidney disease. Did not give any history and stated he was unaware of this if he had it. Placed in ICU antihypertensives were titrated we did manage to get BP down to a reasonable amount over 24 hours. Systolic now running about 160-170 with diastolic in the upper 80s. Did have a run of ventricular tachycardia and has some T wave inversions, we discussed with cardiology, and they recommended outpatient follow-up as is not having any active chest pain or shortness of breath. The polycystic kidneys are most likely the cause of his right upper quadrant pain, we did consult surgery there was some thought that he may have a hemorrhagic cyst in 1 of these areas. After admission, the patient was feeling much better, and stated his pain had resolved, and his BP was stable with the current regimen of Losartan and Clonidine patch. Explained to him the need to follow up with cardiology and nephrology for renal disease. Vitals: **BP 132/89mmHg.** Medications: Inpatient: Clonidine, Dilaudid, Eliquis, Hydralazine, Losartan, Miralax, Pantoprazole, Pravastatin, Sodium Chloride IV, Verapamil, Zofran. Home: Atorvastatin, Catapres, Cefdinir, Eliquis, Losartan, Omeprazole, Tadalafil, Verapamil. SH: Tobacco use: 10 or more cigarettes (1/2 pack or more)/day in the last 30 days. **Electrocardiogram:** **MM/DD/YYYY: Normal sinus rhythm, right bundle branch block. Abnormal EKG. HR 73 bpm.** **MM/DD/YYYY: Normal sinus rhythm, right bundle branch block, T wave abnormality, consider inferior ischemia. Abnormal EKG. HR 78 bpm.** **Labs:** **MM/DD/YYYY: BUN 28 (High), creatinine 2.80 (High), eGFR AA 31, eGFR non-AA 25, urine protein 2+ (abnormal)** **MM/DD/YYYY: BUN 29 (High), creatinine 2.65 (High), eGFR AA 33, eGFR non-AA 27.** **Procedures:** X-ray of the abdomen (MM/DD/YYYY *Read by: ABBC CCCC, M.D.*). Impression: Nonspecific bowel gas pattern with nonobstructive pattern. Moderate fecal material noted. Mild gaseous distention of small bowel in central and left mid abdomen with a few scattered air-fluid levels. Please correlate clinically for signs of localized ileus and

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			constipation/obstipation. **Ultrasound renal (MM/DD/YYYY *Read by: XYX XXX, M.D.*):** **Impression: Multiple bilateral renal cysts consistent with polycystic kidney disease. Bladder distension.** Ultrasound gallbladder (MM/DD/YYYY *Read by ABBC CCCC, M.D.*). Impression: Normal exam. **CT abdomen and pelvis without contrast *(MM/DD/YYYY Read by: RRRR SSSS, M.D.):*** **Findings: Innumerable bilateral low, intermediate, and high-density renal masses, possibly representing autosomal dominant polycystic kidney disease. Several hyperdense lesions likely represent hemorrhagic cysts. Several of these lesions contain partial calcification. An underlying renal neoplasm cannot be excluded. A mild degree of nonspecific stranding about the right kidney.** **Impression: Abnormal appearance of both kidneys, favored to represent abdominal dominant polycystic kidney disease. Nonspecific right perirenal fat stranding.** Discharge plan: Polycystic kidney Accelerated essential hypertension Chronic renal failure Atrial fibrillation Noncompliance with treatment Orders: Cefdinir 300mg, Catapres TTS-2 0.2mg/24 hr patch, Clonidine 0.3mg/24 hr patch, Hydralazine 10mg IV. Patient discharge condition: Good. Discharge disposition: Home. Patient education: Intravenous pyelogram, easy to read, preventing hypertension.
