1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Rosalind P. Whitaker

DOB
02/14/1955

AGE/SEX
71 / Female

MRN / PATIENT ID
RPW-3381047

DATE OF SERVICE
11/05/2026

PROVIDER
Samuel Okonkwo

CREDENTIALS
DO (Endocrinology, Diabetes Clinic)

VISIT TYPE
Hospital Follow-Up — 6 days after discharge

CARE SETTING
Outpatient — Diabetes Clinic

DIABETES TYPE
Type 2 (diagnosed 2004)

PRIMARY CARE PROVIDER, IF APPLICABLE
Linh Tran, MD

REFERRING PROVIDER, IF APPLICABLE
Hospitalist (discharge 10/30/2026)

DIABETES EDUCATOR, IF APPLICABLE
Maria Costa, RN, CDCES

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"My husband found me confused at six in the morning and called the ambulance — my sugar was 38. I didn't feel it coming. Now my numbers are high and I'm scared to take my insulin."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a VISIT CONTEXT & GLYCEMIC CONTROL

Reason for Diabetes Management Visit:

Post-hospital follow-up after severe hypoglycemia: hypoglycemia evaluation, regimen redesign, and first CGM review.

Diabetes History:

Type 2 since 2004 (age 49), found on routine labs. Metformin, then glipizide added 2011, basal insulin 2017. No DKA or HHS. First diabetes admission 10/28–10/30/2026. Diabetes education 2017 only. Complications: kidney disease, mild retinopathy, neuropathy.

Current Glycemic Control:

A1c 7.1% (10/2026) — looks "good" but hides lows. Before admission: fasting 70s–90s, three lows in October. Since discharge on CGM: fasting 150–190, after lunch up to 260, overnight lowest 95. She feels "out of control" with the highs.

Hyperglycemia Symptoms:

Mild thirst and nocturia ×2 since discharge. No vomiting, abdominal pain, or weight loss. Ketones not tested.

Hypoglycemia Symptoms:

10/28: found confused and sweaty at 06:00, glucose 38; EMS gave IV dextrose. Two earlier overnight lows (52, 61) found only on morning checks, plus nightmares. Little warning — shakiness only below ~55. Triggers: glipizide with falling kidney function, skipped supper. No seizure. No glucagon at home.

Home Glucose Monitoring:

Fingersticks once daily (fasting) before admission. Dexcom G7 placed by the inpatient diabetes team 10/30; phone app working. Daughter added as follower. Medicare covers sensors (insulin use + hypoglycemia).

Continuous Glucose Monitor Review, if applicable:

Dexcom G7, 6 days (10/30–11/04), 94% wear. TIR 58%, TAR 40% (12% above 250), TBR 2% (0% below 54). Mean 186 mg/dL, GMI 7.8%, CV 31%. Overnight flat 120–150, low point ~95 at 04:00. Lunch peaks to 260. Short data window.

3b THERAPY

Insulin Therapy, if applicable:

Glargine U-100 pen: 32 units at 21:00 before admission → 20 units at discharge. No bolus or correction insulin. Injects abdomen only, same area. Pen stored correctly. Reads dial with glasses. $35/month cap.

Insulin Pump Therapy, if applicable:

Not applicable — no pump.

Non-Insulin Diabetes Medication History:

Metformin 500 mg BID (reduced from 1,000 BID in 2025 for eGFR). Glipizide 10 mg BID — stopped at discharge. Never tried GLP-1 RA or SGLT2 inhibitor (cost concern in past; now on Part D with Extra Help). Sitagliptin 2015 — stopped, no benefit.

Medication Adherence and Administration:

Took glipizide even when skipping meals. Fills a weekly pillbox herself. Has held some insulin doses since discharge out of fear. Daughter helps with refills.

3c LIFESTYLE & COMPLICATIONS

Nutrition / Meal Pattern:

Light breakfast (toast, tea), large lunch with rice or bread, often skips supper when tired from caregiving. Sweet tea at lunch. No carb counting. No food insecurity.

Physical Activity:

Housework and caregiving; walks 10 minutes a few times a week. Limited by foot numbness and fear of falling.

Weight / Metabolic Context:

Weight stable (BMI 31). Sleeps 6 h, interrupted by husband at night. High stress.

Diabetes Complications:

Kidney disease (stage 3b with albuminuria), mild retinopathy, peripheral neuropathy. No CVD, ulcers, amputation, or gastroparesis.

Eye Health:

Dilated exam 03/2026: mild nonproliferative retinopathy both eyes, no macular edema. No injections or laser. Due 03/2027.

