

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Medical Records - CONFIDENTIAL

FROM: TN - Faculty Physicians

Tina W
1415 OLD WEISGARBER RD SUITE 350, KNOXVILLE, TN 37909-1381
Phone: (865) 588-1605
Fax: (865) 588-1608

TO:

Name: LYNCH, BOBBIE A

DOB: 05/30/1931

Date Range: 01/01/2024 to 09/17/2025

This document contains the following records of the patient:

- **Encounters and Procedures**

This fax may contain sensitive and confidential personal health information that is being sent for the sole use of the intended recipient. Unintended recipients are directed to securely destroy any materials received. You are hereby notified that the unauthorized disclosure or other unlawful use of this fax or any personal health information is prohibited. To the extent patient information contained in this fax is subject to 42 CFR Part 2, this regulation prohibits unauthorized disclosure of these records.

If you received this fax in error, please visit www.athenahealth.com/NotMyFax to notify the sender and confirm that the information will be destroyed. If you do not have internet access, please call 1-888-482-8436 to notify the sender and confirm that the information will be destroyed. Thank you for your attention and cooperation. [ID:4465-A-25546]

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Encounters and Procedures

Clinical Encounter Summaries

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)**Encounter Date: 09/05/2024****Patient**

Name	LYNCH, BOBBIE (93yo, F) ID# 4465	Appt. Date/Time	09/05/2024 01:45PM
DOB	05/30/1931	Service Dept.	HARROGATE
Provider	KYLER DALTON, PA-C		
Insurance	Med Primary: MEDICARE-TN (MEDICARE) Insurance # : 7VK7G74MN66 Med Secondary: BCBS-TN - FEP (PPO) Insurance # : R13718898 Policy/Group # : 104 Prescription: check now		

Chief Complaint

Left Wound Care, painful toenails

Patient's Care Team**Primary Care Provider:** JOHN M ROBERTSON MD: 209 IRISH CEMETARY RD, TAZEWELL, TN 37879, Ph (423) 869-3684, Fax (423) 869-5460 NPI: 1881858215**Patient's Pharmacies****FOOD CITY PHARMACY #428 (ERX): 110 NORTH 11TH STREET, MIDDLESBORO, KY 40965, Ph (606) 248-7689, Fax (606) 242-3079****Vitals**

None recorded.

Allergies

Allergies not reviewed (last reviewed 08/16/2024)

LEVAQUIN**SHELLFISH DERIVED****SULFA (SULFONAMIDE ANTIBIOTICS)****Medications**

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Reviewed Medications

amoxicillin 500 mg capsule	11/15/22	filled
amoxicillin 500 mg-potassium clavulanate 125 mg tablet	08/06/24	filled
atorvastatin 10 mg tablet	02/02/23	filled
benzonatate 100 mg capsule	03/06/23	filled
betamethasone acetate and sodium phos 6 mg/mL suspension for injection	04/19/24	filled
bumetanide 2 mg tablet	05/14/24	filled
carvediloL 3.125 mg tablet	02/28/24	filled
carvediloL 6.25 mg tablet	08/13/24	filled
cefdinir 300 mg capsule	02/17/23	filled
cephALEXin 500 mg capsule	08/08/24	filled
doxycycline hyclate 100 mg tablet	08/25/23	filled
fluticasone propionate 50 mcg/actuation nasal spray,suspension	08/13/24	filled
furosemide 20 mg tablet	04/29/24	filled
furosemide 40 mg tablet	07/15/24	filled
HYDROcodone 5 mg-acetaminophen 325 mg tablet	07/22/24	filled
levothyroxine 50 mcg tablet	08/13/24	filled
lisinopriL 5 mg tablet	10/20/23	filled
omeprazole 20 mg capsule,delayed release	11/18/21	filled
ondansetron HCL 4 mg tablet	08/08/24	filled
potassium chloride ER 10 mEq tablet,extended release	08/13/24	filled

Vaccines

None recorded.

