1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Renata L. Okonkwo

DOB
06/02/1974

AGE/SEX
52 / Female

MRN / PATIENT ID
RLO-5528170

DATE OF SERVICE
10/28/2026

PROVIDER
Daniel Whitfield

CREDENTIALS
MD, FCCP

VISIT TYPE
Follow-Up — HRCT, bronchoscopy, and PFT review (3 months after initial consult)

CARE SETTING
Outpatient — Pulmonology Clinic (ILD program)

PRIMARY CARE PROVIDER, IF APPLICABLE
Sandra Kowalczyk, MD

REFERRING PROVIDER, IF APPLICABLE
Sandra Kowalczyk, MD

INTERPRETER USED, IF APPLICABLE
Not required — English

CC CHIEF COMPLAINT

2 PRIMARY PULMONARY CONCERN

"I still get winded on the stairs and the dry cough hasn't gone away, but it's been a bit better since the birds went to my sister's. I want to know what the scope showed."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTING SYMPTOMS

Reason for Pulmonology Evaluation:

Interstitial lung disease follow-up: review of repeat HRCT, bronchoscopy with BAL, and full PFTs; ILD multidisciplinary discussion outcome; oxygen assessment; treatment decision.

Dyspnea / Shortness of Breath:

Gradual exertional dyspnea for about 2 years, worse over the last 9 months. Now short of breath after one flight of stairs or 2 blocks on level ground (was 4 blocks in July). No rest dyspnea, orthopnea, PND, or edema. No palpitations.

Cough History:

Dry, paroxysmal cough for 18 months, worse at night and after cleaning the bird room. Mild heartburn 2–3 times a week. Not on an ACE inhibitor. No response to a 4-week inhaled steroid trial. Cough intensity down about 30% since the birds were removed 10 weeks ago.

Wheezing / Chest Tightness:

Occasional chest tightness with exertion; no wheeze. Albuterol gives no benefit.

Sputum / Hemoptysis:

None. No hemoptysis.

3b DISEASE-SPECIFIC HISTORY

Asthma History, if applicable:

Not applicable. Told she had "asthma" by urgent care in 2025; methacholine challenge negative (08/2026). No intubations.

COPD / Chronic Bronchitis / Emphysema History, if applicable:

Not applicable — never smoker; no obstruction on spirometry.

Interstitial Lung Disease / Pulmonary Fibrosis Symptoms, if applicable:

Progressive exertional dyspnea and dry cough as above. Exertional desaturation on the July walk test. No Raynaud, rash, joint swelling, or muscle weakness. Kept 6 cockatiels and 2 parakeets indoors for 9 years, plus a feather duvet and pillows. No amiodarone, methotrexate, or nitrofurantoin. No treatment yet.

Lung Nodule / Abnormal Imaging History:

CXR 05/2026 (PCP, for cough): bilateral reticular opacities. HRCT 07/2026 and repeat 10/2026 reviewed today. No nodules.

Respiratory Infection History:

"Bronchitis" ×2 in 2025 treated with azithromycin without lasting benefit. No hospitalizations. Vaccines: influenza 09/2026, COVID-19 2025–26, PCV20 07/2026, RSV not yet given.

Sleep-Related Breathing Symptoms:

Light snoring; no witnessed apneas. Wakes 1–2 times nightly from cough. Epworth 6. No prior sleep study.

Oxygen / Ventilatory Support Use:

No home oxygen. Home pulse oximeter: 95–96% at rest, 87–89% climbing stairs.

Exercise Tolerance and Functional Status:

Independent in ADLs. Stopped Saturday hiking group. Works full-time as a middle-school librarian; stops halfway up the stairs at school. Not yet in pulmonary rehabilitation.

3c EXPOSURES, MEDICATIONS & BACKGROUND

Smoking / Vaping / Inhalational Exposure History:

Never smoker (0 pack-years); no vaping or cannabis. Major bird exposure: 8 indoor birds for 9 years, cleaning cages without a mask. Birds rehomed 08/2026; feather bedding replaced 09/2026. No hot tub, visible mold, farming, asbestos, or silica.

