

Matrix Document Imaging, Inc.

The California Attorney Support Team

www.legal-records.com

Applicant: Julien Olivier

Defendant: County of Los Angeles

Requestor: Straussner & Sherman

Case Number: ADJ14026805

Date of Injury: CT:11/07/1990-12/15/2020

Location Copied : Facey Medical Group
11165 Sepulveda Boulevard
Mission Hills , CA 91345

Records Delivered To: Straussner & Sherman
14555 Sylvan Street
Van Nuys, CA 91411
Attn: Della Garcia

Records Requested: Medical Records

Phone: (626) 966-9959

Fax: (626) 966-9975

527 East Rowland Street, Suite 214, Covina, CA 91723



70847-2

Matrix Document Imaging, Inc.

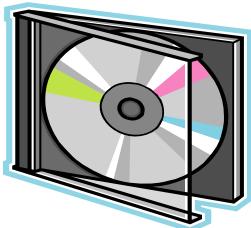
Phone: (800) 737-8840 Fax: (626) 966-9975
527 E. Rowland Street. Suite #215., Covina CA 91723

Records Review (List of injuries, diseases and symptoms) **HIPPA COMPLIANT**

The following Records Review has been prepared by **Matrix Document Imaging, Inc.** This review is not part of the records that were produced by the medical facility. It is limited to injuries, diseases and symptoms that may be in the produced records.

This review is designed and used to identify **apportionment issues** and also to **alleviate** or **terminate** the review charges incurred by treating and reviewing doctors.

All records ordered through **Matrix Document Imaging, Inc.** also include a CD-ROM with the records in **searchable** (OCR) PDF format.



DISCLAIMER: *Matrix Document Imaging Inc.* assumes no responsibility for any omissions, inclusions, misinterpretation or any other errors, either intentional or unintentional, in the attached Records Review. *Matrix Document Imaging, Inc.* is not responsible for the accuracy or completeness of the attached records **review**. This review should not be relied upon for any medical or legal conclusion or opinion. The actual records should be used for all purposes.

Medical Record Review

Name : **Julien Olivier**
 Employer : County of Los Angeles
 WCAB/ADJ # : ADJ14026805
 Copy Location : Facey Medical Group
 : 11165 Sepulveda Boulevard Mission Hills, CA 91345
 Date of Injury : CT: 11/07/1990-12/15/2020

Date of Report	Medical Record Review
01/08/2001 <u>Page 0008</u>	BILATERAL FOOT SERIES -Facey Medical Group -Gregory Paranay, MD CONCLUSION: Mild spurring with no acute bony changes.
06/10/2006 <u>Page 0023</u>	PROGRESS NOTES -Facey Medical Group -Khoa Nguyen, MD HISTORY OF PRESENT ILLNESS: A 38-year-old male came in with bilateral heel pain off and on for three years. The patient has pain more in the left heel now for last several months. He has diagnosis of plantar fasciitis in the past and was given medication for that. IMPRESSION: Plantar fasciitis.
07/30/2006 <u>Page 0024</u>	PROGRESS NOTES -Facey Medical Group -Khoa Nguyen, MD CHIEF COMPLAINT: Bee sting, swollen and itching. IMPRESSION: Insect bite.
08/07/2006 <u>Page 0025</u>	PROGRESS NOTES -Facey Medical Group -Joung H. Lee, DPM SUBJECTIVE: A 39-year-old male presented to clinic complaining of left heel pain for three to four years. Patient reported that this is on and off depending whether he jogs or not. Reported that the right heel on occasion hurts also. IMPRESSION: 1. Plantar fasciitis.

	2. Pain.
08/07/2006 <u>Page 0018</u>	BILATERAL WEIGHT BEARING FOOT SERIES -Facey Medical Group -Gregory Paranay, MD CONCLUSION: 1. Bilateral pes planus. 2. Calcaneal spurring. 3. No acute bony changes.
06/01/2007 <u>Page 0027</u>	PROGRESS NOTES -Facey Medical Group -Khoa Nguyen, MD HISTORY: A 39 years old male presented complaining of recurrent left knee pain for 3 months. Patient noted he rested for two weeks and the pain went away. He however started running again the last two days and noted pain again on the lateral aspect of the left knee. He runs 3 to 4 miles a day as an instructor for new recruits for the LAPD. ASSESSMENT: Left knee pain secondary to running overuse.
06/01/2007 <u>Page 0016</u> <u>Page 0017</u>	LEFT KNEE, 3 VIEWS -Facey Medical Group -Henry Shih, MD IMPRESSION: No fracture. Small joint effusion.
11/27/2007 <u>Page 0028</u>	PROGRESS NOTES -Facey Medical Group -Khoa Nguyen, MD SUBJECTIVE: Patient was a 40 year old male presented complaining of something moving in his left ear. ASSESSMENT: Cerumen impaction.
10/10/2008 <u>Page 0029</u>	PROGRESS NOTES -Facey Medical Group -Atul Sharma, MD CHIEF COMPLAINT: A 41 year old came in after straining his left third finger two weeks ago. IMPRESSION: Resolving strain.

01/02/2010 <u>Page 0030</u>	<p>PROGRESS NOTES -Facey Medical Group -Chris Aghayan, MD</p> <p>HISTORY: Patient developed a pruritic rash on the right wrist one week ago after scratching it and touching his forehead that has a similar rash on the forehead and very pruritic.</p> <p>IMPRESSION: Contact dermatitis.</p>
01/04/2010 <u>Page 0051</u>	<p>PROGRESS NOTES -Facey Medical Group -Zinat Choudhury, MD</p> <p>CHIEF COMPLAINT: Rash on the right hand.</p> <p>DIAGNOSIS: Rash.</p>
10/13/2010 <u>Page 0031</u>	<p>PROGRESS NOTES -Facey Medical Group -Lucy Lo, MD</p> <p>HISTORY: Patient wasa a 43 year old male who complained of a dog bite to his right hand.</p> <p>IMPRESSION: Dog bite, right.</p>
04/22/2011 <u>Page 0032</u>	<p>PROGRESS NOTES -Facey Medical Group -Kevin L. Vuong, MD</p> <p>CHIEF COMPLAINT: Left eye foreign body sensation.</p> <p>IMPRESSION: Foreign body exposure, secondary conjunctivitis.</p>
05/10/2013 <u>Page 0033-0034</u>	<p>PROGRESS NOTES -Facey Medical Group -Riga Pemba, MD</p> <p>CHIEF COMPLAINT: Patient complaint of dizziness.</p> <p>ASSESSMENT: Dizziness.</p>
05/20/2013 <u>Page 0035-0036</u>	<p>PROGRESS NOTES -Facey Medical Group -David Shaw, MD</p> <p>CHIEF COMPLAINT: Patient presented with complaint of equilibrium was off x2 weeks.</p> <p>ASSESSMENT: Vertigo.</p>

08/18/2016 <u>Page 0037</u>	PROGRESS NOTES -Facey Medical Group -Atul Sharma, MD CHIEF COMPLAINT: Patient presented with complaint of rash. IMPRESSION: Cellulitis.
08/22/2016 <u>Page 0038-0039</u>	PROGRESS NOTES -Facey Medical Group -Zinat Choudhury, MD CHIEF COMPLAINT: Patient presented with complaint of rash. IMPRESSION: Herpes labialis.
11/22/2016 <u>Page 0040-0041</u>	PROGRESS NOTES -Facey Medical Group -David Shaw, MD CHIEF COMPLAINT: Patient presented with complaint of left ear plugged up. ASSESSMENT: Impacted cerumen of left ear.
08/19/2018 <u>Page 0042-0047</u>	HISTORY AND PHYSICAL EXAM -Facey Medical Foundation Valencia -Belinda Gay Rouse, NP CHIEF COMPLAINT: Patient was a 51 year old male presented for annual physical. ASSESSMENT: Encounter for screening and preventive care.
10/01/2020 <u>Page 0048-0050</u>	TELEPHONE/TELEHEALTH PROGRESS NOTE -Facey Medical Foundation Valencia -Hurig Katchikian, MD HISTORY: Patient was a 53 year old male who presented with a rash. ASSESSMENT: Facial rash.
01/05/2021 <u>Page 0052-0056</u>	PROVIDER NOTES -Facey Medical Foundation Valencia -Khoa Dang Nguyen, MD CHIEF COMPLAINT: Patient had concerns including follow up medical problem (shortness of breath, pneumonia, treating with steriods and antibiotics - reported he lost his inhaler (Covid + 29th)).

	<p>ASSESSMENT:</p> <ol style="list-style-type: none"> 1. Shortness of breath. 2. Lower respiratory tract infection due to COVID-19 virus. 3. Pneumonia due to COVID-19 virus.
01/05/2021 <u>Page 0014</u>	<p>X-RAY CHEST PA AND LATERAL -Facey Medical Group -Gregory Paranay, MD IMPRESSION: Patchy left lower lobe infiltrates with intermediate suspicion pattern for COVID-19 pneumonia.</p>
Various Date <u>Page 0057-0064</u>	<p>LABORATORY REPORT -Facey Medical Group Reviewed.</p>



www.Legal-Records.com

527 E. Rowland St., Ste. 215

Covina, CA 91723

Tel: 800-737-8840 / Fax: 800-975-1653

Start of Records

**State of California
Department of Industrial Relations
Division of Industrial Accidents
WORKERS COMPENSATION APPEALS BOARD**

Julien Olivier	Claimant / Applicant
DOB: 06/27/1967 SSN: 566-75-4657 DOI: CT:11/07/1990-12/15/2020	If application has been filed, Case Number must be indicated regardless of date of injury.
Vs	
County of Los Angeles	SUBPOENA DUCES TECUM
Employer / Insurance Carrier / Defendant	For non-party Deponents: Deposition Subpoena under LC §5710 & CCP §2020.010 For party Deponents: Notice of Deposition under LC §5710 & CCP §2025.010

See instructions below *

People of the State of California Send Greetings to:

Facey Medical Group , 11165 Sepulveda Boulevard , Mission Hills , CA ., 91345

WE COMMAND YOU to appear before: MATRIX Document Imaging Services. (626) 966-9959

At: 527 East Rowland Street, Suite 214, Covina, CA 91723

On: March, 26, 2021, at 10:00 AM to testify in the above entitled matter and to bring with you and produce the following described documents, papers, books and records:

Any and all outpatient medical records, medical files , charts , reports, notes, writings, diagrams, forms, printouts, test results, lab results, for all dates of injuries, types of injuries, treatment or illness whether industrial or nonindustrial. Including but not limited to notes from all sources, including medical facilities and doctors, insurance companies, employers, investigators and attorneys. Specifically to include the aforementioned records from Hurig Katvhikian, M.D. located at 26357 McBean Parkway, Valencia, CA 91355.

Records on: Julien Olivier

AKA:

D.O.B.: 06/27/1967 SSN#: 566-75-4657 D.O.I.: CT:11/07/1990-12/15/2020

(Do not produce X-rays unless specifically mentioned above)

This Board-approved Subpoena Duces Tecum form shall serve as a Deposition Subpoena under LC §5710 and CCP §2020.010 to set the records-only, non-appearance copy service deposition for any non-party deponent. It shall serve as a written Notice of Deposition under LC §5710 and CCP §2025.010 to set the non-appearance copy service deposition for any Deponent who is a party to the case.

For Failure to attend and to produce said documents you may be deemed guilty of contempt and liable to pay the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto. This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

DO NOT COPY THE ORIGINAL RECORDS OR REFER THIS MATTER TO A RELEASE OF INFORMATION COMPANY

Date Issued: 03/11/2021

Date Due: 03/26/2021

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary, Assistant Secretary, Workers' Compensation Judge

* For injuries occurring on or after January 1, 1990
and before January 1, 1994:

If no application for Adjudication of Claim has been filed, a declaration under penalty of perjury that Employee's™ Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

See reverse side (Page 2 of 2)
Subpoena Invalid without declaration

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within (10) days of the date of service of this subpoena. Evid. Code 1158 clearly states the legal amount that is to be charged in accordance of obtaining medical records.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or City Police Department unless accompanied by notice from the Board that deposit of the witness fee has been made in accordance with Goverment Code 68097.2, et seq.

DIA WCAB FORM 32 (Side 1) (REV. 06/94)

HIPAA Compliant Request

Do not appear! Simply call (626) 966-9959 and somebody will copy the records for you at your office.

Order #: 70847-2

DECLARATION FOR SUBPOENA DUCES TECUM

Case No:
ADJ14026805

State of California, County of: Los Angeles

The undersigned states: Matrix Document Imaging is the authorized Deposition Officer to obtain records by Straussner & Sherman

That he/she is (one of) the attorney (s) of record/representative (s) for the Applicant/Defendant in the action captioned on the reverse hereof.

