CANCER CARE CENTER

707 East Main Street
Middletown NY 10940

Encounter Date: 9/1/2017
Hospital Account: 5000893530
MRN: 318930
Site: EHS MODEL
Contact Serial #: 8856275

ENCOUNTER

Department:	CC INFUSION CENTER	Appt Time:	11:00 AM EDT
Appointment Provider:	CC INF CHAIR 7	Visit Type:	CHEMO 3 HOURS
Attending Provider:		Referring Physician:	Tewari, Deepali, MD
Diagnosis:	Crohn's disease, uns* K50.90		

PATIENT

Name:	DUBIN,MEGAN	Age:	17 y.o. DOB: 6/29/2000
Address:	10 Gardner Ave Ext	Sex:	Female
City:	MIDDLETOWN, NY 10940	Language:	English [22]
PCP:	Brown, Emily R, DO	Primary Phone:	845-341-6719

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work
1. Dubin,Kim		Mother	(845)341-6719	
2. *No Contact Specified*				

auth exp 9/[illegible]/17

GUARANTOR

Guarantor:	DUBIN,KIM A	DOB:	12/26/1966
Address:	10 Gardner Ave Ext	Sex:	Female
	MIDDLETOWN, NY 10940		
Relation to Patient:	Mother	Home Phone:	845-341-6719
Guarantor ID:	40036	Work Phone:	845-368-0104 X228

GUARANTOR EMPLOYER

Employer:	SCHULMAN, KISSEL &	Status:	FULL TIME

Pat Dubin

COVERAGE

PRIMARY INSURANCE

Payor:	BLUE CROSS OF NY	Plan:	BC PPO NY
Group Number:	720947	Insurance Type:	INDEMNITY
Subscriber Name:	DUBIN,ERIC	Subscriber DOB:	12/24/1966
Subscriber ID:	YLK89327216	Verification Status:	
Pat. Rel. to Subscriber:	Child		

1/1/17
9000 (met)
100%

SECONDARY INSURANCE

Payor:		Plan:	
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Subscriber ID:		Verification Status:	
Pat. Rel. to Subscriber:			

Contact Serial # (8856275) August 31, 2017 Chart ID (No chart ID available)
No chart ID available

484239

Remicade

 8/30

Insurance Verification

Name: Megan Dubin DOB: 6/29/00 MR# 318930
Ins. ID # B/C YLR 89327216
Phone#:
Date: 8/31/14 Time: 8:57 DX: ~~Chron~~ Crohn Dis. K50.90
Eff Date: 1/1/17
Copay: DED: 9000 (met)
Percent: OOP:
Name of Person: Rex
REF: 8/31/17-000793
Jcode: Remicade J1745
96413

Auth Req'd YES: ~~[illegible]~~ X NO: ~~[illegible]~~
Auth# Date Span:
Phone: 855-326-6970 Fax:
Name: ~~Laura H.~~ in Med. mgmt. - Needs to transfer internally.
Kaye B

Can we Buy and Bill:
YES: NO:
Specialty Pharmacy:
Phone#: Fax:

Aim - ~~[illegible]~~
877-430-2288

auth # 124066663.
8/31 - 9/28
1 visit
4 weeks

484239
Luz
914-367-0019
Yvette - Dx ...

9/8/17. 12:37pm.
Monique
#2 visits 0, 2, 6
Q8 weeks

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Deepali Tewari, MD Patient Name: Dubin, Megan DOB: 6/29/00

Date Written: 9/8/17 Date of Administration:

Diagnosis: Chron's Disease TNM Stage:

Protocol / Regimen – Cycle of Day

Allergies: ☑ NKDA

Venous Access: ☐ Peripheral ☐ Central

Height	Weight	Body Surface Area (m^2)	Emetic Level
5 ft 5 in	65.9 kg ☒ Actual ☐ Ideal ☐ Adjusted ☐ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: WBC less than: PLT less than: Hgb/Hct less than: SCr greater than:

