

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Rosalind M. Pemberton-Cole

DOB

09/14/1941

AGE / SEX

84 yrs / Female

MRN / PATIENT ID

GER-1180553

DATE OF SERVICE

08/13/2026

PROVIDER

Yusuf A. Demirci, MD

CREDENTIALS

MD, AGSF, CMD

PRIMARY CARE PROVIDER

This provider — home-based primary care program

VISIT TYPE

Comprehensive Geriatric Assessment — unscheduled, prompted by a third fall in 10 weeks

CARE SETTING

Home visit — single-storey bungalow, 62 minutes on site

REFERRAL SOURCE

Daughter's telephone call to the practice after the most recent fall

INTERPRETER USED

No

CAREGIVER / FAMILY MEMBER PRESENT

Daughter, Marguerite Cole, 58 — present throughout

INFORMANT / COLLATERAL SOURCE

Daughter (primary) and neighbour who found her after the last fall

LIVING SITUATION

Lives alone since her husband's death 14 months ago; daughter visits 3–4 times weekly and lives 25 minutes away

CC CHIEF COMPLAINT

2 PRIMARY REASON FOR VISIT

Patient: "I only lost my footing on the rug. I am perfectly capable in my own house."**Daughter:** "This is the third fall since June. She was on the kitchen floor for close to two hours before the neighbour heard her. She has stopped cooking, she is wearing the same cardigan every time I come, and last week she called me by my sister's name twice in one conversation."

3 PATIENT- & CAREGIVER-REPORTED HISTORY

3a PRESENTING CONCERN & INTERVAL HISTORY

Reason for evaluation

Comprehensive geriatric assessment following a third fall in 10 weeks, with a long lie of approximately two hours after the most recent event. Daughter additionally raises memory change, weight loss, self-neglect and her own capacity to continue the current level of support. Patient herself minimises all of these.

Interval history

Last seen in clinic 02/2026, at which point she was independent, cooking daily and driving locally. Since then: husband's death anniversary in June, cessation of driving in April after a minor parking incident she did not report at the time, and three falls — 06/04/2026 in the garden, 07/19/2026 on the stairs to the porch, and 08/09/2026 in the kitchen with the long lie. No emergency attendance for the first two. The third generated an emergency department visit on 08/09 with radiographs of the left hip and wrist, both negative, and discharge home the same day with no follow-up arranged. No hospitalizations, no surgeries. Antihypertensive dose was increased by a covering clinician in May after a single elevated reading.

Chronic medical conditions

Hypertension since 1998. Atrial fibrillation, rate-controlled, diagnosed 2019, on anticoagulation. Osteoporosis diagnosed 2015 with a prior wrist fracture in 2017; alendronate stopped in 2021 after five years and never restarted. Osteoarthritis of both knees and hands. Hypothyroidism. Stage 3a chronic kidney disease. Bilateral cataracts with the right eye operated in 2023 and the left deferred. Bilateral sensorineural hearing loss with hearing aids she rarely wears. No diabetes. No prior stroke or TIA. No known dementia diagnosis.

3b GERIATRIC SYNDROMES

Cognition and memory

Daughter reports 8–10 months of gradual change — repetitive questioning within a single conversation, misnaming family members, two missed appointments, an unpaid electricity bill leading to a disconnection notice found on the sideboard today, and difficulty following a recipe she has cooked for decades. No wandering. No visual hallucinations, no fluctuation in alertness, no REM sleep behaviour disorder. Patient acknowledges only that she is "a bit forgetful, like anyone at 84." She continues to manage her own medications, which the daughter believes she should not.

Mood and behavioural health

Widowed 14 months. Describes herself as "perfectly fine" but has stopped attending her weekly bridge group and church, both of which she attended for over 30 years. Daughter reports she cries when her husband is mentioned and has left his belongings untouched. Reduced motivation, apathy toward cooking and housekeeping. Sleep disrupted. Denies hopelessness and suicidal ideation on direct questioning, asked alone. No agitation, hallucinations or paranoia.

Falls and mobility

Three falls in 10 weeks, all indoors or at the threshold, all unwitnessed, none with loss of consciousness. She describes the most recent as tripping on a rug, but also volunteers that she felt "swimmy" on standing from the kitchen chair beforehand — a description consistent with orthostatic symptoms she has not previously reported. Increasing fear of falling, now holding furniture to move around the house. Owns a walking frame, kept unused in the hall cupboard, which she describes as "for old people." Wears backless slippers indoors. No physical therapy since 2017.