That the subpoenaed custodian of record has in his/her possession or under his/her control the documents described on the reverse side hereof. That the said documents are material to the issues involved in the case and may contain information that is not available from any other known source.

Said records are relevant to the allegations and defenses by the parties in the prosecution of this matter, to provide an accurate medical history of the applicant, to prove an injury and notice thereof, to provide the right to compensation, permanent and temporary disability, medical treatment, and any possible penalties. Pursuant to Labor Code section 5401 form DWC 1 has been duly filed.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured workers whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (*Check box if applicable and part of declaration below. See instructions on page one of the subpoena.*)

I declare under penalty of perjury that the foregoing is true and correct.

Executed on **03/11/2021**, at Covina, Los Angeles, California

14555 Sylvan Street Van Nuys , CA 91411

Address

S> Julie Locks Sherman, Esq.

818-788-1700

Signature on file

Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Los Angeles :

I, the undersigned, state that: I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of person served:
Medical Records

Date of Service:
03/11/2021

Place of Service:
Facey Medical Group
11165 Sepulveda Boulevard
Mission Hills, CA 91345
818-837-5660

I declare under penalty of perjury that the foregoing is true and correct.
Executed on 03/11/2021, at Covina, California

S>
Signature

Order No.: 70847-2

Attachment 'A' Records Requested

Any and all outpatient medical records, medical files , charts , reports, notes, writings, diagrams, forms, printouts, test results, lab results, for all dates of injuries, types of injuries, treatment or illness whether industrial or nonindustrial. Including but not limited to notes from all sources, including medical facilities and doctors, insurance companies, employers, investigators and attorneys. Specifically to include the aforementioned records from Hurig Katvhikian, M.D. located at 26357 McBean Parkway, Valencia, CA 91355.

Date(s) of Injury: CT:11/07/1990-12/15/2020

Claim #:

Case Number(s): ADJ14026805

Pertaining To: Julien Olivier

Date of Birth: 06/27/1967 SSN: 566-75-4657

DECLARATION OF CUSTODIAN OF RECORD

Regarding: Julien Olivier

Birth Date: 06/27/1967 **Ref No:**

70847-2

Soc Sec: 566-75-4657

Injury Date: CT:11/07/1990-12/15/2020

I am duly authorized as Custodian of Records (or other qualified witness) with authority to certify for:

Facey Medical Group

11165 Sepulveda Boulevard , Mission Hills , CA 91345 ph: 818-837-5660

CERTIFICATION OF RECORD COPIES

(Custodian Initials: _____)

Including this declaration, all documents, records and other things called for in the Subpoena Duces Tecum or Authorized which are in my custody have been photocopied (_____ on microfilm) at my office, in my presence, under my direction and control; and the submitted with declaration is a true copy thereof.

To the best of knowledge all record referred to above were prepared or complied by the personnel of the above named business, in ordinary course of business, at or near the time of the acts, conditions, or events recorded. No documents, records or other things have been withheld to prevent being photocopied.

Certain records were omitted because: _____

CERTIFIED OF NO RECORD COPIES (Custodian's Initials: _____)

At through search of the business revealed no records described in the attached subpoena or authorized for the following Reason (s):

- | | |
|---|---|
| Medical/Billing/X-Ray Records
<input type="checkbox"/> Patient never treated at this facility
<input type="checkbox"/> Records destroyed after <u>5</u> <u>7</u> <u>9</u> years.
<input type="checkbox"/> Records were lost / misplaced
<input type="checkbox"/> Loc.searched by Name, DOB & SSN
<input type="checkbox"/> Records destroyed due to <u>Fire</u> <u>Water</u> <u>Theft</u>
<input type="checkbox"/> Patient has his / her records
<input type="checkbox"/> X-rays are <u>nonexistent</u> <u>at another facility</u> :
Name: _____ <input type="checkbox"/> Other
Phone: (_____) _____
<input type="checkbox"/> Billing is <u>lost/misplaced</u> <u>Not kept because of prepaid Health Plan</u> _____ at another facility:
Name: _____
Contact: _____ Phone: (_____) _____
<input type="checkbox"/> Other _____
<input type="checkbox"/> No records for date(s) specified | Personnel/Wage/Non-Medical Records
<input type="checkbox"/> Never Worked for this Company
<input type="checkbox"/> Records destroyed after <u>5</u> <u>7</u> <u>9</u> years
<input type="checkbox"/> Previous owner kept original files
<input type="checkbox"/> Records kept at: _____
<input type="checkbox"/> Records were lost / misplaced _____
<input type="checkbox"/> Records requested do not exist |
|---|---|

This certification is limited to the information in the attached document. Records may exist under another name, spelling or other identifying data.

I DECLARE under penalty of perjury that the foregoing is true and correct.

Executed on _____ at _____
(Date) _____ (City) _____ (State) _____

Declarant _____ Print Name _____

Witness _____ Print Name _____

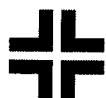
CERTIFICATION OF PROFESSIONAL PHOTOCOPIER

I, the undersigned, declare:

The attached copy of records were transmitted or distributed to the authorized persons or entities.

I declare under penalty of perjury that the forgoing is true and correct.

Executed on April 21 at Los Angeles
(Date) _____ (City) _____ (State) _____
Print Name Jeanne Vidaurri Signature Jeanne Vidaurri



Burbank
191 S Buena Vista St #100
Burbank, CA 91505
(818) 869-7600

■
Canyon Country
17909 W Soledad Cyn Rd
Canyon Country, CA 91387
(661) 250-5200

■
Copper Hill
27924 Seco Canyon Rd
Santa Clarita, CA 91350
(661) 513-2100

■
Mission Hills
11333 N Sepulveda Blvd
Mission Hills, CA 91345
(818) 365-9531

Patient Education
11165 Sepulveda Blvd
Mission Hills, CA 91345
(818) 837-5779

■
Northridge
18460 Roscoe Blvd
Northridge, CA 91325
(818) 734-3600

■
Porter Ranch Plaza
19950 Rinaldi St.
Porter Ranch, CA 91326
(818) 403-2400

■
Simi Valley
2655 First St
Simi Valley, CA 93065
(805) 206-2000

■
Tarzana Ob-Gyn
18411 Clark St #102
Tarzana, CA 91356
(818) 721-2300

■
Tarzana Pediatrics
5525 Etiwanda Ave #212
Tarzana, CA 91356
(818) 721-2400

■
Valencia I
26357 McBean Pkwy
Valencia, CA 91355
(661) 222-2600

■
**Valencia Specialty &
Women's Health**
23803 McBean Pkwy
Valencia, CA 91355
(661) 481-2400

EMRN: 20010147509

Declaration

Patient: Olivier, Julien

DOB: 6/27/1967

REF#: 70847-2

I, Connie Christensen, hereby declare: That I am the duty authorized custodian of medical records of Facey Medical Foundation and have authorization to certify the records. That the copy of the records herein is a true copy of the records described in the subpoena. That these records were prepared by the Personnel of our offices in the ordinary course of business at or near the time of the occurrences contained therein.

I declare under penalty of perjury that the foregoing is true and correct.

Executed at: Mission Hills, Ca.

This: Tuesday March 23, 2021.

Any and All medical records on file were given.

No billing information included.

Please Note: Some of the scanned images are from poor originals. The copies contained within are the best available.

Signature – Custodian of Records

Print Name- Custodian of Records

Initials: A. Zetina

Processed by Sharecare Health Data Services

**FACEY MEDICAL GROUP
URGENT CARE CENTERS**

MISSION HILLS: 11211 Sepulveda Blvd., Mission Hills, CA 91345 • (818) 365-9531
VALENCIA: 26357 McBean Parkway, Santa Clarita, CA 91355 • (661) 222-2600

Time: 0834 Nurse's Signature: Eherrera, M PCP: M. Larson
Complaint: I do feel something in it now

Allergies:	Current Medications		
<u>Nikot</u>			
Medical Problems			
<u>None</u>			
BP: <u>124/67</u>	P: <u>60</u>	RR: <u>16</u>	T: <u>97.7</u>
Age: <u>40 yrs</u>	LMP: _____	Preg: _____	WT: _____ Last TT: <u>?</u>
HISTORY & PHYSICAL EXAM			Time: <u>908</u>
<input type="checkbox"/> CBC <input type="checkbox"/> Chem. Panel <input type="checkbox"/> UA <input type="checkbox"/> Culture <input type="checkbox"/> EKG <input type="checkbox"/> X-ray <input type="checkbox"/> Other: _____			

DISCHARGE INSTRUCTION/DISPOSITION:

Treatment	Time done	Signature	Route	Effect/Result
<u>B/L on 62</u>				

Diagnosis: Cervix in path MD Signature: _____ Time out: _____

OLIVIER JULIEN L 11/27/2007 08:00AM
25791 RANA DR
VALENCIA, CA 91355 UCD GENDER: M
EMRN: 326011 HCL: VA1 V#: 10604087
DOB: 06/27/1967 FSC1: FMF CALCARE COMM.
661-259-9968 CERT: 00040336810
COPAY: 5.00 FSC2:
PBAL: 0.00 CERT:
REF PHYS: #
#900059 URGENT CARE, VALENCIA URG1 VA1

Follow up appointment: Date: _____

Time: _____

Physician: _____

Location: _____

BILATERAL FOOT SERIES:

mH

There is minimal spurring in the lateral aspect of each 1st metatarsal phalangeal joint. There also is some mild plantar calcaneal spurring on the right. There are no fractures or dislocations present.

CONCLUSION:

MILD SPURRING AS ABOVE WITH NO ACUTE BONY CHANGES.

GREGORY PARANAY, M.D. D.A.B.R.
GP:c D: 1/9/01 T: 1/10/01

GP

GP
1/10/01

This report is based solely upon radiological examination. Correlation with the clinical findings is essential. If clinical symptoms persist, repeat examination or any other appropriate modality is recommended.

FACEY MEDICAL GROUP RADIOLOGY REPORT

PATIENT: OLIVER, JULIEN
REF. PHYSICIAN: DR. JASON HO
DATE OF BIRTH: 6/27/67
MR. NUMBER: 326011
PLACE OF VAL
PROCEDURE:
PROCEDURE TYPE: FEET
PROCEDURE DATE: 1/8/01

OLIVIER, JULIEN L
 25791 RANA DR
 VALENCIA, CA
 EMRN: 326011
 DOB: 06/27/1967
 661-259-9968
 COPY: 10.00
 PBAL: 0.00
 REF PHYS: #
 #900059 URGENT CARE, VALENCIA URG1 VA1

