Idaho State University (Acct #3030)

Case ID #: 1429-20210830-001 (Status: Approved) **Date of Service: 8/30/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 87 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: hip pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M16.12 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT HIP

CPT Billing Codes

#1 - 99024 - POSTOPERATIVE FOLLOW-UP VISIT, INCLUDED SURGICAL PACKAGE, E/M PERFORMED

Medications

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

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Aspirin combinations
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:
Other: NKDA

Other Questions About This Case

Clinical Notes

S: Patient presents for postoperative hip replacement visit. The patient had hip surgery 1 month ago. She has been going to physical therapy and states she is doing well with that. She takes ibuprofen or tylenol occasionally, but overall has had minimal pain in the last week. She takes two baby aspirins daily as directed for DVT prophylaxis one month post hip surgery. She reports no fevers, sweats, numbness or tingling in the affected leg.
O: The patient has approximately 140 degrees of flexion in the affected leg. No crepitus or pain with passive ROM. Incision site is closed over with no signs of infection. Left pedal pulse is strong, no LE swelling or redness. Light touch sensation intact left lower leg and foot.
A: Postoperative left total hip arthroplasty.
P: Decrease daily aspirin to 1 baby aspirin daily. Continue physical therapy. Return in two months for 3 month post operative visit. Call office for antibiotic prophylaxis prior to any teeth cleaning or colonoscopy. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210830-002 (Status: Approved) **Date of Service: 8/30/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 39 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: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Hip pain
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Q65.89 - OTHER SPECIFIED CONGENITAL DEFORMITIES OF HIP
#2 - M19.9 - OSTEOARTHRITIS, UNSPECIFIED SITE

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: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - Narcotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Patient states he has had hip pain for the last 14 years. He has chronic right hip dysplasia and pain. He states he takes methadone for pain. His doctor did not prescribe methadone, the patient gets the methadone himself. The patient states he cannot take NSAIDs because he has thrombocytopenia.
O: Cartilage thinning noted right hip on xray, suspect for osteoarthritis. Patient has positive FABER and FADIR right hip. Negative right straight leg raise. No gross deformities noted of the hip on inspection.Right pedal pulse strong, sensation intact right lower leg, no swelling noted right lower leg.
A: Right hip osteoarthritis and dysplasia.
P: Discussed steroid injection. Patient is concerned about bleeding at the site. Will consult patient's physician who is treating thrombocytopenia on safety of further treatment for right hip osteoarthritis.

Idaho State University (Acct #3030)

Case ID #: 1429-20210830-003 (Status: Approved) **Date of Service: 8/30/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 57 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: New Consult
Chief Complaint: Right knee pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M17.11 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE

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: 2
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:
Other: Allergies: pcn

Other Questions About This Case

Clinical Notes

S: Right knee pain. Pain is more prominent on the medial side of her knee, but she has pain all through her knee. The patient is busy and needs to be able to walk, but recently has been limited due to knee pain. The patient has no history of injury.
O: Patient has 135 degree flexion, zero degrees extension. Patient has pain with passive ROM. Negative anterior and posterior drawer, negative Lachman's test. Pulse and sensation intact in lower leg. Negative straight leg raise. Right knee is slightly larger than left knee, no redness or heat on palpation. Cartilage thinning tibial head and femoral condyles noted on right knee xray suspect for arthritis.
A: Right knee osteoarthritis.
P: Discussed treatment options with patient including steroid injections, hyaluronic acid injections, physical therapy, or surgery. Patient has a trip planned next spring, and would like definitive treatment so she can walk during her trip. Patient opted for treatment with surgery. Patient scheduled for total knee arthroplasty in 3 weeks. Appointment scheduled for patient to go to pre-anesthesia clinic prior to surgery.

Idaho State University (Acct #3030)

Case ID #: 1429-20210830-004 (Status: Approved) **Date of Service: 8/30/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 57 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

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

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M17.11 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE

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: 1
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Aspirin combinations
Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Rheumatology - Other

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies NKDA
S: 57 yo female presents for right knee pain. She had a steroid joint injection last month, which helped a lot. Physical therapy is going well. She still has pain, however, and would like to look into surgical treatment for her knee. She understands that total joint surgery cannot be done until 3-4 months post knee steroid injection, but would like to start moving forward with surgery preparation.
O: Right knee osteoarthritis, thinning to absent cartilage between the femur and tibia, present on xray. Pain with passive ROM. Lachman's test, anterior, and posterior drawer tests all negative.
A: Right knee osteoarthtis.
P: Continue physical therapy. Plan for surgery in 3 months, right total knee replacement.

Idaho State University (Acct #3030)

Case ID #: 1429-20210830-005 (Status: Approved) **Date of Service: 8/30/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 87 years
Race: White, Non Hispanic
Gender: Male
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: Divot distal thigh post right knee total arthroplasty
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S76.1 - INJURY OF QUADRICEPS MUSCLE, FASCIA AND TENDON

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: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
GI Agents - H+/K+ ATPase enzyme inhibitors (ie omeprazole)

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies NKDA
S: 87 yo male presents for right thigh deformity post right total knee arthroplasty. His surgery was done 3 months ago, and since then his thigh has had a "divot" where the anterior quadriceps muscle is. The patient describes no pain, but is anxious about the stability of the tendon. The patient would like to have a tendon repair to maintain stability of the muscle, knee, and leg.
O: Right anterior quadriceps muscle deformity. ROM intact, no pain with active or passive ROM. Gait is intact. Lachman, anterior, and posterior drawer tests negative.
A: Right anterior quadriceps muscle deformity, possible quadriceps tendon tear or laxity.
P: Schedule patient for right quadriceps tendon repair. Set patient up for anesthesia preop appointment.

Idaho State University (Acct #3030)

Case ID #: 1429-20210831-001 (Status: Approved) **Date of Service: 8/31/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Left knee osteoarthritis
Encounter #: 6-10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M17.12 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE

CPT Billing Codes

#1 - Z01.8 is not a valid CPT code.
#2 - 27446 - ARTHROPLASTY, KNEE, CONDYLE & PLATEAU; MEDIAL/LATERAL COMPARTMENT

Medications

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

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS
GI Agents - Nausea meds

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient has severe pain in left knee. The pain limits his daily function. He has tried physical therapy and joint injections with no relief. The patient also had his left patella removed back in the 80s for knee pain, which provided relief for years. Now the pain is "deeper," and he would like to move forward with total knee arthroplasty for permanent treatment.
O: Left knee arthritis apparent on xray. No patella noted in left knee via xray. Limited active and passive ROM in left knee. Pedal pulses intact bilaterally. Skin is pink with capillary refill <2 seconds bilateral lower extremities. Lung sounds clear, no apparent distress. Heart rhythm and rate regular. Patient is oriented and responds to questions appropriately.
P: Proceed with left total knee arthroplasty. Post op medications sent to pharmacy electronically.

Idaho State University (Acct #3030)

Case ID #: 1429-20210831-002 (Status: Approved) **Date of Service: 8/31/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 34 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Consult)
Chief Complaint: Left knee pain and instability
Encounter #: 6-10
Type of HP: Comprehensive
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S83.512 - SPRAIN OF ANTERIOR CRUCIATE LIGAMENT OF LEFT KNEE
#2 - S83.412 - SPRAIN OF MEDIAL COLLATERAL LIGAMENT OF LEFT KNEE

CPT Billing Codes

#1 - 99215 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; HIGH LEVEL MED DECISION; 40-54 MIN
#2 - 29866 - ARTHROSCOPY, KNEE, SURGICAL; OSTEOCHONDRAL AUTOGRAFT(S) W HARVEST OF AUTOGRAFT
#3 - 29888 - ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION/RECONSTRUCTION
#4 - 29999 - UNLISTED PROC, ARTHROSCOPY

Medications

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

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS
GI Agents - Nausea meds

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN
S: Severe instability and pain in the left knee. Patient was walking her dog, and tripped over the dog, which caused her to go down on her left knee. The patient has had difficulty walking since then. There was some bruising and swelling of the lft knee after she fell, but it wasn't "that bad." She has no significant past medical history.
O: Lachman and posterior drawer test positive. Tenderness noted on medial aspect of knee palpation. No bruising or swelling of left knee. Pedal pulses present bilaterally. Skin is pink & intact, no rashes. Capillary refill <2 sec. Lungs clear in all lobes on auscultation. Heart rate & rhythm regular. Patient is alert and responds appropriately to questions.
A: Left knee ACL and MCL tears.
P: left knee arthroscopy for ACL and MCL repair. Post op pain medications and anti-nausea medications sent electronically to pharmacy.

Idaho State University (Acct #3030)

Case ID #: 1429-20210901-001 (Status: Approved) **Date of Service: 9/1/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Male
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Rotator cuff tear
Encounter #: 6-10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - m75.120 - COMPLETE ROTATR-CUFF TEAR/RUPTR OF UNSP SHOULDER, NOT TRAUMA

CPT Billing Codes

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

#2 - 23410 - REPAIR, RUPTURED MUSCULOTENDINOUS CUFF, OPEN; ACUTE

Medications

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

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Aspirin combinations
Analgesic/Antipyretic - Narcotics
Analgesic/Antipyretic - NSAIDS
GI Agents - Nausea meds

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: sulfa
S: severe left shoulder pain and altered function. Gradual onset of pain and dysfunction, over the last 6 months. No medical history. Patient drinks occasionally, does not smoke. Patient works construction.
O: Patient is alert and oriented, answers questions appropriately. Positive empty can and neer impingement sign left shoulder. MRI indicates left rotator cuff tear and possible impingement.
A: Left rotator cuff tear, possible left shoulder impingement.
P: The patient would like to move forward with left shoulder arthroscopy and rotator cuff repair. The patient will wear a shoulder immobilizer for two weeks, will follow up in the clinic, then work with physical therapy.

Idaho State University (Acct #3030)

Case ID #: 1429-20210901-002 (Status: Approved) **Date of Service: 9/1/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 10 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 110 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Right thigh mass
Encounter #: 6-10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M85.851 - OTH DISRD OF BONE DENSITY AND STRUCTURE, RIGHT THIGH

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN
#2 - 27355 - EXCISION/CURETTAGE, BONE CYST/BENIGN TUMOR, FEMUR

Medications

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

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - Narcotics
GI Agents - Nausea meds

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: shellfish
S: Hard right thigh mass. Denies pain or paresthesias. Patient is healthy and active, but is embarassed about his leg when he plays sports and wears shorts. The mass has been there for several years, but has gotten bigger in the last few months and the patient and his family would like to move forward with removing the mass.
O: Hard right distal medial thigh mass, approximately 3.5 inches long and 1.5 inches wide. Nontender to touch. Pedal pulse intact right foot, and bilaterally. Light touch intact lower right leg and foot. Overall skin is warm and intact. Patient is alert and oriented. Lung sounds clear, heart rate and rhythm regular. Xray shows bony growth extending from the distal medial femur. MRI shows bony growth extending from the distal medial femur, soft tissues appear to be intact via MRI.
A: Right distal bony femur mass.
P: Proceed with surgical removal of right distal bony femur mass. Follow up at clinic in one week.

Idaho State University (Acct #3030)

Case ID #: 1429-20210902-001 (Status: Approved) **Date of Service: 9/2/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 57 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: left shoulder pain
Encounter #: 2-5
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M75.02 - ADHESIVE CAPSULITIS OF LEFT SHOULDER

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: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Aspirin combinations
Analgesic/Antipyretic - Miscellaneous

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

S: Left shoulder pain and stiffness. Patient has difficulty sleeping at night because of the pain. If she rolls on to her shoulder at night, she awakens in severe pain and cannot go back to sleep. The pain and stiffness is making it difficult for her to function. She has been going to physical therapy as prescribed. The physical therapy is helping. She is also taking the naproxen, with some relief.
O: Positive Neer, Hawkins, and empty can left arm. Active and passive ROM reduced left shoulder. Pain with passive ROM left shoulder. Radial pulse left wrist intact. Heart rate regular. Capillary refill <2 seconds. Left wrist and hand ROM intact.
A: Adhesive capsulitis left shoulder.
P: Patient would like to move forward with cortisone shot left shoulder to help maximize physical therapy. Shoulder injected with lidocaine, bupivicaine, and cortisone via the posterior approach. Continue physical therapy and follow up in one month, sooner for any problems.

