CONFIDENTIAL PATIENT MASTER RECORD

PATIENT ID: 220 | MRN: MRN-220-2025

I. REGISTRATION FACE SHEET

PATIENT IDENTITY	
Name:	Rachel Green
DOB:	1970-05-05
Gender:	female
Race:	Caucasian
Height:	5 ft 4 in
Weight:	155 lbs
Telecom:	212-555-1994
Address:	495 Grove Street, Apt 20, New York, NY 10014
Marital Status:	Divorced
Multiple Birth:	No (Order: 1)

COMMUNICATION	
Language:	English
Preferred:	Yes

EMERGENCY CONTACT	
Relationship:	Emergency Contact
Name:	Monica Geller
Telecom:	212-555-1995
Address:	495 Grove Street, Apt 19, New York, NY 10014
Gender:	female
Organization:	N/A
Period Start:	1994-09-22
Period End:	ongoing

PRIMARY PROVIDER	
General Practitioner:	Dr. Angela Martin, MD
Managing Organization:	Greenwich Village General Hospital

INSURANCE / PAYER	
Payer ID:	J1113
Payer Name:	Aetna
Plan Name:	Gold PPO

Plan Type:	PPO
Group ID:	RAL789
Group Name:	Ralph Lauren
Member ID:	AETNA987654321
Policy Number:	POL789123
Effective Date:	2023-01-01
Termination Date:	ongoing
Copay:	$40
Deductible:	$1500
SUBSCRIBER	
Subscriber ID:	MEM987654321
Subscriber Name:	Rachel Green
Relationship:	Self
Subscriber DOB:	1970-05-05
Subscriber Address:	495 Grove Street, Apt 20, New York, NY 10014

II. MEDICAL BIOGRAPHY & HISTORY

Rachel Green is a 54-year-old female fashion executive with a long-standing history of hypertension, now presenting with a new, life-altering diagnosis of End-Stage Renal Disease (ESRD). Originally from Long Island, Ms. Green moved to New York City in her twenties and has built a successful career. Her social history is notable for a period of smoking in her youth, which she quit over 20 years ago. She drinks socially, consuming 2-3 glasses of wine per week. Her diet has historically been varied, but she is now under instruction to follow strict renal and low-sodium guidelines.

The patient's medical history was unremarkable until her thirties when she was diagnosed with essential hypertension, which has been managed with varying success over the years. Over the past year, she noted increasing fatigue and intermittent swelling in her ankles, which she initially attributed to her demanding work schedule and frequent travel. However, in recent months, the symptoms progressed significantly, accompanied by nausea and a noticeable decrease in urination, prompting a visit to her primary care physician, Dr. Martin. The subsequent workup, including blood tests, revealed severe kidney dysfunction, leading to the diagnosis of ESRD.

This diagnosis has been a significant shock to Ms. Green, who has always maintained an active lifestyle. She is currently struggling with the physical manifestations of her illness, particularly the debilitating fatigue which impacts her work and social life. She has a strong support system in her close friends, particularly her emergency contact, Monica Geller. Clinically, the plan is to initiate hemodialysis as a life-sustaining measure. This request for prior authorization is for the initiation of hemodialysis treatments. Although the referral is being managed by her PCP, this is a necessary and urgent step while a long-term nephrology relationship is established at the chosen dialysis center.

III. CLINICAL REPORTS & IMAGING

■ *PRIMARY CARE PROGRESS NOTE*

Report Text:
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Patient: Rachel Green (MRN: MRN-220)

DOB: 1970-05-05
Date of Service: 2024-08-10
Attending Physician: Dr. Angela Martin, MD

SUBJECTIVE
Chief Complaint: "I feel tired all the time and my ankles are so swollen I can barely get my shoes on."

History of Present Illness: Ms. Rachel Green is a 54-year-old female with a history of hypertension, presenting today with a several-month history of progressively worsening fatigue, generalized weakness, and significant peripheral edema. She reports that the fatigue has become debilitating, making it difficult to perform her duties at work. She notes her energy levels are "at an all-time low." Over the past 4-6 weeks, she has noticed significant swelling in her bilateral ankles and lower legs, which worsens throughout the day and does not fully resolve overnight. She also reports a decrease in urine output and occasional nausea, particularly in the mornings. She denies any chest pain, shortness of breath, fever, or chills. She has been monitoring her blood pressure at home, with readings consistently in the 160s/90s despite adherence to her prescribed lisinopril.

