Idaho State University (Acct #3030)

Case ID #: 1429-20200825-001 (Status: Approved) **Date of Service: 8/25/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 73 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: No referral

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Hand pain bilateral
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M19.049 - PRIMARY OSTEOARTHRITIS, UNSPECIFIED HAND

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 5
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Endocrinology - Oral glucose lowering agents
Neurology - Analeptics
Pulmonary - ÃŸ2-agonist
Pulmonary - Steroid inhalers
Pulmonary - Long Acting ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

73 yo male reporting pain and "locking up" in his hands. The patient has deformation of his left index finger. Pt

Idaho State University (Acct #3030)

Case ID #: 1429-20200825-002 (Status: Approved) **Date of Service: 8/25/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 18 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: No referral

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Depression
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F41.1 - GENERALIZED ANXIETY DISORDER

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Gynecology - Oral contraception
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

18 yo following up after starting Celexa for depression. Previous GAD score of 8 and PHQ-9 of 14. Today her GAD score is 5 and PHQ-9 score is 7. The patient states she is doing better; it's easier to get out of bed in the mornings and is more motivated to go do some things. Celexa was called in to be refilled and education done on remaining on the Celexa until May of next year to re-evaluate. The patient has no known drug allergies.

Idaho State University (Acct #3030)

Case ID #: 1429-20200825-003 (Status: Approved) **Date of Service: 8/25/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 29 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: weight loss
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E63.8 - OTHER SPECIFIED NUTRITIONAL DEFICIENCIES

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Pulmonary - ÃŸ2-agonist
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

29 yo female presents for one month follow up after starting phentramine for weight loss. The patient has lost 13 pound since starting the phentramine. The patient is exercising 3 plus days a week with her friends to prepare for a wedding. The patient has no other complaints and states that she is happy with the results. Phentramine will be refilled and we will re-evaluate when the patient is no longer having weight loss with the medication and exercise. The patient is allergic to Keflex.

Idaho State University (Acct #3030)

Case ID #: 1429-20200825-004 (Status: Approved) **Date of Service: 8/25/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 63 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: DM follow up
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E11.9 - TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Antilipids
Cardiology - Calcium channel blockers
Endocrinology - Insulin

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

63 yo m presents for a DM follow up.
S: Dexcom has been showing low blood sugars throughout the day. He tried to re-calibrate it, so he thought it was working correctly. He's been taking his Lantus in the mornings but hasn't been taking his novalog except for when he eats big meals. Not exercising as much as he says he should.
O: No distress. HgA1C 8.5 today, up from 8.0.
A: Dexcom not working correctly. Hyperglycemia.
P: Diabetes education referral for help calibrating dexcom. Increase Lantus in the mornings from 43 units to 45 units. Continue with diet and exercise. Schedule eye exam; he is due.

Idaho State University (Acct #3030)

Case ID #: 1429-20200825-005 (Status: Approved) **Date of Service: 8/25/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 35 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Right wrist pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - W19 - UNSPECIFIED FALL

CPT Billing Codes

#1 - 99312 is not a valid CPT code.

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Antilipids
Endocrinology - Oral glucose lowering agents
Psychiatric - Antidepressants
Psychiatric - Benzodiazepines

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

35 yo m presents for follow up of right wrist sprain.
S: Right wrist pain has improved. No longer using the splint or using NSAIDs for pain.
O: FROM right wrist. No swelling, redness, or heat noted to the right wrist. No distress noted.
A: Right wrist sprain; improved.
P: Follow up as needed. Continue with diet and exercise and medications.

Idaho State University (Acct #3030)

Case ID #: 1429-20200826-001 (Status: Approved) **Date of Service: 8/26/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 54 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: No referral

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: well woman visit
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Cardiology - ACE inhibitors
Cardiology - Antilipids
Cardiology - Diuretics
Endocrinology - Thyroid
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

54 yo female presents for a well woman visit. Patient has a history of headache, insomnia, hypothyroid, anxiety, hyperlipidemia, and hypertension. She is a never smoker with occasional alcohol use. She is 5'4" and 162 lbs; BMI 27.81. BP today is 148/93, BP 3 months prior was 155/99. The patient is currently on lisinopril 40 mg daily for HTN. Will add hydrochlorothiazide 12.5 mg tab daily to her hypertension medication to potentially gain blood pressure control. Education done on taking the medication in the morning so urinating doesn't interfere with sleep.

Idaho State University (Acct #3030)

Case ID #: 1429-20200826-002 (Status: Approved) **Date of Service: 8/26/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 63 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Wellness
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E78.5 - HYPERLIPIDEMIA, UNSPECIFIED

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Antilipids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

63 yo m presents for his wellness checkup. Lipid panel had been done, the patient's cholesterol levels are all within normal range. The patient has been taking a statin since his last visit. The patient states he take CoQ10 with the statin because it lessens the muscle stiffness/pain that he gets with just taking the statin alone. The patient also recently had left knee surgery and states he has been doing physical therapy for his knee. He states he is doing well with that. The patient has no other complaints. The patient has no known drug allergies.

Idaho State University (Acct #3030)

Case ID #: 1429-20200826-003 (Status: Approved) **Date of Service: 8/26/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 31 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Routine)
Chief Complaint: annual wellness exam
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M95.9 - ACQUIRED DEFORMITY OF MUSCULOSKELETAL SYSTEM, UNSPECIFIED

CPT Billing Codes

#1 - 99204 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 45-59 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Gynecology - Oral contraception
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

31 yo female who presents for her annual wellness exam and to establish care. She is gravida 4 para 2. LMP was 2 weeks ago. No reports of any abnormalities with menstruation. Last pap smear done one year ago. TDAP was given in 2019. Surgical hx: Dilation and curettage in 2018, C-section x2 one in 2014 & one in 2019. Medical hx: asthma, contraception use, does not smoke, use alcohol, or recreational drugs. Allergies to PCN and codeine. Current medications: norgestimage 0.25 mg-ethinyl estradiol 35 mcg tablet, once by mouth daily & albuterol sulfate HFA 90 mcg/actuation aerosol, INH 1-2 puffs daily q 6 hrs prn..The patient lives at home with her husband and 2 children. The patient works full time. The patient does report low back pain that she takes ibuprofen and tylenol for. The patient would like to look into the cause of her back pain. Xray ordered for lumbar pain and physical therapy ordered for treatment of low back pain.

Idaho State University (Acct #3030)

Case ID #: 1429-20200826-004 (Status: Approved) **Date of Service: 8/26/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 55 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Consult)
Chief Complaint: weight loss
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E66.3 - OVERWEIGHT

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - Diuretics
Endocrinology - Oral glucose lowering agents
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

55 yo female presents for follow up on weight loss.
S: Doing well on the phentermine. Exercises regularly and eating less. Has been having low moods for a week or so at a time. Also has sweats during the day that make her very uncomfortable.
O: Lost 9 pounds in the last month. Well groomed well nourished. No acute distress.
A: Overweight. Menopausal symptoms.
P: Continue with diet, exercise, and phentermine. Draw labs for estrogen, progesterone, and testosterone. Follow up with results.

