1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Marcus T. Delacroix

DOB
03/08/1985

AGE/SEX
41 / Male

MRN / PATIENT ID
MTD-5520931

DATE OF SERVICE
11/05/2026

PROVIDER
Priya Raman

CREDENTIALS
MD (Endocrinology)

VISIT TYPE
Endocrinology Consultation — new referral

CARE SETTING
Outpatient — Endocrinology Clinic

PRIMARY CARE PROVIDER, IF APPLICABLE
Helen Osei, MD

REFERRING PROVIDER, IF APPLICABLE
Helen Osei, MD (PCP)

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"My heart races, I've lost 9 kilos without trying, and my eyes are gritty and starting to bulge. Now I see double when I look up. My doctor says my thyroid is overactive."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTATION

Reason for Endocrinology Evaluation:

Initial endocrine consultation for new hyperthyroidism with eye involvement (thyroid disease evaluation).

History of Present Illness:

4 months of palpitations, heat intolerance, tremor, loose stools, and 9 kg weight loss (94 → 85 kg). Gritty, red eyes and a "staring" look for 6 weeks; double vision on upgaze for 2 weeks. PCP labs 10/22: TSH <0.01, free T4 4.1 ng/dL, total T3 412 ng/dL. Propranolol started 10/23 — palpitations better. No prior thyroid history. Smokes 1 pack/day. Worried about his eyes and about driving on night shifts.

3b ENDOCRINE AXIS SYMPTOMS

Diabetes / Glucose-Related Symptoms, if applicable:

No polyuria or polydipsia. Increased appetite (thyrotoxic). Prediabetes since 2024 (A1c 5.9%). No home monitoring. Relevant because IV steroids for eye disease are likely.

Thyroid Symptoms, if applicable:

Heat intolerance, sweating, palpitations, fine tremor, anxiety, 3–4 loose stools/day, fatigue, hair thinning. Mild neck fullness; no dysphagia or voice change. Gritty eyes, tearing, light sensitivity, eyelid swelling on waking, intermittent vertical diplopia. No prior thyroid surgery or radioactive iodine.

Pituitary Symptoms, if applicable:

No headache or field loss. Mildly reduced libido; no erectile dysfunction. No prior pituitary imaging.

Adrenal Symptoms, if applicable:

Palpitations and sweating explained by thyrotoxicosis. Thigh weakness climbing stairs. No salt craving, hyperpigmentation, or prior steroid exposure.

Calcium / Parathyroid / Bone Symptoms:

No fractures, stones, or bone pain. No calcium or vitamin D supplements. Low dairy intake. No prior DEXA.

Reproductive / Gonadal Symptoms:

Low libido as above. No gynecomastia or testicular symptoms. Two children; no further family plans.

Weight / Metabolic Symptoms:

9 kg unintentional loss despite eating more. Previously overweight (BMI 29). Snacks on shift. Little exercise. Sleeps 5–6 h, broken by palpitations and night shifts.

Lipid / Cardiometabolic Risk:

LDL 152 in 2024, untreated. No hypertension or CVD. Snores. Father MI at 59. No statin.

3c TREATMENT & BACKGROUND

Medication History and Response:

Propranolol 20 mg TID since 10/23 — home heart rate 118 → ~90; mild fatigue. No antithyroid drug yet. Cetirizine as needed. Employer insurance; no access barriers.

Steroid / Hormone Exposure History:

No glucocorticoid, anabolic steroid, or testosterone use. Took a "hair, skin and nails" supplement with biotin 5,000 mcg — stopped 3 days ago at PCP advice. No kelp, iodine products, or recent iodinated contrast.

Past Medical and Surgical History:

Prediabetes. Seasonal allergies. Appendectomy age 14. No hospitalizations.

Family History:

Mother — Hashimoto thyroiditis. Sister — vitiligo. Father — type 2 diabetes, MI at 59. No thyroid cancer, endocrine tumors, or MEN.

Social / Lifestyle History:

Warehouse logistics supervisor, rotating night shifts; drives 40 minutes each way. Smokes 1 pack/day for 20 years — willing to quit. 4–6 beers/week. No other substances. Married, two children.

Pertinent Negatives:

No chest pain, syncope, fever, confusion, vomiting, vision loss, colour fading, or rapidly enlarging neck mass. No thyroid storm symptoms.

ROS ENDOCRINOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fatigue, weight change, appetite change, heat/cold intolerance, sweating, tremor, or palpitations
Positive — all, from thyrotoxicosis.