Kidney Health:

eGFR 52 (2024) → 44 (2025) → 38 (10/2026). UACR 420 mg/g. On lisinopril 20 mg. No nephrology yet. Mild ankle swelling. No SGLT2 inhibitor or GLP-1 RA.

Neuropathy / Foot Symptoms:

Numbness and night burning in both feet. Callus under right big toe. Hammer toes. No ulcers. Soft slippers at home. Does not check feet daily. No podiatry.

Cardiovascular Risk:

Hypertension (home 130s/70s) and hyperlipidemia on atorvastatin 40 mg. No CAD, stroke, or PAD. Never smoked. Aspirin 81 mg (self-started). Brother MI at 54.

Pregnancy / Reproductive Considerations, if applicable:

Not applicable (postmenopausal). Gestational diabetes 1986.

Sick-Day / Safety History:

No sick-day plan before admission. No glucagon. Drives short distances. Main caregiver for husband (early Alzheimer disease) — he could not reliably treat a low.

Past Medical and Surgical History:

Obesity, hypertension, hyperlipidemia, CKD 3b, hypothyroidism (levothyroxine 75 mcg), osteoarthritis of knees. Hysterectomy 1998. Admission 10/2026 as above.

Family History:

Mother and two sisters — type 2 diabetes. Brother — MI at 54. Mother — dialysis late in life.

Social / Lifestyle History:

Retired schoolteacher. Lives with husband (dementia); daughter 20 minutes away, visits twice weekly. Never smoked. No alcohol. Smartphone confident. Medicare + Part D with Extra Help. Caregiver burden is her main barrier.

Pertinent Negatives:

No further severe lows since discharge. No vomiting, abdominal pain, chest pain, neurologic deficit, foot ulcer, or fever.

ROS DIABETES REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Polyuria, polydipsia, polyphagia, fatigue, blurred vision, weight change, or dehydration symptoms
Positive — mild thirst, nocturia, fatigue.

Hypoglycemia symptoms, hypoglycemia unawareness, nocturnal hypoglycemia, seizure, or loss of consciousness
Positive — impaired awareness, prior overnight lows, confusion 10/28.

Nausea, vomiting, abdominal pain, ketones, confusion, or DKA/HHS symptoms
Negative since discharge.

Numbness, tingling, burning pain, foot ulcers, calluses, infections, or poor wound healing
Positive — numbness, burning, callus.

Vision changes, retinopathy symptoms, eye pain, or ophthalmology concerns
Negative; known mild retinopathy.

Chest pain, palpitations, dyspnea, edema, claudication, or cardiovascular symptoms
Positive — mild ankle edema.

Foamy urine, edema, hypertension, decreased urine output, or kidney-related symptoms
Positive — foamy urine, edema.

Medication side effects, injection-site issues, device problems, supply barriers, or adherence concerns
Positive — lipohypertrophy, fear-driven missed insulin.

O OBJECTIVE

5 EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
97.9 °F	134/72 mmHg	78 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT**
14 /min	97% RA	160 cm
WEIGHT	**BMI**	**WAIST CIRCUMFERENCE, IF APPLICABLE**
79.4 kg	31.0	102 cm

PAIN SCORE, IF APPLICABLE
3/10 (feet)

5b EXAMINATION

General Appearance:
Alert, oriented, tired. Walks with care, no device. Well hydrated.

Head / Eyes / Ears / Nose / Throat:
Moist mucosa. Upper denture fits well. Wears reading glasses.

Neck:
Thyroid not enlarged. Mild acanthosis at nape.

Cardiovascular:
Regular, no murmur. Trace ankle edema. Capillary refill under 3 s.

Pulmonary:
Clear.

Abdomen:
Soft, non-tender. Rubbery 4 cm lipohypertrophy pad left of the navel (her usual site). Hysterectomy scar.

Extremities / Vascular:
Dorsalis pedis and posterior tibial pulses 1+ both sides. Feet warm. Sparse leg hair. No wounds.

Foot Examination:
Callus under right 1st metatarsal head, no breakdown. Hammer toes 2–4 both feet. Thick toenails (fungal). No Charcot changes. Monofilament 4/10 right, 5/10 left. Vibration absent at both big toes. Pinprick reduced to mid-foot. Proprioception intact. Worn slippers — needs proper shoes.

Skin / Injection Sites:
Lipohypertrophy as above. CGM site (back of left arm) clean. Mild acanthosis. No infection.

Neurologic:
Oriented, MoCA 27/30. Ankle reflexes absent. Strength normal. Romberg mildly unsteady. Stocking sensory loss as above.