Idaho State University (Acct #3030)

Case ID #: 1429-20210902-002 (Status: Approved) **Date of Service: 9/2/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 10 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 25 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Left tibial shaft fracture
Encounter #: 1
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S82.202 - UNSPECIFIED FRACTURE OF SHAFT OF LEFT TIBIA

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: 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

S: Patient was riding with his brother in a razor. The razor rolled, and the patient's leg went out to the side and was broken. The patient was subsequently taken to the ER where they noted a left tibial shaft fracture. The left lower leg was splinted, and the patient was referred to the clinic for follow up.
O: Xray reveals left tibial shaft fracture. The fracture is proximal, but not into the growth plate. No deformity or tenderness to palpation. Minor swelling, non-pitting. Pain noted when patient moved his leg. Pedal, left, pulse strong and intact. Capillary refill <2 seconds. Skin is warm and intact.
A: Left tibial shaft fracture.
P: Full leg cast. May give Tylenol or ibuprofen for pain. Non-weight bearing on left leg, use crutches. Return in two weeks to remove full cast and don lower leg cast. Return sooner for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210902-003 (Status: Approved) **Date of Service: 9/2/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Right hip pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M70.61 - TROCHANTERIC BURSITIS, RIGHT HIP

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: 1
 # Prescriptions currently prescribed: 3
 # 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: NKDA
S: Right hip lateral pain. Minor right groin pain, the lateral hip pain is the primary reason for the patient's visit. The patient is aware she has arthritis, but this pain seems different.
O: Lateral hip tenderness to palpation. Moderate swelling over right lateral femoral head. Pain with right hip abduction. Mild discomfort with FADIR and FABER exam. Xray reveals moderate osteoarthritis right hip.
A: Trochanteric bursitis.
P: Patient would like to move forward with hip steroid injection. Using ultrasound guidance, patient's hip/trachanteric bursa was injected with kenalog and 1% lidocaine.

Idaho State University (Acct #3030)

Case ID #: 1429-20210907-001 (Status: Approved) **Date of Service: 9/7/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 64 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 120 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Left knee osteoarthritis
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M67.20 - SYNOVIAL HYPERTROPHY, NOT ELSEWHERE CLASSIFIED, UNSP SITE

CPT Billing Codes

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

#2 - 27446 - ARTHROPLASTY, KNEE, CONDYLE & PLATEAU; MEDIAL/LATERAL COMPARTMENT

Medications

 # OTC Drugs taken regularly: 4
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - Narcotics
Analgesic/Antipyretic - NSAIDS
Cardiology - Angiotensin II receptor blockers
Cardiology - Diuretics
Rheumatology - Other

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: oxycodone, PCN, codeine (clarified codeine allergy - rxn stomach upset).
S: Left knee pain, increasingly getting worse. Has had knee steroid shots in the past with minimal relief. The patient would like to move forward with a left knee total arthroplasty. The patient is otherwise healthy, blood pressure is well controlled with medication.
O: Left knee joint narrowing/cartilage thinning on xray. Minimal tenderness on left knee palpation. Limited passive and active ROM left knee. Clear fluid with debris found in left knee during procedure.
A: Left knee synovial chondromycosis & osteoarthritis.
P: Physical therapy, Tylenol/hydrocodone (confirmed allergy with patient), ondansetron sent electronically to pharmacy.

Idaho State University (Acct #3030)

Case ID #: 1429-20210907-002 (Status: Approved) **Date of Service: 9/7/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 54 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 230 minutes
Consult with Preceptor:
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Right hip impingement/pain
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M24.851 - OTH SPECIFIC JOINT DERANGEMENTS OF RIGHT HIP, NEC
#2 - S73.191 - OTHER SPRAIN OF RIGHT HIP

CPT Billing Codes

#1 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN
#2 - 29862 - ARTHROSCOPY, HIP, SURGICAL; W/CHONDROPLASTY/ARTHROPLASTY, &/OR RESECTION, LABRUM

Medications

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

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS
GI Agents - Nausea meds

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Right hip pain. Patient plays sports and is a runner. He has been having increasing right hip pain with activity.
O: Positive FADIR and FABER. No tenderness on palpation of lateral right hip. Right hip MRI suggestive of labrum tear.
A: Femoroacetabular impingement, right.
P: Patient would like to move forward with right hip scope for labrum tear fixation. Post op plan to include pain and nausea medication. Patient to see anesthesia for pre-op assessment.

Idaho State University (Acct #3030)

Case ID #: 1429-20210908-001 (Status: Approved) **Date of Service: 9/8/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 53 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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 (Routine)
Chief Complaint: Follow up post left shoulder scope
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M75.102 - UNSP ROTATR-CUFF TEAR/RUPTR OF LEFT SHOULDER, NOT TRAUMA

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: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
GI Agents - Stool softeners
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Follow up for post operative left shoulder arthroscopy that was done one month ago. No problems reported, with exception of some soreness if she does home exercises and physical therapy in one day. Patient wants to know if it's ok to decrease shoulder exercises to once daily. ROM getting better, "definitely better than before surgery."
O: No pain with passive ROM. Radial pulse intact bilaterally, skin warm and pink. FROM in left hand and wrist. No paresthesias.
A: Post operative left shoulder arthroscopy.
P: Continue physical therapy and home exercises; may limit to one per day. Continue to take tylenol or ibuprofen as needed for pain. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210908-002 (Status: Approved) **Date of Service: 9/8/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor:
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Bilateral knee pain
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - m17.0 - BILATERAL PRIMARY OSTEOARTHRITIS OF KNEE

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: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Bilateral knee pain for "years." The patient has had multiple steroid injections in both knees, but she no longer is getting relief with the steroid injections in the left knee. She has difficulty walking because of the pain. She cares for her husband who is disabled, and needs to be able to function again. At this point she wants to talk about knee replacement for her left knee.
O: Xray reveals osteoarthritis bilateral knees. Pseudolaxity of the MCL left knee. Positive valgus stress test left knee. Bilateral valgus alignment noted at the knee joints. Bilateral moderate knee effusions. Limited knee ROM, 110 degree flexion, around 5 degrees on extension bilaterally.
A: Bilateral knee osteoarthritis.
P: Patient would like to move forward with total left knee arthroplasty. Continue steroid injections in right knee as per patient request. Patient scheduled for pre-anesthesia clinic appointment.

Idaho State University (Acct #3030)

Case ID #: 1429-20210908-003 (Status: Approved) **Date of Service: 9/8/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 17 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
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: Episodic
Chief Complaint: Left knee pain
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S83.282 - OTHER TEAR OF LATERAL MENISCUS, CURRENT INJURY, LEFT KNEE

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: 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

Allergies: NKDA
S: The patient had a medial meniscal tear a few months ago and underwent a left knee arthroscopy for repair of the meniscus. He was feeling better and felt it was ok to start playing football again. When he was playing football, he was "caught in a pile up" when he heard a pop. Now he has severe pain in his left knee and it feels like it is unstable.
O: Xray suggests no bony abnormalities or fractures. Anterior and posterior drawer tests negative. Positive McMurray's test left knee. Tenderness on palpation of the lateral aspect of the tibial femoral joint space.
A: Lateral meniscal tear.
P: MRI for definitive diagnosis. Follow up with results of MRI. Limit sports activity. May continue to wear crutches - partial weight bearing.

Idaho State University (Acct #3030)

Case ID #: 1429-20210908-004 (Status: Approved) **Date of Service: 9/8/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 64 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Right knee pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S83.241 - OTHER TEAR OF MEDIAL MENISCUS, CURRENT INJURY, RIGHT KNEE

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: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Fell and dislocated her right knee cap about 20 years ago. Has had increasing pain in the last 6 months. Some instability when walking up stairs, mostly pain with stairs however.
O: Negative lachman, anterior, and posterior drawer. Positive McMurrays. No to minimal osteoarthritis on xray. Crepitus on patellar femoral loading.
A: Meniscus tear, right knee
P: MRI. Patient would like to move forward with a knee scope, consider knee scope once MRI results confirm meniscus tear.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-001 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: palpitations
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - F41.9 - ANXIETY DISORDER, UNSPECIFIED
#2 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION

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: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - ÃŸ Adrenergic blockers
Psychiatric - Antidepressants
Psychiatric - Anxiolytics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN, toradol
S: Heart rate 110-125 over the weekend. She feels like her heart is just "beating out of my chest." She has a pulse oximeter and has been monitoring her heart rate. History of anxiety, takes ativan at night. Ativan is not helping to keep her heart rate down, but she has only been taking half a dose. History of hypertension, takes a baby aspirin each day to keep her heart healthy. Exercises regularly and eats healthy.
O: Afebrile, tachycardic; HR 122. Other vitals stable. EKG reveals sinus tachycardia. Heart sounds bounding, regular rate and rhythm. Skin is pink, no diaphoresis. Capillary refill <2 seconds. Lung sounds clear in all lobes.
A: Sinus tachycardia
P: Consider metoprolol, refill ativan per patient request. Encourage full dose of ativan at night to help with sleep. Return for any concerns. Report to the ER for worsening of symptoms.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-002 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

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

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - E83.42 - HYPOMAGNESEMIA

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: 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

Allergies: NKDA
S: severe fatigue, nausea, not feeling well "at all." Had labs drawn one week ago, magnesium was low. Current every day smoker and alcohol use.
O: Diaphoretic, pale. Appears to be in moderate distress. Hypertensive, tachycardic, oxygen 97%.
A: Probable hypomagnesemia.
P: Sent patient to ER for further workup. Patient's wife wants to drive, refuses ambulance transport.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-003 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 10 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: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: sore throat
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J02.0 - STREPTOCOCCAL PHARYNGITIS

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: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Sore throat x 4 days. History of strep throat, tonsils not removed. Has been going to school, so mother thinks it could be COVID, but wants to get him checked for strep. No nausea or vomiting. No headaches. Sinus and nasal congestion.
O: Afebrile, vitals not significant. Bilateral TMs perl gray, no sinus tenderness on palpation. Eyes clear with no drainage. Nasal congestion present, no rhinorrhea. Pharynx erythematous. Lungs clear on auscultation in all lobes. Heart rate and rhythm regular. Bowel sounds active. COVID swab done and sent. Will call result. Strep swab done; positive for strep.
A: strep throat.
P: Amoxicilin 500 mg PO x 12 hours x 10 days. Patient is 110 lbs. Return if symptoms worsen. Results of COVID will be called. School note written for today, may return to school once COVID results negative or 10 days after symptoms started if COVID is positive.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-004 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 16 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: blood in stool
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K64.9 - UNSPECIFIED HEMORRHOIDS

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:
GI Agents - Stool softeners

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: pcn
S: Bright red blood in stool. Patient is not on her period, so is sure it is in her stool. She has a bowel movement about every 3 days. Last few stools were hard and difficult to pass. She occasionally has problems with difficulty passing stool, but has never had blood in her stool before.
O: Vitals not significant. Patient alert and skin is pink. No apparent distress. Lungs clear on auscultation in all lobes. Heart rate and rhythm regular. Bowel sounds active. Abdomen is soft, no tenderness on palpation. No liver enlargement, no masses noted. No hernias.
A: hemorrhoids.
P: Miralax, over the counter. Take recommended dose twice daily for 2 weeks, follow up in two weeks. Return sooner if symptoms persist or worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-005 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 23 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: Other
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Follow up for wound dressing
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - V89.2xx is not a valid ICD code.

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: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Antidepressants
Psychiatric - Antipsychotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Demerol, phenergan
S: Car accident 2 weeks ago. Right lower leg abrasions and swelling. No broken bones. Has been taking ibuprofen and tylenol for the pain. Has completed keflex.
O: Vitals not significant. Skin pink, no apparent distress. Lungs clear in all lobes, heart rate and rhythm regular. Bowel sounds active. Right lower leg abrasions covering approximately 40% of the lower leg. Minimal serosanguinous drainage. Non-pitting swelling present of the right lower leg and foot. Capillary refill <2 seconds, and right pedal pulse strong.
A: Right lower leg abrasions from MVA.
P: Re-wrap and dress right lower leg. Watch for signs of infection. Return in 1 week for dressing change. Return sooner for any concerns. Elevate leg to reduce swelling. May continue ibuprofen and tylenol for pain.

