# Level 5 – Cardiologist

## HPI:

An established office patient with severe exacerbation of CHF.

Mr. Smith a 65-year-old patient with CHF presents for follow-up.  The patient has a history of significant ischemic cardiomyopathy with an ejection fraction of 30%.  He has experienced worsening leg edema over the past one to two weeks despite well-controlled hypertension on current medication.  In addition, he has been complaining of severe SOB for the past three days.  CAD has been stable with no active chest pain. Despite being compliant with medications, the patient has not been watching his salt intake closely.

## Medications:

Lasix 40 mg po bid  
KCL 20 mEq po bid  
Lisinopril 10 mg po qd  
Coreg 6.25 mg po bid  
Imdur 30 mg po qd  
ASA 81 mg po qd

## Ros:

A complete ROS was conducted and documented and was found to be positive for PND and orthopnea, but negative for chest pain and anginal equivalents. The rest of ROS is noncontributory. Refer to the chart for details in today's ROS form.

## PFSH:

The complete PFSH taken during an earlier encounter was re-examined and discussed with the patient. The details can be found in the dictated note in this chart dated 12/12/2023. A cardiac catheterization with RCA stent deployment was performed on 3/24/24; otherwise, there is no new information to report.

## Physical Exam:

General: Some respiratory distress at rest, but able to speak in full sentences, well nourished.

Vitals: 180/90, 64, 26

HEENT: Moist mucous membranes, positive JVD

Lungs: Bibasilar crackles about half way up

Cardiovascular: RRR, no MRGs

Abdomen: Soft, non-tender, no HSM

Extremities: 3 + bilateral lower extremity edema; no digital cyanosis

## Labs:

BUN 32, creatinine 1.9, HCO3 24, K 3.8, HGB 12

## Assessment:

1. Severe exacerbation of systolic CHF

2. Poorly controlled hypertension

3. Hypervolemia with severe lower extremity edema and exam findings suggestive of pulmonary vascular congestion

4. History of CAD, which appears to be controlled.

## Plan:

1. Patient felt sudden chest pain towards the end of the visit. I advised the patient to go immediately to ER for further evaluation, treatment, and risk assessment. Patient refused and stated that the chest pain is slowly going away. I did advise the patient about the risks of these symptoms he is having and the benefits of possible admission to the hospital or observation, patient understood and deferred hospitalization for now. Patient was instructed to go immediately to ER if SOB acutely worsens or if any chest pain develops

2. Increase lasix to 80 mg po bid times three days

3. Start zaroxyln 2.5 mg po qd times three days

4. Increase KCL to 30 mEq po bid times three days

5. Repeat renal profile in three days

6. The importance of a low sodium diet was explained to the patient

7. Return visit in three days with lab

## Explaination:

**Consider MEAT when diagnosis coding, what is being:**

Monitored

Evaluated

Assessed

Treated

Severe exacerbation of systolic CHF I11.0, I50.23

Hypertension

Hypovolemia E86.1

**Level 99215**

Problem: High

Data: Moderate

Risk: High