Psychiatric:
Anxious, tearful about caregiving and the event. Good insight. Able to manage her own care with support.

GD GLYCEMIC DATA / DEVICE REVIEW

6 DATA REVIEWED

A1C AND TREND
6.6% (2025) → 7.1% (10/2026)

FINGERSTICK GLUCOSE LOG
Fasting only, 70s–90s in October

CGM REPORT AND DATE RANGE
Dexcom G7, 10/30–11/04 (6 days)

TIME IN RANGE
58%

TIME ABOVE RANGE
40% (12% above 250)

TIME BELOW RANGE
2% (0% below 54)

AVERAGE GLUCOSE
186 mg/dL

GLUCOSE MANAGEMENT INDICATOR
7.8%

GLYCEMIC VARIABILITY
CV 31% (stable)

NOCTURNAL TRENDS
Flat 120–150; nadir ~95 at 04:00

FASTING TRENDS
150–190

POSTPRANDIAL TRENDS
Lunch peaks 230–260

HYPOGLYCEMIA EPISODES
None since discharge; 3 in October

INSULIN PUMP DOWNLOAD WHEN APPLICABLE
Not applicable

INSULIN DELIVERY PATTERNS
Glargine 20 units; 2 doses skipped

MISSED BOLUSES OR LATE BOLUSES
Not applicable (no bolus)

SENSOR/PUMP LIMITATIONS
Only 6 days of data; no meal or dose logging

INTERPRETATION AND CLINICAL ACTION TAKEN
Highs after lunch, safe nights — keep basal, add GLP-1 RA, fix lunch carbohydrate

CS DIABETES COMPLICATION SCREENING

7 SCREENING STATUS

DILATED EYE EXAM DATE AND RETINOPATHY STATUS
03/2026 — mild NPDR both eyes, no macular edema

URINE ALBUMIN/CREATININE RATIO
420 mg/g (A3)

EGFR AND RENAL FUNCTION TREND
52 → 44 → 38 over 2 years

FOOT EXAM DATE AND FINDINGS
Today — loss of protective sensation, callus

NEUROPATHY SCREENING
Positive (monofilament, vibration)

BLOOD PRESSURE CONTROL
134/72 — at goal

LIPID PANEL AND STATIN STATUS
LDL 74 on atorvastatin 40 mg

ASCVD HISTORY OR RISK ASSESSMENT

DENTAL CARE WHEN RELEVANT

No ASCVD; 10-year risk 24%

Up to date (denture check 2026)

VACCINATION STATUS WHEN RELEVANT

Flu, COVID 10/2026; pneumococcal and hepatitis B up to date

SMOKING/NICOTINE STATUS

Never

SLEEP APNEA SCREENING WHEN RELEVANT

STOP-Bang 3 — snoring; sleep study not wanted now

DEPRESSION/DIABETES DISTRESS SCREENING WHEN RELEVANT

PHQ-9 9; DDS-2 high

MS MEDICATION / INSULIN SAFETY ASSESSMENT

8 SAFETY REVIEW

CURRENT DIABETES MEDICATIONS

Glargine 20 units nightly; metformin 500 mg BID

DOSE, ROUTE, FREQUENCY, AND TIMING

Glargine SC 21:00; metformin with meals

ADHERENCE AND MISSED DOSES

2 glargine doses skipped from fear

SIDE EFFECTS AND CONTRAINDICATIONS

Sulfonylurea now contraindicated (severe low)

HYPOGLYCEMIA RISK

High: age, CKD, impaired awareness, lives with dementia spouse

RENAL/HEPATIC DOSING CONSIDERATIONS

eGFR 38: metformin max 1,000 mg/day; SGLT2i OK

INJECTION TECHNIQUE

Good, but same site every time

SITE ROTATION

None — taught 4-quadrant rotation

INSULIN STORAGE

Correct

SICK-DAY MEDICATION HOLDS WHEN RELEVANT

New: hold metformin and SGLT2i if vomiting or dehydrated

PREGNANCY/LACTATION CONSIDERATIONS WHEN RELEVANT

Not applicable

DRUG INTERACTIONS

None significant

MEDICATION AFFORDABILITY AND ACCESS

Extra Help — GLP-1 RA and SGLT2i copays under $12

REFILL NEEDS AND PRIOR AUTHORIZATION ISSUES

None; CGM covered

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

A1c 7.1% vs GMI 7.8% — A1c may read low with CKD anemia (Hb 11.0). CGM TIR 58% (goal above 50% for older high-risk adults — met), TBR 2% (goal under 1%). Gold score 5 — impaired hypoglycemia awareness. DDS-2 = 9/12 (high distress). PHQ-9 9 (mild), GAD-7 8. ASCVD 10-year risk 24%. IWGDF foot risk 2 (loss of sensation + deformity). Monofilament 4/10 R, 5/10 L. STOP-Bang 3. No carbohydrate counting. Adherence: good, except recent fear-driven insulin skips.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Glycemic Testing:

A1c 7.1% (10/28). Fructosamine 312 µmol/L (matches GMI ~7.8%). CGM as above. Admission glucose 38 mg/dL.