Idaho State University (Acct #3030)

Case ID #: 1429-20200826-005 (Status: Approved) **Date of Service: 8/26/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 46 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: DM follow up
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E11.8 - TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Angiotensin II receptor blockers
Cardiology - Antilipids
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Calcium channel blockers
Endocrinology - Oral glucose lowering agents
Urology - Erectile dysfunction medication

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

46 yo male presents for type 2 DM follow up
S: Doing well. Not exercising as much as he was. Feels his blood sugars have been fine. Doing well with the medications. No numbness or problems with feeling in his feet. No complaints. Up to date on his eye exam.
O: A1C 6.8, up from 6.5. Pt is well nourished. No sores or abrasions on feet.
A: hyperglycemia.
P: Continue with medications. Continue diet, exercise more. Follow up for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20200831-001 (Status: Approved) **Date of Service: 8/31/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 16 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: No referral

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: shortness of breath
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J45.21 - MILD INTERMITTENT ASTHMA WITH (ACUTE) EXACERBATION

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Corticosteroids
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

16 yo male presents to the clinic reporting shortness of breath. The patient just moved here 2 months ago from Kansas and just started school 2 weeks ago. The patient reports shortness of breath and cough x3 days. The patient has a history of asthma and has used his albuterol inhaler x4 and his albuterol nebulizer x3. The patient has also been taking over-the-counter allergy pill. The mother and the patient do not recall the name of the over-the-counter allergy medication.
Objective: Afebrile. Lung sounds CTA. Pt has dry cough. Left TM red with erythema. Eyes clear with no drainage. Throat slight erythema with no exudates. Mouth moist with no lesions. Nares non obstructed with slight drainage bilaterally.
A: Otitis media left.
P: Z-pack. COVID screen; results to come in Friday. May stay home from school. Get plenty of rest and fluids.

Idaho State University (Acct #3030)

Case ID #: 1429-20200831-002 (Status: Approved) **Date of Service: 8/31/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 27 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Employment Physical
Chief Complaint: employment physical
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
GI Agents - H2 receptor antagonists
Neurology - Migraine

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

27 yo female presents for employment physical evaluation
S: No complaints. On occasion has issues with her right hip; she is seeing physical therapy for treatment for that. No limitations with lifting and activity. Hx of migraines. Has not had any migraines in the last several months. Hx of GERD. Takes omeprazole every day; has not had any issues with GERD recently. No gyn issues reported. The patient is married, in a monogomous relationship. Not pregnant. Does not use birth control.
O: PERRLA. Answers questions appropriately. In no distress. Lung sounds clear bilaterally. Limitation on rotation of right hip. Strength equal bilaterally in upper and lower extremities.

Idaho State University (Acct #3030)

Case ID #: 1429-20200831-003 (Status: Approved) **Date of Service: 8/31/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Rash
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B33.8 - OTHER SPECIFIED VIRAL DISEASES

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Antiviral agents

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

30 yo presents with c/o rash on her left ear, neck, and chest that has not gone away.
S: Burning rash and sores on her left ear, neck, and chest. She came into the clinic last week and was given some lidocaine cream that she has been applying to the rash with some relief. The one sore on her left ear, however, is starting to look infected and she wants to get it checked.
O: Maculopapular rash to left ear, neck, and chest. One lesion just below left ear that is scabbed over with erythma and swelling.
A: Shingles - herpes zoster virus.
P: Continue lidocaine cream. Triamcinolone 0.1% cream to affected area BID. Valacyclovir 1 gm tab PO TID x 7 days.

Idaho State University (Acct #3030)

Case ID #: 1429-20200831-004 (Status: Approved) **Date of Service: 8/31/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: low back pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M48.8X6 - OTHER SPECIFIED SPONDYLOPATHIES, LUMBAR REGION

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

19 yo presents with c/o low back pain.
S: Pt states he twisted wrong and hurt his back about a week ago. Takes Ibuprofen but would like something more for pain.
O: FROM lumbar spine. Normal gait. Strength equal bilateral lower extremities.
A: low back pain
P: Flexeril 10 mg PO TID prn pain.

Idaho State University (Acct #3030)

Case ID #: 1429-20200902-001 (Status: Approved) **Date of Service: 9/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 65 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Follow up
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E11.9 - TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 17
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Antilipids
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins
Endocrinology - Thyroid
Pulmonary - Nonsteroidal anti-inflammatory (ie Tilade)
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

65 yo female presents for follow up
S: Feeling better after she had pneumonia. She is back to work as of the first of August and is happy to be working again. Uses 3 L O2 at night at home. She finished her prednisone taper and feels that helped a lot. Pt states she is using her albuterol HFA at home, but not her other inhalers. Patient also states she takes one metformin in the morning, but not the metformin at night. She is taking her trulicity. Pt stated she has had a rough year with hospitalizations.
O: HgA1C 9.1, up from 8.5. Pt is 5'1" 295 pounds, BMI 55.17. Pt is 92% on room air, no apparent distress. Respirations equal bilaterally.
P: Educate patient on adherence with metformin and inhalers. Encourage weight loss. Follow up for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20200902-002 (Status: Approved) **Date of Service: 9/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 83 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: hypothyroid
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E03.8 - OTHER SPECIFIED HYPOTHYROIDISM

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 10
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Antilipids
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

83 yo m presents for a follow up on labs.
S: Doing well on medications. Recently had bilateral lower extremity vein scans, vein doctor is managing that. Doing well with mobility. No fevers, weakness, or fatigue reported.
O: Pt sitting quietly in no distress. HbA1C 6.5 which is the same as 3 months prior. TSH is elevated.
A: Hypothyroid.
P: Thyroid panel to test for hypothyroidism. Follow up with results.

Idaho State University (Acct #3030)

Case ID #: 1429-20200902-003 (Status: Approved) **Date of Service: 9/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Family Medicine (Pocatello)
Setting Type:

Patient Demographics

Age: 59 years
Race: Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Consult)
Chief Complaint: Arthritis, bilateral shoulders & neck
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M19.019 - PRIMARY OSTEOARTHRITIS, UNSPECIFIED SHOULDER

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Narcotics
Analgesic/Antipyretic - NSAIDS
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins
Endocrinology - Thyroid

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

59 yo f presents for arthritis pain.
S: Bilateral shoulder and neck pain. Pt states she was getting Norco but was told that she couldn't get it refilled. She has had neck and shoulder pain since her c-spine surgery about 10 years ago.