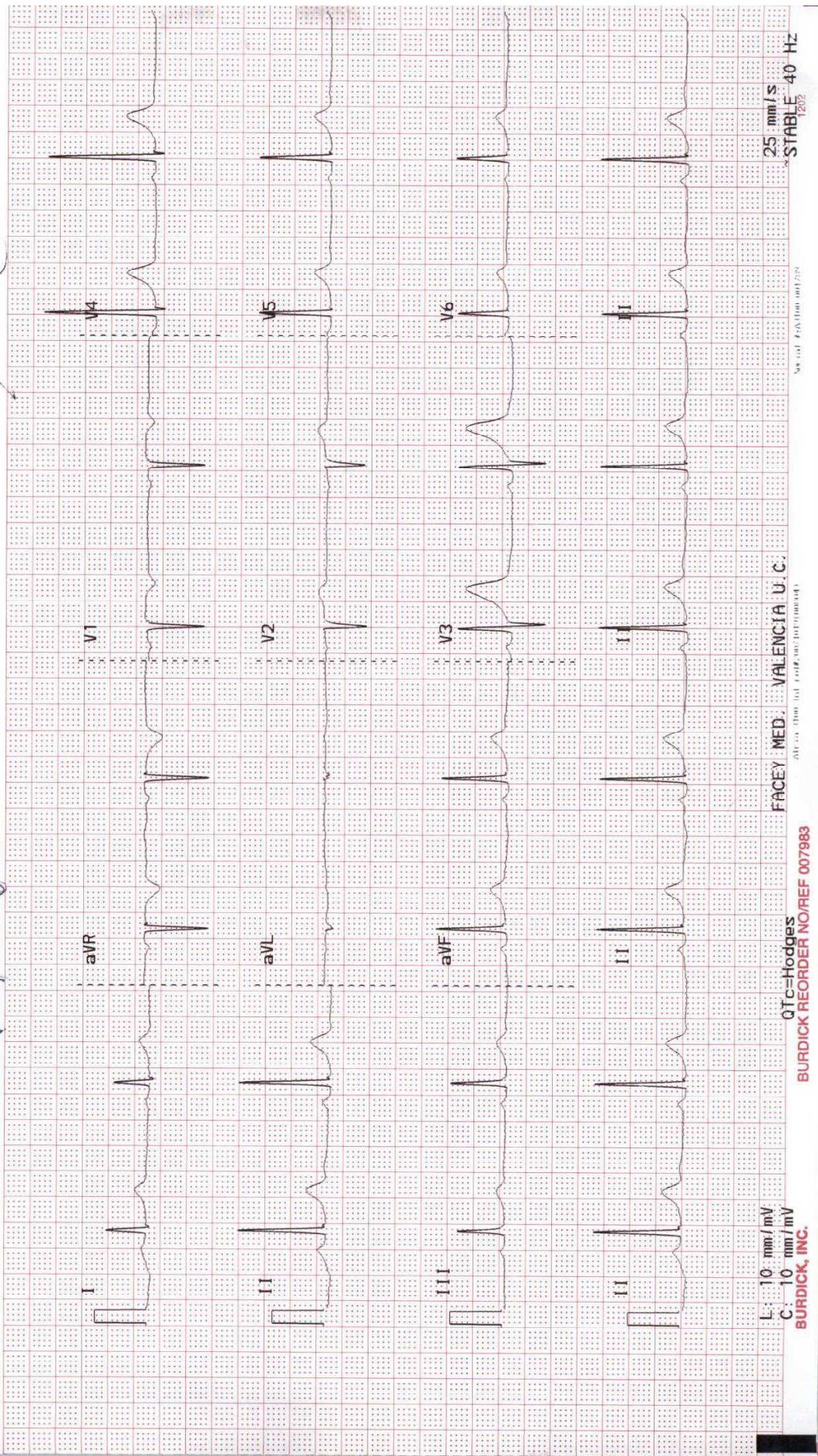
05/10/2013 08:15AM

* Unconfirmed Analysis *

Normal ECG except for rate

Rate:	50 bpm
interval:	1180 ms
interval:	174 ms
duration:	88 ms
interval:	452 ms
interval:	435 ms
sersion:	102 ms
AXIS:	70° 66° 60°

Poor Quality on Original Document



Current Medications

	Disp	Refills	Start	End
albuterol 90 mcg/puff inhaler	1 Inhaler	1	1/5/2021	
Sig: Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath.				
Route: Inhalation				
clotrimazole (LOTRIMIN) 1% cream	60 g	1	8/10/2020	
Sig: Apply to affected area twice a day.				
guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid	180 mL	0	1/5/2021	
Sig: Take 5-10 mLs by mouth every 6 hours as needed.				
Route: Oral				
valACYclovir (VALTREX) 1 g tablet	21 tablet	0	10/1/2020	
Sig: Take 1 tablet by mouth 3 times daily.				
Route: Oral				

0010

Current Medications

	Disp	Refills	Start	End
albuterol 90 mcg/puff inhaler	1 Inhaler	1	1/5/2021	
Sig: Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath.				
Route: Inhalation				
clotrimazole (LOTRIMIN) 1% cream	60 g	1	8/10/2020	
Sig: Apply to affected area twice a day.				
guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid	180 mL	0	1/5/2021	
Sig: Take 5-10 mLs by mouth every 6 hours as needed.				
Route: Oral				
valACYclovir (VALTREX) 1 g tablet	21 tablet	0	10/1/2020	
Sig: Take 1 tablet by mouth 3 times daily.				
Route: Oral				

0011

Current Medications

	Disp	Refills	Start	End
albuterol 90 mcg/puff inhaler	1 Inhaler	1	1/5/2021	
Sig: Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath.				
Route: Inhalation				
clotrimazole (LOTRIMIN) 1% cream	60 g	1	8/10/2020	
Sig: Apply to affected area twice a day.				
guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid	180 mL	0	1/5/2021	
Sig: Take 5-10 mLs by mouth every 6 hours as needed.				
Route: Oral				
valACYclovir (VALTREX) 1 g tablet	21 tablet	0	10/1/2020	
Sig: Take 1 tablet by mouth 3 times daily.				
Route: Oral				

0012

Name	Address	City	State	Zip	Phone	Fax
PROVIDENCE FACEY SEPULVEDA ANNEX HLTH INFO MGMT	11165 N Sepulveda Blvd	Mission Hills	CA	91345- 818-837- 000-000- 1113 5652 0000		

Immunization Summary

Julien L Olivier

Patient Information

Patient Information

Patient Name Olivier, Julien L	Legal Sex Male	DOB 6/27/1967
-----------------------------------	-------------------	------------------

Immunizations

Name	Date	Dose	VIS Date	Route	Site
INFLUENZA PF QUAD (PED/ADOL/ADULT),PSKT or VIAL	10/16/15 (48 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment: valencia 1 clinic;		
INFLUENZA, UNSPECIFIED FORMULATION	11/09/12 (45 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment:		
INFLUENZA, UNSPECIFIED FORMULATION	11/10/11 (44 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment:		
INFLUENZA, UNSPECIFIED FORMULATION	11/18/10 (43 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment:		
INFLUENZA, UNSPECIFIED FORMULATION	10/24/09 (42 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment: FLU CLINIC 10/24/09/.br/U3261AA X 2 0.25ML RIGHT/LEFT DELTOID;		
TDAP, (ADOL/ADULT)	10/13/10 (43 y.o.)				
Given By:			Manufacturer:		
Lot#:			Comment: 10/13/10 16:35 patient had no complaints, Ehrerra,MA;		

Recent PPD Results

No PPD tests on record

0013

XR CHEST PA AND LATERAL

Olivier, Julien L

MRN: 20010147509, Legal Sex: Male, 6/27/1967 (53 yrs), MU Urgent Care
Accession #: 20371476PRV

Final Result

XR CHEST PA AND LATERAL 1/5/2021 2:48 PM

INDICATION: Shortness of breath, positive COVID-19 test.

COMPARISON: None.

FINDINGS:

Patchy pulmonary interstitial infiltrates are present in the left lower lobe. No pneumothorax or pleural effusion. Heart size is normal. The mediastinum is unremarkable. No acute osseous abnormality.

Impression

IMPRESSION:

Patchy left lower lobe infiltrates with intermediate suspicion pattern for COVID-19 pneumonia.

Dictated by: Lily Yang, MD on 1/5/2021 2:49 PM

Electronically signed by: Lily Yang, MD on 1/5/2021 2:51 PM

Signed by Lily C Yang, MD on 1/5/2021 2:51 PM

Appointment Info

Exam Date

1/5/2021

Department

PROVIDENCE FACEY VALENCIA XRAY

661-222-2600

26357 McBean Pkwy

Valencia CA 91355-4488

Reason for Exam

shortness of breath, covid

Providers

PCP

Unknownpctp No

0014

 000-000-0000

 .

Ordering Provider

Khoa Dang Nguyen, MD

 818-869-7200

 11333 N SEPULVEDA BLVD

MISSION HILLS CA 91345

0015

XR UNLISTED PROCEDURE

Olivier, Julien L

MRN: <E20010151205>, Legal Sex: Male, 6/27/1967

Accession #:

Final Result

LEFT KNEE: THREE VIEWS 06/01/2007

COMPARISON: None.

FINDINGS: There is no acute fracture or dislocation. The joints are in near anatomic alignment. The joint spaces are maintained. There is a small joint effusion.

IMPRESSION:

NO FRACTURE. SMALL JOINT EFFUSION.

Electronically signed by: HENRY SHIH M.D. Jun 13 2007 3:40PM PST Author

Electronically signed by: KHOA NGUYEN M.D. Jun 15 2007 8:16AM PST

Signed by Khoa Dang Nguyen, MD on 6/1/2007 8:55 AM

Appointment Info

Reason for Exam

No reason for exam was entered

Providers

PCP

Unknownpcp No

📞 000-000-0000

📍 .

Ordering Provider

Khoa Dang Nguyen, MD

📞 818-869-7200

📍 11333 N SEPULVEDA BLVD

MISSION HILLS CA 91345

0016

XR UNLISTED PROCEDURE

Olivier, Julien L

MRN: <E20010151205>, Legal Sex: Male, 6/27/1967

Accession #:

Final Result

LEFT KNEE: THREE VIEWS 06/01/2007

COMPARISON: None.

FINDINGS: There is no acute fracture or dislocation. The joints are in near anatomic alignment. The joint spaces are maintained. There is a small joint effusion.

IMPRESSION:

NO FRACTURE. SMALL JOINT EFFUSION.

Electronically signed by: HENRY SHIH M.D. Jun 13 2007 3:40PM PST Author

Electronically signed by: KHOA NGUYEN M.D. Jun 15 2007 8:16AM PST

Signed by Khoa Dang Nguyen, MD on 6/1/2007 8:55 AM

Appointment Info

Reason for Exam

No reason for exam was entered

Providers

PCP

Unknownpcp No

📞 000-000-0000

📍 .

Ordering Provider

Khoa Dang Nguyen, MD

📞 818-869-7200

📍 11333 N SEPULVEDA BLVD

MISSION HILLS CA 91345

0017

XR UNLISTED PROCEDURE

Olivier, Julien L

MRN: <E20010151205>, Legal Sex: Male, 6/27/1967

Accession #:

Final Result

BILATERAL WEIGHT BEARING FOOT SERIES: 08/07/06

FINDINGS: There are mild degenerative changes seen about both first metatarsal phalangeal joints. There also is some mild plantar calcaneal spurring bilaterally, more on the right. There is a bilateral pes planus. There is no fracture or dislocation and no bony erosions are present.

CONCLUSION:

BILATERAL PES PLANUS.

CALCANEAL SPURRING.

NO ACUTE BONY CHANGES.

Electronically signed by: GREGORY PARANAY M.D. Aug 14 2006 1:24PM PST

Electronically signed by: JOUNG LEE DPM Aug 14 2006 2:11PM PST

Signed by Joung H Lee, DPM on 8/7/2006 1:40 PM

Appointment Info

Reason for Exam

No reason for exam was entered

Providers

PCP

Unknownpcp No

📞 000-000-0000

📍 .

Ordering Provider

Joung H Lee, DPM

📞 818-365-9531

📍 11333 SEPULVEDA BLVD

MISSION HILLS CA 91345

0018

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, ProviderProgress Notes
Signed

Encounter Date: 1/6/2010

Task Type: .Call/Message

Jan 6 2010 4:47PM Trujillo, Darlene TASK CREATED

Caller: Self Message: (661)259-9968 (Home)

Patient is needing his referral to dermatology to be marked URGENT please so he can get a much sooner appt scheduled. Please call of status.

Jan 7 2010 9:21AM Leal, Jesenia TASK EDITED

called and left message on home number and cell phone number for patient to call back. referral can not be changed to urgent patient has never seen dr kasem. patient has only been seen by urgent care and dr kasem would need to evaluate skin rash. jleal maII

Jan 8 2010 10:12AM Uriarte, Christina TASK EDITED

Pt was informed yesterday referral cannot be changed by Dr. Kasem since she has never seen him. pt was told he needs to make an appt to be seen first. Pt said he was going to check with urgent care, who wrote the referral, to see if they can change it to an urgent. c.uriarte ma II

Jan 8 2010 10:12AM Uriarte, Christina TASK COMPLETED

Last signed by: Provider Unknown Conversion Transaction at 01/06/10 1647

Electronically Signed by Conversion Transaction, Provider on 01/06/10 1647

Data Conversion

Encounter on

1/6/2010

Olivier, Julien L

MRN: 20010147509

Elisabeth Benitez, Medical Assistant

Medical Assistant

Telephone Encounter

Signed

Encounter Date: 3/26/2019

Patient will call back when ready to schedule colonoscopy

Electronically signed by: Elisabeth Benitez, Medical Assistant 3/26/2019 10:39

Electronically Signed by Elisabeth Benitez, Medical Assistant on 03/26/19 1039

Telephone
on
3/26/2019

0020

Olivier, Julien L

MRN: 20010147509

Marisela Zambrano, Medical Assistant
Medical Assistant

Telephone Encounter
Signed

Encounter Date: 6/26/2018

DATE/TIME: 6/26/2018 9:23

Patient has been notified of results , no other concerns. Electronically signed by: Marisela Zambrano, Medical Assistant 6/26/2018 9:23

Electronically Signed by Marisela Zambrano, Medical Assistant on 06/26/18 0924

Telephone
on
6/26/2018

0021

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, Provider**Progress Notes
Signed****Encounter Date: 6/10/2006**

HISTORY OF PRESENT ILLNESS: A 38-year-old male comes in with bilateral heel pain off and on for three years. The patient has pain more in the left heel now for last several months. He has diagnosis of plantar fasciitis in the past and was given medication for that. However, the symptoms then went away. He is expressing frustration with the fact that his previous doctor told him that it would go away in three weeks. He has requested a referral for a podiatrist as well. He states he had been running a lot, but has stopped running for the last month and a half.