Problems

Reviewed Problems

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

- Hypertensive disorder - Onset: 06/08/2022
- Heart disease - Onset: 06/08/2022

Family History

Family History not reviewed (last reviewed 08/22/2024)

Social History

Social History not reviewed (last reviewed 08/16/2024)

Advance Directive

Do you have an advance directive?: Yes

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine?: No

What was the date of your most recent tobacco screening?: 07/23/2024

Has tobacco cessation counseling been provided?: Yes

On what date was tobacco cessation counseling provided?: 07/23/2024

What is your level of alcohol consumption?: None

Do you use any illicit or recreational drugs?: No

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?: 0

What is your level of caffeine consumption?: Moderate

Diet and Exercise

What is your exercise level?: None

Activities of Daily Living

Are you able to care for yourself?: No

Are you able to walk?: Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility

Surgical History

Surgical History not reviewed (last reviewed 08/16/2024)

Past Medical History

Past Medical History not reviewed (last reviewed 08/16/2024)

HPI

Pleasant 93-year-old nondiabetic female presents today for 1 week follow-up post application of skin graft on her wound to her left leg. Patient has had area dressed and intact since home health changed it on Monday. Patient reports that they did not disturb the adapter gauze that has the skin graft under it. Denies much drainage from the area when home health changed. No other complaints at this time.

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, no exercise intolerance, no chills, and no malaise. She reports no dry eyes, no vision change, no irritation, and no eye disease/injury. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. She reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. She reports no fatigue. She reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**.

Neurological: Neurological Right: gross sensation intact, pin prick sensation normal, and no paresthesias. Neurological Left: gross sensation intact, pin prick sensation normal, and no paresthesias. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**. Joints, Bones, and Muscles Left: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**.

Class: Class B Right: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class C Right: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**. Class C Left: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.

Full-thickness ulceration noted to the left lower anterior shin measuring approximately 1 cm x 1 cm with subcutaneous tissue wound bed. Superior to wound on both corners is a dried up healed scar from previous stitches. Minimal surrounding erythema noted.

Left first and second digit abutment. Callus noted medial border left 2nd digit.

Hammertoe right third digit.

DP, PT palpable bilaterally

Procedure Documentation**DR 11042 - Debridement of Open Wound, Subcutaneous:**

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Assessment / Plan**1. Injury of left leg - Left -**

Additional diagnosis detail: Wound of left lower extremity, initial encounter
S81.802A: Unspecified open wound, left lower leg, initial encounter

2. Onychomycosis

B35.1: Tinea unguium

3. Peripheral vascular disease

I73.89: Other specified peripheral vascular diseases

4. Foot callus

L84: Corns and callosities

5. Walking disability

R26.2: Difficulty in walking, not elsewhere classified

6. Antalgic gait

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.

Discussed diagnosis, etiology, and treatment options with patient.

Wound was debrided and dressed today without skin graft to see if body can heal up rest on its own; interval improvement noted. Area covered with Adaptic gauze and In place with Steri-Strips. Area was then covered and dry gauze dressing with light Ace wrap compression. Verbal order was given to home health today to remove dressing down to Adaptic gauze but leave in place to cover skin graft. Home health then to redress area. They plan on doing this on Monday.

Patient is to avoid barefoot walking.

Recommend daily foot inspections.

Recommend stiff-soled shoes and supportive inserts to offload areas of prominence and decrease plantar pressure.

If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.

Patient to follow-up in approximately 1 weeks for continued care.

Return to Office

- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at TAZEWell on 09/11/2024 at 02:15 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton, PA-C, 09/05/2024.

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Encounter performed and documented by Kyler Dalton Vogel, PA-C

Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 09/05/2024 at 02:48 PM

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Encounter Date: 08/28/2024

Patient

Name	LYNCH, BOBBIE (93yo, F) ID# 4465	Appt. Date/Time	08/28/2024 01:15PM
DOB	05/30/1931	Service Dept.	TAZEWELL
Provider	KYLER DALTON, PA-C		
Insurance	Med Primary: MEDICARE-TN (MEDICARE) Insurance # : 7VK7G74MN66 Med Secondary: BCBS-TN - FEP (PPO) Insurance # : R13718898 Policy/Group # : 104 Prescription: check now		

Chief Complaint

painful toenails, Left Wound Care

Patient's Care Team

Primary Care Provider: JOHN M ROBERTSON MD: 209 IRISH CEMETARY RD, TAZEWELL, TN 37879, Ph (423) 869-3684, Fax (423) 869-5460 NPI: 1881858215