Non-chemotherapy orders:	RPh Initials / Nurse initials	
☐ IV Fluids: NS @ KVO (20 mL/hr) to be given 30 minutes before infusion		
① Tylenol 650 mg one dose orally Tablet		
② Benadryl 25 mg orally 1 dose		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed (Rounding to be completed by RPh)	Route	Infusion Rate	RPh / Nurse initials	
Remicade	5mg/kg	330mg →			IV			

*If using a dose reduction, please provide rationale:

MD Name (Print) Deepali Tewari, M.D. MD Signature _____ Date/Time 9/8/17

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

Physician Orders/Blank/Chemotherapy Orders-Z-1/Pharmacy/11-12

N= 20

DOB: 6/29/00

ORANGE REGIONAL MEDICAL CENTER

CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN: Patient Name: Dolan, Megan DOB: 6/29/00

Date Written: 8/29/17 Date of Administration: 9/2/17

Diagnosis: Chron's disease TNM Stage:

Protocol / Regimen – Cycle of Day

Allergies: ☑ NKDA

Venous Access: ☐ Peripheral ☐ Central

Height	Weight		Body Surface Area (m^2)	Emetic Level
5 ft 5 in	64 kg	☒ Actual ☐ Ideal ☐ Adjusted ☐ Dosing		☐ Minimal ☐ Moderate ☐ High

Lab Orders: ☐ CBC/DIFF ☐ BMP ☐ Magnesium ☐ UA

Hold Parameters:

ANC less than: WBC less than: PLT less than: Hgb/Hct less than: SCr greater than:

Non-chemotherapy orders:	RPh initials / Nurse Initials	
☐ IV Fluids: NS @ KVO (20 mL/hr)		
X Pre Infusion Medications		
① Tylenol 650 mg tablet 30 minutes before Infusion orally 1 dose		
② Benadryl 25mg 1 tablet 30 minutes before Infusion 1 dose orally		

Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.

Chemotherapy	Dose per Unit (m^2, kg, AUC)	Dose Reduction* (mg/m^2, mg/kg, AUC)	Calculated Dose	Dose Dispensed (Rounding to be completed by RPh)	Route	Infusion Rate	RPh / Nurse Initials	
Remicade	5mg/kg	x 320mg			IV			

*If using a dose reduction, please provide rationale:

X MD Name (Print) DR. TEWARI MD Signature Day 2 X Date/Time 8/28/17 9:9am

RN Name (Print) _____ RN Signature _____ Date/Time _____

RPh Name (Print) _____ RPh Signature _____ Date/Time _____

N = 20

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTOME A NEW PATIENT IS TO BE SCHEDULED)

NAME: Megan Dubre

DOB: 6/29/00

PT'S PHONE #: 341-6719

PROCEDURE: Remicade

DURATION: IV

DIAGNOSIS: Crons

NAME OF PERSON TALKED TOO:

PHYSIAN & PHONE: Dr. Tewari

INSURANCE:

ALLERGIES:

IMMEDIATELY AFTER MAKING THE APPOINTMENT, FAX THIS FORM AND COPY OF SCRIPT FOR AUTHORIZATION AND PRE-REGISTRATION PROCESS: EXT 1715

*PLEASE SEND A COPY TO PHARMACY IF PATIENT IS TO RECEIVE CHEMOTHERARY: EXT 1124

STACY BUDD
PHONE: (845) 333-1905
FAX: (845) 333-1902

ALLISON ROCHE
PHONE: (845) 333-1906
FAX: (845) 333-1902

9/11

Pediatric Gastroenterology
Boston Children's Health Physicians
Until every child is well

Deepali Tewari MD
100 Crystal Run Road Middletown NY, 10941-
Phone:(914)367-0000 Fax:(914)367-0001

PATIENT:	MEGAN DUBIN
DATE OF BIRTH:	06/29/2000
ENCOUNTER DATE:	Thursday, August 17, 2017
VISIT TYPE:	Office Visit

This 17 year 1 month old female presents for Follow Up of Crohn's disease.