Functional status

ADLs: independent in feeding and toileting; bathing now limited to a strip wash because she cannot step over the bath rim safely; dressing independent but her clothing is visibly unchanged between visits; transfers require both arms to push up from a seated position. **IADLs:** no longer cooking — subsisting on tea, toast and biscuits; shopping done entirely by her daughter; finances slipping with at least one unpaid bill; housekeeping deteriorated with the daughter reporting an unclean kitchen and spoiled food in the refrigerator; no longer driving; telephone use intact.

Nutrition and weight

Weight 121 lb today, down from 138 lb in 02/2026 — a loss of 17 lb, 12.3% of body weight, over six months. Appetite poor, eating alone, describing food as “not worth the bother for one.” No dysphagia. Ill-fitting lower dentures causing discomfort with anything firm. Fluid intake perhaps two cups daily. No food insecurity — the refrigerator is stocked by her daughter but the food is going uneaten and, in part, spoiling.

Sleep

Sleeps 4–5 fragmented hours. Difficulty initiating sleep, waking at 3–4 AM and unable to return to sleep. Naps twice daily in the armchair. Nocturia three times nightly. Takes diphenhydramine most nights, bought over the counter, which neither she nor her daughter regarded as a medication.

Pain

Bilateral knee osteoarthritis pain 5/10 on movement, worse on the left, limiting standing to a few minutes. Hand pain affects jar opening and buttons. Takes paracetamol irregularly. No neuropathic pain. Pain contributes materially to her reduced mobility, poor sleep and abandonment of cooking.

Sensory function

Hearing aids prescribed in 2022, worn perhaps once weekly, batteries flat when tested today. Significant conversational difficulty without them, which had been misread by family as inattention. Left eye cataract untreated with vision measured at 6/24; right eye 6/9 after 2023 surgery. Last optometry review 2023. Both deficits are contributing directly to the falls and to the apparent cognitive impairment.

Bladder and bowel

Urge urinary incontinence with two to three episodes weekly, worse at night, and she now restricts fluids deliberately to control it — compounding both her dehydration and her orthostasis. Nocturia three times nightly. Constipation with bowels opening every three to four days. No fecal incontinence, no retention, no dysuria or hematuria.

3c MEDICATIONS, SUPPORTS & SAFETY

Medication history and polypharmacy

Twelve medications counted from the bathroom cabinet and kitchen counter today, against nine on the practice list. Prescribed: amlodipine 10 mg daily (increased from 5 mg in May), lisinopril 20 mg daily, bisoprolol 5 mg daily, apixaban 5 mg twice daily, levothyroxine 75 mcg daily, furosemide 20 mg daily (started 2021 for ankle swelling, no heart failure diagnosis on record), omeprazole 20 mg daily (started 2019 for a course of NSAIDs, never stopped), amitriptyline 25 mg at night (prescribed 2020 for sleep), oxybutynin 5 mg twice daily (for urinary urgency), paracetamol PRN. Unlisted and self-purchased: diphenhydramine 25 mg nightly and a codeine-paracetamol combination taken for knee pain. Adherence uncertain — multiple part-used boxes, two expired, no pill organizer, and one bottle of a discontinued medication still in use.

Living situation and supports

Lives alone in a single-storey bungalow of 40 years. Daughter visits three to four times weekly, works full time, and is herself the carer for a husband recovering from surgery. A son lives overseas. No formal home care. No personal alarm. No meals service. Neighbour is attentive but not a formal support. Transport entirely dependent on the daughter since driving ceased.

Safety concerns

Long lie of two hours with no means of summoning help. Loose rugs throughout, no bathroom grab rails, poor stair lighting to the porch, and a bath she cannot safely enter. Gas hob left on twice per the daughter, both times found by her. Unpaid utility bill with a disconnection notice. Medications unsupervised with duplication and expired stock. Driving already ceased. No firearms. **No evidence of abuse, exploitation or neglect by others** — the picture is one of self-neglect within a stretched informal support structure.

Advance care planning / goals of care

No advance directive. No documented healthcare proxy. Code status never discussed. When asked directly what matters most to her, she was clear and unhesitating: to remain in her own home, and not to “end up in a home like Arthur did.” She has not discussed any of this with her daughter, who was visibly relieved that it was raised.