2F pg. 6-11	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital JJJJ YXYX, M.D.	**Emergency Department Note** CC: Right upper quadrant abdominal pain. 10/10 pain with movement. States this sharp pain has been present for 2 days. Had a dark bowel movement yesterday. HPI: 2 days of right upper quadrant pain. Took a laxative yesterday and had a darker bowel movement than normal after that has not had any significant gastrointestinal complaints. The pain started suddenly and seems to be worse with movement and if he stays completely still it does not hurt as much. BP was markedly high at the time of admission through the emergency room but did not take medications this morning. Vitals: **BP 201/107mmHg.** Physical exam: Abdomen – Acutely tender in the right upper quadrant but seems to be in the abdominal wall more so. His bowel sounds positive and normal. Reexamination/reevaluation: BP is still markedly high and in fact may be contributing to his pain and he needs to be admitted for control of BP and treatment for pain. Will observe and see how it does with the treatment of BP. Discussed the case with Dr. XXXX and will be admitted to ICU because of extremely elevated BP.

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			Assmt/Plan: Accelerated essential hypertension Acute abdominal pain Chronic renal failure History of atrial fibrillation Noncompliance with treatment Orders: Eliquis 5mg, Losartan 100mg, Pantoprazole 40mg, Pravastatin 80mg, Verapamil 120mg. Admit to inpatient. Check labs.
3F pg. 2-5	MM/DD/YYYY	EFGH – Clinic JJJJ GGGG, N.P.	**Office Visit** CC: Management of cardiac care. Primary physician is Dr. HXDX. HPI: Mostly here with BP issues. No chest pain or dyspnea on exertion. **He has relocated and may be looking for another job.** Wants to get his BP under control again. Vitals: **BP 168/100mmHg.** Plan: Catheter ablation, atrial fibrillation, episode of hypertension, uncontrolled hypertension, hypertensive heart disease without congestive heart failure – Follow up in 4 months. Follow up with RSB. Discussion/Summary: He needs better BP control. He tells me that he has some renal insufficiency and is seeing nephrology this week. I do not have any recent labs on him. He is getting labs today and then we will make medication adjustments from there. Consider Aldactone. Stable atrial fibrillation. Continue calcium channel blockers and Eliquis for now.
3F pg. 6	MM/DD/YYYY	ABCD Associates JJJJ CCCC, M.D., MSC, FACC	**Echocardiogram** Indications: Nonsustained ventricular tachycardia. Findings: Trace mitral regurgitation. Trace tricuspid regurgitation. Trace pulmonic regurgitation. Conclusions: Normal LV systolic function with visual EF 50-55%. Left ventricular cavity is minimally dilated. The left atrial cavity is mildly dilated at 4.4 cm. RVSP measures 18mmHg.
4F pg. 1-2	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital BBBB YYYY, CRNP	**Telehealth Visit** CC: Would like to discuss ways to stop smoking. HPI: Called in today to clinic for Chantix, **patient is in the process get a new job** and would like to be off of his smoking habit he smoked a lot of time and states he likes it. I did explain that the Chantix is currently unavailable. Has had great results with previous cessation attempts at Wellbutrin he states he restarted smoking when he was going through divorce with his wife. Patient does have chronic atrial fibrillation, congestive heart failure and CKD, he is under the care of appropriate specialist states he is compliant since he has been insured. ROS: Psychiatric –anxiety, depression would like to be on Wellbutrin. Vitals: **BP 132/80mmHg.** Assmt/Plan: Atrial fibrillation – continue to see cardiology as scheduled, avoid stimulants, emergency room if any acute chest pain, etc. Tobacco abuse – discussed smoking cessation, patient currently not ready to quit. Start Wellbutrin, will help some for anxiety and might have some benefits for smoking cessation.

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			Orders: Tadalafil 20mg. Reviewed the last labs, creatinine 2.81, he is engaged with nephrology.