Idaho State University (Acct #3030)

Case ID #: 1429-20210913-006 (Status: Approved) **Date of Service: 9/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Straightforward
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Sinus and nasal congestion, cough
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 - 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: 2

Types of New/Refilled Prescriptions This Visit:

ENT - Non-narcotic antitussives
ENT - Nasal decongestants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Nasal and sinus congestion x 2 days. Cough that is keeping him up at night. His kids have been sick, and now he is sick. He can do a lot of his work through zoom, but not sleeping is making working difficult. He has been coughing up phelm, but swallows it; does not know the color. No nausea or vomiting.
O: Vitals not significant, afebrile. Skin is pink; no apparent distress. Sinus and nasal congestion. Bilateral TMs perl gray. Non-erythematous pharynx. Submaxillary lymphadenopathy, non-tender. Congested cough noted. Lungs clear in all lobes, occasional rhonchi cleared with cough.Heart rate and rhythm regular. Bowel sounds active. COVID rapid test negative.
A: upper respiratory infection.
P: Robitussin with codeine may be picked up at pharmacy. May also take pseudoephedrine if desired. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210914-001 (Status: Approved) **Date of Service: 9/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 10 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 x 2 days
Encounter #: 2-5
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 - 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

Allergies: NKDA
S: 10 yr old male, presents c/o sore throat x 2 days. Reports headaches and body aches. No fever, no cough. Some sinus/nasal congestion. Patient has missed two days of school. Patient's mother does not believe it is COVID; she wants to make sure he doesn't have strep. Patient has a history of ear infections.
O: Patient awake and alert, no apparent distress. Respirations 14, SpO2 98% on RA, temp 98.8. No cough noted. Bilateral TMs pearl gray, mild pharyngeal erythema. Bilateral submandibular and tonsillar lymph nodes enlarged and tender. Lungs sounds clear in all lobes. Heart rate and rhythm regular.
A: upper respiratory infection. Possible COVID.
P: Patient's mother denies the need for COVID testing. School note written for last two and one more additional day. Supportive measures, to include drinking plenty of fluids and tylenol or ibuprofen for pain and fever. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210914-002 (Status: Approved) **Date of Service: 9/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 15 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: Follow-up (Consult)
Chief Complaint: cold symptoms x 2 weeks.
Encounter #: 2-5
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 - 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: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN
S: 15 yo male, nasal congestion and cough x 2 weeks. Has two brothers who have also been sick. No fevers. Reports minor sore throat off and on. Has missed school for 4 days.
O: Afebrile, lungs clear, HRR regular. Resp 16, SpO2 99% on RA. Mild maxillary sinus tenderness on palpation. Left ear erythema, mild. Clear nasal drainage. No pharyngeal erythema. No lymphadenopathy.
A: Sinus infection.
P: Z-pac. Tylenol and ibuprofen as needed. Drink plenty of fluids. May return to school day after tomorrow. School note written. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210914-003 (Status: Approved) **Date of Service: 9/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 60 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Episodic
Chief Complaint: sore throat x 1 week
Encounter #: 2-5
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 - 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: 4
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Sore throat for one week. Her grandkids have been sick, she was around them over the past two weekends. Her son tested positive for COVID; the patient and her husband both have been vaccinated against COVID, but she is still concerned she may have COVID so she doesn't spread it.
O: Afebrile, Resp 16. Skin warm and pink. Bilateral TMs clear and gray. Nasal congestion and post nasal drip noted. Pharynx non-erythematous, no lymphadenopathy. Lungs clear in all fields. Heart rate and rhythm regular. COVID test negative.
A: Upper respiratory infection.
P: Supportive measures, drink plenty of fluids. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210914-004 (Status: Approved) **Date of Service: 9/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 5 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Ear pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - H60.391 - OTHER INFECTIVE OTITIS EXTERNA, RIGHT EAR

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Runny and stuffy nose x 1 week. Has been complaining of right ear pain; some left ear pain, but mostly in the right. Decreased appetite. No fever, no nausea or vomiting.
O: Right ear TM erythema, left ear TM pink. Afebrile, vitals not significant. Lungs clear in all lobes. Heart rate and rhythm regular. Bowel sounds active.
A: right ear infection.
P: Amoxicillin, 1600 mg daily; 10 ml BID x 10 days. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210915-001 (Status: Approved) **Date of Service: 9/15/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 30 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: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: left hip pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S73.192 - OTHER SPRAIN OF LEFT HIP

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: left hip pain that has been increasing with time. Patient is a runner, exercises and trains 6-7 days a week. The pain is mostly in his groin.
O: Positive FABER and FADIR. No tenderness on spine, or lateral or posterior hip palpation. Tenderness on anterior hip palpation. MRI reveals labral tearing. Xray reveals acetabular prominence - pincer lesion at the hip joint.
A: Femoroacetabular hip impingement and labral tear.
P: Patient would like to move forward with left hip scope and labral fixation. Risks and benefits explained and informed consent signed. Patient scheduled to see anesthesia pre-op.

Idaho State University (Acct #3030)

Case ID #: 1429-20210915-002 (Status: Approved) **Date of Service: 9/15/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 67 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor:
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Follow-up (Consult)
Chief Complaint: Right knee pain
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M17.11 - UNILATERAL PRIMARY OSTEOARTHRITIS, RIGHT KNEE
#2 - M17.12 - UNILATERAL PRIMARY OSTEOARTHRITIS, LEFT KNEE

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: 1
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Endocrinology - Corticosteroids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Bilateral knee pain, right more than left. Patient has a lot of stairs to climb where she lives, and climbing the stairs is getting increasingly difficult. Will likely be moving to a place without stairs soon, but the pain with stairs currently is making it hard for her to get in and out of her apartment.
O: Bilateral lower legs slightly valgus. Lateral knee joint tenderness on palpation bilaterally. Positive Mcmurrays right knee. Negative anterior and posterior drawer and negative Lachmans bilateral. Bilateral pedal pulses strong, capillary refill <2 seconds. Xray reveals bilateral knee osteoarthritis, right knee more than left.
A: Right knee osteoarthritis, left knee mild osteoarthritis.
P: Patient would like to move forward with steroid injection for the right knee. Lidocaine, marcaine, and kenalog injected right knee. Bandaid placed for dressing.

Idaho State University (Acct #3030)

Case ID #: 1429-20210915-003 (Status: Approved) **Date of Service: 9/15/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 17 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: Low complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Left knee pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S83.207 - UNSP TEAR OF UNSPECIFIED MENISCUS, CURRENT INJURY, LEFT KNEE

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient was playing football when he all of a sudden heard a pop and had severe left knee pain. Patient feels like his knee is about to give out when he walks. He noticed a little swelling, but no bruising after the event. Is worried he may have blown his ACL.
O: Bilateral pedal pulses strong. No swelling or effusions noted bilateral knees. Negative Lachmans left knee. Positive McMurrays left knee. Medial tenderness on palpation of the knee joint. Negative patella crepitus on palpation and femoral loading. Xray reveals no bony abnormalities or fractures.
A: Medial meniscus tear left knee.
P: Patient would like to move forward with left knee scope and meniscus repair. Risks and benefits explained to patient and mother, informed consent signed and anesthesia pre-op appointment scheduled.

Idaho State University (Acct #3030)

Case ID #: 1429-20210915-004 (Status: Approved) **Date of Service: 9/15/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 50 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Left shoulder stiffness and pain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M75.32 - CALCIFIC TENDINITIS OF LEFT SHOULDER
#2 - M19.012 - PRIMARY OSTEOARTHRITIS, LEFT SHOULDER

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Shoulder stiffness and pain. Unable to do her job due to limited shoulder movement and pain. Sometimes the shoulder pain keeps her up at night and she is unable to sleep.
O: Xray reveals no bony fractures, mild osteoarthritis of the left shoulder noted. Positive Neer's and Apley scratch test left shoulder. Postive empty can test left shoulder. Radial pulse, left, strong.
A: Rotator cuff tendinitis and osteoarthritis.
P: Patient would like to move forward with left shoulder cuff steroid injection. Kenalog injection given 2-3 cm inferior to the posterior lateral corner of the acromion, posterior shoulder.

Idaho State University (Acct #3030)

Case ID #: 1429-20210920-001 (Status: Approved) **Date of Service: 9/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 25 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: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: COVID symptoms
Encounter #: 6-10
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 - 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

Allergies NKDA
S: Sinus pressure and minor sore throat since last night. He took 2 benadryl and ibuprofen with relief. This morning he had a loss of taste and smell. Some nausea last night. He has had the COVID vaccine, last known exposure to someone with COVID was 2 weeks ago.
O: Afebrile, stable vital signs. No apparent distress. Bilateral TMs perl gray with crisp cone of light. No sinus tenderness on palpation. Pharynx non-erythematous. No lymphadenopathy. Minimal rhinorrhea. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: Upper respiratory infection.
P: COVID swab sent. Will follow up with results. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210920-002 (Status: Approved) **Date of Service: 9/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 35 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: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: left wrist pain/swelling
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S69.81X is not a valid ICD code.

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: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Endocrinology - Corticosteroids
Rheumatology - Agents for gout (ie colchicine, allopurinol)

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies NKDA
S: Left wrist swelling started yesterday. No reported recent injury; injury several years ago. Last night he took ibuprofen and wore his wrist splint with no relief. He is unable to move his hand and wrist normally due to the swelling and pain. Rates his pain as 7/10 with movement. No paresthesias. History of gout, but "this feels different, it's not gout."
O: Afebrile, stable vital signs. No apparent distress. Moderate left wrist and hand swelling when compared to right wrist and hand. Scars on the medial aspect of distal forearm/upper wrist-previous injury from several years ago. Limited ROM in left wrist/hand. Patient unable to make a fist with the left hand. Capillary refill <2seconds. Radial pulse intact. Xray reveals no bony abnormalities or injury.
A: Differentials: Left wrist sprain, radialstyloid tenosynovitis, arthritis, gout, carpal tunnel syndrome
P: Xray done and read. Referral to hand specialist done. Prednisone 20 mg po daily x 5 days. May continue to use wrist splint.

Idaho State University (Acct #3030)

Case ID #: 1429-20210920-003 (Status: Approved) **Date of Service: 9/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 25 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

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

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - N20.0 - CALCULUS OF KIDNEY

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: 1
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Mild abdominal pain saturday. Felt fine on Sunday, today started having severe right flank and abdominal pain. History of UTIs. Patient states "I don't have hot pee this time, like I did with past UTIs." Denies nausea. Patient just had a child 2 months ago, she is on birth control. States that she thought the initial pain might be menstrual cramps, but today the pain is more severe than she has ever had and doesn't believe it to be menstrual cramps.
O: Leukocytes and blood in urine. Vital signs not significant. Afebrile. Mild low right pelvic tenderness, definite right flank tenderness. Negative McBurney's.
A: probable right kidney stone, UTI
Differentials: Pyelonephritis, appendicitis, right ovarian torsion, right ovarian cyst
P: CBC, ultrasound. Bactrim 160 mg TMP PO q 12 hours x 7 days. Toradol, 60 mg IM x1 now. Flomax 0.4 mg PO daily x 4 days. Hydrocodone acetaminphen 5/325, 1-2 tabs by mouth every 6 hours as needed for pain x 3 days. If pain continues, consider urology referral. If pain worsens, return or go to the ER for further diagnostics/imaging.

Idaho State University (Acct #3030)

Case ID #: 1429-20210920-004 (Status: Approved) **Date of Service: 9/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 40 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Episodic
Chief Complaint: Left ear pain, sinus congestion
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.90 - ACUTE SINUSITIS, 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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies NKDA
S: Sinus pressure and cough x3 days. Left ear pain x 2 weeks. History of sinus infections. No fevers, no nausea or vomiting. Has had COVID vaccine. Works with kids and wants to check to make sure
O: Afebrile, stable vital signs. No apparent distress. Bilateral TMs perl gray with crisp cone of light. Frontal and maxillary sinus tenderness on palpation. Pharynx non-erythematous. Submaxillary lymphadenopathy and tenderness. Nasal and sinus congestion with minimal rhinorrhea. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: Sinusitis
P: COVID swab sent. Will follow up with results. Return for any concerns. Amoxicillin 1 g PO daily x 10 days.

Idaho State University (Acct #3030)

Case ID #: 1429-20210920-005 (Status: Approved) **Date of Service: 9/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right leg pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I82.401 - ACUTE EMBOLISM AND THOMBOS UNSP DEEP VEINS OF R LOW EXTREM

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

Allergies: NKDA
S: Right leg pain x5 days. Increasing pain. Pain is mostly in the back of her leg, it's a throbbing pain. No injuries or activity precipitating the pain. Patient denies recent flights or use of birth control. Denies pain like this in the past.
O: Vital signs not significant. Pedal pulse present right foot. Capillary refill <2 seconds. Bilateral calves measure 47 cm diameter. Right thigh 1 cm larger than left thigh. Tenderness noted right posterior calf and thigh. Spine straight, no tenderness on palpation. FROM spine.
A: Possible DVT
P: Right lower leg ultrasound. Follow up with results.

Idaho State University (Acct #3030)

Case ID #: 1429-20210921-001 (Status: Approved) **Date of Service: 9/21/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 72 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: Episodic
Chief Complaint: heart racing
Encounter #: >10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J18.9 - PNEUMONIA, UNSPECIFIED ORGANISM

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: 0
 # Prescriptions currently prescribed: 3
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Psychiatric - Anxiolytics
Pulmonary - ÃŸ2-agonist

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Heart racing and difficulty breathing with minimal activity. Recent bout of pneumonia that she has been taking amoxicillin for. No fevers. Her home pulse oximeter shows that her oxygen drops down into the 60s and 70s simply when she walks to the bathroom. The oxygen that staff gave her when she came in the door is helping her heart and shortness of breath currently. Current every day smoker, with the exception of yesterday and today. It made her sick to try and smoke yesterday.
O: Dusky appearance. BP 180/90, pulse 118, oxygen 88 on 2 L nasal cannula, respirations 22.
A: Acute respiratory distress, probable pneumonia and COPD.
P: Send to the Emergency room. Patient states she would rather be treated here; explained to the patient concerns, patient agreed to go to the hospital. Report called to the ER.