Pertinent negatives

Denies chest pain, dyspnea, palpitations, syncope with true loss of consciousness, focal weakness, speech disturbance, visual field loss, headache, fever, and suicidal ideation. No head injury or fracture from any fall. No acute confusion or delirium at the time of assessment. No abuse or neglect by others.

ROS GERIATRIC MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fever, fatigue, appetite change, weight loss, weakness, frailty	Positive — 17 lb (12.3%) unintentional loss over 6 months, fatigue, weakness. Afebrile.
Chest pain, palpitations, edema, dyspnea, dizziness, presyncope, syncope	Positive — lightheadedness on standing. No chest pain, no true syncope.
Cough, wheezing, sleep apnea symptoms, oxygen use	Negative.
Abdominal pain, constipation, diarrhea, reflux, dysphagia, blood in stool	Positive — constipation every 3–4 days. No dysphagia, no bleeding.
Urinary frequency, urgency, incontinence, nocturia, retention, dysuria	Positive — urge incontinence 2–3× weekly, nocturia ×3, self-imposed fluid restriction.
Joint pain, back pain, muscle pain, gait difficulty, falls, mobility	Positive — knee OA 5/10, furniture-walking, 3 falls in 10 weeks.
Memory loss, confusion, tremor, weakness, numbness, headache	Positive — 8–10 months of memory change per informant. No focal deficit, no tremor.
Depression, anxiety, sleep disturbance, loneliness, behavioral change, safety	Positive — bereavement, social withdrawal, apathy, insomnia. GDS-15 9/15.
Vision loss, hearing loss, dental concerns, communication barriers	Positive on all four — untreated left cataract, unworn hearing aids, ill-fitting dentures.
Medication side effects, sedation, dizziness, bleeding/bruising, polypharmacy	Positive — sedation, orthostasis, bruising on apixaban, 12 medications with 3 anticholinergics.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
97.6 °F

HEART RATE
72 bpm, irregularly irregular

OXYGEN SATURATION
96% RA

WEIGHT

BLOOD PRESSURE
Supine 142/78

RESPIRATORY RATE
16 /min

HEIGHT
5 ft 3 in (was 5 ft 5 in in 2015)

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WEIGHT

121 lb (138 lb in 02/2026)

BMI

21.4 (was 24.4)

PAIN SCORE

5/10 — both knees on movement

ORTHOSTATIC VITALS

Supine 142/78 (72) → 1 min standing 108/62 (78) → 3 min 104/60 (80), symptomatic lightheadedness at both points

General appearance

Thin, frail-appearing woman seated in a high-backed armchair. Visible temporal and interosseous wasting. Clothing loose-fitting and soiled at the cuff; same cardigan the daughter describes. Hair unwashed. Fingernails long. Alert and socially well preserved — converses fluently and deflects with humour, which has plausibly masked the cognitive change from less frequent observers. Requires two attempts and both armrests to rise from the chair.

HEENT

Conjunctiva pale. Dense left lens opacity visible on penlight examination. Right pupil reactive, left sluggish through the cataract. **Hearing aids in a drawer with flat batteries; conversation requires raised voice and repetition until the daughter's spare batteries were fitted mid-visit, after which comprehension improved markedly.** Oral mucosa dry with reduced turgor. Lower dentures loose, with a shallow ulcer over the left alveolar ridge. Tongue mildly coated.

Neck

Supple. No lymphadenopathy. Thyroid impalpable. No carotid bruits. Jugular venous pressure not elevated.

Cardiovascular

Irregularly irregular pulse at 72. Normal heart sounds, no murmur, no gallop. Peripheral pulses present, capillary refill 3 seconds. **No peripheral edema** — notable given she has taken furosemide daily for five years. Extremities cool.

Pulmonary

Normal effort, vesicular breath sounds, clear bilaterally. No crackles, no wheeze.

Abdomen

Soft, scaphoid, non-tender. Bowel sounds present. Palpable stool in the left iliac fossa. No mass, no organomegaly, no hernia. No bladder distension.