4F pg. 3-5	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital BBBB YYYY, CRNP	**Office Visit** CC: Left knee pain and popping in and out, swelling, tenderness, stiffness, under kneecap hurts. HPI: Left knee pain, instability when standing up, it has given way several times, **able to continue to work** has not seen orthopedic. He is continuing to work. His BP is elevated at home, been out of medications, his last 3 BP readings elevated at an alarming rate, which increases the risk of premature mortality and is worrisome. This morning admits to not taking his BP medications. Been seen by cardiology in the past for chronic atrial fibrillation, stable on Eliquis. Vitals: **BP 180/120mmHg.** Physical exam: Heart – irregular rhythm. Assmt/Plan: Left knee pain/instability of left knee joint – Ordered X-ray of left knee. Hypertension – BP unacceptable. Patient verbalizes understanding, agrees to start taking medications, and continues to monitor BP daily. Atrial fibrillation – continue Eliquis and avoid stimulants counter.
4F pg. 6-8	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital BBBB YYYY, CRNP	**Office Visit** CC: Medications refills and stated he may not have taken BP medications this morning. HPI: He was out of medicines, and had no BP medications this morning, his BP elevated which is worrisome, he does not have his Eliquis, admits he has poor planning. Has chronic atrial fibrillation, called cardiology, and canceled his ablation because of insurance issues. Vitals: **BP 200/102mmHg.** Assmt/Plan: Atrial fibrillation – See cardiology as scheduled. Hypertension – Clonidine 0.1, the patient stated a few minutes states he had to go for a work emergency and left against medical advice. Will restart his medications immediately of course of risk of out-of-hospital events was discussed with him, and he agreed to follow up with cardiology in 2 weeks and has taken some time to recommend that he go through with ablation for Elyse here the recommendations of cardiology. Dyslipidemia – Fasting labs. Orders: Eliquis 5mg, Atorvastatin 20mg, Losartan 100mg, Verapamil 120mg/
4F pg. 9-10	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital BBBB YYYY, CRNP	**Office Visit** CC: Wants to discuss something that has been going on with his cardiologist the last few months. HPI: Seen in XXYX last week for atrial fibrillation, patient is scheduled for ablation in several weeks. On anticoagulation therapy currently, he has permission to use Viagra as needed as long as he avoids nitrates. Stable on medications, not currently on atrial fibrillation. Vitals: **BP 192/99mmHg.** Assmt/Plan: Atrial fibrillation – Seen cardiology as scheduled. BP elevated, states

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			this is good for him. GERD without esophagitis – Continue low acid diet, continue PPI. Elevate head on the bed and avoid eating before bedtime. Erectile dysfunction – Will use Cialis very carefully after discussing with cardiology, risks discussed, avoid nitrates. Orders: Sildenafil 100mg.
5F pg. 1-9	MM/DD/YYYY	CBC Center for Center Care MMMM VVVV, M.D.	**Office Visit** CC: CKD. HPI: Referred for incidental finding of polycystic kidneys on CT scan and ultrasound. Presented to Atmore Hospital ED with hypertension and pain. History of hypertensive urgencies ongoing tobacco use, CKD with elevated creatinine of 2.65, atrial fibrillation, remote deep vein thrombosis (DVT). Given Clonidine Patch and is out of refills. Works on banking machinery. PMH/PSH: YYYY motor vehicle accident with Central nervous system (CNS), DVT and thrombectomy, CNS procedure unspecified facial bone reconstruction. ROS: Constitutional: Positive for malaise/fatigue. Neurological: Positive for weakness. Vitals: **BP: 226/124mmHg, 178/138mmHg.** Assmt/Plan: Stage 3b CKD Autosomal dominant polycystic kidney disease Hypertension Proteinuria, not otherwise specified CKD stage III/IV – creatinine 2.6. Trace blood, 2+ protein. Jynarque candidate after BP controlled. Discussed at the next visit. Urine studies: Low level proteinuria. Hypertension – Episodes of hypertensive urgency. Appears responsive to Clonidine. Restart the Catapres patch. Start home BP log. Anemia of CKD – within normal limits. Renal secondary hyperparathyroidism – update labs. Cardiovascular risk reduction: Statins are encouraged for most patients with CKD, hypertension, and/or diabetes. Possible family history of hemorrhage stroke. Will need CT and/or MRA of brain and reassessment of long-term Eliquis in consultations with neurology/neurosurgery. Patient instructions: Smoking cessation. Avoid nonsteroidals. Return to clinic in 1 month with labs.
