1 Patient & Encounter Information

Name:	Robert D. Calloway
DOB / Age:	07/22/1972 / 52 years
Sex:	Male
MRN:	MRN-5093274
Primary Language:	English
Insurance / Payer:	BlueCross BlueShield PPO
Date of Visit:	April 27, 2025
Location of Service:	Midwest Sleep Disorders Center, Indianapolis, IN
Visit Type:	Follow-up — CPAP Non-Compliance Evaluation
Referring Provider:	Dr. James Watkins, MD (Primary Care)
Sleep Specialist:	Dr. Priya Nair, MD, FCCP, DABSM
Accompanied by:	Wife, Linda Calloway

S Subjective

2 CHIEF COMPLAINT

Primary sleep-related concern:	Persistent excessive daytime sleepiness, CPAP non-compliance, witnessed apneas despite previous diagnosis of severe OSA
Duration:	Snoring and witnessed apneas reported for 7+ years; CPAP prescribed 14 months ago but used fewer than 30% of nights

3 HISTORY OF PRESENT ILLNESS

SLEEP SCHEDULE & PATTERN

Weekday bedtime / wake time:	11:30 PM – 5:15 AM (driven by work schedule)
Weekend bedtime / wake time:	12:30 AM – 8:00 AM
Sleep latency (min):	Less than 5 minutes — falls asleep almost immediately upon lying down
Awakenings (freq / duration):	3–5 awakenings per night, duration 5–20 minutes each; often associated with gasping or choking sensations
Total sleep time:	Approximately 4.5–5.5 hours on weeknights; 6.5 hours on weekends
Sleep quality:	Poor — non-restorative, patient rates sleep quality 2/10. Never feels refreshed in the morning.

NIGHTTIME SYMPTOMS

Difficulty initiating sleep:	Absent — falls asleep within minutes at any time of day or in any environment
Difficulty maintaining sleep:	Present — frequent awakenings with gasping. Wife reports he stops breathing multiple times per night.

Snoring (severity):	Loud, disruptive snoring reported nightly by wife. Audible from adjacent bedroom. Present for over 10 years.
Witnessed apneas:	Wife confirms witnessed apneas — patient stops breathing 10–20 seconds at a time, followed by snort or gasp. Occurs multiple times per hour.
Gasping / choking:	Patient confirms waking with gasping or choking sensation approximately 2–3 times per night.
Abnormal movements / behaviors:	No REM sleep behavior disorder. No sleepwalking. Occasional periodic leg movements reported by wife.

DAYTIME SYMPTOMS

Excessive sleepiness:	Severe — Epworth Sleepiness Scale score 19/24. Falls asleep while driving on 3 separate occasions in past month. Falls asleep during meals.
Fatigue:	Profound fatigue present throughout the day. Cannot complete a full shift without significant effort. Reports cognitive fog.
Non-refreshing sleep:	Universal — patient never wakes feeling rested regardless of sleep duration.
Morning headaches:	Present 4–5 mornings per week. Diffuse, dull, resolves within 1 hour of waking.
Cognitive impairment:	Significant — memory lapses, difficulty concentrating on routes, forgets dispatching instructions. Wife confirms personality changes.
Mood changes:	Increased irritability, depressive symptoms (PHQ-9: 12), withdrawn from family activities over past year.

DISORDER-SPECIFIC SCREENING

Insomnia symptoms:	No difficulty initiating sleep. No conditioned arousal. Sleep restriction not a contributing factor.
Sleep apnea symptoms:	Severe OSA confirmed on prior PSG. AHI 52 events/hour. Predominantly obstructive events. REM-predominant desaturations.
Narcolepsy symptoms:	No cataplexy. No sleep paralysis. No hypnagogic hallucinations. EDS likely attributable to OSA rather than narcolepsy.
Restless legs symptoms:	No classic RLS urge to move. No leg discomfort at rest. PLMs noted on PSG but no RLS diagnosis.
Parasomnias:	No sleepwalking, night terrors, or REM sleep behavior disorder. No enuresis.