Musculoskeletal

Bilateral knee crepitus with fixed flexion deformity of 10 degrees on the left. Heberden nodes in both hands with reduced grip. Kyphosis with a 2-inch height loss since 2015, consistent with vertebral compression. Hip abductor weakness bilaterally at 4-/5. **Gait: slow, wide-based, reduced step height, no arm swing, three steps required to turn, hand on furniture throughout. Timed Up and Go 24 seconds. 30-second chair stand test: unable to complete a single unsupported rise.**

Neurologic

Alert, oriented to person and place, states the month correctly but gives the year as 2025. Cranial nerves intact aside from the sensory deficits noted. Power 5/5 in the upper limbs, 4+/5 proximally in the lower limbs. Sensation intact to light touch and vibration — no peripheral neuropathy. Reflexes 2+ symmetric, plantars downgoing. No tremor, no rigidity, no bradykinesia, no cogwheeling — parkinsonism specifically excluded. Romberg positive with eyes closed. No focal deficit.

Skin

Multiple ecchymoses in varying stages over both forearms and the left hip, consistent with the reported falls and with apixaban. Skin thin, dry and inelastic. A healing 3 cm abrasion over the left elbow, clean, no infection. **No pressure injuries.** No cellulitis, no ulceration. Sacral skin intact.

Psychiatric

Mood described by her as "fine, dear"; affect flattened with reduced range and a single episode of tearfulness on mentioning her husband. Speech normal in rate, quieter than expected. Thought process linear with mild circumstantiality and repetition of one anecdote three times within the visit. No delusions, no hallucinations. **Insight into her functional decline is limited — she attributes all three falls to the rug.** Judgment impaired in the domain of home safety.

Cooperative throughout. No suicidal ideation on direct questioning conducted with the daughter out of the room.

Home environment (direct observation)

Four loose rugs, two over cable runs. No grab rails in the bathroom; a high-sided bath with no board or seat. Bulb out in the hallway. Porch steps without a handrail on the approach side. Kitchen with two saucepans of burnt residue. Refrigerator containing three items past date. Medications distributed across the bathroom cabinet, a kitchen drawer and a bedside table. Telephone in the hall only — no cordless handset, no personal alarm. Thermostat set at 62 °F. Unopened post accumulated on the sideboard including the disconnection notice.

CG COMPREHENSIVE GERIATRIC ASSESSMENT

6 DOMAINS ASSESSED

COGNITION AND MEMORY

Impaired — MoCA 19/30, informant-corroborated 8–10 month decline affecting IADLs

MOBILITY, GAIT, BALANCE, FALL RISK

Severely impaired — TUG 24 s, unable to chair-stand, 3 falls, 1 long lie

NUTRITION AND WEIGHT

Malnourished — MNA-SF 5/14, 12.3% loss in 6 months, dental and social contributors

CONTINENCE AND BOWEL

Urge incontinence driving self-imposed fluid restriction; constipation

MEDICATION BURDEN

12 medications, 3 with high anticholinergic burden, 4 fall-risk agents, 3 candidates for deprescribing

HOME SAFETY

Multiple hazards directly observed — rugs, no rails, no alarm, hob risk, cold home

LEVEL OF CARE NEEDED

Formal home care, therapy input and caregiver relief required now; residential care not indicated and contrary to her expressed goal

MOOD AND BEHAVIORAL HEALTH

Impaired — GDS-15 9/15, complicated bereavement with social withdrawal

ADLS / IADLS

ADL 4/6 (bathing and transfers impaired) · IADL 3/8 — cooking, finances, shopping, transport, housekeeping all lost

VISION, HEARING, DENTAL

All three impaired and all three remediable — untreated cataract, unworn aids, ulcerating dentures

PAIN AND SLEEP

Knee OA 5/10 undertreated; ISI 19 with a self-medicated anticholinergic hypnotic

SOCIAL SUPPORT AND CAREGIVER NEEDS

Single informal carer at capacity, herself caring for a post-operative spouse

ADVANCE CARE PLANNING

Absent — no directive, no proxy, no code status; clear stated preference to remain at home

ST SCREENING / ASSESSMENT TOOLS

7 SCORES, INTERPRETATION, INFORMANT SOURCE & LIMITATIONS

MOCA

19 / 30 — losses in delayed recall (1/5), visuospatial/executive, and orientation to year. Administered after hearing aid batteries were fitted; an earlier attempt without them was invalid.