Idaho State University (Acct #3030)

Case ID #: 1429-20200907-001 (Status: Approved) **Date of Service: 9/7/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 22 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: Urinary frequency
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Sulfonamides

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

22 yo female presents for urinary tract infection symptoms
S: Pt reports urgency, frequency, burning with urination and lower pelvic "burning" when sitting for 2 days. Denies fevers, abdominal pain, nausea, vomiting, or flank pain.
O: Urinalysis results: ketones 15 mg/dl, small amounts of leukocytes, specific gravity 1.02. No flank pain on palpation. No abdominal pain on palpation. Afebrile.
A: Urinary tract infection & dehydration.
P: Bactrim (sulfamethoxazole 800 mg - trimethoprim 160 mg tablet) PO BID x 7 days. Encourage fluids. Drink enough water 8-10 glasses per day, enough to be able to urinate every 2 hours. May drink cranberry juice to help with urinary acidity. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20200907-002 (Status: Approved) **Date of Service: 9/7/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 42 years
Race: Other
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: COVID screening
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B34.2 - CORONAVIRUS INFECTION, UNSPECIFIED

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

42 yo male presents for COVID screening
S: The patient has multiple sick contacts from work who have tested positive for COVID. The patient reports severe fatigue since Friday, occasional fevers, severe headache - the worst headache of his life last night that was relieved with NSAIDs. The patient reports sore and "swollen throat." Pt also reports runny nose and nasal congestion. He has also had a dry cough. Denies chest pain, nausea, vomiting, diarrhea, or abdominal pain.
O: Afebrile, slightly diaphoretic. Lung sounds CTA, heart sounds RRR. TM's perly gray with no erythema bilaterally. Slight nasal congestion and drainage. Throat slight erythema with no exudates or lesions. Slight swelling and tenderness left anterior cervical lymph nodes.
A: COVID exposure. Upper viral symptoms.
P. Self quarantine-inform employer of COVID screening status if needed. Get plenty of rest and fluids. May continue using NSAIDs for headache as needed and as directed. Return for worsening symptoms.

Idaho State University (Acct #3030)

Case ID #: 1429-20200907-003 (Status: Approved) **Date of Service: 9/7/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 74 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: High blood pressure
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Cardiology - ÃŸ Adrenergic blockers
Endocrinology - Minerals/vitamins
Endocrinology - Osteoporosis

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

74 yo f presents to have her blood pressure checked
S: The patient states she went to have her eye exam and they told her that her blood pressure is high and that she needed to go get checked out. The patient denies any symptoms. States that she feels fine. No reports of headache .
O: Blood pressure 194/84. Heart sounds RRR. Lung sounds CTA. No apparent distress. Eyes PERRLA. Pulses strong and equal bilateral upper extremities.
A: Essential hypertension.
P: Bystolic 5 mg PO daily. Follow up in one month. Keep a blood pressure diary, if blood pressures continue to be high, follow up sooner.

Idaho State University (Acct #3030)

Case ID #: 1429-20200907-004 (Status: Approved) **Date of Service: 9/7/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 62 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: low back pain
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.56 is not a valid ICD code.

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN, demerol, iodine, cephalexin
62 yo female presents with low back pain
S: Pt states she fell moving a dresser 3 weeks ago. She fell all the way to the floor and had extreme back pain. She did not go in at that time because she figured the pain would go away. The pain has gotten better, but she states she will get 1-2 episodes of low back pain and will lose strength in her legs and fall to the floor. She denies numbness or tingling in bilateral lower extremities. Denies urinary or bowel incontinence.
O: Strength equal bilateral lower extremiteis. Bilateral tenderness with palpation lumbar spine. FROM in spine. Bilateral lower extremity sensation noted.
A: Low back strain
P: Toradol 60 mg IM x 1 now. Pt refuses flexeril order. Lumbar xray. Follow up with Dr. Cam who she already has established care with.

Idaho State University (Acct #3030)

Case ID #: 1429-20200908-001 (Status: Approved) **Date of Service: 9/8/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 70 years
Race: Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Medicare Wellness exam
Encounter #: >10
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G90.09 - OTHER IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Diuretics
Neurology - Anticonvulsants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

70 yo female presents for her annual Medicare wellness exam.
S: doing well. Been working in my garden. Taking additional gabapentin because she's having additional pain in her legs and knees. She attributes the pain to being more active this summer. She has a new puppy that eats all the vegetables in her garden, but he keeps her busy. She is updated on her mammogram and cologuard. She is planning on getting her flu vaccine in October. She needs a few labs drawn to check her cholesterol and A1C.
O: BMI 34.4. Patient has lost 7 pounds. Afebrile, vital signs not significant. No distress. Patient answered questions appropriately. She was able to draw the time of 10 after 11 on a clock.
A: Peripheral neuropathy and hypertension being managed.
P: update patient on pneumococcal vaccinations. Draw labs for cholesterol and A1C. Continue physical activity.

Idaho State University (Acct #3030)

Case ID #: 1429-20200908-002 (Status: Approved) **Date of Service: 9/8/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 41 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 30 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: annual wellness exam
Encounter #: 1
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R03.0 - ELEVATED BLOOD-PRESSURE READING, W/O DIAGNOSIS OF HTN

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

41 yo male presents for annual exam and to check his blood sugar.
S: No fevers or difficulties eating. Has lost 75 pounds since high school; he's been trying to maintain a healthy lifestyle but is not following any specific diet. Has been having a few issues with numbness and tingling in his hands and feet. He has a family history of diabetes, so he is concerned that he may be developing diabetes. He has also been having issues maintaining an erection. No issues reported with urination. He works graveyard shift and doesn't believe he is getting enough sleep. He has been having occasional issues with choking; difficulty swallowing.
O: 5'9" height, 259 lbs. BMI 38.1. BP: 146/97. Well appearing well nourished. PERRLA. Thyroid raises bilaterally with swallow, no nodules or enlargement noted. Abdomen soft and non-tender. Bowel sounds active x4 quadrants. FROM all extremities. No rashes or lesions noted. Lung fields CTA. Respirations equal and unlabored Heart rate regular. Capillary refill <2 sec.
A: Hypertension, obesity, peripheral neuropathy, erectile dysfunction.
P: CBC, CMP, TSH, lipid panel, testosterone level, magnesium, vit D, and vit B12. Upper GI-swallow study. Discussed diet and exercise for obesity and adverse effects of obesity. Discussed possible use of cialis or viagra for erectile dysfunction. Follow up with results of labs. Possible peripheral nerve function studies.