Patient's Pharmacies

FOOD CITY PHARMACY #428 (ERX): 110 NORTH 11TH STREET, MIDDLESBORO, KY 40965, Ph (606) 248-7689, Fax (606) 242-3079

Vitals

2024-08-28 13:24

Ht: 5 ft 1 in

Allergies

Allergies not reviewed (last reviewed 08/16/2024)

LEVAQUIN

SHELLFISH DERIVED

SULFA (SULFONAMIDE ANTIBIOTICS)

Medications

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Reviewed Medications

amoxicillin 500 mg capsule	11/15/22	filled
amoxicillin 500 mg-potassium clavulanate 125 mg tablet	08/06/24	filled
atorvastatin 10 mg tablet	02/02/23	filled
benzonatate 100 mg capsule	03/06/23	filled
betamethasone acetate and sodium phos 6 mg/mL suspension for injection	04/19/24	filled
bumetanide 2 mg tablet	05/14/24	filled
carvediloL 3.125 mg tablet	02/28/24	filled
carvediloL 6.25 mg tablet	08/13/24	filled
cefdinir 300 mg capsule	02/17/23	filled
cephALEXin 500 mg capsule	08/08/24	filled
doxycycline hyclate 100 mg tablet	08/25/23	filled
fluticasone propionate 50 mcg/actuation nasal spray,suspension	08/13/24	filled
furosemide 20 mg tablet	04/29/24	filled
furosemide 40 mg tablet	07/15/24	filled
HYDROcodone 5 mg-acetaminophen 325 mg tablet	07/22/24	filled
levothyroxine 50 mcg tablet	08/13/24	filled
lisinopriL 5 mg tablet	10/20/23	filled
omeprazole 20 mg capsule,delayed release	11/18/21	filled
ondansetron HCL 4 mg tablet	08/08/24	filled
potassium chloride ER 10 mEq tablet,extended release	08/13/24	filled

Vaccines

None recorded.

Problems

Problems not reviewed (last reviewed 08/22/2024)

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

- Hypertensive disorder - Onset: 06/08/2022
- Heart disease - Onset: 06/08/2022

Family History

Family History not reviewed (last reviewed 08/22/2024)

Social History

Social History not reviewed (last reviewed 08/16/2024)

Advance Directive

Do you have an advance directive?: Yes

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine?: No

What was the date of your most recent tobacco screening?: 07/23/2024

Has tobacco cessation counseling been provided?: Yes

On what date was tobacco cessation counseling provided?: 07/23/2024

What is your level of alcohol consumption?: None

Do you use any illicit or recreational drugs?: No

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?: 0

What is your level of caffeine consumption?: Moderate

Diet and Exercise

What is your exercise level?: None

Activities of Daily Living

Are you able to care for yourself?: No

Are you able to walk?: Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility

Surgical History

Surgical History not reviewed (last reviewed 08/16/2024)

Past Medical History

Past Medical History not reviewed (last reviewed 08/16/2024)

Screening

Name	Score	Notes
Falls Efficacy Scale	Not scored	

HPI

Pleasant 93-year-old nondiabetic female presents today for 1 week follow-up post application of skin graft on her wound to her left leg. Patient has had area dressed and intact since home health changed it on Monday. Patient reports that they did not disturb the adapter gauze that has the skin graft under it. Denies much drainage from the area when home health changed. No other complaints at this time.

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, no exercise intolerance, no chills, and no malaise. She reports no dry eyes, no vision change, no irritation, and no eye disease/injury. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. She reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. She reports no fatigue. She reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam**Constitutional:** General Appearance: well-developed. Level of Distress: NAD.**Cardiovascular:** Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.**Integumentary:** Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**.

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Neurological: Neurological Right: gross sensation intact, pin prick sensation normal, and no paresthesias. Neurological Left: gross sensation intact, pin prick sensation normal, and no paresthesias. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**. Joints, Bones, and Muscles Left: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**.

Class: Class B Right: **skin texture shiny and thin; dorsalis pedis pulse diminished posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny and thin; dorsalis pedis pulse diminished posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class C Right: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**. Class C Left: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.

Full-thickness ulceration noted to the left lower anterior shin measuring approximately 2 cm x 2 cm with subcutaneous tissue wound bed. Superior to wound on both corners is a dried up healed scar from previous stitches. Minimal surrounding erythema noted.