CIRCADIAN RHYTHM

Irregular schedule / shift work / jet lag:	Long-haul truck driver — irregular schedule with overnight shifts 3–4 nights per week. Significant circadian disruption.
Delayed / advanced phase:	No fixed circadian phase disorder, though sleep timing varies widely with work schedule.

CONTRIBUTING FACTORS

Stress / psychiatric conditions:	Work-related stress — job insecurity concerns. Mild depression (PHQ-9: 12). No prior psychiatric hospitalization.
Medical conditions:	Hypertension (on lisinopril), obesity (BMI 38.4), type 2 diabetes (on metformin), hyperlipidemia (on atorvastatin)
Medications affecting sleep:	Lisinopril — associated dry cough disturbing sleep. No sedatives. No stimulants prescribed, uses caffeinated beverages.

Caffeine:	6–8 cups of coffee daily plus energy drinks — uses caffeine to combat sleepiness. Last caffeine 8 PM.
Alcohol / nicotine:	2–3 beers nightly to 'help fall asleep.' Former smoker — quit 5 years ago. Denies illicit substance use.

FUNCTIONAL IMPACT & SAFETY

Work / school impairment:	Severe — near-miss accident 3 weeks ago. Employer concerned about safety. CDL license at risk if EDS not managed.
Quality of life:	Markedly reduced. No longer participates in weekend activities with family. Wife concerned about relationship strain.
Drowsy driving risk:	HIGH — confirmed episodes of drowsy driving. Mandatory reporting discussed per state regulations.

PRIOR EVALUATION & TREATMENT

Prior sleep studies (PSG / HSAT):	In-laboratory PSG performed March 2024 at Community Sleep Lab: AHI 52/hr, nadir SpO2 76%, REM AHI 84/hr, PLMI 18/hr
Prior diagnoses:	Severe obstructive sleep apnea (OSA) — G47.33
Treatments (CPAP, meds, CBT-I):	ResMed AirSense 11 CPAP prescribed at 12 cm H2O fixed pressure. Nasal pillow mask (AirFit P10). No CBT-I pursued.
Response:	Poor — average use 1.8 hrs/night per device download. Adherent on only 22% of nights in past 90 days. Residual AHI reported at 8.4 when used.

4 PAST MEDICAL HISTORY

Hypertension — diagnosed 2018, on lisinopril 10mg daily
Type 2 Diabetes Mellitus — diagnosed 2020, on metformin 1000mg BID, A1c 7.9%
Obesity — BMI 38.4, highest weight 287 lbs
Hyperlipidemia — on atorvastatin 40mg
Severe Obstructive Sleep Apnea — diagnosed March 2024
GERD — on omeprazole 20mg daily

5 PAST SURGICAL HISTORY

Tonsillectomy — age 9 (childhood)
Appendectomy — 2001, uncomplicated
No prior airway or craniofacial surgeries

6 MEDICATIONS

1. Lisinopril 10mg — once daily (HTN)
2. Metformin 1000mg — twice daily with meals (T2DM)
3. Atorvastatin 40mg — nightly (hyperlipidemia)
4. Omeprazole 20mg — once daily (GERD)
5. Aspirin 81mg — once daily (cardiovascular prophylaxis)

7 ALLERGIES

Sulfonamides — rash and urticaria
No known food allergies
No latex allergy

8 SOCIAL HISTORY

Occupation:	Long-haul truck driver — CDL holder. Drives 10–14 hours per shift, 4–5 days per week.
Work schedule:	Irregular — 3–4 overnight shifts per week, remainder daytime. Significant schedule variability.
Sleep environment:	Advised white noise machine for truck cab. Temperature control optimization. Recommended travel CPAP (ResMed AirMini) for use in truck.
Substances / screen use:	Nightly alcohol (2–3 beers). Screen use in bed (phone) until midnight. No marijuana use.