HISTORY OF PRESENT ILLNESS:

Historian: mother

1. Follow Up of Crohn's disease

Informant : mother , patient

Birth History : FT Cesction
Past Medical History : 2013 had a back surgery for severe scoliosis , foot surgery June 2017 for ligament tear in Feb 2017, Blount's disease in infancy : went to NY City was given braces for few years she improved, recurrent oral ulcers x 1 year, shin rash x 2 months
Developmental History : wnl
Allergy : KNDA

Meds : Vancomycin compited the course , Omeprazole , zofran prn , Flagyl, Prednisone
Social History : Attends regular school , parents are divorced , father is remarried
Family History : 4 years older Sister ; Pierre Rubin sequence, MGM : RA, MCousin : MS, MA, MC : Hypothyroidism , PU : muscle dystrophy's, Dad : gout

History of Present Illness :
EGD, colonoscopy : 8/8/17 : Gastritis, duodenitis, pancolitis with scatteres ulcers
Biopsy : TI : chronic active enteritis, purulent exudates, glandular architectural distortion, TC : colitis, DC : cryptitis, crypt abscesses, distortion, ulcer berd, , consisitent with Crohn's disease

Labs : anemia, low albumin, elevated inflammatory markers
Stool 8/17 : Calprotectin 1377, Lactoferrin positive

MRE : bowel wall thickening of the ileum, 25 to 50 cm involved from the level of the ileocecal valve with skip regions. luminal narrowing although Assessment for penetrating disease is highly suboptimal given the incomplete distention. Associated hyperenhancing mucosa compatible with acute Crohn's disease.

Interim Hx : In July Patient was admitted to MFCH for abdominal pain , diarrhea, rectal bleeding ,20 lbs weight loss, joint pain, shin rash likely erythema nodosum , oral ulcers. Her w/u was remarkable for Clostridium difficile infection in stool was treated with Vancomycin

Currently :
Abdominal pain : generalized pain , constant, 5/10, dull cramp , no radiation

BM : 2-3/day, soft - loose, no visible [illegible] occasional nocturnal stools
Joint pain : foot pain
Erytmela nodosum : improved
Appetite : improved , SCD diet
Weight : gained from last visit

Problem List:
No active problems

PAST MEDICAL/SURGICAL HISTORY: (Detailed)

Disease/disorder	Onset Date	Management	Date	Comments
right foot surgery	06/02/2017			
spinal fusion			2013	
sprained right foot				

MEDICATIONS: (active prior to today)

Medication Name	Sig Desc	Start Date	Stop Date
prednisone 10 mg tablet	take 20 mg two times daily	08/09/2017	10/07/2017
omeprazole 20 mg capsule,delayed release	1 capsule Orally daily OR open and sprinkle contents over spoonful of applesauce; swallow all	08/09/2017	12/06/2017
Flagyl 500 mg tablet	1 tablet by Oral route 2 times per day (IBD dose)	08/09/2017	08/22/2017

MEDICATION RECONCILIATION:
Medications reconciled today.

Allergies:

Ingredient	Reaction	Comment
CODEINE	GI problems	

Reviewed, updated.

FAMILY HISTORY: (Detailed)

Relationship	Family Member	Condition	Onset Age	Deceased	Age at Death
Maternal grandfather		Cancer, lung	80	Y	

Pediatric Social History
Preferred language is English.