5F pg. 9-20	MM/DD/YYYY	CBC Center for Center Care HHHH DDDD, APRN	**Office Visit** CC: Hypertensive urgency and CKD4. Feels okay but has lower left quadrant abdominal pain that comes and goes. HPI: Recently seen by cardiologists to add Hydralazine 3 times a day, BP remains high and is frequently in the 200 range per patient. His lowest BP is about 160/100 asymptomatic. Continues to have left lower abdominal pain that comes and goes. ROS: Eyes – Blurred vision. Gastrointestinal – Constipation. Endocrine – Polydipsia. Psychiatric/behavioral – depression, memory loss. The

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			patient is nervous/anxious and has insomnia. Vitals: **BP 238/135mmHg, 215/126mmHg.** Assmt/Plan: CKD stage III/IV – creatinine 2.6 > 2.8. Jynarque candidate after BP controlled. BP is still not controlled. Hypertension – Episodes of hypertensive urgency. Did not bring home a BP log but states systolic range from 160s to 200s. Very rarely has a systolic of 140. Cardiology recently added Hydralazine 25mg. Increase the Clonidine patch to 0.3mg. Add Spironolactone 25mg increase as tolerated. Continue Metoprolol, Verapamil, Losartan, Hydralazine. Given Clonidine 0.1mg in the office today. Recheck BP 190/100. Check doppler renal arteries, metanephrines, renin, and aldosterone. **The patient is getting a sleep study done.** Recommend stopping smoking. Patient instructions: Stop Cardizem – same family as Verapamil. Return in about 4 weeks (around MM/DD/YYYY)
6F pg. 1	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital RRRR SSSS, M.D.	**X-ray of the left knee** Reason for exam: Instability of knee/pain. Impression: Negative.
6F pg. 4-9	MM/DD/YYYY	QCDC Diagnostics	**Labs** **BUN – 28 (High)** **Creatinine – 2.81 (High)** **eGFR AA - 31** **eGFR non AA - 25** **Parathyroid hormone, intact – 67 (High)** **Urine protein – 2+ (Abnormal)** **Urine, random, protein – 37 (High)** **Urine protein/creatinine ratio – 411 (High)**
11F pg. 12-14	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital BBBB YYYY, CRNP	**Office Visit** CC: Check-up states he **needs release to go back to work.** HPI: Does have CKD and chronic atrial fibrillation, has applied for disability but has not heard recently is attempting to go back to work he is struggling pulm a cage around to this back out comes in today to clinic for evaluation. **Admit noncompliance with medications, has not seen cardiology or nephrology due to insurance status is excited insurance will be active probably about 30 days and he can re-establish.** He denies any new worrisome symptoms he is trying to be compliant with a low sodium diet. ROS: Musculoskeletal: Back pain, joint pain. Psychiatric: Anxiety, depression improved. Vitals: **BP 162/88mmHg.** Physical exam: Musculoskeletal: Positive for tenderness spasms lumbar spine. Assmt/Plan:

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			Atrial fibrillation – See cardiology as scheduled Elevated serum creatinine – Needs to see nephrology ASAP. Patient declines labs today due to insurance, he will see us when he gets his insurance active next month. Hypertension – Advised to monitor BP at home. Consume low sodium diet, try to exercise. If BP elevate see us for evaluation. Restart Metoprolol continue to monitor BP closely heart rate is regular today. Lumbago – improved. Stay off NSAIDs. Use Tylenol if needed CS for evaluation if he has the symptoms we discussed today **otherwise, he can return to work.** GERD without esophagitis – continue low acid diet, continue PPI.