Left first and second digit abutment. Callus noted medial border left 2nd digit.

Hammertoe right third digit.

DP, PT palpable bilaterally

Procedure Documentation**Skin Graft-Amnio Tri-Core Amniotic:**

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.

Skin Substitute: Amnio Tri-core

Size-- 2 cm x 2 cm

Product ID-- AMT-5220

Lot Number-- SB24-2317AT-00216110

Expiration Date-- 2027-07-29

Application number-- 3

Zero graft wastage.

Assessment / Plan**1. Injury of left leg - Left -**

Additional diagnosis detail: Wound of left lower extremity, initial encounter

S81.802A: Unspecified open wound, left lower leg, initial encounter

2. Onychomycosis

B35.1: Tinea unguium

3. Peripheral vascular disease

I73.89: Other specified peripheral vascular diseases

4. Foot callus

L84: Corns and callosities

5. Walking disability

R26.2: Difficulty in walking, not elsewhere classified

6. Antalgic gait

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.

Discussed diagnosis, etiology, and treatment options with patient.

Wound was debrided and dressed with skin graft today; interval improvement noted. Skin graft was then covered with Adaptic gauze and in place with Steri-Strips. Area was then covered and dry gauze dressing with light Ace wrap compression. Verbal order was given to home health today to remove dressing down to Adaptic gauze but leave in place to cover skin graft. Home health then to redress area. They plan on doing this on Monday.

Patient is to avoid barefoot walking.

Recommend daily foot inspections.

Recommend stiff-soled shoes and supportive inserts to offload areas of prominence and decrease plantar pressure.

If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

for urgent evaluation.

Patient to follow-up in approximately 1 weeks for continued care.

Return to Office

- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 09/05/2024 at 01:45 PM
- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at TAZEWEEL on 09/11/2024 at 02:15 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton, PA-C, 08/28/2024.

Encounter performed and documented by Kyler Dalton Vogel, PA-C

Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 08/28/2024 at 03:59 PM

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)**Encounter Date: 08/22/2024****Patient**

Name	LYNCH, BOBBIE (93yo, F) ID# 4465	Appt. Date/Time	08/22/2024 10:15AM
DOB	05/30/1931	Service Dept.	HARROGATE
Provider	KYLER DALTON, PA-C		
Insurance	Med Primary: MEDICARE-TN (MEDICARE) Insurance # : 7VK7G74MN66 Med Secondary: BCBS-TN - FEP (PPO) Insurance # : R13718898 Policy/Group # : 104 Prescription: check now		

Chief Complaint

Left Wound Care, painful toenails

Patient's Care Team**Primary Care Provider:** JOHN M ROBERTSON MD: 209 IRISH CEMETARY RD, TAZEWELL, TN 37879, Ph (423) 869-3684, Fax (423) 869-5460 NPI: 1881858215**Patient's Pharmacies****FOOD CITY PHARMACY #428 (ERX): 110 NORTH 11TH STREET, MIDDLESBORO, KY 40965, Ph (606) 248-7689, Fax (606) 242-3079****Vitals**

None recorded.

Allergies

Allergies not reviewed (last reviewed 08/16/2024)

LEVAQUIN**SHELLFISH DERIVED****SULFA (SULFONAMIDE ANTIBIOTICS)****Medications**

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Reviewed Medications

amoxicillin 500 mg capsule	11/15/22	filled
amoxicillin 500 mg-potassium clavulanate 125 mg tablet	08/06/24	filled
atorvastatin 10 mg tablet	02/02/23	filled
benzonatate 100 mg capsule	03/06/23	filled
betamethasone acetate and sodium phos 6 mg/mL suspension for injection	04/19/24	filled
bumetanide 2 mg tablet	05/14/24	filled
carvediloL 3.125 mg tablet	02/28/24	filled
carvediloL 6.25 mg tablet	08/13/24	filled
cefdinir 300 mg capsule	02/17/23	filled
cephALEXin 500 mg capsule	08/08/24	filled
doxycycline hyclate 100 mg tablet	08/25/23	filled
fluticasone propionate 50 mcg/actuation nasal spray,suspension	08/13/24	filled
furosemide 20 mg tablet	04/29/24	filled
furosemide 40 mg tablet	07/15/24	filled
HYDROcodone 5 mg-acetaminophen 325 mg tablet	07/22/24	filled
levothyroxine 50 mcg tablet	08/13/24	filled
lisinopriL 5 mg tablet	10/20/23	filled
omeprazole 20 mg capsule,delayed release	11/18/21	filled
ondansetron HCL 4 mg tablet	08/08/24	filled
potassium chloride ER 10 mEq tablet,extended release	08/13/24	filled

Vaccines

None recorded.