Idaho State University (Acct #3030)

Case ID #: 1429-20210921-002 (Status: Approved) **Date of Service: 9/21/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 41 years
Race: White, Non Hispanic
Gender: Male
Insurance: No insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: High complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Left leg pain
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I82.9 - EMBOLISM AND THROMBOSIS OF UNSPECIFIED VEIN
#2 - S29.012 - STRAIN OF MUSCLE AND TENDON OF BACK WALL OF THORAX

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: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Had pneumonia a few weeks back. He was on antibiotics, started feeling better, so he went for a walk. At that time, he had back pain and suddenly his leg gave out and he fell. Since his fall, he has developed severe pain in the left leg that radiates from his groin to his lower leg. He can't even walk due to the pain.The last 4 days the pain has been the most severe. He does not have insurance, so he wants minimal diagnostics/treatment.
O: Unsteady gait-patient walking with a cane, bearing minimal weight on the left leg. BP: 156/86, resp 24, oxygen 97%, HR 89, temp 98.8. Skin is pink, capillary refill <2 sec. Left lower leg/calf measures 48 cm, right lower leg/calf measures 46 cm. Pedal pulse left foot strong, no erythema. Limited active and passive ROM left leg d/t pain. Lower spine and left posterolateral hip tender on palpation. Bruise left posterolateral hip noted. FROM spine.
A: possible DVT left lower leg, lumbar strain.
P: Left leg ultrasound, 60 mg Toradol IM x1 now.

Results of the ultrasound revealed a DVT that stretches the femoral, popliteal, posterior tibial, and fibular vein. Patient was sent to the ER after attempt to contact vascular doctor.

Idaho State University (Acct #3030)

Case ID #: 1429-20210921-003 (Status: Approved) **Date of Service: 9/21/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 52 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: High complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Just dont feel well
Encounter #: >10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K82.9 - DISEASE OF GALLBLADDER, UNSPECIFIED

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: 1
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Hasn't felt well for the last 5 days. Has abdominal and flank pain. Appetite and drinking habits haven't changed, no constipation, no diarrhea, no vomiting, no nausea. No headaches or fevers. Mostly just feels tired and "not myself." History of "pre-diabetes" that he does not take medication for. Was diagnosed with some kind of gallbladder problem 4 years ago, but didn't have it removed.
O: Vitals not significant. Diffuse abdominal and flank pain on palpation. Bowel sounds active. Lung sounds clear. Heart rate and rhythm regular.

Urine negative for leukocytes, blood, or glucose. Specific gravity 1.02. WBCs not elevated on CBC. Ultrasound shows gallbladder inflammation and thickening.
P: General surgery referral for gallbladder removal.

Differentials

Idaho State University (Acct #3030)

Case ID #: 1429-20210921-004 (Status: Approved) **Date of Service: 9/21/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 13 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: Headaches, congestion
Encounter #: >10
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 - 99213 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; LOW LEVEL MED DECISION; 20-29 MIN
#2 - Z11.5 is not a valid CPT code.

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

Allergies: NKDA
S: headaches x 1 week. Sinus and nasal congestion for about the same amount of time. Has had nausea and vomiting since yesterday. Has two sisters who have also been sick. A family friend recently tested positive for COVID, and the kids were around the family friend when she was sick.
O: Vitals not significant. Bilateral TMs perl gray, no erythema. Nasal congestion present. Pharynx slight erythema. Strep negative. Lymphadenopathy, mild tenderness on palpation. Respirations equal and unlabored, lung sounds clear. Heart rate and rhythm regular.
A: Upper respiratory infection. COVID exposure.
P: Continue with Tylenol and ibuprofen. Zofran 4 mg ODT q 6 hours as needed for nausea.

Idaho State University (Acct #3030)

Case ID #: 1429-20210922-001 (Status: Approved) **Date of Service: 9/22/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Left ankle and foot pain
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S82.832 - OTHER FRACTURE OF UPPER AND LOWER END OF LEFT FIBULA

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: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient was thrown by a bull - cow - and has multiple injuries. The bull's horn went into her left upper medial thigh, and she was thrown into the air before she hit the ground. She was seen by trauma, and has another appointment with trauma in two days. She is here because her left lateral ankle is very sore and it's painful to walk. She was put into a boot, which helps, but she wants to have her ankle fixed if it needs to be fixed.
O: Left foot swelling noted. Pedal pulse present. Wound on left upper medial thigh closed over, bruising present. Lateral ankle tenderness noted. Second toe - metatarsal tenderness with passive second toe ROM present. Xray reveals left fibula avulsion fracture.
A: Left fibula avulsion fracture. Possible metatarsal fracture.
P: Continue to use walking boot. Continue with pain medications as prescribed by trauma. Take one baby aspirin daily while mobility is limited as compared to baseline mobility-likely for one month. Patient educated on possibility of metatarsal fracture; patient would like to think about whether she wants to pursue foot fixation and podiatry referral. Foot xray pending patient's decision.

Idaho State University (Acct #3030)

Case ID #: 1429-20210922-002 (Status: Approved) **Date of Service: 9/22/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 35 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 2 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Post left hip scope, right hip pain
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S73.191 - OTHER SPRAIN OF RIGHT HIP
#2 - Z47.32 - AFTERCARE FOLLOWING EXPLANTATION OF HIP JOINT PROSTHESIS

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: 1
 # 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

Allergies: Sulfa
S: Left hip feels a lot better than it did prior to surgery. Incisions are completely closed over, physical therapy is "going great." Now that her left hip feels better, she has been having more problems with her right hip. She had the MRI of the right hip done and would like to review treatment options for right hip pain.
O: Incisions left hip closed over. FROM left hip, no tenderness on palpation. Right hip positive FABER and FADIR. Right hip MRI reveals Pincer lesion, CAM lesion and labral tear.
A: Right hip labral tear.
P: patient would like to move forward with right hip scope and labral fixation. Risks and benefits discussed, and patient signed informed consent. Pre-op appointment scheduled.

Idaho State University (Acct #3030)

Case ID #: 1429-20210922-003 (Status: Approved) **Date of Service: 9/22/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 20 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Bilateral knee pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M17.0 - BILATERAL PRIMARY OSTEOARTHRITIS OF KNEE

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: 3

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Miscellaneous
Endocrinology - Corticosteroids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Bilateral knee pain. Left knee pain greater than right knee pain. Patient knows she likely has knee osteoarthritis, but doesn't want surgery just yet. She has a busy life and just wants some pain relief for now.
O: Xray reveals bilateral knee osteoarthritis, greater in the left than right. Negative Lachman, anterior and posterior drawer bilateral. Pain on palpation lateral left knee joint. Positive McMurray's left knee. Effusion and posterior baker's cyst noted left knee.
A: Bilateral knee osteoarthritis.
P: Patient would like to move forward with left knee steroid injection. Effusion was drained, approximately 9 cc of fluid removed from left knee prior to lidocaine, marcaine, and kenalog was injected into the left knee.

Idaho State University (Acct #3030)

Case ID #: 1429-20210922-004 (Status: Approved) **Date of Service: 9/22/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

Age: 25 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: Observation only
Reason for Visit: Follow-up (Routine)
Chief Complaint: Post op left knee scope
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S83.241 - OTHER TEAR OF MEDIAL MENISCUS, CURRENT INJURY, RIGHT KNEE

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: 1
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Doing well after meniscus repair/knee scope. No complaints, minimal pain. Has been taking one daily baby aspirin as prescribed. Took a few of the pain medications after surgery, but has not needed them after about day 2 post op.
O: Incisions approximated, sutures intact. No erythema or heat at the sites. Pedal pulse left, strong. No swelling of the foot, lower leg, or knee. Capillary refill < 2 seconds.
A: Post op knee scope/meniscus repair left.
P: Continue with left knee/leg brace. Will adjust knee brace for 0-90 degree flexion and follow up in one week. Continue with daily baby aspirin for one month.

Idaho State University (Acct #3030)

Case ID #: 1429-20210922-005 (Status: Approved) **Date of Service: 9/22/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: MITTON, Tanner
Clinical Site: Idaho Sports & Spine
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Follow-up (Consult)
Chief Complaint: Post op total hip, right
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - T84.51 - INFECT/INFLM REACTION DUE TO INTERNAL RIGHT HIP PROSTHESIS

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: 1
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Doing well since total right hip replacement. Able to walk and working with physical therapy. No swelling or signs of infection that she was told to watch for.
O: Incision closed over, no redness, swelling, or heat at the site. FROM, no tenderness on palpation of the posterior, lateral, or anterior hip.
A: Post op total hip arthroplasty right, 2 month.
P: Follow up for any concerns. One year follow up appointment scheduled.

Idaho State University (Acct #3030)

Case ID #: 1429-20210927-001 (Status: Approved) **Date of Service: 9/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 41 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: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Sinus pressure
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.90 - ACUTE SINUSITIS, UNSPECIFIED

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: 1
 # 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: NKDA
S: Sinus pressure x 2 days. Has a scratchy throat today. Has been sick for about a week now overall, but the sinus pressure has been the worst in the last two days. Had COVID a couple months ago, so doesn't believe that it's COVID. She also needs a work release because they won't let her go to work while she's sick. Reports some headache with sinus pressure. Denies nausea, vomiting, or diarrhea.
O: Afebrile, vital signs not significant. Maxillary sinus tenderness on palpation. Bilateral TMs perl gray. Nasal congestion and inflammation noted. Pharynx non erythematous. No lymphadenopathy. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: Sinusitis.
P: Amoxicillin 500 mg BID PO x 10 days. Work note written.

Idaho State University (Acct #3030)

Case ID #: 1429-20210927-002 (Status: Approved) **Date of Service: 9/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 33 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Shoulder pain, left
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.12 - RADICULOPATHY, CERVICAL REGION

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: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: History of neck injury. Recently the pain has worsened and the pain is radiating through her left shoulder. She has tried physical therapy in the past with no relief. Wears neck brace at night sometimes.
O: Limited ROM neck. Strength and ROM in left shoulder intact. Vital signs not significant. Gait intact. Sensation bilateral hands, forearms, upper arms, and shoulders intact. Bilateral radial pulses intact.
A: Cervical radiculopathy.
P: Ibuprofen 800 mg q 8 hrs as needed for pain. Spine specialist referral for further treatment.

Idaho State University (Acct #3030)

Case ID #: 1429-20210927-003 (Status: Approved) **Date of Service: 9/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 19 years
Race: Hispanic
Gender: Female
Insurance: Private insurance
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: Pregnant, on Valcyclovir; wants to know if its safe
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z34.9 - ENCOUNTER FOR SUPERVISION OF NORMAL PREGNANCY, UNSPECIFIED
#2 - A60.0 - HERPESVIRAL INFECTION OF GENITALIA AND UROGENITAL TRACT

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: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Took a pregnancy test yesterday, it was positive. LMP was 8 weeks ago. She takes Acyclovir for genital herpes. Wants to know if it's safe to take Acyclovir while pregnant.
O: No acute distress, well nourished. Vital signs not significant. Lung sounds clear in all fields. Heart rate and rhythm regular. Bowel sounds active. Urine clear & yellow, HCG positive.
A: Pregnant.
P: Educate patient on establishing care with an OBGYN and early prenatal care. Educate patient on taking Acyclovir to prevent herpetic outbreaks, it's safe for pregnancy. Educate patient on drinking plenty of fluids and taking prenatal vitamin.