13F pg. 1-4, 20, 30-32, 33-34	MM/DD/YYYY	ABCD Healthcare Authority CCCC Hospital WWWW HHHH, M.D.	**Hospital Admission Note** Admission: MM/DD/YYYY Discharge: MM/DD/YYYY Hospital course: Admitted for hypertensive emergency. Placed in ICU on a Cardene drip. Monitored overnight. Was able to wean off Cardene drip and previous home medications were resumed. Going to transfer out to medical floor for continuation of observation and BP monitoring. **Patient decided not to stay in facility anymore and signed out against medical advised despite nursing staff trying to convince him to stay.** Vitals: **BP 176/100mmHg.** **Electrocardiogram MM/DD/YYYY - Normal sinus rhythm. Right bundle branch block. T wave abnormality with ST abnormality, consider inferior ischemia. Abnormal EKG. HR 71 bpm.** **Labs MM/DD/YYYY: BUN 40 (High), creatinine 3.21 (High), eGFR AA 26, eGFR nonAA 22, CKMB 6.4 (High), CKMB index 5.1 (High), Troponin-I 79.2 (High), NT-proBNP 3124 (High)** **MM/DD/YYYY: BUN 31 (High), creatinine 2.76 (High), eGFR AA 31, eGFR nonAA 26.** X-ray of the chest (MM/DD/YYYY, Read by: *TTTT WWWW, M.D.*): Normal. **CT head without contrast (MM/DD/YYYY, Read by: *TTTT WWWW, M.D.*): Right parietal temporal craniotomy and more posteriorly there is a burr hole on the right side.** Discharge plan: Hypertensive emergency – Transfer patient ECHA MM/DD/YYYY Dizziness Nausea and vomiting Chronic kidney disease Orders: Hydralazine 25mg, Metoprolol Succinate ER 100mg, Pravastatin 80mg, Verapamil 120mg. Patient education: Antibiotics medicine, adult, easy to read. Managing your hypertension. Discontinued – Eliquis 5mg.
14F pg. 4-8	MM/DD/YYYY	ABBC Primary Health Care	**Office Visit** HPI: Follow up to labs. Labs indicated LDL above goal given history and risk factors. Will increase statin. BP high today. Review of

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		AAAA BBBB, CRNP	medications shows that he admits to never picking up the prescription of the Cardura. Will take medications as directed and follow up by telehealth after compliance with BP log to determine the need to increase the Hydralazine. CKD is stage 3B, will refer to nephrology. Has new insurance and can afford the Cardiology consult. Moved furniture for mom and strained back. NSAIDs contraindicated, will add anti-spasm medication for few days. ROS: Musculoskeletal: Positive for back pain. Vitals: **BP 228/124mmHg, 190/106mmHg.** Physical exam: Musculoskeletal: General - Tenderness present. Comment: Tenderness to bilateral paraspinous. Assmt/Plan: Secondary hypertension – BP has improved, but not at goal. Consulted Dr. BBBB. Comments: Add Cardura. Advised to monitor BP at home and call with logs next weeks. Referred to Cardiology, Nephrology. Continue Amlodipine 10mg, Eliquis 2.5mg, Doxazosin 2mg, Hydralazine 25mg, Losartan 100mg, Metoprolol Succinate ER 100mg. Stage 3b chronic kidney disease – Comment; Creatinine 3.08 and eGFR 23. Referral to Nephrology. Continue Hydralazine 25mg, Losartan 100mg. Hyperlipidemia – LDL above goal at 110mg/dl, increase statins. Continue Atorvastatin 40mg. Cardiomegaly – Referral to Cardiology. Continue Amlodipine 10mg, Eliquis 2.5mg, Losartan 100mg, Metoprolol Succinate ER 100mg. Atrial fibrillation/Radiofrequency ablation procedure for cardiac arrhythmia – Continue Eliquis 2.5mg, Metoprolol Succinate ER 100mg. Acute bilateral low back pain without sciatica – Negative straight leg test. Start Cyclobenzaprine 5mg.