Idaho State University (Acct #3030)

Case ID #: 1429-20200908-003 (Status: Approved) **Date of Service: 9/8/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial Family Medicine
Setting Type:

Patient Demographics

Age: 72 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: DM follow up
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E11.42 - TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY
#2 - 401.9 is not a valid ICD code.
#3 - E78.5 - HYPERLIPIDEMIA, UNSPECIFIED
#4 - E11.40 - TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSP

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 3
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Cardiology - Antilipids
Cardiology - ÃŸ Adrenergic blockers
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins
Neurology - Anticonvulsants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Pt presents to clinic for 3 month follow up for diabetes
S: Doing well. Exercising daily. Has been tracking blood pressure and blood sugar. Denies any symptoms of headache, nausea, polyuria polydipsia, myalgias, fevers; he states he has been doing well. He's mainly here to check his A1C. He is currently taking metformin 1000 mg BID. PMH: coronary artery disease, HTN, hyperlipidemia, diabetic neuropathy and vitamin D deficiency. Surgical history of coronary stents. Medications include B-complex, aspirin, metformin, pravastatin, lisinopril, and vitamin D.
O: No distress. BP: 154/59. Other vital signs unremarkable. A1C today is 7.5, up from 7.4. Onchomycosis noted to bilateral large toenails. Deep pressure felt to sole and side of bilateral feet. Light pressure not felt to sole and sides of bilateral feet. No sensation to deep and light pressure noted to toes bilateral feet. Strong pedal pulses noted bilaterally. No edema noted to lower extremities. No discoloration noted to lower extremities except bilateral great toenails.

P: Continue to monitor blood sugar. Consider adding oral antidiabetic medication on follow up if blood sugars continue to be high. Eye exam and podiatry referral for bilateral toenail removal.

Idaho State University (Acct #3030)

Case ID #: 1429-20200914-001 (Status: Approved) **Date of Service: 9/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 66 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: UTI
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED
#2 - R03.0 - ELEVATED BLOOD-PRESSURE READING, W/O DIAGNOSIS OF HTN

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Urinary anti-infectives

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

66 yo female presents for symptoms of UTI Allergies to sulfa
S: Back pain and burning on urination that started Saturday. She began taking Cystex, which helped a little but now it's getting out of control. Denies back pain today, but states that she has to urinate frequently and it burns when she urinates. Urine is usually clear, but this morning it was yellow.
O: Urine has moderate amount of blood and some leukocytes. No back pain to palpation. Blood pressure 191/95, rechecked, then 168/91.
A: UTI and hypertension
P: Nitrofurantoin 100 mg PO BID x 7 days. May continue Cystex as directed by manufacturer. Drink plenty of water and cranberry juice. Return if symptoms worsen. Education done on blood pressure. The patient reports that her blood pressure is always high when she goes to the doctor and dentist. She states that at home her systolic pressure is in the 120s- 140s. Education done on following up with primary care provider for continued assessment of blood pressure.

Idaho State University (Acct #3030)

Case ID #: 1429-20200914-002 (Status: Approved) **Date of Service: 9/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 57 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Employment Physical
Chief Complaint: Employment physical
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F17.210 - NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

57 yo male presents for employment physical.
S: Feels good. No headaches, fatigue, or difficulties with sleep, eating, and activities. The patient is an every day smoker at 15 to 16 cigarettes per day. The patient states he had pneumonia once, but no other medical history. The patient also reports numbness in his right pinky and the later aspect of his hand due to a past procedure ORIF of the right elbow.
O: Full ROM in all extremities, back, and neck. Equal strength bilaterally. Normocephalic. Eyes PERRL. No rashes or lesions noted to skin. Responds appropriately to questions. Lungs CTA with no signs of distress. Heart rate regular rhythm and rate.
A: Fit for work with no restrictions.
P: Write note for patient's employer reporting fitness to work. Follow up with regular provider for screenings, updates on vaccinations, and smoking cessation.

Idaho State University (Acct #3030)

Case ID #: 1429-20200914-003 (Status: Approved) **Date of Service: 9/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 37 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Other
Chief Complaint: Medication refill
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E03.8 - OTHER SPECIFIED HYPOTHYROIDISM
#2 - F90.9 - ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Thyroid
Neurology - Amphetamines C-II

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

37 yo male presents for refill of his Adderall
S: No problems, feeling good. Occasionally skips taking Synthroid because he has heat intolerance when working outside for his job.
O: TSH elevated on his last visit. Synthroid dose was increased at that time. The patient had 90 days of synthroid ordered back in April. No nodules or swelling noted to thyroid. Thyroid moves equally bilaterally with swallow. Eyes PERRL. The patient is well appearing with no signs of distress. FROM of all extremities.
A: Hypothyroid and adult ADHD
P: Refill Adderall for 3 months. Refill Synthroid. TSH, T4, & T3 now, then re-check in 3 months. Educate patient on Synthroid adherence. Will consider changing thyroid medication with next visit depending on tolerance of Synthroid.

Idaho State University (Acct #3030)

Case ID #: 1429-20200914-004 (Status: Approved) **Date of Service: 9/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 32 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Gastrointestinal flu symptoms
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K52.9 - NONINFECTIVE GASTROENTERITIS AND COLITIS, UNSPECIFIED

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

32 yo male presents reporting gastrointestinal symptoms.
S: Intermittent nausea, vomiting, diarrhea x 6 days. Fever x 1 several days ago that was relieved with Tylenol. Drinking lots of fluids. Denies headache or weakness.
O: Well nourished well hydrated appearing male. Bowel sounds active x 4 quadrants. No rebound tenderness or tenderness with light and deep palpation of the abdomen. No lymphadenopathy. Lungs CTA, respirations equal and unlabored. Heart rate and rhythm regular. Blood pressure mildly elevated at 148/84, pulse 78.
A: gastroenteritis
P: Stool profile, CBC, CMP. Will call patient with results tomorrow. Continue drinking plenty of fluids and follow up for worsening of symptoms.

Idaho State University (Acct #3030)

Case ID #: 1429-20200914-005 (Status: Approved) **Date of Service: 9/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 23 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: COVID screening
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z20.828 - CONTACT W AND EXPOSURE TO OTH VIRAL COMMUNICABLE DISEASES

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

23 yo male presents reporting COVID exposure
S: Was hanging out with friend 2 weeks ago who just tested positive with COVID yesterday. His friend has significant symptoms - is very sick today. The patient has no symptoms, but is worried he may spread the illness.
O: Well appearing well nourished. Eyes PERRL clear with no discharge. Ears: TMs gray with no erythema. Mild amount of cerumen present bilateral ear canals. Pt removed hearing aids so I could inspect ears. No lymphadenopathy. Lungs clear to auscultation. Heart regular rhythm and rate.
A: COVID exposure
P: COVID swab screen. Follow up for any concerns

Idaho State University (Acct #3030)

Case ID #: 1429-20200928-001 (Status: Approved) **Date of Service: 9/28/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 38 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Rash on face
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B02.9 - ZOSTER WITHOUT COMPLICATIONS