Problems

Reviewed Problems

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

- Hypertensive disorder - Onset: 06/08/2022
- Heart disease - Onset: 06/08/2022

Family History

Reviewed Family History

Social History

Social History not reviewed (last reviewed 08/16/2024)

Advance Directive

Do you have an advance directive?: Yes

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine?: No

What was the date of your most recent tobacco screening?: 07/23/2024

Has tobacco cessation counseling been provided?: Yes

On what date was tobacco cessation counseling provided?: 07/23/2024

What is your level of alcohol consumption?: None

Do you use any illicit or recreational drugs?: No

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?: 0

What is your level of caffeine consumption?: Moderate

Diet and Exercise

What is your exercise level?: None

Activities of Daily Living

Are you able to care for yourself?: No

Are you able to walk?: Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility

Surgical History

Surgical History not reviewed (last reviewed 08/16/2024)

Past Medical History

Past Medical History not reviewed (last reviewed 08/16/2024)

HPI

Pleasant 93-year-old nondiabetic female presents today for application of skin graft. Patient has had a area dressed and intact since last visit. No changes. No other complaints at this time.

Pleasant 93-year-old nondiabetic female presents today for 1 week follow-up post application of skin graft on her wound to her left leg. Patient has had area dressed and intact since home health changed it on Monday. Patient reports that they did not disturb the adapter gauze that has the skin graft under it. Denies much drainage from the area when home health changed. No other complaints at this time.

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, no exercise intolerance, no chills, and no malaise. She reports no dry eyes, no vision change, no irritation, and no eye disease/injury. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. She reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. She reports no fatigue. She reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam**Constitutional:** General Appearance: well-developed. Level of Distress: NAD.**Cardiovascular:** Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.**Integumentary:** Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**.**Neurological:** Neurological Right: gross sensation intact, pin prick sensation normal, and no paresthesias. Neurological Left: gross sensation intact, pin prick sensation normal, and no paresthesias. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

(movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**. Joints, Bones, and Muscles Left: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**.

Class: Class B Right: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class C Right: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**. Class C Left: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.

Full-thickness ulceration noted to the left lower anterior shin measuring approximately 2 cm x 3 cm and 0.5cm x 0.5cm with subcutaneous tissue wound bed. Wound is of irregular shape. Superior to wound on both corners is a dried up healed scar from previous stitches. Minimal surrounding erythema noted.

Left first and second digit abutment. Callus noted medial border left 2nd digit.

Hammertoe right third digit.

DP, PT palpable bilaterally

Procedure Documentation**Skin Graft-Amnio Tri-Core Amniotic:**

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.

Skin Substitute: Amnio Tri-core

Size-- 2 cm x 4 cm

Product ID-- AMT-5240

Lot Number-- SB24-0354AT-00182830

Expiration Date-- 2027-02-15

Application number-- 2

Zero graft wastage.

Assessment / Plan**1. Injury of left leg - Left -**

Additional diagnosis detail: Wound of left lower extremity, initial encounter

S81.802A: Unspecified open wound, left lower leg, initial encounter

2. Onychomycosis

B35.1: Tinea unguium

3. Peripheral vascular disease

I73.89: Other specified peripheral vascular diseases

4. Foot callus

L84: Corns and callosities

5. Walking disability

R26.2: Difficulty in walking, not elsewhere classified

6. Antalgic gait

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.

Discussed diagnosis, etiology, and treatment options with patient.

Wound was dressed with skin graft today. Skin graft was then covered with Adaptic gauze and In place with Steri-Strips. Area was then covered and dry gauze dressing with light Ace wrap compression. Verbal order was given to home health today to remove dressing down to Adaptic gauze but leave in place to cover skin graft. Home health then to redress area. They plan on doing this on Monday.