14F pg. 8-12	MM/DD/YYYY	ABBC Primary Health Care AAAA BBBB, CRNP	**Office Visit** HPI: Wellness exam. BP above goal despite compliance with regimen. Consulted with Dr. BBBB advised to add Cardura 2mg daily and continue with Cardiology consult. Vitals: **BP 179/103mmHg.** Physical exam: Cardiovascular – Bradycardia present. Assmt/Plan: Secondary hypertension – BP has improved, but not at goal. Consulted Dr. BBBB. Add Cardura. BP in 2 weeks. Cardiomegaly – Chest X-ray. Referral to Cardiology, nephrology. CKD – Check labs. Localized swelling, mass, and lump, in the neck. Atrial fibrillation/Radiofrequency ablation procedure for cardiac arrhythmia – Continue medications. Hyperlipidemia - Check labs.
14F pg. 12-15	MM/DD/YYYY	ABBC Primary Health Care AAAA BBBB, CRNP	**Office Visit** HPI: New patient for refills. Advised to refer to ER due to hypertensive urgency as he reports no medications in weeks. Reports only has Lipitor at home. Will provide prescription so BP will be better controlled at follow up by resuming recent regimen.

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			Vitals: **BP 230/145mmHg, 231/130mmHg.** Assmt/Plan: Hypertensive urgency – Advised to go to ER. Asymptomatic. He declined, signed against medical advice. Has no medications and needs refill. Referral to cardiology. Cardiomegaly – Reported. No records. Referral to Cardiology. Chronic kidney disease – Uncertain of stage. Referral to nephrology. Atrial fibrillation/Radiofrequency ablation procedure for cardiac arrhythmia – Referral to Cardiology.
14F pg. 23-24	MM/DD/YYYY	ABCD Medical Center	**Labs** **Urine protein strip – 2+ (Abnormal)**
15F pg. 1	MM/DD/YYYY	ABCD Associates JJJJ CCCC, M.D., MSC, FACC	**Echocardiogram** Indications: Hypertension. Findings: Doppler evidence of grade II (pseudonormal) diastolic dysfunction, and elevated left atrium pressure. Trace mitral regurgitation. Trace tricuspid regurgitation. Conclusions: Normal left ventricular systolic function with visual ejection fraction 50-55%. Left ventricle cavity is dilated. Concentric hypertrophy of the left ventricle. Right ventricular systolic pressure measures 6mmHg.
15F pg. 2-6)	MM/DD/YYYY	ABCD Associates JJJJ CCCC, M.D., MSC, FACC	**Office Visit** CC: Extremely high BP with stage 4 kidney failure. Binging dizzy, palps, dyspnea of evaluation. HPI: Recently lost his job and has a new network. **In the past he has seen Dr. CCCC when he worked at the xxx** Had longstanding hypertension with uncontrolled BP. Been followed by nephrology in Pensacola and was told that has stage IV kidney disease. PMH: Pectus excavatum; Subdural hematoma. ROS: Constitutional: Feeling tired (Fatigue). Cardiovascular: Chest pain, palpitations, and shortness of breath during exertion. Neurological: Dizziness. Vitals: **BP 198/130mmHg** Assmt/Plan: Episode of hypertension – Follow-up 2 weeks AAAA, NP evaluation and treatment. Echocardiogram Uncontrolled hypertension Current everyday smoker – Start Carvedilol 25mg. Start Clonidine 0.1mg. Nonsustained ventricular tachycardia Hypertensive heart Stop Toprol XL 100mg.