Idaho State University (Acct #3030)

Case ID #: 1429-20210927-004 (Status: Approved) **Date of Service: 9/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 52 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: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Shortness of breath, sinus drainage, cough
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.90 - ACUTE SINUSITIS, UNSPECIFIED

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: 1

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Lortab
S: Shortness of breath with activity. Had the COVID rapid test 3 days ago, it was negative. Has headaches, sinus pressure and nasal congestion/drainage. Wants to be tested again for COVID. Has been vaccinated, but the way this feels, he believes he has COVID. No fevers. Has had cough and sinus drainage that is irritating his throat.
O: Vitals not significant, afebrile. Respirations equal and unlabored. Bilateral TMs perl gray, no erythema. Mild pharynx erythema. Maxillary sinus tenderness on palpation. Nasal congestion and rhinorrhea. Lymphadenopathy bilateral submandibular. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: Sinusitis.
P: Patient swabbed for COVID - test sent. Amoxicillin 500 mg BID x 10 days. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210927-005 (Status: Approved) **Date of Service: 9/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 81 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 10 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Bruising and swelling back of left knee
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - I83.9 - ASYMPTOMATIC VARICOSE VEINS OF LOWER EXTREMITIES
#2 - N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED

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: 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

Allergies: NKDI
S: History of UTIs and varicose veins. Wants urinalysis to make sure she hasn't developed another UTI since her last visit. She also has a large bruise and swelling on her left posterior knee. No pain, no injury/trauma. The "bruise just showed up." She was told she can develop blood clots in the back of her leg, so she is concerned it's a blood clot.
O: Urine negative for leukocytes or nitrites. Ultrasound negative for DVT. Purple coloration and swelling posterior knee and distal thigh. No tenderness on palpation. Heart rate and rhythm regular. Lung sounds clear in all lobes.
A: varicose vein, hematoma posterior knee/distal thigh.
P: May use cold packs or heat packs for the swelling. Follow up if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20210929-001 (Status: Approved) **Date of Service: 9/29/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 38 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: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: diarrhea
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R19.7 - DIARRHEA, UNSPECIFIED

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

Allergies: NKDA
S: Diarrhea x 4 days. No fevers, no other symptoms other than mild abdominal tenderness. No blood or mucus in stool. Hasn't eaten much, if anything in the last 4 days due to diarrhea onset with eating. Has been drinking a lot of water, but water even will get diarrhea started. Unsure if he still has appendix, parents deceased.
O: Vitals not significant, afebrile. H-pylori, influenza A & B, and COVID rapid test all negative. REspirations equal and unlabored. Heart rate and rhythm regular and lungs clear in all lobes. Bowel sounds hyperactive. Abdominal tenderness in all quadrants on palpation.
A: Viral diarrhea, possible parasitic or bacterial diarrhea.
P: May take immodium over the counter as directed on the box. Continue to drink plenty of fluids. Return in 2 days if diarrhea has not stopped. Return sooner for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210929-002 (Status: Approved) **Date of Service: 9/29/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Headache, sinus pressure x 2 weeks. Also concerned about thyroid.
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.10 - ACUTE FRONTAL SINUSITIS, UNSPECIFIED
#2 - E03.9 - HYPOTHYROIDISM, UNSPECIFIED

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: 1
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Cardiology - ACE inhibitors
Endocrinology - Corticosteroids
Endocrinology - Thyroid
ENT - Antihistamines
Infectious Diseases - Penicillins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Headaches and sinus pressure x 2 weeks. Has a history of allergies and gets allergy shots, so thought it was just allergies until the last few days. She had night sweats last night and was running a fever yesterday. Not sure why she is not running a fever today. She also has post nasal drainage and swollen sore tonsils. History of swimmer's ear, bilateral. Does not want to be tested for COVID. She had the vaccine. She also feels like her thyroid is low. History of hypothyroid, currently takes 137 mEq of thyroid medication.
O: Afebrile, Vitals not significant. Frontal sinus tenderness on palpation. Nasal congestion noted. Bilateral TMs perl gray, white scar tissue noted in ear canal. Lymphadenopathy noted, tenderness on palpation on left tonsillar lymph. Pharynx non erythematous. Lung sounds clear in all lobes, heart rate and rhythm regular.
A: frontal sinusitis. Hypothyroidism.
P: Amoxicillin 500 mg BID PO x 10 days. Prednisone 50 mg daily, PO x 5 days. Continue with Netti pot and antihistamines. May take tylenol or ibuprofen for fevers. Blood drawn for thyroid panel. Will call results. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20210929-003 (Status: Approved) **Date of Service: 9/29/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 33 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 6 minutes
Type of Decision-Making: High complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: vomiting, diarrhea, not feeling well x 4 days
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - D50.9 - IRON DEFICIENCY ANEMIA, UNSPECIFIED
#2 - K59.00 - CONSTIPATION, 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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: 4 days vomiting, diarrhea, and nausea. Unable to eat or drink. Thought it was a flu or food poisoning, but no one else in the family has been sick. History of alcohol use and alcoholic liver cirrhosis. Reports not drinking anything recently; she is 240 days sober. No longer has an appendix, has a gallbladder still.
O: Vitals not significant, afebrile. Patient is pale. Bowel sounds active. Abdominal tenderness all quadrants. Guarding on liver palpation - no liver enlargement noted. Heart rate and rhythm regular. Respirations equal and unlabored.
A: Anemia & constipation.
P: One view abdomen xray, CBC, CMP. Xray reveals stool throughout the abdomen. CBC reveals low WBC (3.0), RBC (3.98), HGB (9.1), HCT (27.9), MCV (70.2), MCH (23.0), MCHC (32.8), platelets (86.0), lymphocytes (0.8). Normal RDW (14.6).
P after labs and diagnostics: IV iron divided in 2 doses, each dose 510 mg feraheme, one dose today at Portneuf at the IV therapy clinic. Wait 3 to 8 days for second dose of IV iron. PO iron daily, over the counter ferrous sulfate. Bisacodyl 4 tabs today. Drink plenty of water. Follow up in 2 weeks.

Idaho State University (Acct #3030)

Case ID #: 1429-20210929-004 (Status: Approved) **Date of Service: 9/29/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Female
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: Fall, trip down the stairs
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S93.402 - SPRAIN OF UNSPECIFIED LIGAMENT OF LEFT ANKLE

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: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Fell down one stair on her front porch this am, twisted left ankle. Her ankle twisted out and she fell on her side. Now she has pain in her left foot, ankle, knee, and shoulder. She has a prosthesis for her right leg, so it was very difficult for her to get back up after she fell. The majority of the pain she has is in her left ankle and foot. She took ibuprofen this morning for the pain.
O: Xrays reveal no fractures. No abnormalities of the ankle bones indicating displacement or ligament laxity. Bruising of the 5th toe and swelling at the 5th phalangeal joint. Pain with squeeze at the mid calf. Tenderness and swelling of the foot and ankle. Tenderness on palpation of the patella. Limited ROM of the ankle. Pedal pulse intact left foot. No swelling of the knee noted. No swelling of the shoulder noted. FROM shoulder, some tenderness on palpation and with empty can test. Strength on empty can test intact.
A: Syndesmosis ankle sprain
P: Foot, ankle, and knee xrays. Ibuprofen 800 mg q 8 hrs as needed for pain x 5 days. Place walking boot, may continue to use crutches. Return in one week for follow up.

Idaho State University (Acct #3030)

Case ID #: 1429-20210929-005 (Status: Approved) **Date of Service: 9/29/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 64 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 3 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Painful urination
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 - 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: 2
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: painful urination today. Yesterday had some frequent urination, but didn't feel like a UTI. History of UTIs and metastatic breast cancer. Patient is currently on a couple medications for cancer. Is not sure if it's technically chemotherapy.
O: Urine yellow and cloudy, positive for nitrites, leukocytes and blood. Afebrile, vitals not significant. CVA tenderness noted, bilateral. Mild abdominal tenderness. Heart rate and rhythm regular. Lung sounds clear in all lobes.
A: UTI
P: Ciprofloxacin 500 mg ER PO daily x 3 days. Return if symptoms worsen or persist.

Idaho State University (Acct #3030)

Case ID #: 1429-20211011-001 (Status: Approved) **Date of Service: 10/11/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 36 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Swollen tonsils
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J03.90 - ACUTE TONSILLITIS, UNSPECIFIED

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: 2
 # 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: lidocaine, MMR vaccine
S: Sore throat and swollen tonsils and white patches on the back of her throat. Swollen tonsils and white patches showed up this morning, sore throat began yesterday. No other symptoms. History of strep throat, still has her tonsils. History of lupus, does not take any medications for lupus.
O: Afebrile, vitals not significant. Swollen and erythemetous tonsils with white patches on them. Tonsillar and submaxillary lymphadenopathy present. Bilateral TMs perl gray, no nasal or sinus congestion. Heart rate and rhythm regular, lung sounds clear in all fields. Rapid strep test negative.
A: Tonsillitis.
P: Amoxicillin 500 mg BID x 10 days. Return if symptoms worsen or persist.

Idaho State University (Acct #3030)

Case ID #: 1429-20211011-002 (Status: Approved) **Date of Service: 10/11/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 88 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: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: UTI symptoms
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 - 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: 10
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Cardiology - Antilipids
Cardiology - Diuretics
GI Agents - H2 receptor antagonists
GI Agents - H+/K+ ATPase enzyme inhibitors (ie omeprazole)
Infectious Diseases - Fluoroquinolones

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Augmentin
S: No fevers. Frequency, urgency, burning on urination. Left flank pain. History of UTIs. Has not noticed any blood in the urine, but has noticed it has been dark even though she has been drinking "lots of water."
O:
A:
P:

Idaho State University (Acct #3030)

Case ID #: 1429-20211011-003 (Status: Approved) **Date of Service: 10/11/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 32 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: Less than shared
Reason for Visit: Episodic
Chief Complaint: bilateral hand injury
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S63.92X is not a valid ICD code.
#2 - S63.91X is not a valid ICD code.

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: 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

Allergies: NKDA
S: Crashed on his dirt bike yesterday in the sand dunes. He caught himself by extending both hands forward when he crashed, and hurt both hands. Has no pain in his wrists, but cannot bend his right wrist due to the swelling in his hand. Both hands are swollen, right more than left.
O: Vital signs not significant. Right dorsal hand and wrist swollen. Left hand moderately swollen. Limited ROM left 4th finger. Limited ROM right hand. FROM left wrist and right wrist. Xray reveals no acute fractures bilateral hands.
A: Bilateral wrist sprains.
P: Patient prefers no pain medications, he states he only wanted peace of mind of knowing there are no fractures. May take ibuprofen and/or tylenol over the counter. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211011-004 (Status: Approved) **Date of Service: 10/11/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 20 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: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Fever
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - U07.1 - COVID-19

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: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Muscle back pain last night, fever today. Unsure if he has been exposed to COVID. He and his girlfriend work in the service industry, so it's possible he has been exposed. No medical history, other than strep throat as a child and enlarged tonsils. Denies any recent strep throat. Denies sore throat currently.
O: Febrile, 100.4 F. Other vitals not significant. Bilateral TMs perl gray. Enlarged tonsils, left more than right. No sinus tenderness. Tonsillar lymphadenopathy, no tenderness on palpation. Lung sounds clear in all lobes. Heart rate and rhythm regular. Rapid COVID test positive.
A: COVID
P: Tylenol and/or ibuprofen for fever. Rest and fluids. Return if symptoms worsen. Try to isolate for 10 days.

Idaho State University (Acct #3030)

Case ID #: 1429-20211011-005 (Status: Approved) **Date of Service: 10/11/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 35 years
Race: White, Non Hispanic
Gender: Female
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: Follow-up (Consult)
Chief Complaint: biometric screening
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z13.9 - ENCOUNTER FOR SCREENING, UNSPECIFIED

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

Allergies: NKDA
S: Needs blood drawn for biometric screening. Her medical insurance is reduced if she stays healthy and does her yearly biometric screening. Reports no concerns. States that she is active and healthy.
O: Afebrile, vitals not significant. Well nourished, FROM all extremities. Heart rate and rhythm regular. Lung sounds clear in all lobes.
A: Biometric screening.
P: Blood drawn for lipid panel and HbA1C. Vital signs and BMI documented, paper work filled out and given to patient. Results of labs will be sent.