Review of Systems:
- CONSTITUTIONAL: Reports significant fatigue and malaise. Denies fever, chills, weight loss.
- EYES: Denies vision changes.
- HENT: Denies sore throat, earache.
- CARDIOVASCULAR: Denies chest pain, palpitations. Reports bilateral lower extremity edema.
- RESPIRATORY: Denies cough, shortness of breath, or wheezing.
- GASTROINTESTINAL: Reports intermittent nausea. Denies vomiting, diarrhea, or abdominal pain.
- GENITOURINARY: Reports noticeably decreased urine output. Denies dysuria or hematuria.
- MUSCULOSKELETAL: Denies joint pain or muscle aches.
- NEUROLOGICAL: Denies headaches, dizziness, or focal weakness.
- SKIN: Reports dry, itchy skin. No new rashes.

OBJECTIVE
Vitals:
- BP: 162/95 mmHg (seated, right arm)
- HR: 84 bpm
- RR: 16 breaths/min
- Temp: 98.4°F
- SpO2: 97% on...

■ *CARDIOLOGY CONSULT NOTE*

Report Text:
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Patient: Rachel Green (MRN: MRN-220)
DOB: 1970-05-05
Date of Consultation: 2024-08-20
Consulting Physician: Dr. Oscar Martinez, MD, FACC
Referring Physician: Dr. Angela Martin, MD

REASON FOR CONSULTATION: Management of poorly controlled hypertension in the setting of newly diagnosed

Stage 5 Chronic Kidney Disease / End-Stage Renal Disease.

HISTORY OF PRESENT ILLNESS: I had the pleasure of evaluating Ms. Green, a 54-year-old female, in cardiology consultation today. She was referred by Dr. Martin following a recent workup that confirmed a diagnosis of ESRD (GFR of 8 mL/min). The patient has a known history of essential hypertension for approximately 10 years, which has become increasingly difficult to control. Her primary concerns remain fatigue and edema, but Dr. Martin has requested guidance on optimizing her antihypertensive regimen as she is prepared for renal replacement therapy. The patient is currently on Lisinopril 20 mg daily but her home BPs remain in the 160s/90s. She denies any anginal chest pain, dyspnea on exertion, orthopnea, or paroxysmal nocturnal dyspnea. She has no history of myocardial infarction, stroke, or peripheral artery disease.

PAST MEDICAL HISTORY:
1. End-Stage Renal Disease (diagnosed 2024-08-10)
2. Hypertension (for ~10 years)

MEDICATIONS:
1. Lisinopril 20 mg daily

REVIEW OF SYSTEMS:
As per referring note, focused review is negative for chest pain, palpitations, syncope, or claudication. Positive for lower extremity edema and fatigue.

OBJECTIVE
Vitals:
- BP: 158/92 mmHg (left arm, seated), 160/94 mmHg (right arm, seated)
- HR: 80 bpm, regular
- SpO2: 98% on room air

Physical Examination:
- GENERAL: Alert and oriented, appears tired.
- NECK: Carotid upstrokes are 2+ and symmetric without bruits. No JVD.
- LUNGS: Clear to auscultation bilaterally.
- HEART: Regular rhythm. A soft S4 gallop is audible at the apex, consistent with long-stand...

■ *LAB REPORT RENAL PANEL*

Report Text:
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Patient: Rachel Green (MRN: MRN-220)
DOB: 1970-05-05
Accession #: ACC-2024-45901
Collection Date: 2024-09-05 09:15:00
Report Date: 2024-09-05 11:00:00
Ordering Provider: Dr. Angela Martin, MD

TEST: COMPREHENSIVE METABOLIC PANEL

| TEST NAME | RESULT | FLAG | REFERENCE RANGE | UNITS |

|---|---|---|---|---|
SODIUM	138		136-145	mmol/L
POTASSIUM	5.9	H	3.5-5.1	mmol/L
CHLORIDE	104		98-107	mmol/L
CARBON DIOXIDE (BICARBONATE)	17	L	22-29	mmol/L
UREA NITROGEN (BUN)	85	H	7-20	mg/dL
CREATININE, SERUM	8.1	H	0.59-1.04	mg/dL
eGFR NON-AFR AMERICAN	7	L	>60	mL/min/1.73m2
GLUCOSE	95		70-99	mg/dL
CALCIUM	8.2	L	8.6-10.3	mg/dL
PROTEIN, TOTAL	6.1		6.4-8.3	g/dL
ALBUMIN	3.4	L	3.5-5.2	g/dL
ALKALINE PHOSPHATASE	135	H	44-121	IU/L
AST (SGOT)	22		0-32	IU/L
ALT (SGPT)	18		0-33	IU/L
BILIRUBIN, TOTAL	0.5		0.1-1.2	mg/dL

TEST: COMPLETE BLOOD COUNT (CBC) W/ DIFFERENTIAL

| TEST NAME | RESULT...