SMOKING STATUS

Status	Type	Smoking Status	Usage Per Day	Years Used	Total Pack Years
no/never		Never smoker			
no/never		Never smoker			

REVIEW OF SYSTEMS:

System	Neg/Pos	Details
Integumentary	Positive	Rash, Erythema.
GI	Positive	Abdominal pain, Change in bowel habits, Diarrhea, Nausea.
MS	Positive	Back pain, Joint pain.
Eyes	Negative	Eye pain.
Constitutional	Negative	Chills, fever and weight loss.
Hema/Lymph	Negative	Easy bleeding, easy bruising and lymphadenopathy.
Reproductive	Negative	Vaginal discharge.
Respiratory	Negative	Chronic cough, pleuritic pain and wheezing.
GU	Negative	Dysuria and hematuria.
Endocrine	Negative	Cold intolerance and heat intolerance.
Psych	Negative	Anxiety and depression.
Integumentary	Negative	Pruritus.
Allergic/Immuno	Negative	Food allergies.
Cardio	Negative	Chest pain, edema and irregular heartbeat/palpitations.
ENMT	Negative	Ear infections, nasal congestion, sinus infection and sore throat.
GI	Negative	Constipation, decreased appetite, dysphagia, heartburn, hematemesis, hematochezia, melena, reflux and vomiting.
Neuro	Negative	Dizziness, headache, tremors and vertigo.

VITAL SIGNS:

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt oz	Wt kg	BMI	BMI kg/m2	O2 Sat%
11:54 AM	104/64	60			5.0	5.00	165.10	141.00		63.957	23.46		75

MEASURED BY:

Time	Measured by
11:54 AM	Carolyn Smith

PHYSICAL EXAM:

Exam	Finding	Detail
Constitutional	Normal	Well developed.
Eyes	Normal	Conjunctiva - Right: Normal, Left: Normal. Sclera - Right: Normal, Left: Normal.
Nasopharynx	Normal	Buccal mucosa - Normal.
Neck Exam	Normal	Inspection - Normal. Palpation - Normal.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal.
Cardiovascular	Normal	Regular rate and rhythm. No murmurs, gallops, or rubs.
Vascular	Normal	Pulses - Brachial: Normal.
Abdomen	Normal	Inspection - Normal. Abdominal muscles - Normal. Auscultation - Normal. Percussion - Normal. Anterior palpation - Normal. No abdominal tenderness. No hepatic enlargement. No splenic enlargement. No hernia. No hepatic tenderness.
Rectal	Normal	Anus - Normal. Sphincter - Normal Normal fecal material.
Skin	*	Inspection - General inspection: eryhtema +.
Extremity	Normal	No edema.
Neurological	Normal	Fine motor skills - Normal.
Psychiatric	Normal	Oriented to time, place, person, and situation. Appropriate mood and effect.

Assessment/Plan:

1.	Assessment	Crohn's disease of both small and large intestine w abscess (K50.814).
	Impression	17 years old Female with Complicated Chron's disease: erythema nodosum, abdominal pain, joint pains, weight loss, diarrhea, nocturnal stools, rectal bleeding
	Patient Plan	Biospy results explained Agree with SCD diet Omeprazole 20 mg q day Prednisone : taper explained 5 mg every 5 days to 2.5 mg q day x 5 days then discontinue May discontinue Flagyl after 10 days course Hepatits B first dose given at PMD's office Infliximab , 6 MP , Humira and Mesalamine discussed with side effects in detail patient and mother willing to start with Infliximab Induction and maintenance infusion dose and plan explained Infusion to be set up at near by hospital : office manager aware If condition worsens or any new concerns call office and/ or take to nearest ED will consider further work up pending above ie SB evaluation, BM density , repeat labs
	Provider Plan	The risks, benefits and side effects of treatment were discussed with the patient and mother.
2.	Assessment	Pain in joint (M25.50)
3.	Assessment	Generalized abdominal pain (R10.84)
4.	Assessment	Erythema nodosum (L52)

Completed by: Deepali Tewari08/17/2017 02:50 PM
Document generated by: Deepali Tewari 08/17/2017 02:49 PM

Electronically signed by Deepali Tewari MD on 08/18/2017 03:05 PM

WESTCHESTER MEDICAL CENTER

WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.®

VALHALLA • NEW YORK • 10595

Patient DUBIN, MEGAN | Birth Date 06/29/2000 | Sex F | Rm/Bed
Attending | MR # 000001547935 | Pt# 95803375 | Adm Date 08/08/2017