Renal Monitoring:

Cr 1.42, eGFR 38. UACR 420 mg/g. K 4.8. Bicarbonate 22. Urinalysis: protein 2+, no blood.

Cardiometabolic Labs:

LDL 74, HDL 46, TG 168. AST/ALT 22/26. ApoB 82. Home BP 130s/70s.

Diabetes Classification Testing:

Not needed — classic type 2 history. Inpatient C-peptide 2.1 ng/mL (with glucose 140) confirms preserved insulin production.

Medication Safety Labs:

B12 248 pg/mL (low-normal) with methylmalonic acid 0.48 (raised) — deficient. TSH 2.3 on levothyroxine. Hb 11.0 (CKD-related).

Complication Evaluation:

Eye exam 03/2026 as above. ABI 0.98 R, 1.02 L (2025). ECG in hospital: sinus rhythm, no ischemia. No nephrology records.

Hospital / Emergency Records:

EMS 10/28: glucose 38, IV D10. Admission 10/28–10/30: 2 further lows (58, 64) on day 1 — prolonged glipizide effect. No infection. Discharge: glipizide stopped, glargine 32 → 20 units, CGM placed.

Prior Records Reviewed:

PCP notes 2022–2026, hospital records, inpatient diabetes team note, eye report 03/2026, pharmacy fill history, Dexcom Clarity download.

A ASSESSMENT

11 DIABETES INTERPRETATION

1) Type 2 diabetes, 22 years, with a level 3 (severe) hypoglycemic event caused by glipizide building up as kidney function fell, plus skipped meals and impaired awareness. 2) A1c 7.1% understated risk. Since glipizide stopped: no lows, but daytime highs (GMI 7.8%), driven by large lunches. 3) Goal now: avoid lows first. Individualized A1c under 8.0%, TBR under 1%, TIR above 50%. 4) Kidney: CKD 3b, A3 albuminuria, eGFR falling about 6/year. Highest priority for organ protection — add SGLT2 inhibitor and GLP-1 RA (both lower glucose with little low risk and protect kidney and heart). 5) Sulfonylureas permanently stopped. Metformin dose OK at eGFR 38; stop if eGFR under 30. 6) Neuropathy with loss of protective sensation and callus — high foot risk. Worsened by B12 deficiency (metformin). 7) Mild NPDR — slow GLP-1 RA titration is reasonable; eye exam on schedule. 8) Biggest non-medical risk: she is a caregiver for a husband with dementia and has high diabetes distress. CGM with daughter following and glucagon at home make her safer.

P PLAN

12 MANAGEMENT BY PROBLEM

Glycemic management plan,

A1c goal under 8.0%. Target 100–180 mg/dL; bedtime above 120. Continue Dexcom G7. Low alert 70, urgent low 55, high alert 250. Daughter follows alerts. Fingerstick if symptoms don't match the sensor.

Medication plan,

Start empagliflozin 10 mg daily (kidney and heart protection). Start semaglutide 0.25 mg weekly ×4 weeks, then 0.5 mg. Continue metformin 500 mg BID. Glipizide permanently stopped and listed as an allergy-style alert. Stop self-started aspirin (no ASCVD; bleeding risk). Start B12 1,000 mcg daily.

Insulin plan,

Glargine 20 units nightly — do not skip. Lower by 2 units for any reading under 80 or if fasting under 100 on 2 days. As semaglutide takes effect, expect to lower further. No mealtime insulin. Rotate sites; avoid the lipohypertrophy pad (absorption may change — check CGM closely for 1 week).

Pump/CGM plan,

Alerts as above, with sound on overnight. Clarity clinic sharing enabled. 90-day sensor supply through DME. Back-of-arm sites, rotate sides.

Hypoglycemia plan,

Nasal glucagon 3 mg prescribed; daughter trained today. Rule of 15 with glucose tablets by bed and in purse. Never skip supper after insulin — keep simple backup meals. No driving for 3 months after the severe event, then only if CGM shows no lows and glucose above 90 before driving. Medical ID bracelet.