9 FAMILY HISTORY

Father: OSA, hypertension, MI at age 68
Mother: Type 2 diabetes, stroke at age 72
Brother (age 55): Obesity, snoring — untreated
No family history of narcolepsy or RLS

10 REVIEW OF SYSTEMS

Sleep / Neurologic:	EDS severe (ESS 19). No cataplexy or sleep paralysis. Cognitive symptoms prominent.
Psychiatric:	PHQ-9: 12 (moderate depression). GAD-7: 7. No suicidal ideation. No prior psychiatric treatment.
Cardiovascular:	Hypertension on treatment. No known arrhythmia. No prior cardiac events. No palpitations.
Respiratory:	No asthma. Dry cough (ACE inhibitor-related). SpO2 92% on room air at rest in clinic.

O Objective

11 VITALS & ANTHROPOMETRICS

BP:	148/92 mmHg (right arm, seated, after 5-minute rest)	**SpO2:**	92% on room air at rest	**Weight:**	274 lbs (124.3 kg)
HR:	84 bpm, regular	**Height:**	5'11" (180 cm)	**BMI / Neck circumference:**	BMI 38.2 kg/m² / Neck circumference 18 inches (45.7 cm)

12 PHYSICAL EXAMINATION

General:	Obese male appearing mildly fatigued, yawning during interview. Alert and oriented x3. No acute distress.
Airway (Mallampati, tonsils):	Mallampati Class III. Tonsils 2+ bilaterally, not obstructing. Elongated uvula noted. Narrowed posterior oropharynx.
Craniofacial:	Retrognathia present. Macroglossia noted. Nasal septum mildly deviated to right. No craniofacial syndromes.

Cardiopulmonary:	Regular heart rate and rhythm. No murmurs. Lung fields clear to auscultation bilaterally. No wheezes or crackles.
Neurological:	Cranial nerves II–XII grossly intact. No focal deficits. Reflexes 2+ symmetrically. Mildly slowed processing noted.

13 SLEEP SCALES

ESS score:	19/24 — severe excessive daytime sleepiness
STOP-BANG score:	7/8 — very high risk for OSA (positive for Snoring, Tired, Observed apneas, Pressure, BMI >35, Age >50, Neck >40cm, Male)
ISI score:	14/28 — moderate clinical insomnia (sleep maintenance subtype)
Other:	PHQ-9: 12 (moderate depression); Drowsy Driving Risk Assessment: HIGH

14 DIAGNOSTIC DATA REVIEWED

PSG / HSAT:	In-lab PSG (March 2024): Total sleep time 387 min, sleep efficiency 81%, AHI 52/hr, REM AHI 84/hr, NREM AHI 38/hr, nadir SpO2 76%, PLM index 18/hr, mean SpO2 89%
MSLT / MWT:	Not performed — EDS attributed to OSA; MSLT not indicated at this time given clear OSA etiology
Actigraphy:	Not performed at this visit. Recommended for circadian rhythm assessment given shift work schedule.
Labs (iron, TSH, etc.):	TSH 2.1 mIU/L (normal). Serum ferritin 38 ng/mL (low normal). CBC: Hgb 15.2, Hct 46%. HbA1c 7.9%.
Independent interpretation performed:	Yes — PSG data reviewed and independently interpreted by Dr. Nair at this visit

15 PAP / DEVICE DATA

Device:	ResMed AirSense 11 AutoCPAP
Settings:	Fixed CPAP 12 cm H2O (prescribed); device reports median pressure 11.8 cm H2O when in use
Usage (hrs / night):	Average 1.8 hours per night over past 90 days (device download reviewed in clinic)
Compliance (% nights >4 hrs):	22% of nights with >4 hours use — CMS non-compliant
Mask issues:	Reports nasal pillow uncomfortable during nasal congestion. Removes mask when congested. Mask seal adequate when used.
Residual AHI:	8.4/hr on nights device is used (acceptable); problem is frequency of non-use