MINI-COG

2 / 5 — recall 1/3, clock abnormal

GERIATRIC DEPRESSION SCALE-15

9 / 15 — suggestive of depression

TIMED UP AND GO

24 seconds — markedly elevated fall risk (>13.5 s threshold)

4-METRE GAIT SPEED

0.51 m/s — below the 0.8 m/s frailty threshold

KATZ ADL / LAWTON IADL

4 / 6 and 3 / 8 — the IADL collapse is the headline finding

INSOMNIA SEVERITY INDEX

19 — moderate clinical insomnia

ELDER ABUSE / NEGLECT SCREENING (EASI)

Negative for abuse by others; positive for self-neglect

INTERPRETATION AND LIMITATIONS

All cognitive testing was invalid until hearing was corrected mid-visit — a MoCA of 19 in a woman with an ACB score of 6, a GDS of 9, malnutrition and untreated sensory loss cannot be read as a dementia score. It is a baseline to be repeated after those four factors are corrected.

PHQ-9

11 — moderate; concordant with GDS

30-SECOND CHAIR STAND

0 unsupported rises — severe lower limb weakness

CLINICAL FRAILTY SCALE

6 — moderately frail (was 3, managing well, in 02/2026)

MINI NUTRITIONAL ASSESSMENT-SF

5 / 14 — malnourished

ANTICHOLINERGIC COGNITIVE BURDEN SCORE

6 — amitriptyline 3, oxybutynin 3, diphenhydramine 3 (self-purchased)

MR

MEDICATION REVIEW / DEPRESCRIBING ASSESSMENT

8 MEDICATION SAFETY REVIEW

RECONCILIATION COMPLETED

Yes — all containers gathered from three rooms; 12 in use against 9 on the practice list

HIGH-RISK MEDICATIONS IDENTIFIED

Amitriptyline, oxybutynin, diphenhydramine, furosemide, amlodipine 10 mg, codeine

ANTICHOLINERGIC BURDEN

ACB score 6 — strongly associated with cognitive impairment and falls in this age group

ANTICOAGULANT USE & BLEEDING RISK

Apixaban 5 mg BID — dose review required: age >80 and weight now 121 lb (<60 kg) meet two of three reduction criteria

INTERACTIONS

Amitriptyline with oxybutynin with diphenhydramine — additive anticholinergic effect; codeine with amitriptyline — additive sedation

TOTAL NUMBER OF MEDICATIONS

12 (10 prescribed, 2 self-purchased and previously unknown)

SEDATING MEDICATIONS

Amitriptyline, diphenhydramine, codeine — three agents, all contributing to falls

FALL-RISK AGENTS

Amlodipine 10 mg, lisinopril, bisoprolol, furosemide, amitriptyline, diphenhydramine, codeine

RENAL / HEPATIC DOSING

eGFR 52 — relevant to apixaban dosing and to furosemide-driven volume depletion

DUPLICATE THERAPIES

Two antihypertensive escalations without review; two sedating hypnotic-type agents

ADHERENCE BARRIERS

No organizer, medications in three locations, expired stock in use, cognitive impairment, no supervision

SUPPORT IN PLACE

None currently — self-managed. Blister-pack dispensing and daughter oversight to be arranged

DEPRESCRIBING DECISIONS AGREED TODAY

Stop diphenhydramine and codeine immediately. Taper and stop amitriptyline over 4 weeks. Stop oxybutynin. Stop furosemide (no heart failure diagnosis, no edema, contributing to volume depletion and nocturia). Reduce amlodipine to 5 mg. Deprescribe omeprazole with a 4-week taper. Reduce apixaban to 2.5 mg BID on age and weight criteria. Each decision explained to and agreed by the patient and daughter together.

L

LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED OR ORDERED

Routine labs (drawn at home today)

Ordered: CBC, CMP, magnesium, phosphate, TSH with free T4, HbA1c, vitamin B12, folate, vitamin D, ferritin and iron studies, albumin and prealbumin, calcium with parathyroid hormone, urinalysis with culture. Prior results from 02/2026: hemoglobin 11.8, creatinine 1.02 with eGFR 54, sodium 138, potassium 4.0, albumin 3.9, TSH 2.6.

Medication monitoring

Renal function required for apixaban dose confirmation. Sodium and potassium required after furosemide withdrawal. No INR needed on a direct oral anticoagulant.

Cognitive / reversible cause workup

B12, folate, TSH, calcium and urinalysis all sent as part of the reversible-cause screen. Neuroimaging deferred at this stage — there are no focal signs, no rapid progression and no atypical features, and four highly reversible contributors are being corrected first. Non-contrast CT head to be reconsidered at the 3-month reassessment if the MoCA does not improve.