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

38 yo female presents for left tonsil pain, left ear pain, left submandibular lymph node pain, and scabbed rash on left side of her face.
S: Significant pain on the left side of her throat and tonsil. She denies fever, fatigue, or chills. She also reports that she got a rash on the left side of her face that just suddenly came on. She states that she doesn't believe that it's shingles because the rash came on and scabbed over so sudden, it didn't look like shingles at the start of it. She also reports no pain with the rash, the pain is in her throat and tonsil mostly. The patient also wants to be screened for STDs where she has a new boyfriend. She has no symptoms of STDs, but she believes it is important to be screened. The patient also reports that she was tested for COVID on Friday, but doesn't have the results yet. The patient also states that she had been on antifungals and has recently been taken off of them. She states that she had masoactivation syndrome after a car accident about 2 years ago. Since then her "system has been pretty messed up."
O: Left face, below the eye, scaboid rash. Throat erythematous. No lymph node enlargement, but tenderness of the submandibular lymph node on palpation. Ears - TMs pearly gray with no erythema bilaterally. Eyes clear & PERRL. Heart sounds RRR. Lung sounds CTA. Abdomen non tender with no masses.
A: Shingles
P: Valtrex 1000 mg PO TID x 7 days. Keep rash clean and dry. Follow up for any concerns.
Blood tests taken for HIV, chlamydia, gonnorrhea, HSV--1 and HSV-2.

The patient called back reporting "tingling" in her left eye. The patient lives out of town and does not have an optometrist locally. We called a local OD and got her an appointment for today to have an eye examination. The OD to prescribe a eye drop for treatment.

Idaho State University (Acct #3030)

Case ID #: 1429-20200928-002 (Status: Approved) **Date of Service: 9/28/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 39 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: sore throat, cough, flu symptoms
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J06.9 - ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Macrolides

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

39 year old male presents reporting sore throat and cough.
S: Reports sore throat, deep productive cough, chest pain with cough, chest congestion, runny nose, & watery eyes. Took and has been taking ibuprofen for fever and mild headache.
O: Afebrile, heart rate 92, other vitals not significant. Ears - TM red in the right ear. Nasal erythema and mild clear drainage. Mild pharyngeal erythema. Lung sounds CTA, productive cough noted. Abdomen soft & tender, bowel sound active x 4 quadrants. No rashes noted.
A: Upper respiratory infection.
P: Rapid strep test done and culture sent. COVID swab taken and sent. Will call results of both. Rest and fluids encouraged. Follow up for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20200928-003 (Status: Approved) **Date of Service: 9/28/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Flu symptoms
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J06.9 - ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED

CPT Billing Codes

#1 - 99202 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 15-29 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

19 yo male presents with flu symptoms.
S: Productive cough, watery eyes, stuffy and runny nose, headache, fevers, body aches, chills, has had occasional diarrhea. Has been drinking a lot of fluids and taking ibuprofen for headache and fevers.
O: Mildly febrile at 100.8 F, heart rate 89 bpm, other vital signs not significant. Patient appears slightly flushed. TMs erythema noted bilaterally, nasal erythema noted with mild clear drainage. Eyes clear and PERRL. Throat erythema noted, slight swelling of right tonsil. Lung sounds CTA, productive cough present. Abdomen soft & non-tender. No rashes or musculoskeletal abnormalities noted.
A: Upper respiratory infection
P: Strep test done and culture sent. Mono test done. Both rapid strep and mono tests were negative. COVID swab taken and sent. Z-pack ordered, 500 mg PO on day one, then 250 mg PO daily x 4 days. Continue with fluids and ibuprofen as directed. Get plenty of rest.

Idaho State University (Acct #3030)

Case ID #: 1429-20200928-004 (Status: Approved) **Date of Service: 9/28/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 44 years
Race: Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: UTI
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Endocrinology - Oral glucose lowering agents
Infectious Diseases - Miscellaneous antibiotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

44 yo female presents with flank pain and UTI symptoms
S: Has an extensive history of UTIs and kidney infections due to complications of UTIs. She took pyridium when she started feeling burning on urination yesterday and came in today to get an antibiotic. She has severe flank pain bilaterally, burning on urination, frequency, urgency, and hasn't been able to empty her bladder completely when she urinates. No fevers reported. History of diabetes and is on oral antidiabetics as well as a medication for blood pressure.
O: Afebrile. Vital signs not significant. Tenderness on CVA palpation. No tenderness on abdominal palpation. Bowel sounds active x 4 quadrants.
A: UTI
P: She has an allergy to sulfa. Nitrofurantoin 100 mg PO q 6 hrs x 7 days. May take pyridium for one more day but no longer. Drink plenty of fluids including unsweetened cranberry juice. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20200928-005 (Status: Approved) **Date of Service: 9/28/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: POWELL, Kay
Clinical Site: Bingham Memorial 1st Choice Urgent Care &Fam Med
Setting Type:

Patient Demographics

Age: 7 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: flu symptom
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - H66.90 - OTITIS MEDIA, UNSPECIFIED, UNSPECIFIED EAR
#2 - J45.901 - UNSPECIFIED ASTHMA WITH (ACUTE) EXACERBATION

CPT Billing Codes

#1 - 99201 - (Deleted 2020) OFFICE/OP VISIT, NEW PT, 3 KEY COMPONENTS: PROB FOCUS HX; PROB FOCUS EXAM; STRTFRWD MED DECISION

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Penicillins
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

7 yo male brought in by his father who reports cold and flu symptoms for 3 days
S: cough, runny nose, fevers. History of asthma.
O: Vital signs not significant. Afebrile. TMs erythema bilaterally. Eyes clear and PERRL. Rhinorrhea noted, no nasal erythema noted. No erythema noted of the throat, tonsils not swollen. Respirations equal and unlabored. Mild wheezing noted in left lung fields. Heart RRR, no murmurs. Abdomen soft, nontender. Bowel sounds noted x 4 quadrants.
A: Otitis media bilateral, asthma
P: COVID swab done and sent. The patient has no known allergies. Amoxicillin 1000 mg PO BID x 7 days. Encourage rest and fluids. Continue with albuterol inhaler as directed.

Idaho State University (Acct #3030)

Case ID #: 1429-20201012-001 (Status: Approved) **Date of Service: 10/12/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 55 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Influenza vaccine and wellness visit
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E78.5 - HYPERLIPIDEMIA, UNSPECIFIED

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

55 yo male presents wanting a flu shot.
S: Healthy, has been getting exercise with hunting this year. No complaints, just wants to get his flu shot. He figured he would get his wellness exam as well. Significant family history of cardiovascular disease. Personal history of hyperlipidemia, decided he did not want to take his statin because it didn't make him feel good. He has been dieting and exercising and does not believe he needs the statin any longer.
O: Pulse 86, BP 132/80, 98% on room air, 263 lbs, 6ft 2in tall. BMI 33.8. Lungs CTA, Heart rate RRR, no mumurs. Bowel sounds active, no masses or bulges. No edema noted. Lipid panel in 2018 revealed elevated LDL. Triglycerides, total cholesterol, and HDL were all within normal range.
A: History of hyperlipidemia.
P: Lipid panel. Influenza shot. CBC, CMP, PSA - screening. The patient has a treadmill nuclear stress test in 2018 which revealed normal results.