Patient is to avoid barefoot walking.

Recommend daily foot inspections.

Recommend stiff-soled shoes and supportive inserts to offload areas of prominence and decrease plantar pressure.

If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.

Patient to follow-up in approximately 1 weeks for continued care.

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Return to Office

- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at TAZEWELL on 08/28/2024 at 01:15 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton, PA-C, 08/22/2024.

Encounter performed and documented by Kyler Dalton Vogel, PA-C

Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 08/22/2024 at 12:04 PM

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Encounter Date: 08/16/2024

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

(Last amended by Kyler Dalton Vogel, PA-C on 08/22/2024 at 11:00am)

Patient			
Name	LYNCH, BOBBIE (93yo, F) ID# 4465	Appt. Date/Time	08/16/2024 11:30AM
DOB	05/30/1931	Service Dept.	TAZEWELL
Provider	KYLER DALTON, PA-C		
Insurance	Med Primary: MEDICARE-TN (MEDICARE) Insurance # : 7VK7G74MN66 Med Secondary: BCBS-TN - FEP (PPO) Insurance # : R13718898 Policy/Group # : 104 Prescription: CVS CAREMARK - Member is eligible. details		

Chief Complaint

painful toenails, Left Wound Care

Patient's Care Team

Primary Care Provider: JOHN M ROBERTSON MD: 209 IRISH CEMETARY RD, TAZEWELL, TN 37879, Ph (423) 869-3684, Fax (423) 869-5460 NPI: 1881858215

Patient's Pharmacies

FOOD CITY PHARMACY #428 (ERX): 110 NORTH 11TH STREET, MIDDLESBORO, KY 40965, Ph (606) 248-7689, Fax (606) 242-3079

Vitals

2024-08-16 11:45

Ht: 5 ft 1 in

Allergies

Reviewed Allergies

LEVAQUIN

SHELLFISH DERIVED

SULFA (SULFONAMIDE ANTIBIOTICS)

Medications

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Reviewed Medications

amoxicillin 500 mg capsule	11/15/22	filled
amoxicillin 500 mg-potassium clavulanate 125 mg tablet	08/06/24	filled
atorvastatin 10 mg tablet	02/02/23	filled
benzonatate 100 mg capsule	03/06/23	filled
betamethasone acetate and sodium phos 6 mg/mL suspension for injection	04/19/24	filled
bumetanide 2 mg tablet	05/14/24	filled
carvediloL 3.125 mg tablet	02/28/24	filled
carvediloL 6.25 mg tablet	08/13/24	filled
cefdinir 300 mg capsule	02/17/23	filled
cephALEXin 500 mg capsule	08/08/24	filled
doxycycline hyclate 100 mg tablet	08/25/23	filled
fluticasone propionate 50 mcg/actuation nasal spray,suspension	08/13/24	filled
furosemide 20 mg tablet	04/29/24	filled
furosemide 40 mg tablet	07/15/24	filled
HYDROcodone 5 mg-acetaminophen 325 mg tablet	07/22/24	filled
levothyroxine 50 mcg tablet	08/13/24	filled
lisinopriL 5 mg tablet	10/20/23	filled
omeprazole 20 mg capsule,delayed release	11/18/21	filled
ondansetron HCL 4 mg tablet	08/08/24	filled
potassium chloride ER 10 mEq tablet,extended release	08/13/24	filled

Vaccines

None recorded.

Problems

Reviewed Problems

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

- Hypertensive disorder - Onset: 06/08/2022
- Heart disease - Onset: 06/08/2022

Family History

Reviewed Family History

Social History

Reviewed Social History

Advance Directive

Do you have an advance directive?: Yes

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine?: No

What was the date of your most recent tobacco screening?: 07/23/2024

Has tobacco cessation counseling been provided?: Yes

On what date was tobacco cessation counseling provided?: 07/23/2024

What is your level of alcohol consumption?: None

Do you use any illicit or recreational drugs?: No

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?: 0

What is your level of caffeine consumption?: Moderate

Diet and Exercise

What is your exercise level?: None

Activities of Daily Living

Are you able to care for yourself?: No

Are you able to walk?: Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility

Surgical History

Reviewed Surgical History

Past Medical History

Reviewed Past Medical History

HPI

Pleasant 93-year-old nondiabetic female presents today for 2 week follow-up on wound to her anterior left lower leg. Patient reports that home health has been dressing the area with dry gauze, Kling, Ace bandage. She reports the area does not cause her any pain. She believes that the area has improved since last visit. She is currently still wheelchair-bound for most of the day. No other complaints at this time.

