**Ashley Williams: Patient Information** 

Patient Record Number:6294

Texas Physician House Calls (H)
2925 Skyway Circle North, Irving, TX, USA, 75038-3510
www.texashousecalls.com, Phone:(972) 675-7313, Fax:(972) 675-7310,
Email:hhsupport@texashousecalls.com

Name: Ashley N Williams External ID: 6294 **DOB**: 1990-04-26 Sex: Female

Marital Status: Divorced

Patient Drive Folder: 0B0x\_tbqdBDPhWkhvLUVYMGMyY3M

Address: 3006 Mesa View Dr

City: Dallas State: Texas Postal Code: 75241 Country: USA

Guardian's Name: Jakson Dennis Emergency Contact: 469-348-1541 Street Address: 3006 Mesa View Dr

Apt/Suite/Other: House

## **Family History:**

Last Recorded On: 01-26-2017.

Father: Father died, complaints of sleep apnea, hypertension, and diabetes mellitus 2. .

Mother: Mother is alive ..

Siblings: Three brothers and three sisters..

Offspring: None..

## **Social History:**

Last Recorded On: 01-26-2017.

Tobacco: Smokes 1 pack per day. Status: Current Alcohol: Drinks 12 pack weekly. Status: Current Recreational Drugs: No drug abuse. Status: Never

Nutrition History: Regular diet..

Developmental History: Educational level is 12th grade..

Other History: No immunizations..

#### Insurance:

## Humana (61101)

**Priority:** Primary **Start Date**: 2016-09-01

Relationship to Insured: Self

Type: N/A

Payer: Humana (61101)

Copay:

**Insured ID Number:** H7406018800

**Group Number:** 

Employer Name: Ashley Williams

### **Immunizations:**

**Ashley Williams: Chief Complaint** 

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> Seen by Sumana Ketha MD Seen on 27-December-2016

#### Chief Complaint Status: finalized

Follow-up home visit to prevent further decline of the following chronic medical conditions of schizophrenia, insomnia, epilepsy, and major depression. Patient complains of lower back pain.

## **History of Present illness:**

#### **HPI Status:**Finalized

A 26-year-old Caucasian female in no acute distress with multiple chronic conditions of schizophrenia, insomnia, epilepsy, and major depression. Patient states that she has been having lower back pain for several years and that is chronic. Patient denies any other issues upon examination. Patient denies any chest pain, headache, nausea/vomiting recently.

#### Vitals:

Service Date	BPS	BPD	Wt	Ht	Temperature	RR	Note	BMI	Head circ
2016-12-27	116	82	190.00	66.00	97.60	16.00	~	30.7	0.00

## **Review of Systems:**

#### Constitutional:

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**Eine** Dedi

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No Diembea

No Constipation

## **Physical Exam:**

#### NEBRO:

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#### ESYCH:

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Aboling 了 C 本A Sa MA fit Coince Stroom a Oppiporito priately-Within Normal Limits.

Lungs Clear, Rales, Rhonchi, Wheezes-Within Normal Limits .

## **Medication:**

Description	Status	Start Date	End Date
Topiramate ,50 MG TABS, TAKE 1 TABLET TWICE DAILY, Quantity:			
60, Refill Quantity: 2			
Unknown or N/A	Active	2017-01-05	
by ketha, Dr sumana - BK6230281			
Texas Physician House Calls			

Omeprazole, 20 MG CPDR, TAKE ONE CAPSULE ONCE DAILY, Quantity: 30, Refill Quantity: 2 Unknown or N/A Active 2016-11-28 by Jones, Derrick - MJ3217331 Texas Physician House Calls Sertraline HCI ,100 MG TABS, TAKE 1 TABLET AT BEDTIME, Quantity: 30, Refill Quantity: 2 2016-11-28 Active Unknown or N/A by Jones, Derrick - MJ3217331 Texas Physician House Calls TraZODone HCI,50 MG TABS, TAKE 1 TABLET AT BEDTIME, Quantity: 30, Refill Quantity: 2 Active 2016-11-28 Unknown or N/A by Jones, Derrick - MJ3217331 Texas Physician House Calls