Polyuria, polydipsia, blurred vision, hypoglycemia symptoms, hyperglycemia symptoms, or neuropathy symptoms
Negative (blurring is from diplopia, not glucose).

Neck swelling, dysphagia, voice change, thyroid eye symptoms, constipation, or diarrhea
Positive — neck fullness, eye symptoms, loose stools.

Headache, visual changes, galactorrhea, libido changes, infertility, or menstrual irregularity
Positive — diplopia on upgaze, low libido.

Dizziness, salt craving, weakness, bruising, striae, episodic headaches, sweating, or hypertension
Positive — proximal weakness, sweating.

Bone pain, fractures, kidney stones, muscle cramps, paresthesias, or height loss
Negative.

Acne, hirsutism, hot flashes, erectile dysfunction, gynecomastia, or reproductive hormone symptoms
Negative.

Medication side effects, adherence barriers, injection issues, device issues, or access concerns
Mild fatigue on propranolol.

O OBJECTIVE

5 EXAMINATION

5a VITALS

TEMPERATURE **98.9 °F**	BLOOD PRESSURE **138/72 mmHg**	HEART RATE **92 bpm (on propranolol)**
RESPIRATORY RATE **16 /min**	OXYGEN SATURATION **98% RA**	HEIGHT **180 cm**
WEIGHT **85.1 kg**	BMI **26.3**	WAIST CIRCUMFERENCE, IF APPLICABLE **94 cm**
PAIN SCORE, IF APPLICABLE **0/10**		

5b EXAMINATION

General Appearance:

Alert, restless, thinner than ID photo. Warm and sweaty. No distress.

Head / Eyes / Ears / Nose / Throat:

Bilateral proptosis (Hertel 23 mm R, 22 mm L, base 102). Upper lid retraction with lid lag. Redness and swelling of conjunctiva and caruncles; eyelid swelling. Restricted upgaze with diplopia. Acuity 20/20 both eyes. Colour vision 15/15 (Ishihara). Pupils equal, no RAPD. Fields full to confrontation.

Neck / Thyroid:

Diffusely enlarged, smooth, non-tender gland (~2.5× normal) with a bruit over both lobes. No nodule or lymphadenopathy. Trachea midline.

Cardiovascular:

Regular, 92. Soft 1/6 flow murmur. No edema. Pulses brisk.

Pulmonary:

Clear. Normal effort.

Abdomen:

Soft, non-tender. Old appendectomy scar. No hepatomegaly.

Extremities:

Fine tremor of outstretched hands. Hip flexion 4+/5 both sides. No edema. Monofilament normal.

Skin:

Warm, moist, smooth. Fine scalp hair. No vitiligo, pretibial myxedema, or acropachy.

Neurologic:

Reflexes 3+ and symmetric with fast relaxation. Sensation and gait normal. No focal deficit.

Psychiatric:

Anxious, fast speech, irritable. Good insight. Motivated. No safety concerns.

DA ENDOCRINE DISEASE-SPECIFIC ASSESSMENT

6 FOCUSED ASSESSMENT

CURRENT ENDOCRINE DIAGNOSIS OR SUSPECTED DIAGNOSIS

Graves disease with active, moderate-to-severe thyroid eye disease (TED)

SYMPTOM CONTROL AND DISEASE TRAJECTORY

Uncontrolled thyrotoxicosis; eyes worsening over 6 weeks

RELEVANT HORMONE AXIS INVOLVED

Thyroid (TSH-receptor antibody driven)

LAB TREND INTERPRETATION

TSH suppressed; free T4 4.1 → 3.8; T3-predominant

IMAGING CORRELATION WHEN APPLICABLE

Ultrasound: diffuse, hypervascular gland, no nodules

MEDICATION ADHERENCE AND TREATMENT RESPONSE

Adherent to propranolol; heart rate improved

SIDE EFFECTS OR SAFETY CONCERNS

Baseline CBC and LFTs normal before methimazole

COMORBIDITIES AFFECTING ENDOCRINE MANAGEMENT

Smoking, prediabetes, night-shift driving

NEED FOR ADDITIONAL TESTING, MEDICATION ADJUSTMENT, SPECIALIST REFERRAL, OR URGENT ESCALATION

Start methimazole; urgent ophthalmology; likely IV steroids for TED

DM DIABETES / METABOLIC MONITORING, IF APPLICABLE

7 GLYCEMIC RISK REVIEW

DIABETES TYPE AND DURATION

CURRENT MEDICATION REGIMEN

Prediabetes since 2024

None for glucose

INSULIN REGIMEN AND DOSING PATTERN IF DOCUMENTED

Not applicable

HOME GLUCOSE READINGS OR CGM METRICS

Fingersticks to start with IV steroids

HYPOGLYCEMIA FREQUENCY AND SEVERITY

None

HYPERGLYCEMIA TRENDS

None known

A1C TREND

5.7% (2024) → 5.9% (10/2026)