18F pg. 4-10	MM/DD/YYYY	NNNN Associates WWWW	**Office Visit** CC: Chronic kidney disease (CKD). HPI: Referred for abnormal kidney function. In early YYYY, creatinine is 2.6 to 2.8 mg/dL. Earlier this year, creatinine 3.0 mg/dL. Previously

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		LLLL, M.D.	seen RRXD in PXDY, but insurance recently changed, and it required him to see different doctors. Never been offered Jynarque. Had episodes of gross hematuria and passed kidney stones but none in past 5 years or so. Have atrial fibrillation and sees Dr. CCC. Previously failed ablation and remains on Eliquis for anticoagulation. Does smoke 1 pack/day. Father died of heart attack at an early age and mother does have kidney disease presumably related to diabetes and her kidney function better than this. Have mild back pain. States blood pressure always high regardless of what does or takes. Previously on Clonidine patch which helped, did not have to remember to take his medications orally. Previously evaluated for renal artery stenosis and pheochromocytoma and negative for both. Vitals: **BP 237/141mmHg.** Physical exam: Cardiovascular: Irregular rhythm. SH: **Chemical operative but unemployed/disabled due to hypertension.** Assmt/Plan: Stage IV CKD due to polycystic kidney disease (PCKD) – function slowly progressive with creatinine 3 mg/dL, try Jynarque if able to procure quantify proteinuria, on angiotensin retention blocker, stop Chlorthalidone due to concerns for volume depletion. Hypertensive urgency – Poor BP chronically, change Hydralazine to Minoxidil 2.5mg, Clonidine 0.1mg to avoid hospitalization, BP 201 systolic at end of visit. Smoker – counseled to quit. Atrial fibrillation – anticoagulated, rate controlled. Return to clinic in 1 month.
19F pg. 16-21, 50-55, 60	MM/DD/YYYY	DDDD Medical Center HHHH MMMM, M.D.	**Hospital Admission Note** Admission: MM/DD/YYYY Discharge: MM/DD/YYYY Admission diagnosis: Atrial fibrillation with rapid ventricular response (RVR) Final Diagnosis Atrial fibrillation with RVR, Chronic kidney disease V Hospital course: Presented to the hospital with heart palpitations. Admitted to intensive care unit and found atrial fibrillation with RVR. Begun on Cardizem infusion and converted to normal sinus rhythm. Then placed on Toprol and Eliquis. Successfully transition to oral Cardizem and monitored on telemetry unit. Creatinine level 3.7 compared to 1.9 several years ago. Followed with nephrology associates with last creatinine 3.9 in office. On day 2, medically stable for discharge to follow-up with primary care physician and subspecialists. **Labs** **MM/DD/YYYY: BUN 34 (High), creatinine – 3.66 (High), estimated GFR 19 (Low), Troponin T – 0.09 (High)** **MM/DD/YYYY: BUN 38 0 High), creatinine – 3.71 (High),**

EXHIBIT REF	DATE	PROVIDER	OCCURRENCE/TREATMENT
			estimated GFR 19 (Low), Troponin T – 0.11 (High) **Electrocardiogram** **Atrial fibrillation. Right bundle branch block. Nonspecific repolarization abnormalities. HR 81.** After discharge recommendations Follow up MDs. Discharge condition – good. Prognosis: Fair. Prescribed Diltiazem CD 24hr 240mg. Consults: Physician consult to: XYX CBA, M.D., Nephrology. Consult to cardiology Physician consult. Patient instructions: Diet – cardiac diet.
21F pg. 1-2	MM/DD/YYYY	CCCC Hospital Laboratory	**Labs** **BUN - 33 (High)** **Creatinine - 3.23 (High)** **eGFR CKD-EPI - 22**
21F pg. 3	MM/DD/YYYY	CCCC Hospital Laboratory	**Labs** **BUN - 37 (High)** **Creatinine - 3.58 (High)** **eGFR CKD-EPI - 19**
21F pg. 4-5	MM/DD/YYYY	CCCC Hospital Laboratory	**Labs** **BUN - 40 (High)** **Creatinine - 3.97 (High)** **eGFR CKD-EPI – 17 (Low)**