Idaho State University (Acct #3030)

Case ID #: 1429-20201012-002 (Status: Approved) **Date of Service: 10/12/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 67 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: Establish care and A1C check
Encounter #: 1
Type of HP: Detailed
Social Problems Addressed: Interpersonal Relationships

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E11.9 - TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS
#2 - E78.5 - HYPERLIPIDEMIA, UNSPECIFIED
#3 - F41.9 - ANXIETY DISORDER, UNSPECIFIED
#4 - B35.1 - TINEA UNGUIUM

CPT Billing Codes

#1 - 99203 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 30-44 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Cardiology - ACE inhibitors
Cardiology - Miscellaneous cardiac
Endocrinology - Insulin
Endocrinology - Oral glucose lowering agents

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

67 yo female presents to establish care and to have her HbA1C checked.
S: She had her blood checked and her urine at another clinic and they lost the specimens. Before that she had had her HbA1C checked, 6 months ago, and it was at an 8. She has had a lot of stress lately with her son's x-wife who lives with her and she believes her A1C is higher now than it was then. She used to take a statin for her hyperlipidemia, but she believes it was also contributing to her high blood sugar, so she stopped taking it. She believes statins are very bad for her and states that she would refuse to ever take it again. She also had a UTI about a month ago. She believes the UTI was also caused by the statin. She says she believes she has anxiety and didn't realize before that anxiety was "a thing you could have." She is currently taking 81 mg aspirin daily, humalog 3 times a day15 units with meals, and 30 units lantus twice a day, in the morning and at night. She says that she is not taking her lisinopril because when they lost her labs, they had forgotten to refill her lisinopril so she hasn't been able to take it. She reports she checks her feet regularly and her son clips her toenails for her. She reports "a little" numbness and tingling in both feet. She states she had an eye exam this year and has also seen the dentist.

O: Vitals: BP 143/90, pulse 83, temp 98.0, R 16, BMI 43. Respirations equal and unlabored, CTA, no wheezes, rhonchi, or rales. Heart rate regular rate and rhythm. Bowel sounds active, no tenderness on palpation. Urine was cloudy with scant red blood cells. Patient appears anxious when speaking with her. Memory is intact. Eyes full ROM, no redness or drainage, PERRL. Mouth moist. No lower extremity edema. Feet - Callouses on right 2nd and 4th toes noted. Onychomycosis noted in all toenails. Skin is dry and slightly cracked bilateral heels. Sensation intact to deep and light pressure.
A: Type II diabetes mellitus, hyperlipidemia, onychomycosis of the toenails, anxiety
P: Draw labs; CBC, CMP, HbA1C. Urine already ran as noted. Continue good foot care and check feet daily. Continue Insulin and metformin. Refill lisinopril. Educate patient on anxiety and options on treatment - deferred for now per patient. Will re-evaluate diabetic medications and possible increase of insulin with results of HbA1C. Follow up in 2 weeks.

Idaho State University (Acct #3030)

Case ID #: 1429-20201012-003 (Status: Approved) **Date of Service: 10/12/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 54 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: UTI
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Urinary anti-infectives
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

54 yo f presents for burning on urination and feeling like she has a UTI.
S: Burning on urination, frequency, nocturia, not emptying bladder when urinating. She has had UTIs in the past; it's usually when she has not been drinking enough water. She has been busy lately and has just not been drinking water like she feels she should be.
History of vertigo, she takes a prn medication for that. No other problems reported.
O: Urine results with leukocytes and nitrites. No CVA tenderness, no abdominal pain. Lungs are CTA, heart rate and rhythm regular. PERRL. Patient unable to lie down for stomach palpation due to vertigo.
A: UTI
P: Allergies to Tylenol. Patient also states she has a reaction to sulfa drugs, added sulfa to allergy list. Nitrofurantoin ER 100 mg PO BID x 7 days. Drink plenty of water. Urine culture sent, will call if antibiotic change needed per culture. Follow up for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20201014-001 (Status: Approved) **Date of Service: 10/14/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 49 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Depression
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F32.9 - MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
#2 - E03.9 - HYPOTHYROIDISM, UNSPECIFIED
#3 - F41.9 - ANXIETY DISORDER, UNSPECIFIED

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN

Medications

 # OTC Drugs taken regularly: 2
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Thyroid
Psychiatric - Antidepressants
Psychiatric - Miscellaneous psychiatric

Adherence Issues with Medications:
Other: Allergies: ibuprofen, toradol

Other Questions About This Case

Clinical Notes

49 yo female presents reporting severe depression.
S: Wants to establish with a different provider due difficulties with her other doctor. The patient states she has not been taking all of her medications. She reports the medications she is still taking is the Wellbutrin, flexeril, Ambien, and levothyroxine. She also takes 2 bendryl and a unisom with her ambien at night however. She cannot sleep, so she breaks her ambien in half and takes half of it with the benadryl and unisom, then takes the other half about 3 hours later. She states she is having severe flashbacks to childhood abuses. She reports that the flashbacks are vivid and she can't make them stop. The patient also reports that her periods stopped about a year ago and wonders if menopause is contributing.
O: Well nourished, well appearing female. Vital signs not significant. Eyes PERRL. Bilateral nares clear. No lesions noted in mouth, throat without erythema. Neck supple with no nodules or lymph node swelling. Thyroid raises bilaterally equally. Lung sounds CTA. Heart sounds regular in rhythm and rate. ROM in all extremities in tact.
P: Labs: CBC, CMP, vitamin D level, vitamin B12 level, thyroid panel, lipid panel. Sleep study referral. Education on not taking benadryl and unisom in conjunction with ambien. Take full 10 mg tab of ambien at night and do not break in half. Refer the patient to counseling. Educate the patient on sleep hygiene and limiting caffeine intake.

Idaho State University (Acct #3030)

Case ID #: 1429-20201019-001 (Status: Approved) **Date of Service: 10/19/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 62 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: pelvic exam
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z00.00 - ENCNTR FOR GENERAL ADULT MEDICAL EXAM W/O ABNORMAL FINDINGS

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Cardiology - Antilipids

Adherence Issues with Medications:
Other: Allergies: NKDA

Other Questions About This Case

Clinical Notes

62 yo female presents for wellness visit and pelvic exam
S: No complaints. She's due for her annual wellness and pap smear. She is post menopausal, last menstrual cycle in 2010. She would also like her flu shot. Her last lipid panel-cholesterol screen was a year ago, which showed high LDL cholesterol, but her other levels were within normal limits. She was prescribed atorvastatin, however, she would like her lipid panel re-done because she did not think that her cholesterol is bad enough to take the atorvastatin. She has also lost about 10 pounds and is wondering if that was enough to decrease her cholesterol. She has not been taking her atorvastatin, so she believes another cholesterol screen will be accurate.
O: Well nourished 62yo female in no distress. Lung sounds CTA, heart sounds RRR. Cranial nerves and ROM intact. No masses palpated on pelvic exam, cervix was pink with no lesions or abnormalities noted.
A: Annual wellness. Hyperlipidemia.
P: Labs; lipid panel and pap smear. Flu vaccine given. Re-evaluate atorvastatin with lipid panel follow up.