MEDICATIONS: None.

ALLERGIES: None.

PHYSICAL EXAMINATION: Vital Signs: Temperature 98.6 degrees, respirations 16, and blood pressure 177/79. Extremities: On his exam, he is tender on the bottom of the heel only on the left side but he is walking and ambulating without difficulty.

IMPRESSION AND PLAN: Plantar fasciitis. Heel stretching and arch support advised. He was given a handout on plantar fasciitis. He has been given a prescription for Naprosyn 500 mg b.i.d. #60 with one refill. He has been referred to a podiatrist as requested. Icing, resting, and stretching advised. Follow up or return with podiatry for further treatment.

Khoa Nguyen, MD
FAMILY PRACTICE
D: 06/10/2006 T: 06/12/2006 JobID: 1149964383
KN/AM:atmt1/atqal

Electronically signed by:KHOA NGUYEN M.D. Jun 26 2006 12:22PM PST

Last signed by: Provider Unknown Conversion Transaction at 06/10/06 0900

Electronically Signed by Conversion Transaction, Provider on 06/10/06 0900

Outpatient
Historical on
6/10/2006

0022

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, ProviderProgress Notes
Signed

Encounter Date: 7/30/2006

CHIEF COMPLAINT: Bee sting, swollen and itching.**SUBJECTIVE:** A 39-year-old male patient came with a history of bee sting on the right hand two days before. Currently, swollen, tight, and itchy. No fever. No local tenderness.**PAST MEDICAL HISTORY:** None.**CURRENT MEDICATIONS:** Ibuprofen and Benadryl.**ALLERGIES:** None.**OBJECTIVE:** A 39-year-old male patient with stable vital signs. The right hand, dorsum of the hand there is a bee sting mark noted, surrounding area is mildly swollen, edematous, but there is no localized tenderness. No streak mark of the vein noted.**IMPRESSION:** Insect bite.**TREATMENT:** Triamcinolone cream apply locally 0.025% b.i.d., continue Benadryl cream and for pain ibuprofen.

Zinat Choudhury, MD
URGENT CARE
D: 07/30/2006 T: 07/30/2006 JobID: 1154281503
ZC/AM:tgmt3/tgqa1

Electronically signed by: ZINAT CHOUDHURY M.D. Aug 4 2006 4:51PM PST

Last signed by: Provider Unknown Conversion Transaction at 07/30/06 0900

Electronically Signed by Conversion Transaction, Provider on 07/30/06 0900

Outpatient
Historical on
7/30/2006

0023

Olivier, Julien L

MRN: 20010147509

Jeffery Jo H. Lee, DPM
Doctor of Podiatric Medicine
Specialty: Podiatry

Progress Notes
Signed

Encounter Date: 8/7/2006

08/07/2006 14:00

OLIVIER, JULIEN

MRN: 326011

DictaideID: 1154986752

SUBJECTIVE: A 39-year-old male presents to clinic complaining of left heel pain for three to four years. Patient reports that this is on and off depending whether he jogs or not. Reports that the right heel on occasion hurts also. Otherwise no other problems.

MEDICATIONS: None.

ALLERGIES: None.

PAST MEDICAL HISTORY: Unremarkable.

OBJECTIVE:

Vital Signs: Height 5 feet 11 inches, weight 200 pounds, temperature 97.5 degrees.

Dermatological: Normal texture, turgor, and elasticity of skin. No open lesions. No signs of infection at this time.

Neurovascular Status: Intact with symmetrical palpable pedal pulses bilaterally. Capillary refill time less than 3 seconds to each digit, bilateral.

Musculoskeletal: Pain on palpation at the medial tubercle on the calcaneus left foot, otherwise unremarkable.

X-RAYS: X-rays are reviewed, which are significant for inferior calcaneal spurs on bilateral feet, right worse than left.

ASSESSMENT:

1. Plantar fascitis.
2. Pain.

PLAN: Patient's diagnoses and treatment plan were discussed today. Discussed stretching exercises, arch supports, proper shoes, anti-inflammatories, and icing for this problem. Handouts provided. Patient will try this. Return to clinic if not asymptomatic.

Joung H Lee, DPM
PODIATRY
D: 08/07/2006 T: 08/07/2006 JobID: 1154986752
JL/AM:ismt4/isqa3

Electronically signed by: JOUNG LEE DPM Aug 10 2006 2:44PM PST

0024

Last signed by: Joung H Lee, DPM at 08/07/06 1400

Electronically Signed by Joung H Lee, DPM on 08/07/06 1400

Outpatient
Historical on
8/7/2006

0025

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, ProviderProgress Notes
Signed

Encounter Date: 6/1/2007

HPI: 39 years old male presented complaining of recurrent left knee pain for 3 months. Patient noted he rested for two weeks and the pain went away. He however started running again the last two days and noted pain again on the lateral aspect of the left knee. He runs 3 to 4 miles a day as an instructor for new recruits for the LAPD. No particular trauma or injury reported.

PMH: Unremarkable.

Current Meds: None.

Allergies: No known drug allergy.

Physical Exam: Well-developed, well-nourished male in NAD.

Vital signs: Temp 97.2, pulse 50, respiration 16 and blood pressure 160/76.

Left knee examination noted no obvious swelling, effusion, erythema, scar or obvious tenderness on palpation. Range of motion of the knee was intact passively and actively. Gait was normal with no limp.

X-ray of the left knee was normal.

Assessment and Plan: Left knee pain secondary to running overuse. There may be also a lateral collateral ligament strain. He should rest, ice and take nonsteroidal anti-inflammatory with Naprosyn 500 mg b.i.d., number 60. A knee support was also given. Follow-up with PCP if not better next two weeks or sooner if there is any other problem.

Electronically signed by: KHOA NGUYEN M.D. Jun 1 2007 9:47AM PST

Last signed by: Provider Unknown Conversion Transaction at 06/01/07 0800

Electronically Signed by Conversion Transaction, Provider on 06/01/07 0800

Outpatient
Historical on
6/1/2007

0026

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, Provider

Progress Notes
Signed

Encounter Date: 11/27/2007

Time of evaluation: 9:08 a.m.

Subjective: 40 years old male presents here complaining of something moving in his left ear. There is no pain, fever, chills, difficult to the hearing or other complaint.

Current medications: None.

Allergies: NKDA.

Objective: Well-developed and well-nourished male in no acute distress. Temperature 98.7, pulse 60, respiratory rate 16 and blood pressure 124/67. HEENT exam: TMs are intact. There are moderate wax in bilateral ear canal. Oral cavity and oropharynx are clear.

Assessment and plan: Cerumen impaction. Ear lavage was performed good results. Follow up with PCP or return if not better.

Electronically signed by: KHOA NGUYEN M.D. Nov 27 2007 9:50AM PST

Last signed by: Provider Unknown Conversion Transaction at 11/27/07 0800

Electronically Signed by Conversion Transaction, Provider on 11/27/07 0800

Outpatient
Historical on
11/27/2007

0027

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, ProviderProgress Notes
Signed

Encounter Date: 10/10/2008

Chief Complaint

- 41-year-old comes in after straining his left third finger two weeks ago. He notes it's gotten better but is still some slight puffiness to the finger. He has complete normal range of motion and usage with no pain.

Physical exam

Patient looks well, in no apparent distress, alert, energetic.

MSK: Left third finger notice color no deformity no redness no heat, normal range of motion, minimal slight mid phalanx puffiness noted.

Impression: Resolving strain. Management and follow up as discussed

Allergies

No Known Allergies.

Vital Signs

Recorded by Herrera,Elisa on 10 Oct 2008 01:00 PM

BP:152/67,

HR: 55 b/min,

Resp: 16 r/min,

Temp: 97.2 F, Oral.

Signature

Signed By: ATUL SHARMA M.D.: 10/10/2008 4:22 PM PST.

Last signed by: Provider Unknown Conversion Transaction at 10/10/08 1230

Electronically Signed by Conversion Transaction, Provider on 10/10/08 1230

Outpatient

Historical on

10/10/2008

0028

Olivier, Julien L

MRN: 20010147509

Chris Aghayan, MD

Physician

Specialty: Urgent Care

Progress Notes

Signed

Encounter Date: 1/2/2010

Allergies

No Known Allergies.

Vital Signs

Recorded by CALHOUN,KARLA on 02 Jan 2010 08:14 AM

BP:148/67,

HR: 58 b/min,

Resp: 16 r/min,

Temp: 97.8 F.

Provider Note

Chief complaint: Rash

History of present illness: The patient developed a pruritic rash on the right wrist one week ago after scratching it and touching his forehead that has a similar rash on the forehead and very pruritic

Review of systems: Denies fever chills or sick contacts

Physical exam: Small area of macular erythematous nonblanching rash on the palmar aspect of right wrist and is also a small patch on the forehead, no papules or pustules

Impression: Contact dermatitis

Plan: Use cream as directed, if not improved within 48 hours return to urgent care otherwise followup with PCP

Orders

Betamethasone Dipropionate 0.05 % Cream:APPLY SPARINGLY TO AFFECTED AREA(S) TWICE DAILY:
Qty1: R0: Rx.

Signature

Electronically signed by: CHRIS AGHAYAN M.D.: 01/02/2010 9:17 AM PST.

Last signed by: Chris Aghayan, MD at 01/02/10 0805

Electronically Signed by Chris Aghayan, MD on 01/02/10 0805

Electronically Signed by Edi, Transcription Conversion on 06/04/17 0931

Outpatient

Historical on

1/2/2010

0029

Olivier, Julien L

MRN: 20010147509

Lucy Lo, MD
Physician
Specialty: Internal Medicine

Progress Notes
Signed

Encounter Date: 10/13/2010

Current Meds

Betamethasone Dipropionate 0.05 % Cream:APPLY SPARINGLY TO AFFECTED AREA(S) TWICE DAILY: Rx
Ketoconazole 2 % Cream:APPLY A THIN LAYER TO AFFECTED AREA(S) TWICE DAILY.: Rx.

Allergies

No Known Allergies.

Vital Signs

Recorded by Ham,Sonny on 13 Oct 2010 04:09 PM

BP:141/72,
HR: 50 b/min,
Resp: 18 r/min,
Temp: 97.4 F.

Provider Note

Patient is a 43-year-old male who complains of a dog bite to his right hand today. Patient states he was trying to catch a stray dog who looked as if it had an owner. Patient has some puncture wounds over his right hand. Patient had pain when the dog bit his thumb.

NAD

R hand with superficial puncture wounds scabs/ over thumb and dorsal hand
Minimal tenderness over radial side of the thumb over puncture wound scab
Right hand neurovascular intact, radial pulse 2+
Motor 5 out of 5 all fingers of right hand, sensory intact.

Assessment

- Dog bite Right: (E906.0): hand

Orders

Amoxicillin-Pot Clavulanate 875-125 MG Tablet:TAKE 1 TABLET EVERY 12 HOURS DAILY: Qty14: R0: Rx.

Plan

Tdap IM x 1
Antibiotics prescribed
Ibuprofen as needed for pain
Continue to monitor for improvement
Follow up if symptoms persist or worsen.

Signature

Electronically signed by: LUCY LO M.D.: 10/13/2010 5:06 PM PST.

Last signed by: Lucy Lo, MD at 10/13/10 1600

Electronically Signed by Lucy Lo, MD on 10/13/10 1600

Electronically Signed by Edi, Transcription Conversion on 06/04/17 0931

Outpatient
Historical on
10/13/2010

0030

Olivier, Julien L

MRN: 20010147509

Kevin L Vuong, MD

Physician

Specialty: Urgent Care

Progress Notes

Signed

Encounter Date: 4/22/2011

Provider Note

Chief complaint: Left eye foreign body sensation.

Subjective: The patient reported foreign body sensation to the light 2 days ago. He was doing garden work, when dirt particle flew into his lf eye. Patient reportedly vigorous irrigation subsequently. However persistent left upper lid foreign body sensation.

Denies any visual change. Denies any ocular pain, photosensitivity.