Falls and bone health testing

DEXA ordered — last performed 2015. Vitamin D and calcium sent. Orthostatic vitals recorded above and clearly positive. EKG performed on a portable device: atrial fibrillation at 72, no ischemia, QTc 442 ms. Lateral thoracolumbar radiograph ordered given the 2-inch height loss and kyphosis, to identify vertebral fractures. Hip and wrist radiographs from 08/09/2026 reviewed — both negative.

Imaging and diagnostic testing

No other imaging indicated today. Echocardiogram from 2019 reviewed — normal left ventricular function, which supports the conclusion that furosemide has no ongoing indication.

Preventive screening results

Mammography ceased at 75 in line with life expectancy and preference — appropriate. Colorectal screening ceased 2018 — appropriate. Immunizations: influenza 10/2025, COVID-19 11/2025, pneumococcal 2016, RSV not given, zoster not given. Optometry 2023, dental review overdue by 4 years.

Prior records reviewed

Emergency department record of 08/09/2026 including both radiograph reports, practice notes from 02/2026 and the covering clinician's May entry documenting the amlodipine increase after a single reading, 2019 cardiology and echocardiogram reports, 2015 DEXA, and the pharmacy dispensing history for the past 12 months.

A

ASSESSMENT

- **Recurrent falls with a long lie, multifactorial (R29.6, W19.XXXA).** This is not a rug. The contributors are identifiable and largely reversible: symptomatic orthostatic hypotension (34/18 mmHg drop) driven by an unnecessary diuretic, an unreviewed amlodipine increase and self-imposed fluid restriction; three sedating and anticholinergic medications; severe lower limb weakness with an inability to chair-stand; untreated left cataract at 6/24; unworn hearing aids; unsafe footwear; and an unmodified home environment. The two-hour long lie without an alarm is the most urgent single finding.
- **Cognitive impairment, unspecified — not yet a dementia diagnosis (R41.3, G31.84).** MoCA 19/30 with an 8–10 month informant-corroborated decline affecting IADLs. However, this score was obtained in a patient with an anticholinergic burden score of 6, a GDS of 9, an MNA-SF of 5, and uncorrected hearing and vision loss.
Attaching a dementia label today would be premature and would misdirect the entire plan. The correct action is to remove the reversible contributors and re-test in 3 months.
- **Protein-energy malnutrition, moderate (E44.0).** 12.3% unintentional loss over 6 months with an MNA-SF of 5. Causes are social (eating alone after bereavement), dental (ulcerating lower dentures), and functional (no longer cooking) — not occult malignancy on current evidence, though the weight trend warrants continued vigilance.
- **Complicated bereavement with depressive symptoms (F43.21, F32.1).** GDS-15 9/15 and PHQ-9 11 at 14 months of widowhood, with loss of two long-standing social roles, apathy and insomnia. Substantially overlaps with and amplifies both the cognitive and nutritional findings.
- **Polypharmacy with a high anticholinergic burden (Z79.899).** Twelve medications, three unknown to the practice, ACB score 6, seven fall-risk agents, and at least four with no current indication. This is the most modifiable driver of every other problem on this list.
- **Symptomatic orthostatic hypotension (I95.1)** — iatrogenic, from furosemide without indication, an amlodipine increase made on a single reading, and volume depletion from deliberate fluid restriction.
- **Moderate frailty, Clinical Frailty Scale 6** — a three-point deterioration in six months, which is itself the signal that this is an acute-on-chronic decline rather than a stable baseline.
- **Osteoporosis, untreated since 2021, with height loss and probable vertebral fracture (M81.0).** Prior fragility fracture, five years off treatment, and a 2-inch height loss with kyphosis. Recurrent falls plus untreated osteoporosis is the combination that produces a hip fracture.
- **Anticoagulation dose above criteria.** Apixaban 5 mg BID with age >80 and weight <60 kg — two of three reduction criteria met, in a woman falling repeatedly.
- **Remediable sensory and dental impairment** — left cataract, unworn hearing aids with flat batteries, and ulcerating dentures. Three fixable problems currently masquerading as cognitive and functional decline.
- **Self-neglect within a stretched informal support network (Z91.89, Z63.6).** No evidence of abuse or exploitation. The daughter is a competent and willing carer who is at capacity, and the plan must relieve her rather than assume more of her.
- **Absent advance care planning.** No directive, no proxy, no code status — in a moderately frail 84-year-old with a clear and unambiguous stated preference to remain at home.
- **Level of care:** she is appropriately and safely managed at home *provided* formal support, therapy, medication correction and an alarm are put in place now. Residential care is not indicated on today's findings and would contradict her explicit goal.