### Plan Note:

#### Plan Note Status: Finalized

Continue same treatment plan his previous provider. Reviewed and continue same medications, no new medications noted this visit. Medication adherence education was given to the patient and the patient educated on the benefits of low salt, low-fat, low cholesterol diet with current medical conditions. Patient was instructed to go to ER for symptoms of chest pain, shortness of breath, excessive headache, blurry vision or systolic blood pressure greater than 200. Patient was encouraged to exercise daily as tolerated. No labs needed this visit. Patient verbalized understanding of the above plan and was given the office number for any questions or concerns. Prognosis is fair and patient is stable. Reviewed old records of the patient. Follow up appointment in 4-6 weeks.

Epilepsy continue current plan
Lumbago w/chronic pain continue current plan
Major Depression continue current plan
Chronic Pain Syndrome continue current pain medication
Insomnia continue current plan
Schizophrenia continue current plan

Medication refills as follows, Loratadine 10 mg q.d. Hydralazine 50 mg t.i.d. Gabapentin 100 mg t.i.d. Topiramate 50 mg b.i.d. Norco 10/325 mg t.i.d. Sertraline 100 mg q.d. Trazadone 50 mg q.h.s. Omerprazole 20 mg q.d.

## **Medical Problem:**

Description	Status	Start Date	End Date
Chronic pain syndrome ( ICD10:G89.4 Chronic pain syndrome) Unknown or N/A	Active	2016-12-27	
Low back pain ( ICD10:M54.5 Low back pain) Unknown or N/A	Active	2016-11-23	
Other chronic pain ( ICD10:G89.29 Other chronic pain) Unknown or N/A	Active	2016-11-23	
Schizophrenia, unspecified (ICD10:F20.9 Schizophrenia, unspecified) Unknown or N/A	Active	2016-10-12	
Acute pharyngitis, unspecified ( ICD10:J02.9 Acute pharyngitis, unspecified) Unknown or N/A	Active	2016-09-06	
Insomnia, unspecified ( ICD10:G47.00 Insomnia, unspecified) Unknown or N/A	Active	2016-09-06	

Epilepsy, unspecified, not intractable, without status epilepticus (ICD10:G40.909 Epilepsy, unspecified, not intractable, without status epilepticus) Unknown or N/A	Active	2016-09-06
Major depressive disorder, single episode, unspecified		
( ICD10:F32.9 Major depressive disorder, single episode, unspecified)	Active	2016-09-06
Unknown or N/A		

# **Allergies:**

	Description	Status	Start Date	End Date
Penicillin.		Active		
Unknown or N/A				

## **Surgeries:**

Description	Status	Start Date	End Date
Tubal ligation in 2012.	Active		
Unknown or N/A	Active		
Hospitalized for snake bite.	Active		
Unknown or N/A	Active		

## **Face to Face HH Plan:**

Patient Home Bound or Can't Drive: YES Is Home Health Care Needed: YES

Does Patient have reliable other Primary Care Physician: NO

Is House Visit Needed: YES Next Visit Duration (in days): 31

Current home health agency: Kingdom Home

**Primary Justification Medical Conditions:** Schizophrenia, Epilepsy **Additional Medical Conditions:** Major Depression and Insomnia

Nursing Required: YES Physical Therapy:

Occupational Therapy Required: Speech-language Pathology Required: Requested Care/Treatments Required:

Clinical Findings To Justify Home Health: Patient is homebound due to mental illness.

Certification Statement: Skilled nursing is needed due to mental illness and the inability to self medicate corrected.

Signed by (NP): 16

**Signed On (NP):** 2016-12-27 01:34 **Signed By (Physician):** 18

Signed on (Physician): 2017-01-03 01:34

Form\_status: finalized

### **Procedure Order:**

Patient ID	6294	Order ID	1416
Patient Name	Williams, Ashley N	Ordered By	Love-Jones, Derrick
Order Date	2017-01-28	Print Date	2017-01-28
Order Status	complete	Encounter Date	2017-01-28
Lab	.HH Agency	Specimen Type>	

Ordered Procedure	Report				Results						
	Reported	Specimen	Status	Note	Code	Name	Abn	Value	Range	Units	Note
026: Pulse Oximetry						•					