Objective: -Alert, no acute distress, pleasant. Visual Acuity: OD 20/25, OS 20/20, OU 20/20. Conjunctiva slightly hyperemic. Upper eyelid everted, no foreign body seen. Cornea no evidence of foreign body or abrasion, with fluorescein exam. Anterior chambers clear. PERRLA, EOMs intact.-

Impression: 1. Foreign body exposure, secondary conjunctivitis.

Plan: Polytrim ophthalmic drops, 2 drops t.i.d. as directed. Advised to avoid rubbing the eyes. Recheck in 48 hours if still symptomatic.

Current Meds

Betamethasone Dipropionate 0.05 % Cream:APPLY SPARINGLY TO AFFECTED AREA(S) TWICE DAILY: Rx Ketoconazole 2 % Cream:APPLY A THIN LAYER TO AFFECTED AREA(S) TWICE DAILY.: Rx Polymyxin B-Trimethoprim 10000-0.1 UNIT/ML-% Solution:INSTILL 2 DROP 3 TIMES DAILY to affected eye (s) as directed.: Rx

Allergies

No Known Allergies.

Vital Signs

Recorded by Luna,Angie on 22 Apr 2011 12:31 PM

BP:138/77,

HR: 52 b/min,

Resp: 16 r/min,

Temp: 97.6 F.

Signature

Electronically signed by: KEVIN VUONG : 04/22/2011 1:16 PM PST.

Last signed by: Kevin L Vuong, MD at 04/22/11 1230

Electronically Signed by Kevin L Vuong, MD on 04/22/11 1230

Electronically Signed by Edi, Transcription Conversion on 06/03/17 0633

Outpatient
Historical on
4/22/2011

0031

Olivier, Julien L

MRN: 20010147509

Riga Pemba, MD

Physician

Specialty: Internal Medicine

Progress Notes

Signed

Encounter Date: 5/10/2013

Chief Complaint

- JULIEN OLIVIER is a 45 year old male who presents with complaint of dizziness

Provider Note

SUBJECTIVE: Patient presents to the urgent care with symptoms of disequilibrium for the past few days. According to the patient he was at the gym exercising and performing abdominal crunches when he had symptoms of increased dizziness with room spinning. However, this lasted a few minutes and the patient is able to continue with his exercises. According to the patient he did quite a bit of exercises of that as well. There is no associated chest pains, palpitations, shortness of breath, increased headache or any focal neurological symptoms. He hasn't had any recent URI symptoms but he feels that the hives it sinus congestion.

Review of systems: No other associated symptoms.

Past medical and surgical history:

Family & social history:

OBJECTIVE: Patient is in no acute distress. Vitals as above. Pupils equal react to light. Fundus is normal. There is no nystagmus. No carotid bruits. Neurologic examination was entirely normal. There may be slight wasting of the right interosseous muscle however Froment's test was negative. Dix-Hallpike was negative. Tandem walking was normal. Sinuses non-tender. TMs are normal. Oral mucosa is normal. Lungs CTA with no wheezing and no crackles. Normal heart sounds.

EKG: Normal sinus rhythm with no acute ST/T-wave changes. Heart rate is 50 beats a minute.

ASSESSMENT AND PLAN: Dizziness

Discussed with patient regarding diagnosis and treatment. Discussed with patient the differential diagnosis. This time patient does not have any focal neurological symptoms. We will continue to monitor and have the patient avoid any sudden motions of the head. Patient may try meclizine. If no better call back as discussed. Patient was then need further imaging studies. Patient has been advised to return to the urgent care if no better or if the patient has any new symptoms. Advised also followup with PCP as recommended to ensure full resolution. Precautions reviewed with patient's full understanding.

Personal Hx

Never A Smoker.

Current Meds

No Reported Medications:: RPT.

Allergies

No Known Allergies.

Vital Signs

Recorded by Carter, Gaynell on 10 May 2013 08:36 AM

BP: 147/77,

HR: 57 b/min,

Resp: 16 r/min,

Temp: 96.3 F,

Height: 71.000000 in, Weight: 199.000000 lb, BMI: 27.8 kg/m²,

O2 Sat: 99 (%SpO₂),

BSA Calculated: 2.10 ,

BMI Calculated: 27.86.

Signature**0032**

Electronically signed by : RIGA PEMBA M.D.: 05/10/2013 9:07 AM PST: Administrative.

Last signed by: Riga Pemba, MD at 05/10/13 0815

Electronically Signed by Riga Pemba, MD on 05/10/13 0815

Electronically Signed by Edi, Transcription Conversion on 05/29/17 1804

Outpatient

Historical on

5/10/2013

0033

Olivier, Julien L

MRN: 20010147509

David Shaw, MD

Physician

Specialty: Family Medicine

Progress Notes

Signed

Encounter Date: 5/20/2013

Chief Complaint

- JULIEN OLIVIER is a 45 year old male who presents with complaint of equilibrium is off x 2 weeks

HPI

Patient complains of a dizziness which has been on going for the last 2 weeks.

He states began when he was doing sit-ups at the gym. He was seen last week and took Dramamine which was ineffective.

He notes he continues to have dizziness which is intermittent in nature.

There's been no fevers or chills

ROS

No nausea, vomiting, abdominal pain

No constipation or diarrhea.

No chest pain, palpitations, diaphoresis

No shortness of breath.

ALLERGIES:

foods: none

ALLERGIC rhinitis: None

Asthma: none

Smoking: none

Drugs: None.

Personal Hx

Never A Smoker.

Current Meds

No Reported Medications:: RPT.

Allergies

No Known Allergies.

Vital Signs

Recorded by Rodriguez,Blanca on 20 May 2013 03:57 PM

BP:138/78,

HR: 53 b/min,

Resp: 16 r/min,

Temp: 97.6 F,

Height: 71.000000 in, Weight: 199.000000 lb, BMI: 27.8 kg/m²,

O2 Sat: 99 (%SpO₂),

BSA Calculated: 2.10 ,

BMI Calculated: 27.86.

Physical Exam

General appearance:

Well developed, well nourished.

In no acute distress.

Alert and oriented x 3

Affect appropriate

HEENT:

Ears:

Hearing grossly intact bilaterally

Pinnae: Negative for any scars lesions or masses

Canals: Clear bilaterally

0034

Tympanic membranes: Neutral

Nose:

Nasal mucosa moist

Septum intact

Turbinates normal

Oral:

Lips unremarkable

Teeth intact

Gums intact without injury

Hard and soft palate intact without lesion

Pharynx:

No tonsillar enlargement

No posterior pharyngeal erythema

Neurologic exam:

Cranial nerves: III through XII are intact bilaterally.

Patient demonstrates 5/5 strength in all extremities.

Gait normal, Rhomberg negative.

Assessment

- Vertigo (780.4)

Plan

Patient counseled on benign positional paroxysmal vertigo.

He was instructed on the Epley maneuver.

Return to clinic included if this persists more than 5 days.

Signature

Electronically signed by : DAVID SHAW M.D.: 05/20/2013 7:35 PM PST.

Last signed by: David Shaw, MD at 05/20/13 1545

Electronically Signed by David Shaw, MD on 05/20/13 1545

Electronically Signed by Edi, Transcription Conversion on 05/29/17 1804

Outpatient

Historical on

5/20/2013

0035

Olivier, Julien L

MRN: 20010147509

Atul Sharma, MD

Physician

Specialty: Urgent Care

Progress Notes

Signed

Encounter Date: 8/18/2016

Chief Complaint

- JULIEN OLIVIER is a 49 year old male who presents with complaint of rash

Provider Note

49-year-old comes in with a slight rash started on the right corner of his mouth and has started to spread down his chin. He did have a slight rash on the ventral aspect of his tongue which has now markedly improved spontaneously. No fevers, no vomiting.

Physical exam

Patient looks well, in no apparent distress, alert, energetic.

Slight area of inflammation noted from the right cord or of the mouth with some reddish macular eruption along the right shin. Pharynx clear, slight resolving canker noted on the tongue, no other lesions. Sclera clear.

Impression: Cellulitis. Canker. Medication as prescribed. Side effects advised. Management and follow up as discussed. Patient understood and will comply.

Personal Hx

Never A Smoker.

Current Meds

No Reported Medications:: RPT.

Past Meds

No Reported Medications:: Qty0: R0: RPT.

Allergies

No Known Allergies.

Vital Signs

Recorded by Monge,Hugo on 18 Aug 2016 06:37 PM

BP:136/78,

HR: 46 b/min,

Resp: 16 r/min,

Temp: 96.7 F,

Height: 71 in, Weight: 199 lb, BMI: 27.8 kg/m²,

BMI Calculated: 27.75 ,

BSA Calculated: 2.10 ,

O2 Sat: 98 (%SpO₂).

Orders

Sulfamethoxazole-Tripenoprim 800-160 MG Oral Tablet(Bactrim DS):TAKE 1 TABLET TWICE DAILY:

Qty14: R0: Rx.

Signature

Electronically signed by : ATUL SHARMA M.D.: 08/18/2016 6:56 PM PST.

Last signed by: Atul Sharma, MD at 08/18/16 1830

Electronically Signed by Atul Sharma, MD on 08/18/16 1830

Electronically Signed by Edi, Transcription Conversion on 07/21/17 0607

Outpatient

Historical on

8/18/2016

0036

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, ProviderProgress Notes
Signed

Encounter Date: 8/22/2016

Chief Complaint

- JULIEN OLIVIER is a 49 year old male who presents with complaint of rash

Provider Note

Subjective: 49-year-old male patient is complaining of tender, blister like lesion on lips for a few days. Stated that patient had this type of infection before.

He came to urgent care 2-3 days before.

Bactrim was prescribed.

Stated that he is not improving.

Currently complaining of increase local erythematous blister lesion on the right corner of the lips and cheek.

Complaining of mild itching

Objective: Vital: Stable

HEENT: Both TMs and external auditory canals healthy looking

Oropharynx tonsils not enlarged not erythematous

Neck supple no lymphadenopathy

Lungs: Clear, no wheezing, no rhonchi

Heart: Rate regular rhythm

Lips: On the right corner of the lip and cheek: Significant erythematous blister noted. No pustular formation.

No sign of secondary infection

No localized lymphadenopathy

Assessment: Herpes labialis

Plan: Valtrex 1 g 3 times a day

Zovirax ointment apply locally 2-3 times a day

Followup if no improvement

DISCLOSURE: Please note that portions of the chart has been dictated using Dragon voice recognition software. Occasional wrong word or sound like substitution may have occurred due to the inherent limitations of the voice recognition software. Please read the chart carefully and recognize, using context, where these substitutions have occurred.

Personal Hx

Never A Smoker.

Current Meds

Sulfamethoxazole-Tripenoprim 800-160 MG Oral Tablet (Bactrim DS): TAKE 1 TABLET TWICE DAILY.: Rx.

Allergies

No Known Allergies.

Vital Signs

Recorded by Valdez,Loretta on 22 Aug 2016 10:16 AM

BP:124/75,

HR: 52 b/min,

Resp: 16 r/min,

Temp: 97 F,

O2 Sat: 99 (%SpO2).

Assessment

Herpes labialis (054.9) (B00.1).

Orders

0037

ValACYclovir HCl - 1 GM Oral Tablet: TAKE 1 TABLET 3 TIMES DAILY: Qty21: R0: Rx.
Acyclovir 5 % External Ointment: APPLY A SMALL AMOUNT 3 TIMES DAILY AS DIRECTED: Qty1: R0: Rx.

Signature

Electronically signed by : ZINAT CHOWDHURY M.D.: 08/22/2016 11:29 AM PST.

Last signed by: Provider Unknown Conversion Transaction at 08/22/16 1000

Electronically Signed by Conversion Transaction, Provider on 08/22/16 1000

Outpatient

Historical on

8/22/2016

0038

Olivier, Julien L

MRN: 20010147509

David Shaw, MD

Physician

Specialty: Family Medicine

Progress Notes

Signed

Encounter Date: 11/22/2016

Chief Complaint

- JULIEN OLIVIER is a 49 year old male who presents with complaint of left ear plugged up today

HPI

Patient comes in with complaint of decreased hearing to the left ear over the last several days.
No nasal congestion, sore throat, fever, chills

ALLERGIES:

Drugs: None

foods: none

Pollen: none

Asthma: none

Smoking: none.

Active Problems

Herpes labialis (054.9) (B00.1).

Personal Hx

Never A Smoker.

Current Meds

Sulfamethoxazole-Trimethoprim 800-160 MG Oral Tablet (Bactrim DS): TAKE 1 TABLET TWICE DAILY.: Rx
Acyclovir 5 % External Ointment:APPLY A SMALL AMOUNT 3 TIMES DAILY AS DIRECTED.: Rx.