Medication History and Response:

Fluticasone/salmeterol 250/50 (stopped 07/2026 — no benefit). Albuterol as needed (rarely used). Omeprazole 20 mg daily (started 07/2026). Levothyroxine 75 mcg. No antifibrotic or immunosuppressant yet. Insured; no cost barriers.

Relevant Medical History:

Hypothyroidism (Hashimoto's), GERD, allergic rhinitis. BMI 27. Prediabetes (A1c 5.9%). No cardiac disease, VTE, cancer, or immunosuppression.

Family History:

No family history of pulmonary fibrosis. Mother — rheumatoid arthritis. Father — COPD (smoker). Sister — asthma.

Social / Occupational History:

School librarian. Lives with husband in a 1990s house; no water damage. Birds now at sister's home — she has not visited since. No TB exposure or recent travel. Alcohol: 2 glasses of wine weekly.

Pertinent Negatives:

Denies rest dyspnea, chest pain, syncope, hemoptysis, cyanosis, fever, leg swelling, weight loss, or night sweats. Positive only for exertional desaturation.

ROS PULMONOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Dyspnea, cough, wheezing, chest tightness, sputum production, or hemoptysis
Positive — exertional dyspnea, dry cough, mild chest tightness. No wheeze, sputum, or hemoptysis.

Fever, chills, night sweats, weight loss, fatigue, or recurrent infections
Positive — fatigue after work. No fever, sweats, or weight loss.

Chest pain, palpitations, orthopnea, edema, syncope, or exercise intolerance
Positive — exercise intolerance. Negative for the rest.

Snoring, witnessed apneas, daytime sleepiness, nocturnal dyspnea, or morning headaches
Light snoring only.

Reflux, aspiration symptoms, dysphagia, postnasal drip, or sinus symptoms
Positive — heartburn, improved on omeprazole. No dysphagia.

Joint pain, Raynaud symptoms, rash, sicca symptoms, muscle weakness, or autoimmune symptoms
Negative.

Inhaler side effects, steroid side effects, oxygen issues, CPAP/BiPAP intolerance, or medication adherence barriers
Negative.

Anxiety, activity limitation, sleep disruption, work limitation, or quality-of-life impact related to respiratory disease
Positive — anxious about "lung scarring"; stopped hiking; cough disrupts sleep.

O OBJECTIVE

5 CARDIOPULMONARY EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.2 °F	124/78 mmHg	84 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**OXYGEN FLOW RATE, IF APPLICABLE**
18 /min	95% RA at rest	None (room air)
HEIGHT	**WEIGHT**	**BMI**
165 cm	73.5 kg	27.0
PAIN SCORE, IF APPLICABLE		
0/10		

5b EXAMINATION

General Appearance:

Alert, well-appearing, no distress at rest. Speaks in full sentences. No accessory muscle use or cyanosis. Coughs 3–4 times during the visit.

Head / Eyes / Ears / Nose / Throat:

Mild turbinate swelling; no cobblestoning or postnasal drainage. Mallampati II. Moist mucosa.

Neck:

No JVD. Trachea midline. No lymphadenopathy. Thyroid not enlarged. Neck circumference 35 cm.

Cardiovascular:

Regular rate and rhythm. No murmur or gallop. P2 not accentuated. No edema. Pulses 2+ throughout.

Pulmonary:

Unlabored at rest. Fine "Velcro" inspiratory crackles in both mid zones, plus scattered end-inspiratory squeaks in the upper zones. Bases fairly spared. No wheeze, rhonchi, or rub. Good air movement.

Chest Wall:

Normal shape. Mildly reduced but symmetric expansion. No tenderness.

Abdomen:

Soft, non-tender, no hepatomegaly or ascites.

Extremities:

No clubbing, cyanosis, or edema. No synovitis, digital ulcers, or calf tenderness.

Skin:

No rash, telangiectasias, sclerodactyly, mechanic's hands, or Gottron papules.

Neurologic:

Alert and oriented. Normal gait. Proximal strength 5/5. No asterixis.