Idaho State University (Acct #3030)

Case ID #: 1429-20211012-001 (Status: Approved) **Date of Service: 10/12/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 4 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Left ear pain and eye discharge
Encounter #: 6-10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - H60.392 - OTHER INFECTIVE OTITIS EXTERNA, LEFT EAR
#2 - H10.33 - UNSPECIFIED ACUTE CONJUNCTIVITIS, BILATERAL

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: 2

Types of New/Refilled Prescriptions This Visit:
Infectious Diseases - Penicillins
Infectious Diseases - Miscellaneous antibiotics

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Last night had "goopy eyes." This morning she is complaining of left ear pain and her eyes are still "goopy." No history of ear infections or sinus issues, but concerned she has an ear infection and pink eye. No fevers, nausea, or vomiting. Some stuffy and runny nose.
O: Afebrile, vital signs not significant. Bilateral light green eye and nasal discharge. Right TM clear, left TM erythema. Nasal and sinus congestion noted. No lymphadenopathy. Pharynx non - erythematous. Lung sounds clear, heart rate and rhythm regular.
A: Left otitis media, conjunctivitis
P: Amoxicillin 500 mg/ml, 7.5 ml by mouth twice daily, azithromycin opthalmic 1 drop bilateral eyes twice daily x 2 days, then once daily for 5 days. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211012-002 (Status: Approved) **Date of Service: 10/12/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 35 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: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: COVID exposure and symptoms
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - U07.1 - COVID-19

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

Allergies: NKDA
S: Works in a hospital with COVID patients. Wears his PPE, but recently has been having muscle aches, fever, and loss of taste and smell this morning. Is concerned he has COVID.
O: Afebrile, vital signs not significant. Bilateral TMs clear, perl gray. Throat non-erythematous. Lymphadenopathy noted, non-tender. No sinus tenderness. No nasal or sinus congestion. Rapid COVID test positive. Lung sounds clear, heart rate and rhythm regular.
A: COVID 19
P: Supportive measures. Positive COVID test result printed for patient's work. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211012-003 (Status: Approved) **Date of Service: 10/12/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 12 years
Race: American Indian or Alaskan Native
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: cough
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z11.52 - ENCOUNTER FOR SCREENING FOR COVID-19

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: 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

Allergies: NKDA
S: Cough for 2 days. Has missed school, mom is worried he may have COVID and doesn't want him to spread it to others. No history of asthma. Patient denies ear pain, throat pain, shortness of breath or nasal congestion.
O: Afebrile, vitals not significant. Bilateral TMs clear, no erythema. Pharynx no erythema. Nasal congestion noted. No sinus tenderness. No lymphadenopathy. Lung sounds clear, heart rate and rhythm regular.
A: COVID screen
P: Swab done and sent. Note for school written, patient to stay home until COVID results in 1-2 days.

Idaho State University (Acct #3030)

Case ID #: 1429-20211012-004 (Status: Approved) **Date of Service: 10/12/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 42 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: UTI
Encounter #: >10
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

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: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Just finished antibiotic two days ago, started having symptoms again of UTI today. History of UTIs, no UTIs as of late until the one she just finished the antibiotic for.
O: Afebrile, vitals not significant. Urine positive for leukocytes and nitrites. No CVA tenderness on palpation. Lungs clear throughout all lobes. Heart rate and rhythm regular.
A: UTI, recurring
P: Ciprofloxacin 500 mg ER once daily for 7 days. Patient unsuccessful on Bactrim.
Return if symptoms persist or worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211013-001 (Status: Approved) **Date of Service: 10/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: neck muscle strain
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S16.1XX is not a valid ICD code.

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: 2
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - Muscle relaxants
Analgesic/Antipyretic - Narcotics
Analgesic/Antipyretic - NSAIDS
Endocrinology - Corticosteroids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: toradol
S: Neck pain x 2 weeks. Had teeth pulled 2 weeks ago, and thinks maybe her neck was in a weird position when she was under anesthesia. Pain radiates up into her head and into her left shoulder, but not into her hand.
O: FROM neck and left shoulder. Tenderness in neck, no tenderness in left shoulder on palpation. Vitals not significant, afebrile. Gums and oral mucosa intact, no erythema or drainage.
A: Neck strain.
P: cyclobenzaprine 15 mg by mouth daily x 1 week. Prednisone, 20 mg by mouth daily for 5 days. May continue other pain medications as already directed. May try neck stretching exercises. Paper with examples of neck exercises given. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211013-002 (Status: Approved) **Date of Service: 10/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 90+ years
Race: White, Non Hispanic
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: Nose bleed
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R04.0 - EPISTAXIS

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: 2
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Nose bleed off and on for the last week. Wakes up in the middle of the night with a nose bleed and has difficulty getting the bleeding to stop. Has had nose bleeds most of his life, they have to cauterize his nose with each episode.
O: Head normocephalic. Vitals not significant, afebrile. No nasal congestion or sinus tenderness. Erythemetous inflamed vessels medial left nostril. Dried blood noted on outside of his nose.
A: epistaxis, chronic and acute.
P: ENT referral. Last episode was more successful with cauterization by ENT MD.

Idaho State University (Acct #3030)

Case ID #: 1429-20211013-003 (Status: Approved) **Date of Service: 10/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 47 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: Sinus pressure, seasonal allergies
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J30.2 - OTHER SEASONAL ALLERGIC RHINITIS

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: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Corticosteroids
ENT - Antihistamines

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Seasonal allergies. She thought they would go away with the snow, but she is having even more sinus issues with the weather. Her eyes are itchy and sinuses are clogged. Also has runny nose and nasal congestion. No fevers, nausea, cough, wheezing, or shortness of breath.
O: Afebrile, vitals not significant. Eyes clear, no drainage. Bilateral TMs clear, perl gray. Sinus tenderness on palpation. No lymphadenopathy. No pharynx erythema. Lung sounds clear in all lobes, heart rate and rhythm regular.
A: Seasonal allergies.
P: Kenalog, 40 mg IM x1 now. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211013-004 (Status: Approved) **Date of Service: 10/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 88 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
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: Bilateral foot rash, swollen right leg
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - L23.9 - ALLERGIC CONTACT DERMATITIS, UNSPECIFIED CAUSE

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN
S: Was out doing yard work a week or so ago and developed a rash mostly on her right foot, and now she has a rash developing on her left foot. The patient's son reports that the patient put triple antibiotic on her feet, which is probably why she has the rash. The patient is not sure if she is allergic to the triple antibiotic or not, but they threw it away and is no longer applying the antibiotic.
O: Maculopapular rash dorsal foot and distal anterior ankle bilateral. Bulla present dorsal right foot. Right calf swelling, right calf measures 33 cm circumferential and left calf measures 17 cm circumferential. Lung sounds clear all lobes. Heart rate and rhythm regular, murmur noted left subclavicular area.
A: allergic contact dermatitis bilateral dorsal feet. Possible DVT right calf. Heart murmur.
P: Doxycycline 100 mg tab, 1 tab by mouth daily for 5 days. Triamcinolone topical 0.025%, three times daily to bilateral dorsal feet. Right lower leg ultrasound. Will follow up with results of ultrasound.

Idaho State University (Acct #3030)

Case ID #: 1429-20211013-005 (Status: Approved) **Date of Service: 10/13/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 58 years
Race: Hispanic
Gender: Male
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Fatigue, right leg pain
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R73.9 - HYPERGLYCEMIA, 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: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - Acetaminophen combinations
Analgesic/Antipyretic - NSAIDS
Endocrinology - Insulin
Endocrinology - Oral glucose lowering agents

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Severe fatigue. Falling asleep in the middle of conversations. Can't stay awake. Was taking Lantus, but had issues with getting it, so has not been taking his Lantus. Spouse reports that he urinates "all of the time." Patient also reports shortness of breath and activity intolerance.
O: urine shows 3+ glucose, negative for ketones. CBC reveals blood sugar as 563 mg/dl. Afebrile, other vital signs not significant. Gait unsteady, patient walks with a cane. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: hyperglycemia
P: Pharmacy called, Basaglar comes in a pen and is covered by the patient's insurance. Basaglar prescription and humalog refill sent to pharmacy. Patient educated on taking the Basaglar 45 units SQ daily. 40 units humalog three times daily prior to meals. Patient educated on adherence with insulin and complications of hyperglycemia. Referral to diabetes specialist done.

Idaho State University (Acct #3030)

Case ID #: 1429-20211014-001 (Status: Approved) **Date of Service: 10/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 48 years
Race: Hispanic
Gender: Male
Insurance: Private insurance
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: Episodic
Chief Complaint: trichomoniasis exposure
Encounter #: 2-5
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z11.3 - ENCNTR SCREEN FOR INFECTIONS W SEXL MODE OF TRANSMISS

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: 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

Allergies: NKDA
S: May have been exposed to trichomoniasis. Wanted to get tested in case he has it.
O: Afebrile, vitals not significant. Lungs clear, heart rate and rhythm regular. Urine clear.
A: Trichomoniasis exposure.
P: Obtain urine sample and send it to lab for microscopic examination. Follow up with results.

Idaho State University (Acct #3030)

Case ID #: 1429-20211014-002 (Status: Approved) **Date of Service: 10/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 34 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: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: COVID exposure
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - U07.1 - COVID-19

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: 0
 # Prescriptions currently prescribed: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Neurology - Amphetamines C-II
Urology - Erectile dysfunction medication

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: COVID exposure. His son was around his dad who is positive for COVID, now he has been having symptoms for 2 days. His work requires that he get tested for COVID, so he wants to get tested so he can return to work.
O: Vitals not significant, afebrile. Bilateral TMs perly grey. No sinus tenderness, nasal and sinus congestion noted. Pharynx slightly erythematous. No lymphadenopathy. Lung sounds clear throughout all lobes. Heart rate and rhythm regular. COVID 19 test positive.
A: COVID 19 infection.
P: Positive test result printed for patient's work. Stay home for 10 days after symptoms started. Return if symptoms worsen, for shortness of breath or increasing sore throat. Patient also requested medication refill on 2 medications, Refill prescriptions sent to patient's pharmacy.

Idaho State University (Acct #3030)

Case ID #: 1429-20211014-003 (Status: Approved) **Date of Service: 10/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 49 years
Race: American Indian or Alaskan Native
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: Shortness of breath
Encounter #: 1
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 - 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: 2
 # New/Refilled Prescriptions This Visit: 4

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Shortness of breath for about a week. Shortness of breath has been worsening. Ran out of asthma medications, and needs a refill on asthma medications. History of asthma and pneumonia, reports getting pneumonia about once a year.
O: Afebrile, vitals not significant. Bilateral TMs perly grey. Maxillary sinus tenderness. Pharynx non-erythematous. Wheezing and crackles noted in all lung fields. Heart rate and rhythm regular. Chest xray reveals patchy ground glass appearing infiltrates all lobes.
A: Viral and possibly bacterial pneumonia. Asthma exacerbation.
P: Albuterol nebulizer given in office. Patient reports some relief. Nebulizer tubing given to patient. Albuterol prescription refilled, both pro-air and nebulizer albuterol prescriptions. Azithromycin, z-pack, prescription and prednisone orders written. Azithromycin 500 mg x1 on day one, then 250 mg by mouth daily for 4 days. Prednisone, 50 mg by mouth daily for 5 days. Return if symptoms worsen. Go to the ER for any immediate concerns or worsening of shortness of breath.

Idaho State University (Acct #3030)

Case ID #: 1429-20211014-004 (Status: Approved) **Date of Service: 10/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 19 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: dizziness
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R21 - RASH AND OTHER NONSPECIFIC SKIN ERUPTION

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: 1
 # 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: NKDA
S: Started taking minocycline for a rash on the side of her nose. She had two doses, one yesterday morning and one last night. This morning she was really dizzy when she got up to get ready for school. She doesn't believe it could be the minocycline after just two doses, but there has been no other change in medications, diet, or exercise. No tongue swelling or shortness of breath.
O: Afebrile, vitals not significant. Well nourished, no distress. Small rash on right lateral nares, approximately 2 cm. No sinus tenderness, no nasal congestion. Pharynx non-erythematous. No lymphadenopathy. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: rash, possible side effect of minocycline.
P: Meclizine 12.5 mg by mouth every 6 hours as needed for dizziness. Discontinue minocycline and return to the skin institute where the minocycline was originally ordered for rash for continued management of rash. If symptoms worsen, report to the ER.

Idaho State University (Acct #3030)

Case ID #: 1429-20211014-005 (Status: Approved) **Date of Service: 10/14/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
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: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Diarrhea, abd pain, body aches, headaches x 2 weeks
Encounter #: >10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - R10.9 - UNSPECIFIED ABDOMINAL PAIN

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: 1
 # Prescriptions currently prescribed: 5
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Cardiology - ACE inhibitors
Cardiology - Diuretics
Endocrinology - Oral glucose lowering agents
Endocrinology - Minerals/vitamins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Abdominal pain and watery diarrhea x 2 weeks. No blood or mucus in the diarrhea. No nausea or vomiting. Body aches and headaches for 2 weeks as well. Has been drinking plenty of water to replace the fluids. He take a "water pill" and potassium supplements, so he urinates a lot as well. Has not eaten or drank anything unusual, baseline diet. He still has his gallbladder. History of type 2 diabetes and hypertension.
O: Afebrile, vital signs not significant. Abdominal obesity. Urine clear, no nitrites, leukocytes or blood. Diffuse abdominal tenderness. Active bowel sounds x4. No masses or hernias noted. FROM all extremities. Heart rate and rhythm regular. Lung sounds clear in all lobes. No diaphoresis or pallor.
A: Abdominal pain and diarrhea.
P: Abdominal ultrasound. May continue over-the-counter antidiarrheal as needed. Follow up with results of abdominal ultrasound.