Allergies

No Known Allergies.

Vital Signs

Recorded by Roberts,Frances on 22 Nov 2016 04:58 PM

BP:139/78,

HR: 48 b/min,

Resp: 18 r/min,

Temp: 97.6 F,

Weight: 182 lb,

BMI Calculated: 25.38 ,

BSA Calculated: 2.03 ,

Pain Scale: 0,

O2 Sat: 99 (%SpO2).

Physical Exam

General appearance:

Well developed, well nourished.

In no acute distress.

Alert and oriented x 3

Affect appropriate

Vital Signs:

Blood pressure, heart rate and temperature reviewed

Ear exam:

Pinnae negative for erythema or swelling.

Canals clear on the right, positive cerumen on the left

TMs neutral

Assessment

Impacted cerumen of left ear (380.4) (H61.22): Resolved: 29Nov2016.

0039

Plan

Patient had left ear lavaged successfully and discharged home in good condition.

Signature

Electronically signed by : DAVID SHAW M.D.: 11/22/2016 6:27 PM PST.

Last signed by: David Shaw, MD at 11/22/16 1645

Electronically Signed by David Shaw, MD on 11/22/16 1645

Electronically Signed by Edi, Transcription Conversion on 07/21/17 0607

Outpatient

Historical on

11/22/2016

0040

Olivier, Julien L

MRN: 20010147509

Belinda Gay Rouse, NP
 Nurse Practitioner
 Specialty: Registered Nurse

Progress Notes
 Signed

Encounter Date: 6/22/2018

FACEY MEDICAL FOUNDATION VALENCIA INTERNAL MEDICINE - HISTORY AND PHYSICAL EXAM

Patient Name: Julien L Olivier | **Age:** 51 y.o. | **DOB:** 6/27/1967 | **Medical Record Number:** 20010147509 | **Author:** Belinda Rouse, NP | **Date of Encounter:** 8/19/2018

CHIEF COMPLAINT:

Julien L Olivier is a 51 y.o. male who presents for annual physical.

HPI:

Patient presents to the clinic for annual review of his medications and therapies.

ASSESSMENT & PLAN:

1. Encounter for screening and preventative care (Primary)

- Basic Metabolic Panel; Future; Expected date: 06/22/2018
- CBC with Differential; Future; Expected date: 06/22/2018
- Occult Blood, Fecal Immunochemical Test (FIT); Future; Expected date: 06/22/2018
- Hemoglobin A1C; Future; Expected date: 06/22/2018
- Hepatic Function Panel; Future; Expected date: 06/22/2018
- T4, Free; Future; Expected date: 06/22/2018
- TSH; Future; Expected date: 06/22/2018
- PSA, Screen; Future; Expected date: 06/22/2018
- Lipid Panel; Future; Expected date: 06/22/2018
- Urinalysis with Microscopic with Culture if Indicated; Future; Expected date: 06/22/2018
- Hepatitis C Ab; Future; Expected date: 06/22/2018

Follow Up:

After care instructions & AVS given.

Return if symptoms worsen or fail to improve. Sooner if necessary, or as discussed.

Educated pt about the risks, benefits, alternatives, and side effects of the medications.

Pt verbalized understanding and agreed with the plan of care. All questions were answered to patient's satisfaction.

LATEST LAB RESULTS

WBC

Date

Value

Ref Range

Status

0041

06/22/2018	12.2 (H)	3.8 - 10.8 Thousand/uL	Final
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Hemoglobin A1c

Date	Value	Ref Range	Status
06/22/2018	5.2	<5.7 % of total Hgb	Final

Comment:

For the purpose of screening for the presence of diabetes:

- <5.7% *Consistent with the absence of diabetes*
- 5.7-6.4% *Consistent with increased risk for diabetes (prediabetes)*
- > or =6.5% *Consistent with diabetes*

This assay result is consistent with a decreased risk of diabetes.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes in children.

According to American Diabetes Association (ADA) guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations.
Standards of Medical Care in Diabetes(ADA).

TSH

Date	Value	Ref Range	Status
06/22/2018	3.95	0.40 - 4.50 mIU/L	Final

Hct

Date	Value	Ref Range	Status
06/22/2018	46.8	38.5 - 50.0 %	Final

Absolute Lymphocytes

Date	Value	Ref Range	Status
06/22/2018	3575	850 - 3900 cells/uL	Final

Platelet Count

Date	Value	Ref Range	Status
06/22/2018	310	140 - 400 Thousand/uL	Final

Sodium

Date	Value	Ref Range	Status
06/22/2018	141	135 - 146 mmol/L	Final

Potassium

Date	Value	Ref Range	Status
06/22/2018	4.1	3.5 - 5.3 mmol/L	Final

Calcium

Date	Value	Ref Range	Status

0042

06/22/2018	9.5	8.6 - 10.3 mg/dL	Final
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BUN

Date	Value	Ref Range	Status
06/22/2018	26 (H)	7 - 25 mg/dL	Final

Creatinine

Date	Value	Ref Range	Status
06/22/2018	1.20	0.70 - 1.33 mg/dL	Final

Comment:

For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.

AST (SGOT) (REF)

Date	Value	Ref Range	Status
06/22/2018	18	10 - 35 U/L	Final

ALT (SGPT) (REF)

Date	Value	Ref Range	Status
06/22/2018	22	9 - 46 U/L	Final

ALK PHOS

Date	Value	Ref Range	Status
06/22/2018	69	40 - 115 U/L	Final

Cholesterol

Date	Value	Ref Range	Status
06/22/2018	182	<200 mg/dL	Final

HDL Cholesterol

Date	Value	Ref Range	Status
06/22/2018	66	>40 mg/dL	Final

LDL, Calculated

Date	Value	Ref Range	Status
06/22/2018	89	mg/dL (calc)	Final

Comment:

Reference range: <100

Desirable range <100 mg/dL for primary prevention; <70 mg/dL for patients with CHD or diabetic patients with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins calculation, which is a validated novel method providing better accuracy than the Friedewald equation in the estimation of LDL-C.

*Martin SS et al. JAMA. 2013;310(19): 2061-2068
(<http://education.QuestDiagnostics.com/faq/FAQ164>)*

Triglycerides

Date	Value	Ref Range	Status
06/22/2018	174 (H)	<150 mg/dL	Final

0043

PAST MEDICAL HISTORY:

He has no past medical history on file.

Immunization History

Administered	Date(s) Administered
• INFLUENZA PF QUAD (PED/ADOL/ADULT),PSKT or VIAL	10/16/2015
• INFLUENZA, UNSPECIFIED FORMULATION	10/24/2009, 11/18/2010, 11/10/2011, 11/09/2012
• TDAP, (ADOL/ADULT)	10/13/2010

PAST SURGICAL HISTORY:

He has a past surgical history that includes Colonoscopy.

FAMILY HISTORY:

His family history includes Other (see comment) in his father and mother.

SOCIAL HISTORY:

reports that he has never smoked. He has never used smokeless tobacco. He reports that he drinks alcohol. He reports that he does not use drugs.

Home Medications-Taking

Medication	Sig
• predniSONE (DELTASONE) 10 mg tablet	TAKE 3 TABS 2XDAY X3DAYS, 2 TABS 2XDAY X3DAYS, 1 TAB 2XDAY X3DAYS 1 TAB DAILY X 3 DAYS

MEDICATIONS:

No current outpatient prescriptions on file prior to visit.

No current facility-administered medications on file prior to visit.

Patient's Medications**New Prescriptions**

No medications on file

Modified Medications

No medications on file

Discontinued Medications

No medications on file

:

ALLERGIES:

No Known Allergies

HEALTH MAINTENANCE:**Preventative Services**

TOPIC	LAST DONE	NEXT DUE
Colorectal Cancer Screening (Fit)	7/03/2018	7/03/2019

0044

TOPIC	LAST DONE	NEXT DUE
Vaccine: Influenza	10/16/2015	9/01/2018
Vaccine: Dtap/Tdap/Td	10/13/2010	10/13/2020

CARE TEAM:

Patient Care Team:
Unknownpcp No as PCP - General

REVIEWED LAB(S):

Recent Results (from the past 1344 hour(s))
Occult Blood, Fecal Immunochemical Test (FIT)
 Collection Time: 07/03/18 10:59

Result	Value	Ref Range
FECAL OCC BLD IMMUNO	SEE NOTE	

REVIEWED RADIOLOGY:

No results found.

Review of Systems:

Constitutional: Denies any fevers, chills, night sweats, decreased appetite or unintentional weight loss.

HEENT: Denies any difficulty swallowing, sore throat, visual disturbance, sinus congestion, otalgia, or hearing loss

Cardiovascular: Denies any chest pain, shortness of breath, palpitations, PND, orthopnea, or syncope.

Respiratory: Denies any dyspnea on exertion, pleuritic chest pain, cough, congestion, wheezing or hemoptysis.

Gastrointestinal: Denies any abdominal pain, heartburn, nausea, vomiting, diarrhea, constipation, melena or hematochezia.

Genitourinary: Denies any hematuria, dysuria, frequency, urgency, discharge, genital lesions, or pain.

Skin: Denies any rashes, inflammation, ulcerations or skin changes.

Neurologic: Denies any headache, seizures, numbness/tingling, weakness, memory loss, .

Endocrine: Denies any polyuria, polydipsia, polyphagia, or any cold or heat intolerance.

PHYSICAL EXAM:**VITAL SIGNS:**

BP (!) 146/92 | Pulse 54 | Resp 16 | Temp 36.8 °C (98.3 °F) | Wt 83.1 kg (183 lb 3.2 oz) | BMI
 Body mass index is 25.55 kg/m².

Blood pressure, heart rate and temperature reviewed.

Constitutional: No apparent distress. Non-toxic appearance. Alert & oriented. Normal speech.

HEENT: Normocephalic. Atraumatic. Neck supple without adenopathy. Oropharynx is clear with moist mucous membranes. Pupils equal, extra ocular movement intact. Sclera are anicteric. Ear canals clear. Tympanic membranes intact. No frontal or maxillary sinus tenderness.

Pulmonary: Lungs clear to auscultation bilaterally, without wheezes, rales or rhonchi. Good respiratory effort. No respiratory distress.

Cardiovascular: S1-S2 Regular rate and rhythm without murmurs, rubs or gallops.

0045

Abdomen: Bowel sounds normal, Soft, No tenderness, No masses, No pulsatile masses. No peritoneal signs. No hepatosplenomegaly.

Extremities: No cyanosis, or edema. Palpable peripheral pulses.

Musculoskeletal: Good ROM throughout all extremities.

Neurological: Face symmetric, speech normal, cranial nerves intact, deep tendon reflexes 2+ throughout, strength 5/5

Skin: Warm and dry. Well perfused. No lesions, erythema, ecchymosis, or rashes noted.

Genitals: normal circumcised penis, no urethral discharge, scrotal contents normal to inspection and palpation, normal testes palpated bilaterally, normal cremasteric reflex, no varicocele present and no hernia detected

Rectal: exam declined by patient

Electronically Signed by Belinda Gay Rouse, NP on 08/19/18 2109

Office Visit
on
6/22/2018

0046

Olivier, Julien L

MRN: 20010147509

Hurig Katchikian, MD
Physician
Specialty: Family Medicine

Progress Notes
Signed
Encounter Date: 10/1/2020

FACEY MEDICAL FOUNDATION VALENCIA INTERNAL MEDICINE TELEPHONE/TELEHEALTH PROGRESS NOTE

Billing Info

Patient Name: Julien L Olivier | **Age:** 53 y.o. | **DOB:** 6/27/1967 | **Medical Record Number:** 20010147509 | **Author:** Hurig Katchikian, MD | **Date of Encounter:** 10/1/2020
Patient Phone: 661-714-7629 (home)

Chief Complaint:

He had no chief complaint listed for this encounter..

HPI:

Julien L Olivier is a 53 y.o. male who presents with a rash.

Pt requesting a referral to a dermatologist.

Pt states that he has had a rash on his forehead for months and tried calamine then nystatin/triamcinolone which he received from the UC which didn't work as well. Has also tried topical washes that have not showed any improvement.

This has now been ongoing for 4 months.

The rash is not itchy, has tried changing shampoo and detergent and rash still persists. Pt states that it is not particularly painful or tender, just causes discomfort with moderate palpation.

Pt states that he has never had shingles before, has not received his shingles vaccine. Denies fevers, changes in eye site, spreading of lesion to other areas.