A Assessment

16 DIAGNOSES

Primary Diagnosis:	Severe Obstructive Sleep Apnea (OSA)
ICD-10 Code:	G47.33
Secondary Diagnoses:	

	Excessive daytime sleepiness (G47.10); Hypertension (I10); Type 2 Diabetes Mellitus (E11.9); Obesity (E66.9); GERD (K21.0); Moderate Depression (F32.1)

17 SEVERITY

Severity (Mild / Moderate / Severe):	Severe
Based on AHI + clinical context:	AHI 52/hr with nadir SpO2 76%, significant EDS (ESS 19), occupational safety risk (CDL driver), and cardiovascular comorbidities confirm severe OSA classification

18 DIFFERENTIAL DIAGNOSIS

1. Central Sleep Apnea — less likely given predominantly obstructive events on PSG; no Cheyne-Stokes breathing pattern
2. Narcolepsy Type 1 — no cataplexy, no sleep paralysis, EDS attributable to severe OSA
3. Idiopathic Hypersomnia — excluded; clear OSA etiology
4. Shift Work Sleep Disorder — contributing factor given irregular schedule but not primary diagnosis
5. Periodic Limb Movement Disorder — PLM index 18/hr noted but not clinically significant

19 RISK ASSESSMENT

Cardiovascular risk:	HIGH — untreated/undertreated severe OSA significantly increases risk of hypertension progression, atrial fibrillation, and sudden cardiac death. Blood pressure currently elevated despite antihypertensive therapy.
Metabolic risk:	HIGH — OSA contributes to insulin resistance and suboptimal glycemic control. A1c 7.9% despite metformin. Weight loss essential.
Safety risk (drowsy driving / occupational):	CRITICAL — CDL holder with confirmed drowsy driving episodes. Mandatory state reporting discussed. Patient counseled about legal obligation to report condition to DMV and employer.

20 MEDICAL DECISION MAKING

Problems Addressed:	Severe OSA with CPAP non-compliance; occupational safety risk; cardiovascular risk modification; depression screening
Data Reviewed:	PSG report (March 2024); CPAP device download (90-day data); labs (TSH, CBC, HbA1c, ferritin); PHQ-9
Risk Level (Low / Moderate / High):	HIGH — due to CDL driving with severe EDS, cardiovascular comorbidities, and CPAP non-compliance

P Plan

21 MEDICAL MANAGEMENT

1. Switch from fixed CPAP to AutoCPAP (APAP) range 8–16 cm H2O to improve comfort and compliance
2. Trial full-face mask (ResMed AirFit F20) given nasal congestion as barrier to nasal pillow use
3. Add fluticasone nasal spray 50mcg each nostril nightly to reduce nasal congestion
4. Continue lisinopril 10mg; consider ARB switch to eliminate cough side effect — referral to PCP
5. Initiate mirtazapine 7.5mg nightly — dual benefit for sleep consolidation and depression (PHQ-9: 12)
6. Alcohol cessation counseling — nightly alcohol worsens OSA severity and suppresses arousal response

22 PAP THERAPY

Initiation / Adjustment:	Transitioning from fixed CPAP 12 cm H2O to APAP 8–16 cm H2O. New prescription written today.
Mask fitting:	Sized and fitted for ResMed AirFit F20 full-face mask (medium) in clinic. Seal confirmed adequate. Headgear adjusted.
Adherence counseling:	Extensive counseling provided regarding CDL safety implications, health risks of untreated OSA, and strategies for improving CPAP use. Wife included in session. Motivational interviewing approach used.

23 BEHAVIORAL THERAPY

CBT-I referral:	CBT-I not primary focus at this visit. Sleep consolidation to follow CPAP optimization. Refer if insomnia persists after 3 months of adequate PAP therapy.
Sleep hygiene counseling:	Advised alcohol cessation (minimum 3 hours before bed), limit caffeine after 2 PM, maintain consistent wake time even on days off, reduce screen time in bed.