Idaho State University (Acct #3030)

Case ID #: 1429-20211018-001 (Status: Approved) **Date of Service: 10/18/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 20 years
Race: Hispanic
Gender: Male
Insurance: No insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Abdominal pain, weakness, fatigue
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - K21.9 - GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS

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: 1
 # 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

Idaho State University (Acct #3030)

Case ID #: 1429-20211018-002 (Status: Approved) **Date of Service: 10/18/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 33 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
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: sore throat, swollen glands
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J02.9 - ACUTE PHARYNGITIS, 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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: sore throat, swollen glands, low grade fever, headaches x 2 days. Glands are so swollen, it hurts to swallow. Wants COVID test. History of strep throat.
O: Afebrile, vitals not significant. Bilateral TMs perl gray, no erythema. Pharynx erythemetous. Positive for lymphadenopathy and tenderness. Lungs clear throughout all fields. Heart rate and rhythm regular. COVID and strep test negative.
A: Lymphadenopathy, pharyngitis.
P: Prescription for amoxicillin sent. Patient educated on filling amoxicillin and taking as directed by pharmacy if symptoms worsen. If symptoms subside in the next two days, patient instructed to not take the antibiotic due to possibility of viral cause. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211018-003 (Status: Approved) **Date of Service: 10/18/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 5 minutes
Consult with Preceptor: 10 minutes
Type of Decision-Making: High complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Shortness of breath
Encounter #: >10
Type of HP: Detailed
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J12.82 - PNEUMONIA DUE TO CORONAVIRUS DISEASE 2019

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: 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

Allergies: NKDA
S: Sick x 10 days. Shortness of breath has been increasing each day. Fevers the last two days. She reports headaches, body aches, and overall not feeling well. No sore throat or ear pain.
O: Chest xray reveals ground glass appearance. Afebrile. Oxygen 88% on 2L oxygen via nasal canula. Heart rate 110. Blood pressure 150/90. Patient tripoding posture. Patient in moderate respiratory distress. Crackles and wheezing noted in all lung lobes. Heart rate and rhythm regular, diminished sounds.
A: COVID pneumonia
P: Sent patient to ER. Ensured patient had oxygen with nasal cannula, patient denied EMS transport.

Idaho State University (Acct #3030)

Case ID #: 1429-20211018-004 (Status: Approved) **Date of Service: 10/18/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 50 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
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 - J18.9 - PNEUMONIA, UNSPECIFIED ORGANISM
#2 - J45.909 - UNSPECIFIED ASTHMA, UNCOMPLICATED

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: 2
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:

Endocrinology - Corticosteroids
Infectious Diseases - Macrolides
Pulmonary - ÃŸ2-agonist
Pulmonary - Miscellaneous pulmonary

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Cough, sinus congestion, post nasal drip x 1 week. Has sore throat with the post nasal drip. No history of strep. History of asthma. Uses nebulizer and rescue inhaler at home for shortness of breath. Headaches with the sinus congestion, ibuprofen helps. Is not concerned for COVID. No fevers, nausea, or vomiting.
O: Afebrile, vitals not significant. Bilateral TMs perl gray with no erythema. Maxillary sinus tenderness noted, mild. Lymphadenopathy, mild noted. Mild pharynx erythema. Lungs mild wheezing in all lobes with occasional rhonchi cleared with cough. Heart rate and rhythm regular.
A: Pneumonia, unspecified. Asthma.
P: Continue home asthma medications. Nebulizer treatment given in office. Prednisone, 20 mg oral daily for 5 days. Amoxicillin 1000 mg by mouth three times daily for 10 days. Return if symptoms worsen. Go to the ER for any immediate concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211018-005 (Status: Approved) **Date of Service: 10/18/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 34 years
Race: White, Non Hispanic
Gender: Female
Insurance: No insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: cyst, lower right anterior neck
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - L72.3 - SEBACEOUS CYST

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: 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

Allergies: NKDA
S: Tender, painful abscess or lump on lower front neck. Tried to lance it herself, but it just got bigger. Now it hurts to put a shirt on. It's red and swollen. Wants it to be gone, wants us to do what we have to do to get rid of it.
O: Cyst, approximately 5 cm in diameter, right clavicle region. Skin is erythemetous, not warm. Cyst is well encapsulated.
A: Sebaceous cyst
P: Area was localized with 1% lidocaine with epinephrine, and excised. Cyst sac was isolated and removed. Incision was dressed with telfa, non adherent gauze, and tegaderm. Prescription for keflex 500 mg by mouth twice daily for 7 days. Return for any signs of infection or for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211020-001 (Status: Approved) **Date of Service: 10/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Cough. Sick for about a month
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
#2 - J20.9 - ACUTE BRONCHITIS, 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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 3

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Corticosteroids
Infectious Diseases - Cephalosporins
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Sick for about a month. Just finished a Z-pack four days ago for a sinus infection, with no relief. Was sent home from work today due to cough. Patient has not been sleeping well due to cough. Not concerned about COVID, but does work with kids several of who are home because of COVID. History of bronchitis, she states she gets bronchitis about once per year. No other history.
O: Afebrile, vitals not significant. Obese. Congested cough. Bilateral TMs perl gray. Maxillary sinus tenderness on palpation left side. Lymphadenopathy, greater on left side. Pharynx non erythematous. No nasal congestion. Lung sounds rhonchi, bilateral upper lobes, clears with cough. Lower lung lobes bilateral clear on auscultation. Heart rate and rhythm regular.
A: Bronchitis.
P: Prednisone, 20 mg by mouth once daily x 5 days. Cefdinir 300 mg by mouth twice daily x 10 days. Cough medicine - codeine/guaifenesin, 10 mL by mouth every 6 hours for cough. Return if symptoms worsen. Work note written for today through the end of the week.

Idaho State University (Acct #3030)

Case ID #: 1429-20211020-002 (Status: Approved) **Date of Service: 10/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 23 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: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: car accident, concussion 5 days ago
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S06.0X0 - CONCUSSION WITHOUT LOSS OF CONSCIOUSNESS

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

Allergies: NKDA

S: Patient was in a car accident 5 days ago. He lost consciousness at the time. Since then he has not had any problems, just a slight headache. No dizziness or confusion. No difficulties walking. He believes his memory to be intact. No light sensitivity, no nausea or vomiting. He was told after the accident that he had a concussion and that he should not go to work until he saw a provider. He wants to know if it's ok to go to work now that it has been 5 days.

O: Afebrile, vital signs not significant. Gait intact. Patient is alert and oriented, responds to questions appropriately. FROM all extremities. FROM neck and back. Smile is symmetrical. PERLLA. Finger to nose test intact. Romberg test negative.

A: Concussion.

P: Wait one more week to return to work. If no symptoms of concussion (paper with a list of symptoms given), then he may return to work after one week. Note written for his employer.

Idaho State University (Acct #3030)

Case ID #: 1429-20211020-003 (Status: Approved) **Date of Service: 10/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 51 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: right ankle pain/injury
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - S93.439 - SPRAIN OF TIBIOFIBULAR LIGAMENT OF UNSPECIFIED ANKLE

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: 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

Allergies: NKDA
S: Was riding his dirt bike two days ago and wrecked. He was able to get up and walk afterwards, did not feel like he needed to get an xray, but his right ankle is hurting worse with time and increasing in swelling. He wants to get an xray in case he broke his ankle.
O: Mild swelling right ankle. Lateral ankle tenderness. Pedal pulses intact. Xray reveals no acute fractures or abnormalities. Lung sounds clear to auscultation all lobes. Heart rate and rhythm regular.
A: Right ankle sprain.
P: Ankle wrapped with ace wrap. Patient denies need for crutches. May use ibuprofen or tylenol over-the-counter for pain. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211020-004 (Status: Approved) **Date of Service: 10/20/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 88 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: cough
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J18.9 - PNEUMONIA, UNSPECIFIED ORGANISM

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: 2

Types of New/Refilled Prescriptions This Visit:
Endocrinology - Corticosteroids
Infectious Diseases - Penicillins

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Cough for 4 days. Normally has a cough, but recent cough is getting severe. She is concerned she may have COVID, but more concerned about pneumonia. Had fallen and broke her hip 2 years ago, her husband died about 6 months after she had broken her hip. She has a neighbor that checks in on her, but she is worried that if she has pneumonia, she might fall again and be hospitalized again.
O: Afebrile, vital signs not significant. Congested cough noted. Chest rise symmetrical, skin color not significant, not diaphoretic. Lung sounds crackles in lower lobes. No sinus tenderness, pharynx non-erythematous, no lymphadenopathy. Bilateral TMs perl gray. Chest xray shows haziness right lower lobe.
A: Right lower lobe pneumonia.
P: Amoxicillin 500 mg tabs, 2 tabs by mouth three times daily. Prednisone 20 mg by mouth daily for 5 days. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211025-001 (Status: Approved) **Date of Service: 10/25/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 2 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Employment Physical
Chief Complaint: DOT physical
Encounter #: 1
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z02.4 - ENCOUNTER FOR EXAMINATION FOR DRIVING LICENSE

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: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Just got hired on to a nearby construction company and here for his DOT physical. No medical history, no current problems or concerns. Takes no medications.
O: FROM all extremities, FROM neck and back - spine. No scoliosis, no hip dysplasia. Heart rate and rhythm regular. Lungs clear in all lobes. Sensation in 4 extremities intact. Patellar reflexes intact. Patient responds to questions appropriately.
A: DOT physical.
P: DOT paperwork completed. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211025-002 (Status: Approved) **Date of Service: 10/25/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 30 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 2 minutes
Type of Decision-Making: Low complexity
Student Participation: Shared (50-50)
Reason for Visit: Employment Physical
Chief Complaint: DOT physical
Encounter #: 6-10
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - Z02.4 - ENCOUNTER FOR EXAMINATION FOR DRIVING LICENSE
#2 - I10 - ESSENTIAL (PRIMARY) HYPERTENSION

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
Cardiology - ACE inhibitors

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Here for a DOT physical. Has had a lower back surgery, right shoulder surgery, and sinus surgery. No health concerns today. Doesn't take any medications, and no current medical problems. Patient states he was put on a pill for blood pressure after his sinus surgery, but has not taken it "for a long time."
O: Blood pressure on presentation 166/96, follow up blood pressure 15 minutes later 166/108. FROM all extremities, neck, and back. No hip dysplasia, no scoliosis. Patient responds to questions appropriately. Lung sounds clear in all lobes. Heart rate and rhythm regular. DTR intact. Sensation in all extremities intact.
A: DOT physical, hypertension.
P: Lisinopril 20 mg by mouth daily, take first pill today. See your primary care provider in two weeks for follow up on blood pressure, sooner for any concerns. DOT physical paperwork completed.

Idaho State University (Acct #3030)

Case ID #: 1429-20211025-003 (Status: Approved) **Date of Service: 10/25/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 41 years
Race: White, Non Hispanic
Gender: Male
Insurance: Medicaid
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: Neck and low back pain
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - M54.2 - CERVICALGIA
#2 - M54.5 - LOW BACK PAIN

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: 3

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - Muscle relaxants
Analgesic/Antipyretic - NSAIDS
Endocrinology - Corticosteroids

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Neck and lower back pain. No injury, except a distant injury as a child. Patient unable to specify injury. Pain is rated a 8/10 - he describes it as an aching pain. He has been having difficulty sleeping due to the pain. The patient doesn't have a place to live, he has been staying at a local motel. Reports no health history, does not take any medications. Has not tried tylenol or ibuprofen for the pain. He is an every day smoker.
O: Patient restless on appearance. Answers questions appropriately. Afebrile, vitals not significant. Spine straight, no scoliosis. No tenderness on palpation. FROM lumbar spine. Limited active cervical spine range of motion. FROM all extremities. Pulses, pedal and radial, strong and regular. Lung sounds clear in all lobes. Heart rate and rhythm regular.
A: cervical and lumbar pain.
P: Flexeril 10 mg by mouth three times daily as needed. Ibuprofen 800 mg by mouth every 8 hours as needed for pain. Prednisone 50 mg by mouth daily x 5 days. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211025-004 (Status: Approved) **Date of Service: 10/25/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 88 years
Race: White, Non Hispanic
Gender: Female
Insurance: Medicare
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Frequency, burning on urination
Encounter #: 2-5
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

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: 2
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:

Analgesic/Antipyretic - NSAIDS
Infectious Diseases - Urinary anti-infectives
Neurology - Alzheimer's disease

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Patient has a history of dementia. She reported to her husband that she had burning when she urinated. He also noticed that she has to use the bathroom frequently lately. He tries to get her to drink more water, but has not had much success. Patient's husband reports macrobid has been successful in the past in clearing up her UTIs.
O: Afebrile, vitals not significant. Urine positive for leukocytes and blood. No CVA tenderness, lower abdominal tenderness noted.
A: UTI
P: Macrobid 100 mg by mouth twice daily for 10 days. Return if symptoms worsen. Culture sent. Will follow up with culture as needed.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-001 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 50 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: Low complexity
Student Participation: Less than shared
Reason for Visit: Episodic
Chief Complaint: Sinus pressure
Encounter #: >10
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 - 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: 2
 # New/Refilled Prescriptions This Visit: 0