■ *AV FISTULA PLACEMENT OP NOTE*

Report Text:
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PATIENT: Rachel Green
MRN: MRN-220
DATE OF PROCEDURE: 2024-09-15
SURGEON: Dr. Kevin Malone, MD
ANESTHESIA: Monitored Anesthesia Care (MAC) with local

PRE-OPERATIVE DIAGNOSIS: End-Stage Renal Disease (N18.6)
POST-OPERATIVE DIAGNOSIS: End-Stage Renal Disease (N18.6)

PROCEDURE PERFORMED: Creation of left brachiocephalic arteriovenous fistula (CPT 36831)

INDICATIONS FOR PROCEDURE:
Ms. Green is a 54-year-old female with ESRD who requires permanent access for hemodialysis. Preoperative duplex ultrasonography demonstrated suitable cephalic vein and brachial artery in the left upper extremity. The risks, benefits, and alternatives to the procedure were discussed at length with the patient, and she provided informed consent.

DESCRIPTION OF PROCEDURE:
The patient was brought to the operating room and positioned supine on the operating table. The left upper extremity was prepped and draped in the usual sterile fashion. Monitored anesthesia care was initiated by the anesthesia team. A timeout was performed confirming correct patient, procedure, and site.

A transverse incision was made in the antecubital fossa of the left arm. The brachial artery and cephalic vein were identified and dissected free from surrounding tissues using careful sharp and blunt dissection. Vessel loops were placed around the artery and vein for proximal and distal control.

After ensuring adequate mobilization, the cephalic vein was ligated distally. A small venotomy was made. The vein was then spatulated and prepared for anastomosis. Proximal and distal control of the brachial artery was obtained. A longitudinal arteriotomy of approximately 6 mm was made with a #11 blade. The artery was flushed with heparinized saline.

A side-to-side anastomosis was then created between the cephalic vein and the brachial artery using a running 7-0 Prolene suture. Before completing the anastomosis, both vessels were back-bled and flushed to e...

■ *DIALYSIS TREATMENT PLAN*

Report Text:
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Patient: Rachel Green (MRN: MRN-220)
DOB: 1970-05-05
Date of Plan: 2024-10-20
Author: Dr. Angela Martin, MD

SUBJECT: Plan of Care for Initiation of Renal Replacement Therapy

ASSESSMENT: Ms. Green is a 54-year-old female with End-Stage Renal Disease (N18.6) secondary to hypertensive nephrosclerosis. Her most recent GFR is 7 mL/min/1.73m2. She is experiencing significant uremic symptoms including severe fatigue, metabolic acidosis, hyperkalemia, and volume overload despite medical management. Her condition is now refractory to conservative therapies. The patient has successfully undergone placement of a left brachiocephalic AV fistula on 2024-09-15, which has been examined and is maturing well with a good thrill and bruit. She is now clinically indicated and prepared for the initiation of hemodialysis.

PROBLEM LIST:
1. End-Stage Renal Disease (ESRD) - Requiring renal replacement therapy.
2. Hypertensive Chronic Kidney Disease
3. Anemia of Chronic Kidney Disease
4. Secondary Hyperparathyroidism
5. Fluid Volume Overload

TREATMENT GOALS:
1. Alleviate uremic symptoms (fatigue, nausea).
2. Correct metabolic derangements (acidosis, hyperkalemia, hyperphosphatemia).
3. Manage fluid volume to control blood pressure and edema.
4. Improve overall quality of life and ability to function.

PLAN:
1. Procedure: Initiation of outpatient hemodialysis (CPT 90935).
- **Frequency**: Three times per week (Monday, Wednesday, Friday).
- **Duration**: 4 hours per session.

- **Target Start Date**: On or around 2024-11-15.
- **Location**: This request is to authorize treatment at the Greenwich Village Dialysis Center.

2. Dialysis Prescription (to be managed by dialysis center nephrologist upon acceptance):
- **Dialyzer**: High-flux synthetic membrane.
- **Blood Flow Rate (BFR)**: To start at 300 mL/min and titrate up as tolerated.
- **Dialysate Flow Rate (DFR)**:...