Surgical Pathology | Aug 08, 2017 14:19

LABIMAGE null

WESTCHESTER MEDICAL CENTER

FINAL
SURGICAL PATHOLOGY REPORT

Pati DUBIN, MEGAN
ent:

Accession Number: SC-17-11057

Patient: DUBIN, MEGAN
MRN: W1547935

Billing #: W95803375

DOB: 06/29/2000 SEX: F

Address:
10 GARDNER AVE EXT
MIDDLETOWN, NY 10940-

Accession Number: SC-17-11057
Procedure Date: 08/08/2017 14:19
Accession Date: 08/08/2017 16:36
Report Date: 08/10/2017 15:33
Location: AMBULATORY SURGERY
Requested By: DEEPALI TEWARI
Reported By: LARISA BEBELENKO, M.D.

FINAL DIAGNOSIS:
A. Duodenum, biopsy:
Deodenal mucosa, within normal limits.

B. Stomach, biopsy:
Chronic active gastritis.
H. Pylori immunostain negative.

C. Esophagus, biopsy:
Squamous mucosa, within normal limits.

D. Small intestine, terminal ileum, biopsy:
Chronic active enteritis with purulent exudate and mild glandular architectural distortion.

E. Colon, rectum and right, biopsies:
Colonic mucosa, within normal limits.

F. Colon, transverse, biopsies:
Colonic mucosa with focal cryptitis.

G. Colon, descending, biopsies:
Chronic active colitis with cryptitis, crypt abscesses and mild-to-moderate glandular architectural distortion.
Inflamed granulation tissue, consistent with ulcer bed.

4. Rectum, biopsy:
Colonic mucosa, within normal limits.

Comment:
The findings are consistent with Crohn disease in an appropriate clinical setting. Clinical correlation is recommended.

IHC ANALYSIS: Paraffin sections are analyzed by immunohistochemistry (IHC). This test was developed and its performance characteristics determined by Department of Pathology of Westchester Medical Center. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes only. Controls are staining appropriately. . . . .

CLINICAL DATA:
17 years old female with diarrhea, weight loss, elevated inflammatory markers.

GROSS DESCRIPTION:
A) Received in formalin, labeled with the patient's name and "Duodenum", consists of multiple irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.7 x 0.6 x 0.6 cm. Entire specimen is submitted in one cassette.

B) Received in formalin, labeled with the patient's name and "Gastric", consists of multiple irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.6 x 0.5 x 0.5 cm. Entire specimen is submitted in one cassette.

C) Received in formalin, labeled with the patient's name and "Esophagus", consists of two irregular fragments of white pinkish, soft tissue, measuring in aggregate 0.4 x 0.3 x 0.3 cm. Entire specimen is submitted in one cassette.

D) Received in formalin, labeled with the patient's name and "Terminal ileum", consists of two irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.4 x 0.2 x 0.2 cm. Entire specimen is submitted in one cassette.

E) Received in formalin, labeled with the patient's name and "Cecum and right colon", consists of multiple irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.5 x 0.4 x 0.3 cm. Entire specimen is submitted in one cassette.

F) Received in formalin, labeled with the patient's name and "Transverse colon", consists of multiple irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.6 x 0.6 x 0.5 cm.

Entire specimen is submitted in one cassette.

G) Received in formalin, labeled with the patient's name and "Descending colon/left colon", consists of multiple irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.8 x 0.8 x 0.7 cm. Entire specimen is submitted in one cassette.

H) Received in formalin, labeled with the patient's name and "Rectum", consists of three irregular fragments of tan-pink, soft tissue, measuring in aggregate 0.4 x 0.4 x 0.3 cm. Entire specimen is submitted in one cassette.