P PLAN

- **Immediate safety (today):** personal alarm pendant ordered with same-week installation — the two-hour long lie makes this the single highest-priority action. All four loose rugs removed during the visit with the daughter's help. Hallway bulb replaced. Backless slippers exchanged for the enclosed shoes found in the wardrobe. Thermostat raised to 68 °F and heating support information given.
- **Medication optimization (deprescribing, staged and explained):** stop diphenhydramine and codeine today. Stop oxybutynin today. Stop furosemide today — no heart failure, no edema, normal echocardiogram. Reduce amlodipine to 5 mg. Taper amitriptyline 25 mg to 10 mg for 2 weeks then stop. Begin an omeprazole taper over 4 weeks. Reduce apixaban to 2.5 mg twice daily on age and weight criteria. Continue lisinopril, bisoprolol and levothyroxine unchanged. Blister-pack weekly dispensing arranged with the pharmacy, delivered, with the daughter as a named contact. All expired and discontinued stock removed from the house today with consent.
- **Orthostatic hypotension:** the above medication changes are the treatment. Fluid target of 1.5 L daily, reframed with her — the incontinence will be managed by bladder retraining rather than by dehydration. Slow staged rising taught and practised. Repeat orthostatic measurements at the nurse visit in one week.
- **Falls and mobility:** urgent referral to physical therapy for a home-based strength and balance program, twice weekly for 8 weeks, with an explicit target of achieving unsupported chair rise. Occupational therapy home assessment within 7 days for bathroom grab rails, a bath board or level-access shower, a porch handrail, a raised toilet seat, and a perching stool for the kitchen. The walking frame retrieved from the cupboard, height-adjusted and, after a frank conversation about what it protects rather than what it signals, accepted for outdoor use.
- **Cognition:** reversible-cause bloods sent today. **No dementia diagnosis made or communicated.** Both patient and daughter told explicitly that the score is provisional and that four correctable factors are being addressed first. Repeat MoCA at 3 months. Referral to the memory service placed now so the appointment falls after the reassessment rather than before it. Driving already ceased — confirmed, no further action. Financial capacity discussed; daughter to assist with bills and the disconnection notice resolved during the visit by telephone.
- **Nutrition:** urgent dental referral for denture refitting and the alveolar ulcer — she cannot eat properly until this is fixed. Dietitian referral. Oral nutritional supplements twice daily started today. Home-delivered meals arranged five days weekly, with a deliberate preference for a service where the driver stays for a brief conversation. Weekly weights recorded by the daughter on a chart left in the kitchen.
- **Mood and bereavement:** no antidepressant started today — three sedating agents are being withdrawn simultaneously and a fourth drug would confound the picture. Referral to a bereavement counselling service. Practical re-engagement prioritised: the bridge group contacted with her permission and a member will collect her; church transport arranged through the parish. Repeat GDS-15 at 4 weeks, with sertraline to be considered then if symptoms persist after sleep, nutrition and social contact have improved.
- **Sleep:** diphenhydramine stopped. Sleep hygiene discussed — no daytime armchair naps beyond 30 minutes, consistent rising time, no evening fluid restriction as a substitute for continence management. Nocturia should improve with furosemide withdrawal alone.
- **Pain:** regular paracetamol 1 g three times daily, scheduled rather than as needed — undertreated pain is driving both immobility and the codeine use. Topical NSAID gel to both knees. Physical therapy as above. Reassess at 4 weeks; consider orthopedic referral for the left knee if function does not improve.
- **Continence:** oxybutynin stopped — its anticholinergic cost exceeds its benefit here. Bladder retraining with a timed voiding schedule, taught today with a written chart. Continence service referral. Constipation managed with macrogol daily, increased fluid and dietary fibre.
- **Sensory and dental:** hearing aid batteries replaced today, with a six-monthly supply ordered and a written reminder on the kitchen calendar. Audiology re-review booked. Ophthalmology referral for left cataract surgery — this alone may materially reduce her fall risk. Dental as above.
- **Bone health:** restart alendronate 70 mg weekly once the dental review is complete, with colecalciferol 800 IU and dietary calcium. DEXA and thoracolumbar radiograph ordered. Fracture risk explained plainly to both patient and daughter.
- **Formal care and caregiver support:** home care package requested at twice daily — a morning visit for washing, dressing and medication prompting, and an evening visit for a meal and safety check. Carer's assessment requested for the daughter in her own right; respite options discussed. Social work referral placed for benefits

review and the utility arrears.