Idaho State University (Acct #3030)

Case ID #: 1429-20201019-002 (Status: Approved) **Date of Service: 10/19/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 85 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Medicare Wellness
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION
#2 - E78.00 - PURE HYPERCHOLESTEROLEMIA, UNSPECIFIED
#3 - I48.91 - UNSPECIFIED ATRIAL FIBRILLATION

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 5
 # Prescriptions currently prescribed: 6
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Antianginals
Cardiology - ÃŸ Adrenergic blockers
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers
Endocrinology - Minerals/vitamins
Endocrinology - Sex steroids/hormones
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

85 yo female presents for Medicare Wellness Visit
S: No complaints. Here for her annual wellness visit.
O: No distress. Answers questions appropriately.
A: 85 yo female with history of hypertension, hyperlipidemia, and atrial fibrillation. Patient is due for her bone density scan.
P: Schedule bone density scan. Will follow up with results.

Idaho State University (Acct #3030)

Case ID #: 1429-20201102-001 (Status: Approved) **Date of Service: 11/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 26 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: thoracic back pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.6 - PAIN IN THORACIC SPINE

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Gynecology - Intrauterine device

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

26 yo female presents with thoracic back pain on the right side.
S: She had a gastric sleeve surgery in Mexico and has had pain in her right thoracic back since. She states she has lost 20 pounds since the surgery and feels great other than her right thoracic back pain. No other complaints.
O: BMI 37.9 currently, has lost 20 pounds since last visit. Vitals non significant. Full ROM in all extremities and back. Tenderness on palpation right side of thoracic back. Patient reports mild pain with arm extension and motion of back.
A: Back strain.
P: Continue with over the counter Tylenol. Avoid Ibuprofen due to possible GI effects. Physical therapy referral. Continue with diet and exercise as well as with vitamin supplementation.

Idaho State University (Acct #3030)

Case ID #: 1429-20201102-002 (Status: Approved) **Date of Service: 11/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 34 years
Race: Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Follow-up (Consult)
Chief Complaint: follow up
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K85.9 - ACUTE PANCREATITIS, UNSPECIFIED

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Gynecology - Oral contraception

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

34 yo female presents for follow up after hospital procedure over the weekend.
S: patient states she went to the ER over the weekend after being diagnosed with cholelithiasis and cholecystitis last week. She states that she was sent to interventional radiology in Idaho Falls to have gallstones removed from her duct to relieve pancreatitis caused by the blockage of the duct. The patient is scheduled to have a laparoscopic cholecystectomy this week. She states that she was told to follow up with her regular provider prior after her procedure for follow up.
O: Well nourished, no acute distress. Right upper abdominal tenderness. Bowel sounds active x 4 quadrants. Lung sounds CTA, heart sounds RRR. BP 112/58. BMI 22.1. Labs reviewed; elevated lipase and amylase.
P: Continue with plan for procedure-laparoscopic cholecystectomy.

Idaho State University (Acct #3030)

Case ID #: 1429-20201102-003 (Status: Approved) **Date of Service: 11/2/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 24 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Painful urination
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N41.0 - ACUTE PROSTATITIS

CPT Billing Codes

#1 - 99204 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 45-59 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

24 yo male reports with painful urination since this morning.
S: Recently moved from Texas, last month. His ex-girlfriend was positive for 2 STIs, the patient reports he was screened when he learned of her positive results and his results came back negative for STIs. The patient is upset because he just learned that he is 300 pounds, he doesn't weigh himself at home. The patient has had a lot going on recently so he has had increased stress. Right now he wants to focus on what is going on with the painful urination however. He also is open to a diet plan.
O: BP 122/70, pulse 91, temperature 97.7, 97% on RA, 182 kg, 69 inches tall, BMI 59.1. Morbidly obese, well appearing, no acute distress. Urine is clear with no sediment. No nitrites or leukocytes in urine. No STIs on urinalysis. Respiratory sounds CTA, Heart sounds RRR, bowel sounds active x 4 quadrants.
A: possible prostatitis, possible UTI, morbid obesity.
P: Urine culture sent. Referral to urologist. CBC, CMP, hemoglobin A1c, Lipid panel. Pamphlets on diet given. Education on internet information through the American Diabetic Association for diet and exercise done.

Idaho State University (Acct #3030)

Case ID #: 1429-20201103-001 (Status: Approved) **Date of Service: 11/3/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 63 years
Race: Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 45 minutes
Consult with Preceptor: 15 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Medicare Wellness
Encounter #: 2-5
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - G40.909 - EPILEPSY, UNSP, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS
#2 - M06.9 - RHEUMATOID ARTHRITIS, UNSPECIFIED
#3 - S12.9XX is not a valid ICD code.

CPT Billing Codes

#1 - 99215 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; HIGH LEVEL MED DECISION; 40-54 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Narcotics
Neurology - Anticonvulsants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

63 yo male presents for annual Medicare Wellness visit
S: Has fallen in the last 3 months. Fell at work in 2017, hit his head and fractured his neck at that time. His vision has gotten progressively worse, especially in the last 3 months. He has been having more falls because of his vision. He also gets horrible headaches in the left side of his head and he is concerned he may have damaged his brain in his fall in 2017. He also thinks the pain in his head has something to do with his vision loss. His wife is not at home very much and he has little support at home. He has removed rugs and items in his living room to decrease his fall risk. His dad drives him to places so he can get groceries so he has food at home and can get to appointments. He has a lot of pain in his neck after his neck surgery to fix the fracture. He believes his vision loss is due to when he hit his head in 2017. Has not had his pneumonia vaccine yet. Updated on colonoscopy screening. Updated on flu shot.
O: 63yo thin male. Limited mobility in left shoulder and arm. Full physical not done due to medicare wellness criteria.
A: Vision loss, history of falls including recent fall, neck fracture, limited mobility in left shoulder and arm post neck surgery, rheumatoid arthritis, epilepsy.
P: Neurology consult for rapid recent decrease in vision and patient reports of headache. Pneumonia vaccine. Social work consult.