ALGAT 8/8/2017 8:18:13 PM

SOURCE(S):
(A) DUODENUM, BIOPSY
(B) GASTRIC, STOMACH, BIOPSY
(C) ESOPHAGUS, BIOPSY
(D) SMALL INTESTINE, TERMINAL ILEUM, BIOPSY
(E) COLON, CECUM AND RIGHT COLON, BIOPSY
(F) COLON, TRANSVERSE, BIOPSY
(G) COLON, DESCENDING, BIOPSY
(H) RECTUM, BIOPSY

Residents: RUGVED PATTARINE, MD
<Sign Out Dr. Signature>
Reported By: LARISA DOBELENKO, M.D.
Reported On: 08/10/2017 15:33

Westchester Medical Center

Esophagogastroduodenoscopy/ColonoscopyProcedure Report

Patient:	Megan Dubin	**Attending Physician:**	Deepali Tewari M.D.
Patient ID:	MRN-1547935	**Referring Physician:**	Not available
Exam Date:	08/08/2017	**Scope(s) Used:**	GIF-H190-2515807 PCF-H190DL-2400161

Introduction: A patient presents for Esophagogastroduodenoscopy/Colonoscopy.

Indications:

- **EGD Indications:**
- Abdominal pain (789.00).
- Anemia.
- **Colonoscopy Indications:**
- Abdominal pain (789.00).
- Diarrhea (787.91).
- Loss of weight (783.21).
- Fecal occult blood positive (792.1). Abnormal MRE

Clinical History: Attached.

Physical Exam: Attached.

Consent: The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient's mother.

Preparation: EKG, pulse, pulse oximetry and blood pressure were monitored throughout the procedure.

Procedural Medications: Propofol Administered by Anesthesiologist.

Performed By: Dr Tewari , assisted by Senior GI fellow

Procedure: **EGD Procedure:** The endoscope was passed with ease through the mouth under direct visualization and advanced to the 2nd portion of the duodenum. The scope was withdrawn and the mucosa was carefully examined. Retroflexion was performed in the fundus.

Colonoscopy Procedure: The endoscope was passed with ease through the anus under direct visualization and advanced to the terminal ileum, confirmed by ileocecal valve. The scope was withdrawn and the mucosa was carefully examined. The quality of the preparation was good.

Findings:

Esophagus: The esophagus appeared to be normal. Multiple biopsies were taken.

Stomach: There were multiple small areas of linear erosion in the body of the stomach and on the anterior wall of the antrum. They were not bleeding. Multiple biopsies were taken.

Duodenum: There were multiple small ulcers in the duodenum. Multiple biopsies were taken.

Colon: There was evidence of severe colitis in the terminal ileum, cecum, ascending colon, transverse colon, descending colon, and rectum. The mucosa appeared edematous, erosive, erythematous, friable, and ulcerated , multiple scattered linear ulcers were seen with severe inflammation and edema in the entire colon and TI. Multiple biopsies were taken.

Complications: There were no unplanned events.

Estimated Blood Loss: Insignificant.

Impressions:

- Normal esophagus. Multiple biopsies taken.
- Areas of erosion were found in the body of the stomach and on the anterior wall of the antrum (535.4). Multiple biopsies taken.
- Multiple duodenal ulcers were found (532.90). Multiple biopsies taken.

- Severe colitis (558.9) found in the terminal ileum, cecum, ascending colon, transverse colon, descending colon, and rectum with multiple scattered linear ulcers seen with severe inflammation and edema in the entire colon and TI. Multiple biopsies taken.

Recommendations:

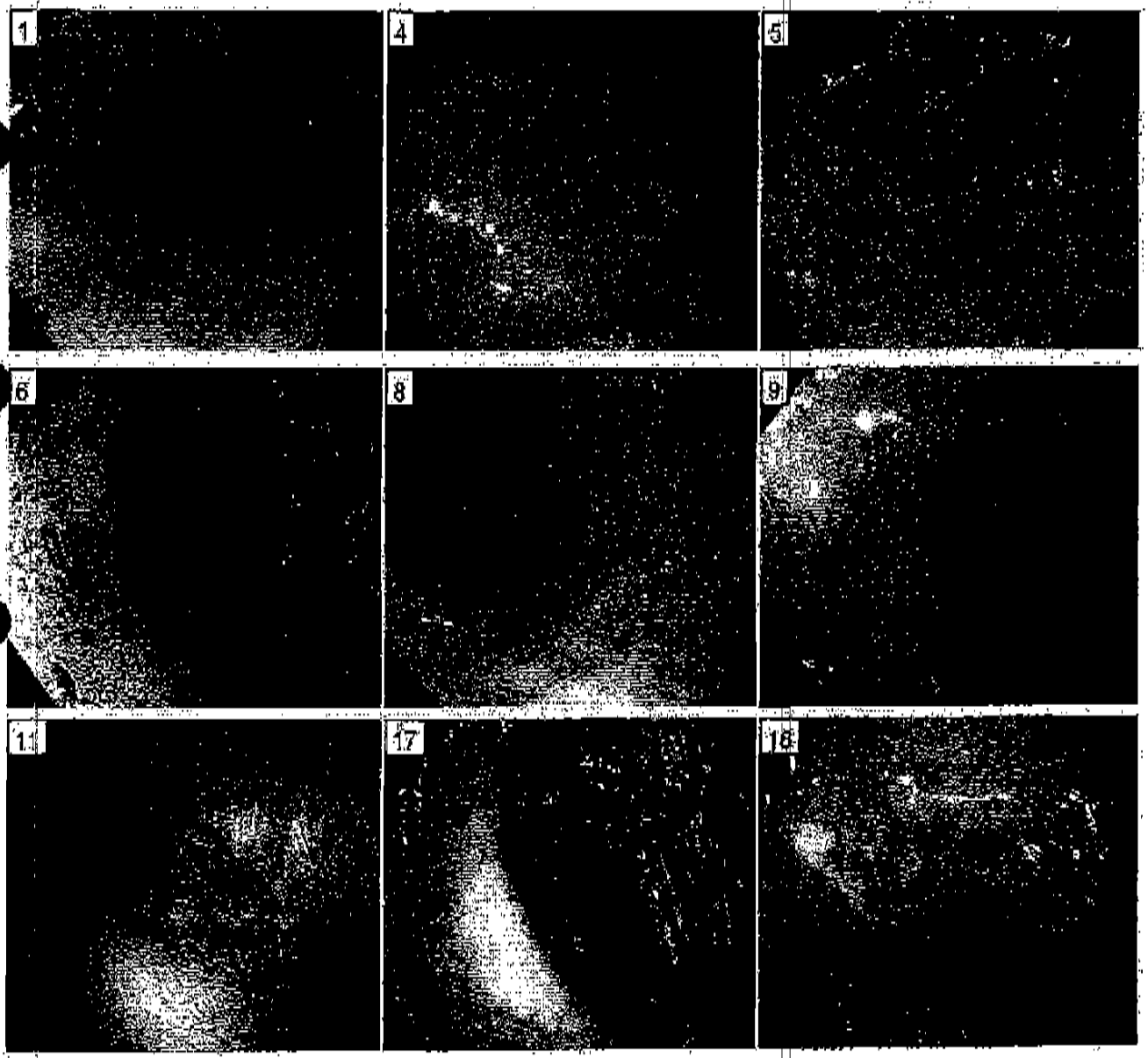
- Follow-up on the results of the biopsy specimens.
- Provide with the appropriate diet sheet.
- Lab studies ordered: Calprotectin and C diff toxin.