DIET AND PHYSICAL ACTIVITY

Shift snacking; little exercise

FOOT EXAM STATUS

Normal monofilament

EYE EXAM STATUS

Ophthalmology for TED this week

KIDNEY SCREENING STATUS

eGFR >90; UACR 8 mg/g

CARDIOVASCULAR RISK MANAGEMENT

Smoking, LDL, father's MI — revisit when euthyroid

VACCINATION STATUS WHEN RELEVANT

Influenza 10/2026

DEVICE USE, SUPPLY ACCESS, AND EDUCATION NEEDS

Glucometer prescribed for steroid course

TN THYROID / NECK ASSESSMENT, IF APPLICABLE

8 THYROID REVIEW

THYROID DIAGNOSIS OR SUSPECTED DIAGNOSIS

Graves disease

TSH, FREE T4, T3, THYROID ANTIBODY TRENDS

TSH <0.01; FT4 3.8; T3 398; TRAb 14.2 IU/L

THYROID ULTRASOUND FINDINGS

Diffusely enlarged (R lobe 6.1 cm), heterogeneous, hypervascular

THYROID NODULE SIZE AND RISK FEATURES

None

FINE NEEDLE ASPIRATION HISTORY OR NEED

Not needed

THYROID MEDICATION ADHERENCE AND TIMING

Methimazole starts today, once daily

BIOTIN OR SUPPLEMENT INTERFERENCE RISK

Biotin stopped 72 h before today's labs — valid

COMPRESSIVE SYMPTOMS

None

EYE INVOLVEMENT IF HYPERTHYROIDISM/GRAVES DISEASE IS RELEVANT

Active TED: CAS 5/7, moderate-to-severe (EUGOGO), Gorman diplopia grade 2

SURGICAL OR RADIOACTIVE IODINE HISTORY

None; RAI avoided (active TED, smoker)

NEED FOR ENDOCRINOLOGY, SURGERY, NUCLEAR MEDICINE, OR OPHTHALMOLOGY COORDINATION

Ophthalmology/oculoplastics within 1 week; surgery information visit

PA PITUITARY / ADRENAL ASSESSMENT, IF APPLICABLE

9 STEROID EXPOSURE REVIEW

HORMONE AXIS INVOLVED
Adrenal — iatrogenic suppression risk only

PITUITARY OR ADRENAL IMAGING FINDINGS
Not indicated

VISUAL SYMPTOMS OR VISUAL FIELD TESTING
Diplopia from muscle restriction; formal fields by ophthalmology

DYNAMIC ENDOCRINE TESTING RESULTS OR NEED
Not needed

STEROID EXPOSURE AND ADRENAL SUPPRESSION RISK
Planned IV methylprednisolone 4.5 g over 12 weeks — low risk

REPLACEMENT THERAPY STATUS
None

STRESS-DOSE STEROID EDUCATION WHEN APPLICABLE
Not needed for weekly pulses; revisit if oral steroids follow

ADRENAL INCIDENTALOMA WORKUP
Not applicable

HYPERTENSION OR HYPOKALEMIA EVALUATION WHEN RELEVANT
K 4.1; systolic rise from thyrotoxicosis

NEED FOR NEUROSURGERY, ENDOCRINE SURGERY, OPHTHALMOLOGY, OR ADRENAL CRISIS PRECAUTIONS
Ophthalmology only

MM MEDICATION / HORMONE THERAPY MONITORING

10 SAFETY REVIEW

CURRENT ENDOCRINE MEDICATIONS
Propranolol 20 mg TID; methimazole 20 mg daily (new)

DOSE, ROUTE, FREQUENCY, AND ADHERENCE
Oral; adherent

TREATMENT RESPONSE
Heart rate 118 → 92

SIDE EFFECTS OR TOXICITY SYMPTOMS
Mild fatigue on propranolol

LAB MONITORING STATUS
Baseline CBC (ANC 2.4) and LFTs normal

INJECTION TECHNIQUE OR DEVICE USE WHEN APPLICABLE
Not applicable

PREGNANCY, FERTILITY, OR CONTRACEPTION CONSIDERATIONS WHEN RELEVANT
Not applicable

DRUG INTERACTIONS AND SUPPLEMENT INTERFERENCE
Biotin stopped; no interacting drugs