Hyperglycemia / sick-day plan,

If vomiting, unable to eat, or dehydrated: hold empagliflozin, metformin, and semaglutide; keep glargine but at half dose; check urine ketones (strips sent) — SGLT2i can cause ketoacidosis even with normal glucose. Call if glucose above 300 twice or ketones moderate or more.

Nutrition plan,

Plate method; halve lunch starch, add vegetables and protein. Unsweetened tea. Three meals a day — simple supper options (eggs, yogurt, frozen meals). Kidney-aware protein around 0.8 g/kg. Dietitian referral.

Physical activity plan,

Seated and chair-based strength exercises 3×/week. Walk 10 minutes after lunch (also blunts the lunch peak). Proper shoes before walking further. Check CGM before activity.

Weight and cardiometabolic plan,

Modest weight loss expected on semaglutide — goal 5%. BP under 130/80; continue lisinopril 20 mg and amlodipine. Continue atorvastatin 40 mg (LDL goal under 70). Sleep study offered later.

Complication screening plan,

Nephrology referral (A3 albuminuria, falling eGFR). BMP and UACR in 4 weeks (SGLT2i start). Podiatry within 4 weeks — callus care, diabetic shoes and insoles. Dilated eye exam 03/2027 (sooner with vision change).

Pregnancy/reproductive plan,

Not applicable.

Education and self-management plan,

CDCES session today and in 2 weeks: CGM alerts, site rotation, glucagon, sick-day rules. Daily foot check with a mirror. Written one-page plan on the fridge.

Referral and care coordination plan

CDCES, dietitian, podiatry, nephrology, behavioral health (caregiver stress). Social work for respite care and memory-care support for husband. PCP updated (aspirin, glipizide alert).

Patient education

Explained why the low happened and why the new medicines are safer. Teach-back correct. Call 911 for a low that doesn't respond or confusion. Seek urgent care for vomiting with ketones, glucose above 400, chest pain, sudden weakness, or a foot wound.

F FOLLOW-UP

13 REASSESSMENT PLAN

Remote CGM review in 1 week (nurse call). CDCES visit in 2 weeks. Labs (BMP, UACR) in 4 weeks. Clinic visit in 4 weeks: CGM review, semaglutide step-up, glargine adjustment. A1c in 3 months. Podiatry and nephrology within 4–6 weeks. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
55 minutes

DIABETES COUNSELING TIME
15 minutes (cause of low, goals)

MEDICATION / INSULIN COUNSELING TIME
10 minutes (new agents, glargine rules)

CGM / PUMP REVIEW TIME, IF APPLICABLE
10 minutes (6-day Dexcom report)

NUTRITION / LIFESTYLE COUNSELING TIME, IF APPLICABLE
5 minutes

HYPOGLYCEMIA SAFETY COUNSELING TIME, IF APPLICABLE
5 minutes (glucagon, driving)

CARE COORDINATION TIME
5 minutes (referrals, social work)

RECORDS REVIEW TIME, IF APPLICABLE
5 minutes (hospital records)

LAB / DEVICE DATA REVIEW TIME, IF APPLICABLE
Included in CGM review

14a BILLING CONSIDERATIONS — E/M / DIABETES MANAGEMENT CODING

E/M LEVEL
99215-25 + G2211

CGM INTERPRETATION CODE(S), IF APPLICABLE
95251 (CGM analysis and report, ≥72 h)

INSULIN PUMP / DEVICE MANAGEMENT CODE(S), IF APPLICABLE
Not applicable

DIABETES EDUCATION / TRAINING CODE(S), IF APPLICABLE
G0108 — billed by CDCES

MEDICATION MONITORING DOCUMENTATION, IF APPLICABLE
Insulin + SGLT2i + GLP-1 RA initiation in CKD 3b

BASIS FOR BILLING
Medical Decision Making (high) + Device data interpretation

ICD-10 DIAGNOSIS CODES

E11.649 — Type 2 diabetes mellitus with hypoglycemia without coma

[SECONDARY HYPERGLYCEMIA / HYPOGLYCEMIA / COMPLICATION / MEDICATION MONITORING DIAGNOSIS CODE(S), IF APPLICABLE]

E11.22 — T2DM with diabetic CKD; N18.32 — CKD stage 3b; I12.9 — Hypertensive CKD; E11.42 — T2DM with polyneuropathy; E11.3293 — T2DM with mild NPDR without macular edema, bilateral; E53.8 — B12 deficiency; Z79.4 — Long-term insulin use

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Samuel Okonkwo	DO	Endocrinology / Diabetes Management

DATE	TIME
11/05/2026	14:05

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