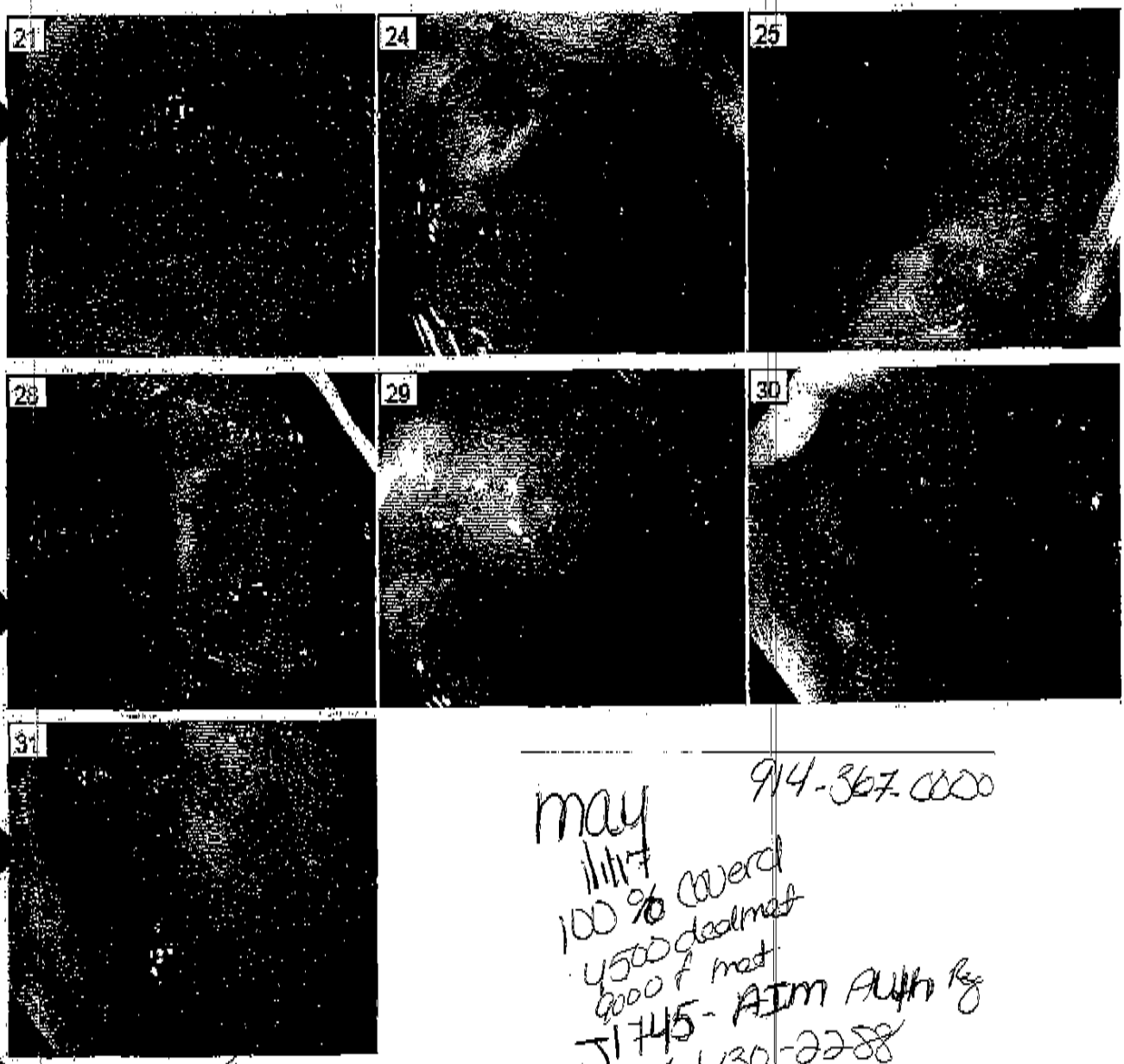
Implants/Grafts: None

Specimens: Multiple biopsies taken from esophagus. Multiple biopsies taken from stomach and duodenum. Multiple biopsies taken from TI. Multiple biopsies taken from colon. Associated finding: Colitis.

Procedure Codes:

- [43239]EGD with biopsy
- [45380]Colonoscopy with biopsy





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90413 Q Auth Req.

Ref# 060517-010825

Signature
Deepali Tewari M.D.