REFILL NEEDS AND INSURANCE/ACCESS BARRIERS
30-day supplies sent; covered

EDUCATION PROVIDED AND TEACH-BACK WHEN PERFORMED
Agranulocytosis warning; teach-back correct

ST SCREENING / ASSESSMENT TOOLS

11 SCORES & INTERPRETATION

A1c 5.9% (prediabetes; up from 5.7%). CGM and glucose logs: none yet. ASCVD 10-year risk 6.8% (borderline, smoker) — unreliable while thyrotoxic; repeat when euthyroid. FRAX and DEXA not indicated. Thyroid ultrasound: no nodules, so no TI-RADS scoring. TED: Clinical Activity Score 5/7 (active); EUGOGO moderate-to-severe; GO-QOL visual function 56, appearance 50. Burch–Wartofsky 25 (no storm). STOP-Bang 3 (snoring, male, neck 41 cm) — rescreen when euthyroid. PHQ-9 8, GAD-7 12 — thyrotoxicosis likely contributes. Adherence: good.

L LABORATORY AND DIAGNOSTIC RESULTS

12 REVIEWED & ORDERED

Diabetes / Metabolic Labs:

A1c 5.9%. Fasting glucose 104. CMP: ALP 158 (bone turnover), AST/ALT 28/34, albumin 4.2. Cr 0.71, eGFR >90. UACR 8 mg/g. Lipids: LDL 118 (lower than 2024 — thyrotoxic effect), HDL 38, TG 140.

Thyroid Testing:

TSH <0.01 mIU/L. Free T4 3.8 ng/dL (0.8–1.8). Total T3 398 ng/dL. TRAb 14.2 IU/L (<1.75). TPO Ab 210 IU/mL. Ultrasound 10/30 as above. Uptake scan not needed (diagnosis clear). No FNA.

Pituitary Testing:

Not indicated — TSH appropriately suppressed. Formal visual fields by ophthalmology.

Adrenal Testing:

Not indicated. K 4.1, Na 139. Pre-steroid screen: hepatitis B sAg/cAb and hepatitis C negative.

Calcium / Bone / Parathyroid Testing:

Calcium 10.1 (upper normal), PTH 18 (appropriately low-normal), 25-OH vitamin D 22 ng/mL (insufficient). ALP raised as above. DEXA not ordered.

Reproductive Hormone Testing:

Not ordered. SHBG rises in thyrotoxicosis and distorts total testosterone; check only if low libido persists once euthyroid.

Lipid / Cardiometabolic Testing:

Lipids as above. Lp(a) 92 nmol/L (raised) — adds to family risk. ECG 10/22: sinus tachycardia 104, no atrial fibrillation.

Prior Records Reviewed:

PCP notes and labs 10/2026, 2024 labs, ECG 10/22, thyroid ultrasound report 10/30, optometry note 10/28 (dry eye, proptosis).

A ASSESSMENT

13 ENDOCRINE INTERPRETATION

1) Graves disease with moderate thyrotoxicosis (free T4 about 2× upper limit, T3-predominant) and strongly positive TRAb. 2) Differential: painless or subacute thyroiditis (excluded — high TRAb, hypervascular gland, eye disease); toxic nodular goiter (no nodules); biotin artefact (biotin stopped; antibodies and exam confirm). 3) Active, moderate-to-severe TED (CAS 5/7, diplopia, proptosis 23 mm). Sight not threatened today — acuity, colour, and pupils normal. Smoking is the main modifiable risk. 4) Treatment: methimazole first-line, planned 12–18 months. Radioactive iodine avoided (active TED, smoker). Thyroidectomy is the definitive option if TRAb stays high or relapse occurs. 5) TED: likely IV methylprednisolone 4.5 g over 12 weeks per ophthalmology, plus selenium. Teprotumumab is the alternative

if steroids fail or diplopia worsens (watch hearing and glucose). 6) Steroid risks: prediabetes needs glucose checks; hepatitis screen negative; monitor BP and LFTs. 7) Cardiovascular: sinus tachycardia controlled on beta-blocker, no AF. Lipids, Lp(a), and smoking to address once euthyroid. 8) Barriers: night shifts and driving with diplopia — work letter; no night driving until diplopia is controlled.

P PLAN

14 MANAGEMENT BY PROBLEM

Diagnostic plan,

Free T4, T3, CBC, and LFTs at 4 weeks, then every 4–6 weeks while titrating. TRAb at 6 and 12–18 months to guide stopping. A1c and lipids once euthyroid. Vitamin D in 3 months.