Pleasant 93-year-old nondiabetic female presents today for application of skin graft. Patient has had a area dressed and intact since last visit. No changes. No other complaints at this time.

ROS

Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, no exercise intolerance, no chills, and no malaise. She reports no dry eyes, no vision change, no irritation, and no eye disease/injury. She reports no difficulty hearing and no ear pain. She reports no frequent nosebleeds, no nose problems, and no sinus problems. She reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. She reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. She reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. She reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. She reports no incontinence, no difficulty urinating, no hematuria, and no increased frequency. She reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. She reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. She reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. She reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. She reports no fatigue. She reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. She reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam**Constitutional:** General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules and skin temperature normal and **dry**.

Neurological: Neurological Right: gross sensation intact, pin prick sensation normal, and no paresthesias. Neurological Left: gross sensation intact, pin prick sensation normal, and no paresthesias. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

(movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**. Joints, Bones, and Muscles Left: no malalignment or bony abnormalities and **contractures, limited ROM, and pain to palpation**.

Class: Class B Right: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny and thin; dorsalis pedis pulse diminished, posterior tibial pulse diminished, advanced trophic changes, hair growth decrease, nail changes, and pigmentary changes**; and skin color normal and no redness. Class C Right: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**. Class C Left: no burning, paresthesias, claudication, cold foot, or temperature changes and **edema**.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.

Full-thickness ulceration noted to the left lower anterior shin measuring approximately 4 cm x 3 cm with subcutaneous tissue wound bed. Wound is of irregular shape. Superior to wound on both corners is a dried up healed scar from previous stitches. Minimal surrounding erythema noted.

Left first and second digit abutment. Callus noted medial border left 2nd digit.

Hammertoe right third digit.

DP, PT palpable bilaterally

Procedure Documentation**Skin Graft-Amnio Tri-Core Amniotic:**

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.

Skin Substitute: Amnio Tri-core

Size-- 2 cm x 4 cm

Product ID-- AMT-5240

Lot Number-- SB24-0358AT-00182958

Expiration Date-- 2027-02-15

Application number-- 1

Zero graft wastage.

Assessment / Plan**1. Injury of left leg - Left -**

Additional diagnosis detail: Wound of left lower extremity, initial encounter

S81.802A: Unspecified open wound, left lower leg, initial encounter

2. Onychomycosis

B35.1: Tinea unguium

3. Peripheral vascular disease

I73.89: Other specified peripheral vascular diseases

4. Foot callus

L84: Corns and callosities

5. Walking disability

R26.2: Difficulty in walking, not elsewhere classified

6. Antalgic gait

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.

Discussed diagnosis, etiology, and treatment options with patient.

Wound was dressed with skin graft today. Skin graft was then covered with Adaptic gauze and In place with Steri-Strips. Area was then covered and dry gauze dressing with light Ace wrap compression. Verbal order was given to home health today to remove dressing down to Adaptic gauze but leave in place to cover skin graft. Home health then to redress area. They plan on doing this on Monday or Tuesday of next week.

Patient is to avoid barefoot walking.

Recommend daily foot inspections.

Recommend stiff-soled shoes and supportive inserts to offload areas of prominence and decrease plantar pressure.

If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.

Patient to follow-up in approximately 1 weeks for continued care.

LYNCH, Bobbie A (id #4465, dob: 05/30/1931)

Return to Office

- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 08/22/2024 at 10:15 AM
- Kyler Dalton, PA-C for ESTABLISHED PATIENT 15 at TAZEWEEL on 08/28/2024 at 01:15 PM

Amendment Sign-Off

Encounter signed-off by Kyler Dalton, PA-C, 08/22/2024.

Encounter performed and documented by Kyler Dalton Vogel, PA-C

Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 08/16/2024 at 12:44 PM

Amendment closed by Kyler Dalton Vogel, PA-C on 08/22/2024 at 11:00 AM