24 LIFESTYLE MODIFICATIONS

Weight management:	Discussed 5–10% weight loss goal. Referred to structured weight management program. Even 10% weight reduction may reduce AHI by 30–40%.
Exercise:	Encouraged 30 minutes of moderate aerobic exercise 5 days per week. Discussed exercise timing — avoid vigorous exercise within 3 hours of bedtime.
Substance reduction:	Alcohol cessation strongly recommended — alcohol is a potent OSA aggravator and respiratory depressant. Referred for alcohol reduction counseling.
Sleep environment:	Advised white noise machine for truck cab. Temperature control optimization. Recommended travel CPAP (ResMed AirMini) for use in truck.

25 DIAGNOSTIC PLAN

1. APAP device download review in 4 weeks via telehealth
2. Actigraphy x 2 weeks to characterize circadian patterns with shift work schedule
3. Repeat PSG if APAP data shows persistent high residual AHI after mask/pressure changes
4. Ferritin recheck in 3 months (low normal — assess for iron deficiency contribution to PLMs)

26 REFERRALS

ENT / Pulm / Neuro / Psych:	ENT referral placed for evaluation of nasal septum deviation and uvulopalatopharyngoplasty candidacy. Psychiatry referral for PHQ-9: 12 and alcohol use.

27 PATIENT EDUCATION

Patient and wife educated on: (1) severe risks of untreated OSA including motor vehicle accidents, hypertension, arrhythmia, and premature death; (2) CDL legal requirements — patient must report condition and treatment status to employer and DMV per Indiana regulations; (3) CPAP as life-saving treatment; (4) importance of alcohol cessation; (5) APAP therapy benefits over fixed pressure; (6) ResMed myAir app for tracking compliance and sharing data with clinic.

28 FOLLOW-UP & MONITORING

Symptom tracking:	Patient to complete daily sleep diary for 4 weeks. ESS and PHQ-9 to be repeated at 3-month follow-up.
PAP compliance follow-up:	APAP device data to be uploaded via AirView at 2 and 4 weeks. Telehealth visit at 4 weeks to review compliance data.
Medication monitoring:	Mirtazapine efficacy and tolerability review at 4-week telehealth. LFTs at 3-month visit. Monitor weight and blood pressure.
Follow-up timeline:	Telehealth in 4 weeks for APAP data review; in-person at 3 months with ESS, PHQ-9, CPAP download, and labs.

29 TIME / BILLING

Total time (minutes):	65 minutes
Includes (face-to-face / documentation / care coordination):	Face-to-face 45 min; documentation 12 min; care coordination (ENT referral, PCP communication, DMV reporting) 8 min

30 PROCEDURES

Procedure performed:	PSG data independent interpretation; CPAP device download and analysis; mask fitting and APAP setup
Details:	CPAP device download reviewed: 90-day average use 1.8 hrs/night, 22% nights >4 hours, residual AHI 8.4/hr on nights used. New APAP prescription written. Full-face mask fitted.

31 TELEHEALTH

Patient location:	Midwest Sleep Disorders Center, Indianapolis, IN 46202
Provider location:	Same as patient location — in-person visit
Consent obtained:	Yes — verbal and written consent obtained for telehealth component of future follow-up
Platform used:	Doxy.me (HIPAA-compliant) for future telehealth visits

Provider name & credentials:	Dr. Priya Nair, MD, FCCP, DABSM
Signature:	P. Nair, MD
NPI:	1598473621
Date / Time:	April 27, 2025 — 2:30 PM EST
Facility:	Midwest Sleep Disorders Center, 8800 N. Michigan Rd., Indianapolis, IN 46202
Visit type:	Office Visit — Follow-up (99214, High Complexity MDM)