Diabetes plan,

Prediabetes — no medication. If IV steroids start: fingerstick 2 h after lunch on infusion day and the next day for the first 4 infusions; call if above 250 mg/dL. A1c in 3 months.

Thyroid plan,

Methimazole 20 mg daily; titrate toward 5–10 mg maintenance. Propranolol 20 mg TID, tapered once free T4 is normal. No radioactive iodine. Endocrine surgery information visit if he prefers definitive treatment. Thyroid storm warning signs reviewed.

Pituitary plan,

Not applicable — no pituitary concern.

Adrenal plan,

No testing needed. If oral steroids follow the IV course for more than 3 weeks, taper and sick-day guidance will be given.

Bone/calcium/parathyroid plan,

Vitamin D3 2,000 IU daily. Dietary calcium 1,000 mg/day. Bone turnover should settle as thyroid levels normalize. DEXA only if steroids are extended.

Reproductive hormone plan,

Expect libido to recover. AM testosterone and SHBG only if still low 3 months after euthyroid.

Weight/metabolic plan,

Expect weight regain as thyroid normalizes; dietitian referral to avoid overshoot past prior BMI 29. Regular meals on shift; swap sugary snacks.

Medication monitoring plan,

CBC and LFTs at 4 weeks and urgently with fever, sore throat, mouth ulcers, jaundice, or dark urine. Written agranulocytosis card given. Glucose, BP, and LFTs checked at each methylprednisolone infusion.

Lifestyle plan,

Smoking cessation is the most important step for his eyes — varenicline started (PCP to continue), quitline referral, quit date 11/15. Alcohol under 7 drinks/week. Request day shifts for 3 months.

Referral and care coordination plan

Ophthalmology/oculoplastics (urgent, within 1 week — booked 11/10). Endocrine surgery (optional information visit). Dietitian. PCP for smoking cessation and lipids. Occupational health letter.

Patient education

Explained Graves disease, its link to the eyes, and how smoking worsens both. Lubricating drops, sunglasses, head-of-bed raised, temporary prism per ophthalmology. Emergency care for vision loss, colour fading, severe eye pain, fever with sore throat, chest pain, fainting, confusion, or high fever with agitation.

F FOLLOW-UP

15 REASSESSMENT PLAN

Ophthalmology 11/10. Telehealth review of 4-week labs. Clinic visit in 6 weeks (methimazole titration, TED plan, glucose log if on steroids). Then every 6–8 weeks until stable. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

16 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
60 minutes

ENDOCRINE COUNSELING TIME
20 minutes (Graves, treatment options)

MEDICATION / HORMONE THERAPY COUNSELING TIME
10 minutes (methimazole safety)

DIABETES DEVICE / GLUCOSE REVIEW TIME, IF APPLICABLE
5 minutes (steroid glucose plan)

LIFESTYLE / NUTRITION COUNSELING TIME, IF APPLICABLE
5 minutes (smoking cessation)

CARE COORDINATION TIME
10 minutes (urgent ophthalmology)

RECORDS REVIEW TIME, IF APPLICABLE
5 minutes

LAB / IMAGING REVIEW TIME, IF APPLICABLE
5 minutes (labs, ultrasound)

16a BILLING CONSIDERATIONS — E/M / ENDOCRINOLOGY CODING

E/M LEVEL
99205

CGM INTERPRETATION CODE(S), IF APPLICABLE
Not applicable

DIABETES EDUCATION / DEVICE MANAGEMENT CODE(S), IF APPLICABLE
Not applicable

THYROID FNA / ULTRASOUND REVIEW CODE(S), IF APPLICABLE
Outside ultrasound reviewed — not separately billed

MEDICATION MONITORING / HIGH-RISK MEDICATION DOCUMENTATION, IF APPLICABLE
Methimazole — drug requiring intensive monitoring for toxicity

BASIS FOR BILLING
Medical Decision Making (high)

ICD-10 DIAGNOSIS CODES
E05.00 — Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm (Graves disease with ophthalmopathy)

[SECONDARY DIABETES / THYROID / HORMONE / METABOLIC / MEDICATION MONITORING DIAGNOSIS CODE(S), IF APPLICABLE]

H53.2 — Diplopia; R73.03 — Prediabetes; F17.210 — Nicotine dependence, cigarettes, uncomplicated; E55.9 — Vitamin D deficiency, unspecified

SO SIGNATURE

17 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Priya Raman	MD	Endocrinology

DATE	TIME
11/05/2026	10:20