PFT PULMONARY FUNCTION / RESPIRATORY TESTING

6 TESTS REVIEWED OR PERFORMED

SPIROMETRY RESULTS

Restrictive pattern; no obstruction

FEV1, FVC, FEV1/FVC RATIO

FEV1 2.04 L (74%), FVC 2.49 L (71%), ratio 0.82

BRONCHODILATOR RESPONSE

None significant (+2%)

LUNG VOLUMES

TLC 3.52 L (69%) — mild restriction

DLCO

11.9 (54% predicted, Hb-corrected) — moderately reduced

FLOW-VOLUME LOOP INTERPRETATION

Small, steep, "witch's hat" loop; no upper airway obstruction

PEAK FLOW WHEN RELEVANT

Not performed

FRACTIONAL EXHALED NITRIC OXIDE IF PERFORMED

12 ppb (low) — argues against T2 asthma

6-MINUTE WALK TEST

10/28/2026: 402 m (07/2026: 438 m)

AMBULATORY OXYGEN TESTING

Nadir SpO2 86% at minute 4 on RA; 92% or above on 2 L/min pulsed

ARTERIAL OR VENOUS BLOOD GAS WHEN APPLICABLE

Not indicated

OVERNIGHT OXIMETRY

Ordered — pending

SLEEP STUDY RESULTS WHEN RELEVANT

Not done; STOP-Bang 2 — low risk

COMPARISON TO PRIOR TESTING

FVC fell 0.21 L (–7.8%) and DLCO –4 points since 07/2026

TEST QUALITY AND LIMITATIONS

ATS/ERS acceptable and repeatable (grade A)

IM IMAGING / NODULE / LUNG DISEASE ASSESSMENT

7 CHEST IMAGING REVIEW

IMAGING MODALITY AND DATE

HRCT with inspiratory, expiratory, and prone images — 07/16/2026 and 10/14/2026

INDICATION FOR IMAGING

Progressive dyspnea, restrictive PFTs, abnormal CXR

LUNG NODULES

None

INFILTRATES, CONSOLIDATION, ATELECTASIS, BRONCHIECTASIS, EMPHYSEMA, FIBROSIS, GROUND-GLASS OPACITIES, PLEURAL EFFUSION, PNEUMOTHORAX, LYMPHADENOPATHY, OR MASS

Upper- and mid-zone reticulation with traction bronchiectasis; patchy ground-glass and centrilobular nodules; mosaic attenuation with air-trapping on expiration ("three-density" sign). No honeycombing, effusion, or mass. Mildly enlarged mediastinal nodes (largest 12 mm, reactive)

ILD PATTERN WHEN APPLICABLE

Typical for fibrotic hypersensitivity pneumonitis (ATS/JRS/ALAT 2020)

COMPARISON TO PRIOR IMAGING

Ground-glass slightly less (after antigen removal); fibrosis stable

RISK STRATIFICATION WHEN RELEVANT

Fibrotic phenotype; FVC decline of 5–10% with worsening symptoms — high risk of progression

NEED FOR REPEAT IMAGING, PET/CT, BIOPSY, BRONCHOSCOPY, REFERRAL, OR SURVEILLANCE

Bronchoscopy with BAL done 09/2026; no lung biopsy now (MDD confident). Repeat HRCT in 6–12 months

INH INHALER / DEVICE TECHNIQUE ASSESSMENT

8 TECHNIQUE & ADHERENCE

CURRENT INHALERS AND NEBULIZED THERAPIES

Albuterol MDI as needed only

CONTROLLER VERSUS RESCUE USE

No controller (ICS/LABA stopped — no benefit)

FREQUENCY OF RESCUE MEDICATION USE

Less than once a month

SPACER USE

Yes

INHALER TECHNIQUE OBSERVED

NEBULIZER EQUIPMENT FUNCTION

Correct with spacer

Not applicable

OXYGEN EQUIPMENT USE

New — portable concentrator, pulsed 2 L/min, prescribed today

CPAP/BIPAP ADHERENCE AND MASK FIT WHEN APPLICABLE

Not applicable

BARRIERS INCLUDING COST, ACCESS, COGNITION, DEXTERITY, OR MISUNDERSTANDING

Worried about oxygen at work; no cost barrier

EDUCATION PROVIDED AND TEACH-BACK IF PERFORMED

Oxygen use with exertion and pulse-oximeter targets; teach-back correct

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

mMRC 2 (was 1 in 07/2026). Leicester Cough Questionnaire 13.1 (was 11.4 — improving). Epworth 6 — normal. STOP-Bang 2 — low risk. 6MWD 402 m (−36 m since 07/2026). Borg dyspnea 5 at end of walk. Desaturation to 86% — meets criteria for ambulatory oxygen. Pulmonary rehab: eligible; referral placed. GAD-7 8 (mild anxiety). PHQ-9 4. Smoking cessation: not applicable. ACT and CAT not used — not asthma or COPD.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Pulmonary Function Testing:

Full PFTs 10/28/2026 as above. Methacholine challenge 08/2026 negative (PC20 above 16 mg/mL). FeNO 12 ppb. 6MWT 402 m with desaturation.

Imaging:

HRCT 07/16 and 10/14/2026 as above. Echocardiogram 08/2026: LVEF 60%, RVSP 31 mmHg, normal RV size and function.

Laboratory Testing:

Avian precipitin panel: positive for pigeon, parakeet, and cockatiel serum IgG. ANA 1:80 speckled (low titer). RF, anti-CCP, SSA/SSB, Scl-70, myositis panel, and ANCA negative. CK normal. CBC normal (eosinophils 210). CMP normal. NT-proBNP 88. TSH 2.1. Hep B, Hep C, and QuantiFERON negative (pre-immunosuppression screen).

Microbiology:

BAL 09/22/2026 (right middle lobe): lymphocytes 38%, neutrophils 4%, eosinophils 1%; CD4:CD8 0.9. Bacterial, AFB, and fungal cultures negative. PJP negative. Cytology negative for malignancy.

Sleep / Oxygen Testing:

Ambulatory oximetry today: qualifies for exertional oxygen (SpO2 86% on RA). Overnight oximetry ordered.

Cardiopulmonary Testing:

EKG 08/2026: normal sinus rhythm. Echo as above — no pulmonary hypertension signal. No right heart catheterization indicated.

Prior Records Reviewed:

PCP notes 2024–2026, urgent care notes 2025, CXR 05/2026, ILD MDD summary 10/20/2026, bronchoscopy report, and medication list.

A ASSESSMENT

11 PULMONARY CLINICAL INTERPRETATION

1) Fibrotic hypersensitivity pneumonitis (avian antigen) — confident diagnosis at ILD MDD 10/20/2026. Basis: typical fibrotic HP pattern on HRCT, identified avian exposure with positive precipitins, and BAL lymphocytosis of 38%. No lung biopsy needed. 2) Differential: fibrotic NSIP or CTD-ILD (low-titer ANA only, no CTD features — unlikely); IPF (upper-zone, air-trapping, and BAL pattern argue against); sarcoidosis (BAL CD4:CD8 0.9 — unlikely); asthma (methacholine negative, FeNO low — excluded). 3) Severity and trajectory: mild–moderate physiology (FVC 71%, DLCO 54%) with a progressive phenotype — FVC −7.8% in 3 months, falling 6MWD, worse mMRC — despite antigen removal. Ground-glass improving suggests some reversible inflammation remains. 4) Exertional hypoxemia: new ambulatory oxygen need. No pulmonary hypertension on echo. 5) Contributors: avian antigen (removed); GERD (treated); possible residual antigen from car or clothing; mild anxiety. 6) Plan: start mycophenolate as steroid-sparing therapy; consider adding nintedanib if progression continues at 6 months; pulmonary rehab; oxygen; overnight oximetry. No hospitalization or urgent escalation needed.

P PLAN

12 PULMONOLOGY MANAGEMENT BY PROBLEM

Dyspnea evaluation plan

Workup complete. Cause established (fibrotic HP); echo excludes significant cardiac or pulmonary hypertension contribution. Repeat 6MWT and PFTs in 3 months.

Asthma plan

Not applicable — asthma excluded. Keep albuterol for rare chest tightness only.

COPD plan

Not applicable.

Chronic cough plan

Cough attributed to HP with GERD contribution. Continue omeprazole 20 mg daily and reflux measures. Benzonatate 100 mg TID as needed for nighttime cough.

Abnormal imaging or lung nodule plan

No nodules. Reactive mediastinal nodes — reassess on next HRCT. No biopsy.