Assessment and Plan:

1. Facial rash (Primary)

- valACYclovir (VALTREX) 1 g tablet; Take 1 tablet by mouth 3 times daily. Dispense: 21 tablet; Refill: 0
- AMB REFERRAL TO DERMATOLOGY FMF

Discussed trial of acyclovir as vesicles and history suggestive of shingles, has been unresponsive to topical creams and steroids. Pt in agreement to try antiviral, however will place referral to dermatology if sees no response by Monday.

All pertinent labs, studies & exam findings were reviewed today and discussed with patient. Patient expresses understanding of assessment & plan. All questions answered.

0047

Type of Encounter/Disclaimer:

VIRTUAL VIDEO VISIT: I was located at my office. The patient confirmed they were at their permanent address on file, which is in a state in which I am licensed. I was able to see the patient using a 2 way, encrypted connection. They were notified that a copay may be required.

I confirm this is a state in which I am licensed.

Encounter Time:

Total time: 10 minutes

Follow Up:

No follow-ups on file. using the follow up section.
as needed

Active Problems:

There is no problem list on file for this patient.

Medications:**Current Outpatient Medications on File Prior to Visit**

Medication	Sig	Dispense	Refill
• clotrimazole (LOTRIMIN) 1% cream	Apply to affected area twice a day.	60 g	1
• predniSONE (DELTASONE) 10 mg tablet	TAKE 3 TABS 2XDAY X3DAYS, 2 TABS 2XDAY X3DAYS, 1 TAB 2XDAY X3DAYS 1 TAB DAILY X 3 DAYS		0

No current facility-administered medications on file prior to visit.

Allergies:

Patient has no known allergies.

Social History:

- reports that he has never smoked. He has never used smokeless tobacco.
- reports current alcohol use.
- reports no history of drug use.

Family History:**Family History**

Problem	Relation	Age of Onset
• Other (see comment) <i>unknown</i>	Mother	
• Other (see comment) <i>unknown</i>	Father	

Results for most recent visit:

0048

Appointment on 07/03/2018

Component	Date	Value	Ref Range	Status
• FECAL OCC BLD IMMUNO	07/03/2018	SEE NOTE		Final

FECAL GLOBIN BY IMMUNOCHEMISTRY**MICRO NUMBER:** 81740459**TEST STATUS:** FINAL**SPECIMEN SOURCE:** STOOL**SPECIMEN QUALITY:** ADEQUATE**RESULT:** Not Detected**ROS:**

Per HPI/Assess/Plan

Physical Exam:BP taken remotely by digital device
and reviewed by provider.**BP Readings from Last 2 Encounters:**06/22/18 **(!) 146/92**

Video exam: CONSTITUTIONAL: Conversant, and in no acute distress. Alert and Oriented x 3.

EYES: No conjunctival injection or sclera anicteric. No lid swelling. Grossly normal extraocular motions. Pupils are equal bilaterally.

EARS: Hearing grossly intact, external ears appear normal.

NOSE: No external deformities or lesions.

MOUTH: No visible perioral lesions, no perioral cyanosis, no lip swelling.

NECK: Grossly symmetric with normal range of motion. No visible thyroid enlargement.

LUNGS: No audible wheezing, speaking in full sentences. Respiratory effort is normal.

EXTREMITIES: No clubbing or cyanosis noted. Fingernails appear normal.

SKIN: Vesicular rash, mildly erythematous Across right side of forehead, not crossing midline.

Mildly TTP however no weeping, active bleeding or exudate appreciated

PSYCH: Judgment and insight good. Normal mood and affect. Recent memory is good.

Answers questions appropriately.

Hurig Katchikian, MD

Electronically Signed by Hurig Katchikian, MD on 10/01/20 1721

Virtual Office

Visit on

10/1/2020

0049

Olivier, Julien L

MRN: 20010147509

Conversion Transaction, Provider

H&P

Encounter Date: 1/4/2010

Signed

C/C: Rash

Subjective: 42-year-old gentleman complaining off is severely itchy rash on the right hand for last few weeks. He has been treated with hydrocortisone cream without any improvement

Past medical problem : Denied

Social history : Denied smoking

Allergy : None

Objective: 42-year-old gentleman not any apparent distress

Vital: Blood pressure 146/79, pulse 47, respiratory 16, temperature 97.3

Right wrist area: few blister/ erythematous rash noted

Labs/x-rays:

Diagnosis: Rash

Plan: Ketoconazole cream apply locally b.i.d.

If no improvement would refer this patient to dermatology

Electronically signed by: ZINAT CHOUDHURY M.D. Jan 4 2010 5:09PM PST

Last signed by: Provider Unknown Conversion Transaction at 01/04/10 1515

Electronically Signed by Conversion Transaction, Provider on 01/04/10 1515

Outpatient

Historical on

1/4/2010

0050

Olivier, Julien L

MRN: 20010147509

Khoa Dang Nguyen, MD
 Physician
 Immediate Care

UC Provider Notes 
 Signed

Date of Service: 01/05/21 1503
 Creation Time: 01/05/21 1503

FACEY MEDICAL FOUNDATION VALENCIA IMMEDIATE CARE NOTE

Time of evaluation: 3 PM

Patient Name: Julien L Olivier | **Age:** 53 y.o. | **DOB:** 6/27/1967 | **Medical Record Number:** 20010147509 | **Author:** Khoa D. Nguyen, MD | **Date of Encounter:** 1/5/2021

Chief Complaint:

He had concerns including Followup Medical Problem (SOB, pneumonia, treating with steriods and antibiotics - reports he lost his inhaler (covid + 29th)).

HPI:

Julien L Olivier is a 53 y.o. male who presents with Followup Medical Problem (SOB, pneumonia, treating with steriods and antibiotics - reports he lost his inhaler (covid + 29th)). Patient complains of persistent shortness of breath cough and significant fatigue for over a week. Patient was treated to the hospital on January 1 for Covid pneumonia with azithromycin. He noted no improvement of his symptoms. He also is requesting for refill of albuterol inhaler. He denies current fever, chills, headache, nausea, vomiting or chest pain.

Assessment and Plan:

1. Shortness of breath

- albuterol 90 mcg/puff inhaler; Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath. Dispense: 1 Inhaler; Refill: 1
- XR Chest PA and Lateral; Standing
- XR Chest PA and Lateral
- doxycycline (VIBRAMYCIN) 100 mg capsule; Take 1 capsule by mouth 2 times daily for 10 days. Dispense: 20 capsule; Refill: 0
- dexamethasone (DECADRON) 4 mg tablet; Take 1.5 tablets by mouth Daily for 7 days. Dispense: 10 tablet; Refill: 0
- guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid; Take 5-10 mLs by mouth every 6 hours as needed. Dispense: 180 mL; Refill: 0

2. Lower respiratory tract infection due to COVID-19 virus

- albuterol 90 mcg/puff inhaler; Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath. Dispense: 1 Inhaler; Refill: 1
- XR Chest PA and Lateral; Standing
- XR Chest PA and Lateral
- doxycycline (VIBRAMYCIN) 100 mg capsule; Take 1 capsule by mouth 2 times daily for 10 days. Dispense: 20 capsule; Refill: 0
- dexamethasone (DECADRON) 4 mg tablet; Take 1.5 tablets by mouth Daily for 7 days. Dispense: 10 tablet; Refill: 0
- guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid; Take 5-10 mLs by mouth every 6 hours as needed. Dispense: 180 mL; Refill: 0

3. Pneumonia due to COVID-19 virus

- doxycycline (VIBRAMYCIN) 100 mg capsule; Take 1 capsule by mouth 2 times daily for 10 days. Dispense: 20 capsule; Refill: 0

0051

- dexamethasone (DECADRON) 4 mg tablet; Take 1.5 tablets by mouth Daily for 7 days.
Dispense: 10 tablet; Refill: 0
- guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid; Take 5-10 mLs by mouth every 6 hours as needed. Dispense: 180 mL; Refill: 0

XR Chest PA and Lateral

Result Date: 1/5/2021

XR CHEST PA AND LATERAL 1/5/2021 2:48 PM INDICATION: Shortness of breath, positive COVID-19 test. COMPARISON: None. FINDINGS: Patchy pulmonary interstitial infiltrates are present in the left lower lobe. No pneumothorax or pleural effusion. Heart size is normal. The mediastinum is unremarkable. No acute osseous abnormality.

IMPRESSION: Patchy left lower lobe infiltrates with intermediate suspicion pattern for COVID-19 pneumonia. Dictated by: Lily Yang, MD on 1/5/2021 2:49 PM Electronically signed by: Lily Yang, MD on 1/5/2021 2:51 PM

Chest x-ray shows left lower lobe infiltrate as noted.

ED Prescriptions

	Sig
albuterol 90 mcg/puff inhaler	Inhale 2 puffs into the lungs every 6 hours as needed for Wheezing or Shortness of Breath.
doxycycline (VIBRAMYCIN) 100 mg capsule	Take 1 capsule by mouth 2 times daily for 10 days.
dexamethasone (DECADRON) 4 mg tablet	Take 1.5 tablets by mouth Daily for 7 days.
guaiFENesin-codeine (ROBITUSSIN AC) 100-10 mg/5 mL liquid	Take 5-10 mLs by mouth every 6 hours as needed.

Patient was evaluated in the Surge Clinic. All contact personnel wore PPE protection during history, physical exam, testing, treatment and instructions prior to discharge.

Home quarantine for 10 days from the onset of symptoms. A lot of basic reassurance given. His pulse ox and pulse are normal today.

I recommended Vitamin C 500 mg BID, Vit D 2000-4000 mg/day and Zinc 100 mg/day Increase fluids, rest and OTC medication were advised.

Follow up if symptoms worsen, high fever, SOB, chest pain or not resolved after 10 days.

I spent more than 30 minutes face-to-face interaction with patient and more than 50% of that time was on direct counseling.

Follow Up:

Chart was reviewed. Care instructions and warning signs were discussed. Medications per orders. Side effects discussed. All pertinent labs, studies & exam findings were reviewed today and discussed with patient. Patient expresses understanding of assessment & plan. All questions were answered prior to discharge.

AVS printed and given to patient and printed information sheet was provided. General an ER precautions were reviewed.

Follow-up with primary care doctor for further evaluation and treatment if no improvement or as directed.

Review of Systems:

Constitutional: No unintentional weight loss.

HEENT: No difficulties with hearing. No difficulty swallowing, sore throat or mouth pain.

Heme/Lymphatic: No abnormal bleeding or bruises. Unaware of any adenopathy.

Cardiovascular: No anginal chest pain, palpitations or orthopnea.

Gastrointestinal: No nausea, vomiting, diarrhea, or significant change in bowels. No melena or hematochezia.

Genitourinary: No hematuria, dysuria, increased frequency or urgency.

Skin: No rashes, inflammation, ulcerations or skin changes.

Neurologic: No new numbness, weakness or tingling.

Endocrine: No polyuria or polydipsia. No cold or heat intolerance.

All other pertinent review of systems are negative.

Active Problems:

There is no problem list on file for this patient.

Medications:

PTA Home Medications

Medication	Sig
• clotrimazole (LOTRIMIN) 1% cream	Apply to affected area twice a day.
• valACYclovir (VALTREX) 1 g tablet	Take 1 tablet by mouth 3 times daily.

Medications - No data to display

Allergies:

Patient has no known allergies.

Past Medical History:

No past medical history on file.

Past Surgical History:

Past Surgical History:

Procedure	Laterality	Date
• COLONOSCOPY		

Social History:

Social History

Socioeconomic History

• Marital status:	Married
Spouse name:	Not on file
• Number of children:	Not on file
• Years of education:	Not on file
• Highest education level:	Not on file

Tobacco Use

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used

0053

Substance and Sexual Activity

- Alcohol use: Yes
Comment: 2-3 beers a month
- Drug use: No

Social Determinants of Health**Financial Resource Strain:**

- Difficulty of Paying Living Expenses: Not on file

Food Insecurity:

- Worried About Running Out of Food in the Last Year: Not on file
- Ran Out of Food in the Last Year: Not on file

Transportation Needs:

- Lack of Transportation (Medical): Not on file
- Lack of Transportation (Non-Medical): Not on file

Physical Activity:

- Days of Exercise per Week: Not on file
- Minutes of Exercise per Session: Not on file

Stress:

- Feeling of Stress : Not on file

Social Connections:

- Frequency of Communication with Friends and Family: Not on file
- Frequency of Social Gatherings with Friends and Family: Not on file
- Attends Religious Services: Not on file
- Active Member of Clubs or Organizations: Not on file
- Attends Club or Organization Meetings: Not on file
- Marital Status: Not on file

Intimate Partner Violence:

- Fear of Current or Ex-Partner: Not on file
- Emotionally Abused: Not on file
- Physically Abused: Not on file
- Sexually Abused: Not on file

Family History:**Family History**

Problem	Relation	Age of Onset
• Other (see comment) <i>unknown</i>	Mother	
• Other (see comment) <i>unknown</i>	Father	

Physical Exam:**Triage Vital Signs:**

BP 121/85 | Pulse 68 | Temp 36.6 °C (97.9 °F) | Resp 18 | SpO2 95%

The vital signs were reviewed.