Idaho State University (Acct #3030)

Case ID #: 1429-20201103-002 (Status: Approved) **Date of Service: 11/3/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 53 years
Race: White, Non Hispanic
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sinus pressure & cough
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.9 - ACUTE SINUSITIS, UNSPECIFIED

CPT Billing Codes

#1 - 99211 - OFFICE/OP VISIT, EST PT, MINIMAL, NOT REQUIRING PHYSICIAN PRESENCE

Medications

 # OTC Drugs taken regularly: 3
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

ENT - Antihistamines
GI Agents - H2 receptor antagonists
GI Agents - Stool softeners

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

53 yo female reports to the clinic reporting 3 weeks of sinus pressure and drainage.
S: Sinus pressure and drainage x3 weeks. Associated headaches, cough, and left ear fullness. Yesterday she started having a "plastic crackling feeling" in her right upper lung area. She is able to cough something up, but worries this might turn into pneumonia. No fevers. She has tried Afrin, sinus nasal sprays and Tylenol with some relief.
O: Afebrile, vital signs not significant. Bilateral maxillosinus tenderness. TMs clear bilaterally. Productive cough. Rhonchi noted in her right upper lung fields, but clears when she coughs.
A: Sinusitis.
P: Allergy to PCN. Keflex 500 mg PO three times daily x 10 days. Continue with saline sinus sprays and Tylenol. Avoid using Afrin for longer than 2 days. Drink plenty of fluids and return if symptoms worsen or persist.

Idaho State University (Acct #3030)

Case ID #: 1429-20201104-001 (Status: Approved) **Date of Service: 11/4/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 59 years
Race: Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: High complexity
Student Participation: Shared (50-50)
Reason for Visit: Initial Visit
Chief Complaint: Decreased cognition
Encounter #: 1
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N63.0 - UNSPECIFIED LUMP IN UNSPECIFIED BREAST
#2 - R41.0 - DISORIENTATION, UNSPECIFIED
#3 - L04.2 - ACUTE LYMPHADENITIS OF UPPER LIMB

CPT Billing Codes

#1 - 99205 - OFFICE/OP VISIT, NEW PT, MEDICALLY APPROPRIATE HX/EXAM; HIGH LEVEL MED DECISION; 60-74 MIN

Medications

 # OTC Drugs taken regularly: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

GI Agents - H2 receptor antagonists
Psychiatric - Antidepressants
Urology - Antispasmodic, urinary

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: 59 yo female that presents with her husband who reports that the patient has been declining in mental status for 3 years. The patient and her husband moved to Idaho two months ago from California because the husband believes it is safer here in Idaho. The patient was getting lost in big California parking lots and one time, while the patient was still able to drive, the patient drove to her old house where she no longer lived. The patient is no longer able to drive, cook, or even shower by herself. The patient's husband is concerned about a brain tumor. He states that the patient had a surgery where they removed a right breast mass 4 years ago. The patient had an injured left shoulder after the surgery, and the husband was concerned that the patient had fallen off of the surgical bed. The surgeon denied anything happening during the surgery. The patient's husband states that the lump was not cancer. He is concerned about the scar on her right breast now too because he states it has been growing and it" just doesn't look right." The patient's husband also reports that she complains of headaches every 2-3 days.
O: Vital signs not significant. No distress. PERRL.ROM intact in all extremities. MMSE results 11/30. The patient is happy and cooperative. The patient will switch to multiple unrelated subjects in a sentence. Long term memory is somewhat intact, short term memory is not intact. Breast examination revealed 2 cm medial inferior mobile right breast mass that was not attached to the scar but close to the scar. The scar on her right breast is hypertrophied and purple in color. Right axillary adenopathy present. Left breast and axilla not significant.

A: right breast mass. right axillary adenopathy. Confusion and decreased cognition.
P: Right breast ultrasound, diagnostic mammogram, MRI brain, neurology consult.

Idaho State University (Acct #3030)

Case ID #: 1429-20201104-002 (Status: Approved) **Date of Service: 11/4/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 66 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: nausea, vomiting, UTI
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E86.0 - DEHYDRATION
#2 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

CPT Billing Codes

#1 - 99212 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; STRTFWD MED DECISION; 10-19 MIN

Medications

 # OTC Drugs taken regularly: 4
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - Diuretics
Endocrinology - Minerals/vitamins
GI Agents - Nausea meds
Infectious Diseases - Cephalosporins
Psychiatric - Antidepressants
Psychiatric - Miscellaneous psychiatric

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

66 yo female presents with severe back pain, nausea, vomiting for 5 days.
S: Was diagnosed with a UTI 7 days ago, she started taking Keflex which helped for 2 days, then she became nauseous. She was prescribed ondansetron at that time, which helped for another 2 days. Now she has been vomiting for 3 days and has started having excruciating back pain today.
O: Vitals 128/68, pulse 99, 99% on RA, pain 9/10, temp 99.1, resp 18. Urine positive for nitrites and WBCs. CVA tenderness. The patient is in a wheelchair and unable to stand. Skin is tenting. Radial pulses weak and thready. Heart sounds RRR. Lung sounds CTA.
A: Urinary tract infection, possible pyelonephritis.
P: Refer patient to the ER. Suggest IV therapy with D5NS 1 liter, 1 gram of Rocephin IV, and 4 mg IV Zofran or IV phenergan. Follow up in 1 week or as directed by ER physician.

Idaho State University (Acct #3030)

Case ID #: 1429-20201104-003 (Status: Approved) **Date of Service: 11/4/2020**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS6642L: Primary Care of the Young Adult Lab
Preceptor: TURNER, Roberta
Clinical Site: Portneuf Primary Care & Behavioral Health Center
Setting Type:

Patient Demographics

Age: 68 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: sinus drainage
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J18.9 - PNEUMONIA, UNSPECIFIED ORGANISM

CPT Billing Codes

#1 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN

Medications

 # OTC Drugs taken regularly: 1
 # Prescriptions currently prescribed: 7
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - Angiotensin II receptor blockers
Cardiology - Antilipids
Psychiatric - Antidepressants
Psychiatric - Benzodiazepines
Pulmonary - ÃŸ2-agonist
Pulmonary - Steroid inhalers
Pulmonary - Long Acting ÃŸ2-agonist

Adherence Issues with Medications:
Other: Allergies: sildenafil

Other Questions About This Case

Clinical Notes

68 yo Male presents with sinus drainage that is causing a cough.
S: History of COPD and pneumonia. Has had sinus drainage for "about a week" now that is starting to cause a cough because of the post nasal drip. Uses a C-pap at night, otherwise does not use oxygen. He gets pneumonia about once a year and is worried that he might be getting pneumonia.
O: Vitals 122/60, temp 98.2, 88% on RA, resp 18, HR 98. Crackles noted in right lung base. Diminished lung sounds in the left base. Wheezing noted in all other lung fields. Heart sounds RRR. Sinuses non-tender. Rhinorrhea noted. Ears-TMs no erythema.
A: community acquired pneumonia.
P: Chest xray, doxycycline 100 mg x 10 days. Prednisone 40 mg PO x 5 days. Follow up in 10 days or sooner for any concerns.