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Psychiatric - Antidepressants

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Sinus pressure and headache since last night. Fever last night. Positive for chills. Denies sore throat, cough, or shortness of breath. Did not take any tylenol or ibuprofen for fever or headache.
O: Afebrile, vital signs not significant. Sinus tenderness. Bilateral TMs no erythema. Pharynx non-erythematous. No lymphadenopathy. Lungs clear in all lobes, heart rate and rhythm regular.
A: Upper respiratory infection
P: Supportive measures. May take over the counter analgesics as needed. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-002 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 25 years
Race: White, Non Hispanic
Gender: Male
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 2 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Annual/Well-Person Exam
Chief Complaint: Wellness exam for insurance screening
Encounter #: 1
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 - 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: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Here for an annual wellness for his insurance. No medical history, surgical history included right shoulder surgery - arthroscopy and anchor placement. Takes no medications. No current issues or concerns.
O: Afebrile, vitals not significant. FROM neck, back, and extremities. Sensation intact all extremities. Back straight. Lungs clear in all lobes, heart rate and rhythm regular. Patient answers questions appropriately.
A: Wellness exam
P: CBC, CMP, Lipid panel - as routine for wellness. Paperwork sent. Return for any concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-003 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 51 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Low complexity
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sinus congestion & pressure
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J01.90 - ACUTE SINUSITIS, 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: 0
 # Prescriptions currently prescribed: 1
 # New/Refilled Prescriptions This Visit: 1

Types of New/Refilled Prescriptions This Visit:
ENT - Intranasal steroids
Infectious Diseases - Fluoroquinolones

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA, "prednisone intolerance"
S: Sinus congestion and pressure for 5 days. Loss of taste and smell today. Positive for headaches, fever, chills, and tender lymph nodes - "glands." Has been taking Dayquil with tylenol with mild relief. History of sinus infections and multiple sinus surgeries due to problems with "bacteria pooling in right side of sinuses." She has been on many antibiotics, but levoquin seems to be the antibiotic that works.
O: Mild fever of 100.1 fehrenheit. Other vital signs not significant. Sinus tenderness, frontal and maxillary, and congestion noted. Bilateral TMs clear with no erythema. Pharynx non erythematous. Lymphadenopathy noted. Lungs clear in all lobes. Heart rate and rhythm regular.
A: sinusitis.
P: Levofloxacin 500 mg by mouth daily for 10 days. Return if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-004 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 25 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: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Sore throat
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J02.0 - STREPTOCOCCAL PHARYNGITIS

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: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Sore throat since yesterday. No fevers, cough, nausea, vomiting, or really any other symptoms; just the sore throat. Had strep throat as a kid, but has not had any problems with strep as an adult. History of asthma, no current medications or problems with asthma. Takes no medications.
O: Temp 99.5 F. HR 115, other vital signs not significant. Bilateral TMs clear with no erythema. No sinus tenderness. Throat - bilateral tonsils swollen with erythema and exudate. Lymphadenopathy noted. Lung sounds clear in all lobes, heart rate and rhythm regular but tachy. Rapid strep test positive.
A: Srep throat.
P: Amoxicillin 1000 mg by mouth twice daily for 10 days. Change toothbrush after 24 hours of being on the medication

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-005 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 59 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Moderate complexity
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: Not feeling well
Encounter #: 2-5
Type of HP: Expanded Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - A09 - INFECTIOUS GASTROENTERITIS AND COLITIS, 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: 0
 # Prescriptions currently prescribed: 4
 # New/Refilled Prescriptions This Visit: 2

Types of New/Refilled Prescriptions This Visit:
Miscellaneous - Not covered elsewhere

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Hydroxyzine, sulfa
S: Nausea, vomiting, diarrhea, and decreased appetite for 6 days. Took a home COVID test 4 days ago, test was positive for COVID. The diarrhea has been getting worse. She has been drinking a lot of water to make up for the fluid loss. She is getting increasingly weak and fatigued. No fevers. Positive for cough, but states she gets a cough a lot when she gets sick. History of kidney transplants and is on immunosuppressive therapy for prophylactic. Did not eat anything that she believes could have caused stomach upset.
O: Pale on appearance. Temp 99.5 fehrenheit, other vital signs not significant. CBC results not significant. Patient unable to urinate - no urinalysis done. Bilateral TMs clear with no erythema. No sinus tenderness or pharynx erythema. No lymphadenopathy. Lung sounds clear in all lobes. Heart rate and rhythm regular. Bowel sounds hyperactive, no abdominal tenderness.
A: gastroenteritis
P: 1L normal saline IV x 1 in office. Zofran ODT 8 mg by mouth every 8 hours as needed for nausea/vomiting. May try bland diet as tolerated. Continue with drinking plenty of fluids. Return if symptoms continue. Present to the ER if symptoms worsen.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-006 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 3 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: Medicaid
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: Fever, cough, not feeling well x 4 days
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - B97.4 - RESPIRATORY SYNCYTIAL VIRUS CAUSING DISEASES CLASSD ELSWHR

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: 1

Types of New/Refilled Prescriptions This Visit:
Analgesic/Antipyretic - NSAIDS

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Cough, fever, runny nose, fussiness, sleeping more than normal for the last 4 days. She is normally very active and eats well. She hasn't been eating as good as normal either.
O: Fever 101.9 fehrenheit. Other vitals not significant. RSV test positive, COVID and flu negative. Lung sounds clear. Bilateral TMs no erythema. Rhinorrhea and nasal congestion noted. Heart rate rapid, rhythm regular.
A: RSV
P: Ibuprofen 200 mg oral x1 now for fever. Offer plenty of fluids for her to drink. May use Tylenol and ibuprofen at home for fever. Encourage plenty of rest. Supportive measures.

Idaho State University (Acct #3030)

Case ID #: 1429-20211027-007 (Status: Approved) **Date of Service: 10/27/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Observation only
Reason for Visit: Episodic
Chief Complaint: Foreign object left eye
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - T15.92X is not a valid ICD code.

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: 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

Allergies: NKDA
S: Something irritating left eye. He has been working outside, yesterday, in the wind, and he believes he got something in his eye. This morning he woke up and his eye was red and swollen. He states it feels like he has glass in his eye; it's a sharp pain.
O: Vitals not significant. Left eye redness and swelling. No foreign object noted, no stye.
A: Left eye foreign object.
P: Left eye was irrigated and dyed with flourescein. Wood light revealed no foreign object. Supportive measures, including saline flushes for left eye. Return if swelling increases, does not subside, or eye becomes warm.

Idaho State University (Acct #3030)

Case ID #: 1429-20211028-001 (Status: Approved) **Date of Service: 10/28/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 30 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: Less than shared
Reason for Visit: Episodic
Chief Complaint: Right hand swelling
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - W57.XXA is not a valid ICD code.

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: 0
 # Prescriptions currently prescribed: 0
 # New/Refilled Prescriptions This Visit: 1

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

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies NKDA
S: Woke up yesterday with right hand swelling, believes he got bit by a spider. He put some steroid ointment on it, but the swelling has increased. He tried to open it up and drain it to reduce the swelling, he wasn't able to get much out of it.
O: Vital signs not significant. Right second posterior metacarpal area swelling. Swelling is about 1.5 inches in diameter. Area is erythematous and warm to touch. Most elevated area is open and scabbed over. No redness outside of swollen area.
A: Insect bite, infected.
P: Keflex 500 mg by mouth twice daily x 7 days. Return if symptoms worsen or continue. Wound was irrigated with chlorhexadine and saline. Area of swelling was marked off with a sharpie and patient educated to return if swelling increased. Open area dressed with bacitracin and a bandaid.

Idaho State University (Acct #3030)

Case ID #: 1429-20211028-002 (Status: Approved) **Date of Service: 10/28/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

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

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Burning on urination
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 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 MIN

Medications

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

Types of New/Refilled Prescriptions This Visit:

Cardiology - ACE inhibitors
Cardiology - Thrombolytics/ Anticoagulants/ Blood modifiers
Infectious Diseases - Fluoroquinolones

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: Sulfa and PCN
S: Burning on urination that came and went for about a week. She tried to drink lots of water with lemon, but this morning the burning on urination is intolerable.
O: Afebrile, vitals not significant. Urine is cloudy and amber in color. Urinalysis reveals leukocytes, nitrites, and blood in urine. No CVA tenderness. No abdominal tenderness. Bowel sounds active, lung sounds clear in all lobes, heart rate and rhythm regular.
A: UTI
P: Ciprofloxacin 500 mg by mouth twice daily x 7 days. Drink plenty of water. Return if symptoms worsen or persist.

Idaho State University (Acct #3030)

Case ID #: 1429-20211028-003 (Status: Approved) **Date of Service: 10/28/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 25 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 3 minutes
Type of Decision-Making: Straightforward
Student Participation: Shared (50-50)
Reason for Visit: Episodic
Chief Complaint: COVID screen
Encounter #: 1
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - U07.1 - COVID-19

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: 0

Types of New/Refilled Prescriptions This Visit:

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: NKDA
S: Started having body aches last night. Woke up this am with headache, body ache, sore throat, and fever. No cough, nasal congestion, or runny nose. Took an at home COVID screening which was positive.
O: Rapid COVID screen positive. Temp 37.4 celcius, heart rate 112, other vitals not significant. Bilateral TMs perl gray, no erythema, no sinus tenderness. No pharynx erythema. Mild lymphadenopathy. Heart rate and rhythm regular, lung sounds clear in all lobes.
A: COVID-19
P: Positive COVID test result printed for patient's employer. Stay home as much as possible for 10 days after symptoms started. Return or seek immediate medical care for any shortness of breath or concerns.

Idaho State University (Acct #3030)

Case ID #: 1429-20211028-004 (Status: Approved) **Date of Service: 10/28/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 36 years
Race: American Indian or Alaskan Native
Gender: Female
Insurance: Medicaid
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Burning on urination
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 - 99214 - OFFICE/OP VISIT, EST PT, MEDICALLY APPROPRIATE HX/EXAM; MODERATE LEVEL MED DECISION; 30-39 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 - Fluoroquinolones

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: amoxicillin
S: Burning on urination since this morning. No nausea, vomiting, or diarrhea. No flank pain. Positive for frequency and urgency.
O: Afebrile, vitals not significant. Urine cloudy yellow. Positive for leukocytes. No CVA tenderness. Bowel sounds active, no abdominal tenderness. Heart rate and rhythm regular. Lung sounds clear in all lobes.
A: UTI
P: Ciprofloxacin 500 mg by mouth twice daily for 7 days. Return if symptoms worsen or persist. Drink lots of water.

Idaho State University (Acct #3030)

Case ID #: 1429-20211028-005 (Status: Approved) **Date of Service: 10/28/2021**

Student Information - Combs, Elizabeth

Semester: Fall
Course: NURS7740L: Primary Care Throughout the Lifespan La
Preceptor: Kener, Titus
Clinical Site: Physicians Immediate Care Center
Setting Type:

Patient Demographics

Age: 28 years
Race: White, Non Hispanic
Gender: Female
Insurance: Private insurance
Referral: Other

Clinical Information

Time with Patient: 15 minutes
Consult with Preceptor: 5 minutes
Type of Decision-Making: Straightforward
Student Participation: Primary (>50%)
Reason for Visit: Episodic
Chief Complaint: Chest tightness, shortness of breath
Encounter #: >10
Type of HP: Problem Focused
Social Problems Addressed:

Procedures/Skills (Observed/Assisted/Performed)

ICD-10 Diagnosis Codes

#1 - J45.909 - UNSPECIFIED ASTHMA, UNCOMPLICATED

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: 2

Types of New/Refilled Prescriptions This Visit:

Pulmonary - ÃŸ2-agonist
Pulmonary - Steroid inhalers

Adherence Issues with Medications:

Other Questions About This Case

Clinical Notes

Allergies: PCN
S: History of asthma, ran out of rescue inhaler. Has had increased shortness of breath and feels like she has been wheezing. Shortness of breath is worse at night. She was prescribed the "long acting inhaler that you take every day." The inhaler was over $100 even with insurance and she could not afford it.
O: Vital signs not significant. Afebrile. Wheezing noted right lower and middle lobe. Heart rate and rhythm regular.
A: Asthma
P: Refill ProAir, 1-2 puffs as needed every 4 hours while awake. Found solumeterol inhaler on GoodRX for less than $50. Sent prescription for solumeterol inhaler and informed patient of price. Return for any concerns.