Constitutional: No apparent distress. Does not appear ill. Non-toxic appearance. Alert & oriented. Normal speech.**0054**

HEENT: Normocephalic. Atraumatic. Throat not examined. Pupil's equal, extra ocular movement intact. Neck supple without adenopathy. Sclera anicteric. TMs are intact and clear bilaterally.

Pulmonary: Lungs clear to auscultation without wheezes, rales or rhonchi. Good respiratory effort. No respiratory distress.

Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops.

Extremities: No cyanosis, or edema. Palpable peripheral pulses.

Skin: Warm and dry. No erythema. No petechiae.



Khoa Dang Nguyen, MD

01/05/21 1524

Electronically Signed by Khoa Dang Nguyen, MD on 01/05/21 1524

UC on 1/5/2021

Note shared with
patient

0055

△ Occult Blood, Fecal Immunochemical Test (FIT)

Order: 600976582

Collected: 7/3/2018 10:59

[View Full Report](#)

Component 2 yr ago
FECAL OCC BLD SEE NOTE
IMMUNO

Comment: FECAL GLOBIN BY IMMUNOCHEMISTRY

MICRO NUMBER: 81740459
 TEST STATUS: FINAL
 SPECIMEN SOURCE: STOOL
 SPECIMEN QUALITY: ADEQUATE
 RESULT: Not Detected

Result Care Coordination [Result Notes](#)**Older Notes**

Notes recorded by Belinda Gay Rouse, NP on 7/9/2018 at 14:41 PDT
 Stool negative for blood.

[Follow-up Encounters](#)[7/9/2018 Letter \(Out\)](#)**❗ Urinalysis with Microscopic with Culture if Indicated**

Order: 600976579

Collected: 6/22/2018 14:39 Status: Edited Result - FINAL

Specimen Information: Urine, Clean Catch

[View Full Report](#)

	Ref Range & Units	2 yr ago
Color, UA	YELLOW	YELLOW
Clarity, Urine	CLEAR	CLOUDY !
Specific Gravity, Urine	1.001 - 1.035	1.029
pH, Urine	5.0 - 8.0	5.5
Glucose, UA	NEGATIVE	NEGATIVE
Bilirubin, UA	NEGATIVE	NEGATIVE
Ketones, UA	NEGATIVE	NEGATIVE
Blood, UA	NEGATIVE	NEGATIVE
Protein, UA	NEGATIVE	NEGATIVE
Nitrite, UA	NEGATIVE	NEGATIVE
Leukocyte esterase, UA	NEGATIVE	NEGATIVE
WBC, UA	< OR = 5 /HPF	NONE SEEN
RBC, UA	< OR = 2 /HPF	0-2

0056

Squamous epithelial, UA	< OR = 5 /HPF	NONE SEEN
Bacteria, UA	NONE SEEN /HPF	MODERATE !
Crystals, Uric Acid	NONE OR FEW /HPF	MANY !
Hyaline cast, UA	NONE SEEN /LPF	NONE SEEN
Comment	MODERATE MUCOUS THREADS	

Result Care Coordination



Older Notes

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

Please advise patient to increase water. His urine is cloudy.

His thyroid function, blood count, prostate, kidney function, and electrolytes, screening for diabetes, and liver function is WNL

Hepatitis C negative

Triglycerides are elevates. Eat more fruits and vegetables. Avid fats, red meat, carbs, and processed foods.



6/26/2018 Telephone

cultura, Urine, Reflexive

Order: 600976581 - Reflex for Order 600976579

Collected: 6/22/2018 14:39

Specimen Information: Urine, Clean Catch

[View Full Report](#)

Component 2 yr ago

Culture Result NO CULTURE INDICATED

Result Care Coordination



Older Notes

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

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6/26/2018 Telephone

cultura, Hemoglobin A1C

Order: 600976578

0057

Collected: 6/22/2018 13:00

[View Full Report](#)

	Ref Range & Units	2 yr ago
Hemoglobin A1c	<5.7 % of total Hgb	5.2

Comment: For the purpose of screening for the presence of diabetes:

- | | |
|-------------|---|
| <5.7% | Consistent with the absence of diabetes |
| 5.7-6.4% | Consistent with increased risk for diabetes (prediabetes) |
| > or = 6.5% | Consistent with diabetes |

This assay result is consistent with a decreased risk of diabetes.

Currently, no consensus exists regarding use of hemoglobin A1c for diagnosis of diabetes in children.

According to American Diabetes Association (ADA) guidelines, hemoglobin A1c <7.0% represents optimal control in non-pregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes (ADA).

Estimated Average Glucose	(calc)	103
Estimated Average Glucose	(calc)	5.7

Result Care Coordination[Result Notes](#)[Older Notes](#)

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

Triglycerides are elevated. Eat more fruits and vegetables. Avoid fats, red meat, carbs, and processed foods.

[Follow-up Encounters](#)

[6/26/2018 Telephone](#)

! Lipid Panel

Order: 600976577

Collected: 6/22/2018 12:59 Status: Edited Result - FINAL

0058

[View Full Report](#)

	Ref Range & Units	2 yr ago
Cholesterol	<200 mg/dL	182
HDL Cholesterol	>40 mg/dL	66
Triglycerides	<150 mg/dL	174 ▲
LDL, Calculated	mg/dL (calc)	89

Comment: Reference range: <100

Desirable range <100 mg/dL for primary prevention;
<70 mg/dL for patients with CHD or diabetic patients
with > or = 2 CHD risk factors.

LDL-C is now calculated using the Martin-Hopkins
calculation, which is a validated novel method providing
better accuracy than the Friedewald equation in the
estimation of LDL-C.

Martin SS et al. JAMA. 2013;310(19): 2061-2068
(<http://education.QuestDiagnostics.com/faq/FAQ164>)

Chol/HDL Ratio	<5.0 (calc)	2.8
Non-HDL Cholesterol	<130 mg/dL (calc)	116
Comment: For patients with diabetes plus 1 major ASCVD risk factor, treating to a non-HDL-C goal of <100 mg/dL (LDL-C of <70 mg/dL) is considered a therapeutic option.		

Related Result Highlights

[Basic Metabolic Panel](#) Edited Result - FINAL

6/22/2018

[PSA, Screen](#) Final result

6/22/2018

Result Care Coordination

[Result Notes](#)



Older Notes

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

Triglycerides are elevated. Eat more fruits and vegetables. Avoid fats, red meat, carbs, and processed foods.

[Follow-up Encounters](#)

6/26/2018 Telephone

[PSA, Screen](#)

Order: 600976576

0059

Collected: 6/22/2018 12:59

[View Full Report](#)

	Ref Range & Units	2 yr ago
PSA, Total	< OR = 4.0 ng/mL	1.2

Comment: The total PSA value from this assay system is standardized against the WHO standard. The test result will be approximately 20% lower when compared to the equimolar-standardized total PSA (Beckman Coulter). Comparison of serial PSA results should be interpreted with this fact in mind.

This test was performed using the Siemens chemiluminescent method. Values obtained from different assay methods cannot be used interchangeably. PSA levels, regardless of value, should not be interpreted as absolute evidence of the presence or absence of disease.

Related Result Highlights[Basic Metabolic Panel](#) Edited Result - FINAL

6/22/2018

[Lipid Panel](#) Edited Result - FINAL

6/22/2018

Result Care Coordination[Result Notes](#)**Older Notes**

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

Triglycerides are elevated. Eat more fruits and vegetables. Avoid fats, red meat, carbs, and processed foods.

[Follow-up Encounters](#)

6/26/2018 Telephone

❗ CBC with Differential

Order: 600967734

Collected: 6/22/2018 12:59

[View Full Report](#)

	Ref Range & Units	2 yr ago
WBC	3.8 - 10.8 Thousand/uL	12.2 ▲
Red Blood Cells	4.20 - 5.80 Million/uL	4.95
Hemoglobin	13.2 - 17.1 g/dL	15.8

0060

Hct	38.5 - 50.0 %	46.8
MCV	80.0 - 100.0 fL	94.5
MCH	27.0 - 33.0 pg	31.9
MCHC	32.0 - 36.0 g/dL	33.8
RDW	11.0 - 15.0 %	12.4
Platelet Count	140 - 400 Thousand/uL	310
MPV	7.5 - 12.5 fL	9.8
Absolute Neutrophils	1500 - 7800 cells/uL	7393
Absolute Lymphocytes	850 - 3900 cells/uL	3575
Absolute Monocytes	200 - 950 cells/uL	1061 ▲
Absolute Eosinophils	15 - 500 cells/uL	122
Absolute Basophils	0 - 200 cells/uL	49
ABSOLUTE NUCLEATED	0 cells/uL	0
RBC		
% Neutrophils	%	60.6
% Lymphocytes	%	29.3
% Monocytes	%	8.7
% Eosinophils	%	1.0
% Basophils	%	0.4

Result Care Coordination



Older Notes

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

Triglycerides are elevates. Eat more fruits and vegetables. Avid fats, red meat, carbs, and processed foods.



6/26/2018 Telephone

Basic Metabolic Panel

Order: 600967733

Collected: 6/22/2018 12:59 Status: Edited Result - FINAL

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Glucose	Ref Range & Units 65 - 99 mg/dL	2 yr ago 89
Comment:		
Fasting reference interval		

BUN	7 - 25 mg/dL	26 ▲
Creatinine	0.70 - 1.33 mg/dL	1.20

0061

Comment: For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.

eGFR if not AFRICAN AMERICAN	> OR = 60 mL/min/1.73m ²	70
eGFR, African American	> OR = 60 mL/min/1.73m ²	81
BUN/Creatinine Ratio	6 - 22 (calc)	22
Sodium	135 - 146 mmol/L	141
Potassium	3.5 - 5.3 mmol/L	4.1
Chloride	98 - 110 mmol/L	101
Carbon dioxide	20 - 31 mmol/L	27
Calcium	8.6 - 10.3 mg/dL	9.5

Related Result Highlights

[PSA, Screen](#) Final result

6/22/2018

[Lipid Panel](#) Edited Result - FINAL

6/22/2018

Result Care Coordination

[Result Notes](#)



Older Notes

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

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Hepatitis C negative

Triglycerides are elevated. Eat more fruits and vegetables. Avid fats, red meat, carbs, and processed foods.

[Follow-up Encounters](#)

[6/26/2018 Telephone](#)

TSH

Order: 600967732

Collected: 6/22/2018 12:59 Status: Edited Result - FINAL

[View Full Report](#)

	Ref Range & Units	2 yr ago
TSH	0.40 - 4.50 mIU/L	3.95

Related Result Highlights

[Hepatic Function Panel](#) Final result

6/22/2018

[T4, Free](#) Edited Result - FINAL

6/22/2018

0062

Result Care Coordination**Older Notes**

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

Please advise patient to increase water. His urine is cloudy.

His thyroid function, blood count, prostate, kidney function, and electrolytes, screening for diabetes, and liver function is WNL

Hepatitis C negative

Triglycerides are elevates. Eat more fruits and vegetables. Avid fats, red meat, carbs, and processed foods.



[6/26/2018 Telephone](#)

△ T4, Free

Order: 600967731

Collected: 6/22/2018 12:59 Status: Edited Result - FINAL

[View Full Report](#)

	Ref Range & Units	
FREE T4 (REF)	0.8 - 1.8 ng/dL	2 yr ago 1.5

Related Result Highlights

[Hepatic Function Panel](#) Final result

6/22/2018

[TSH](#) Edited Result - FINAL

6/22/2018

Result Care Coordination**Older Notes**

Notes recorded by Belinda Gay Rouse, NP on 6/25/2018 at 23:41 PDT

Please advise patient to increase water. His urine is cloudy.

His thyroid function, blood count, prostate, kidney function, and electrolytes, screening for diabetes, and liver function is WNL

Hepatitis C negative

Triglycerides are elevates. Eat more fruits and vegetables. Avid fats, red meat, carbs, and processed foods.



[6/26/2018 Telephone](#)

0063