- **Advance care planning:** initiated today with both present, 22 minutes. Daughter named as healthcare proxy with forms completed and witnessed. Her stated priority — remaining at home — documented verbatim in the record so that any future decision-maker sees it in her own words. Code status discussion begun and deliberately left open for a further conversation rather than forced to a conclusion today.
- **Immunizations:** RSV and recombinant zoster vaccines both indicated; arranged for the nurse visit next week. Influenza in October.
- **Education and red flags:** written summary of every change left in the kitchen, with a one-page medication schedule. Both counselled on when to call and when to seek emergency care — any fall with head injury or inability to weight-bear, acute confusion, chest pain, breathlessness, bleeding, or fever. Alarm use demonstrated once installed.

F

FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up

Practice nurse home visit in 7 days for orthostatic vitals, weight, blood pressure after the amlodipine reduction and furosemide withdrawal, RSV and zoster vaccination, and review of the blister pack and alarm installation. Laboratory results reviewed within 48 hours with telephone contact to the daughter. Provider home visit at 4 weeks for reassessment of falls, orthostasis, nutrition and mood, and to complete the amitriptyline taper. Comprehensive reassessment at 3 months with a repeat MoCA, GDS-15, Timed Up and Go, Clinical Frailty Scale and MNA-SF — the memory service appointment is deliberately scheduled after this point. Occupational therapy within 7 days, physical therapy within 14 days, dental and ophthalmology within 6 weeks. Immediate emergency attendance for a fall with head injury or inability to weight-bear, acute confusion, chest pain, breathlessness, bleeding or fever; same-week practice contact for any further fall without injury, ongoing weight loss, or carer breakdown.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

96 minutes — 62 minutes in the home, 34 minutes coordination and documentation

MEDICATION REVIEW / DEPRESCRIBING

21 minutes — reconciliation across three rooms and shared decision-making on eight changes

RECORDS REVIEW TIME

11 minutes

E/M LEVEL

99350 — home visit, established patient, high complexity MDM

ANNUAL WELLNESS VISIT CODE

Not applicable — problem-focused urgent assessment

CAREGIVER / FAMILY COUNSELING

24 minutes with the daughter, including 9 minutes alone at her request

CARE COORDINATION TIME

19 minutes — home care, therapy, pharmacy, social work, utility company

ADVANCE CARE PLANNING TIME

22 minutes — patient and proxy present

ADVANCE CARE PLANNING CODE

99497 — first 30 minutes; 22 minutes documented

COGNITIVE ASSESSMENT / CARE PLANNING

99483 not billed today — deferred deliberately to the 3-month reassessment, when cognitive testing will be valid after reversible contributors are corrected

CHRONIC CARE MANAGEMENT

99490 — to commence in the following calendar month

TRANSITIONAL CARE MANAGEMENT

Not applicable — ED attendance only, no inpatient admission

BASIS FOR BILLING

High-complexity medical decision making — multiple chronic illnesses with exacerbation, extensive prescription drug management including eight deprescribing decisions, and independent interpretation of outside records. Advance care planning separately identifiable and timed.

PRIMARY ICD-10

R29.6 — Repeated falls

SECONDARY ICD-10

W19.XXXA unspecified fall, initial encounter · R41.3 other amnesia · E44.0 moderate protein-calorie malnutrition · F43.21 adjustment disorder with depressed mood · I95.1 orthostatic hypotension · M81.0 age-related osteoporosis without current fracture · R54 age-related physical debility · Z79.899 other long term drug therapy · H25.13 age-related nuclear cataract, bilateral · H90.3 sensorineural hearing loss, bilateral · N39.41 urge incontinence · K59.00 constipation · Z91.89 other specified personal risk factors · Z63.6 dependent relative needing care at home · Z71.89 advance care planning counseling

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Yusuf A. Demirci

CREDENTIALS

MD, AGSF, CMD

SPECIALTY

Geriatric Medicine

DATE

08/13/2026

TIME

1:14 PM