Interstitial lung disease plan

Strict, permanent avoidance of avian antigen: no birds, feather bedding, or down; deep-clean the bird room and replace HVAC filters; avoid the sister's home. Start mycophenolate mofetil 500 mg BID ×2 weeks, then 1000 mg BID; PJP prophylaxis not required at this dose without steroids. Short prednisone bridge declined by patient after discussion. Antifibrotic (nintedanib) to be added if FVC falls ≥5% or symptoms worsen at 6 months. Rheumatology review of low-titer ANA not needed per MDD.

Respiratory infection plan

No active infection. Give RSV vaccine today. Counsel on infection risk on mycophenolate; call early for fever.

Oxygen and ventilatory support plan

Prescribe portable oxygen concentrator, pulsed 2 L/min with exertion (target SpO2 ≥90%). Overnight oximetry to assess nocturnal need. Oxygen safety reviewed: no open flames; husband does not smoke.

Smoking/vaping cessation plan

Not applicable — never smoker. Not eligible for lung cancer screening.

Pulmonary rehabilitation and lifestyle plan

Referral to an ILD-focused pulmonary rehabilitation program (36 sessions). Goals: return to a 3-mile flat walk and stairs at work without stopping. Pursed-lip breathing and pacing taught. Aim for 5% weight loss.

Medication plan

Start mycophenolate (as above). Labs: CBC and CMP every 2 weeks ×2 months, then monthly ×3, then every 3 months. Counseling on GI upset, cytopenias, infection, skin cancer (sunscreen), and pregnancy avoidance (postmenopausal since 2023). Continue omeprazole and levothyroxine.

Referral and care coordination plan

Pulmonary rehabilitation; oxygen supplier (order and CMN faxed today); PCP update letter. Work note supporting oxygen use at school. ILD program nurse for lab tracking. Lung transplant referral not indicated now.

Patient education

Explained HP as a lung allergy to bird proteins with some scarring; antigen avoidance is the most important treatment. Written ILD action plan given. Seek urgent care for rest dyspnea, SpO2 below 88% at rest, fever above 100.4 °F on mycophenolate, chest pain, or hemoptysis.

F FOLLOW-UP

13 REASSESSMENT PLAN

Nurse phone call in 2 weeks (mycophenolate tolerance, first labs). Overnight oximetry results reviewed by portal in 2 weeks. Return in 3 months with spirometry, DLCO, and 6MWT to assess treatment response and oxygen need. HRCT in 6–12 months. Re-present at ILD MDD if FVC declines further. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
62 minutes

PULMONARY COUNSELING TIME
22 minutes

INHALER / DEVICE EDUCATION TIME
8 minutes (oxygen and oximeter)

SMOKING CESSATION COUNSELING TIME, IF APPLICABLE
Not applicable

OXYGEN / PAP COUNSELING TIME, IF APPLICABLE
included above

CARE COORDINATION TIME
10 minutes

RECORDS REVIEW TIME, IF APPLICABLE
12 minutes

TEST REVIEW TIME, IF APPLICABLE
10 minutes (PFT, HRCT, BAL)

14a BILLING CONSIDERATIONS — E/M / PULMONOLOGY CODING

E/M LEVEL
99215

PULMONARY FUNCTION TESTING CODE(S), IF APPLICABLE
94010, 94726, 94729

6-MINUTE WALK / OXYGEN TESTING CODE(S), IF APPLICABLE
94618

SMOKING CESSATION COUNSELING CODE(S), IF APPLICABLE
Not applicable

SLEEP / PAP MANAGEMENT CODE(S), IF APPLICABLE
Not applicable

CARE COORDINATION CODE(S), IF APPLICABLE
Not separately billed

BASIS FOR BILLING
Medical Decision Making (high — drug therapy requiring intensive toxicity monitoring) + Test interpretation

ICD-10 DIAGNOSIS CODES
J67.2 — Bird fancier's lung

[SECONDARY RESPIRATORY / IMAGING / SYMPTOM DIAGNOSIS CODE(S), IF APPLICABLE]
J84.10 — Pulmonary fibrosis, unspecified; R09.02 — Hypoxemia; K21.9 — GERD without esophagitis; Z79.899 — Other long-term drug therapy

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME
Daniel Whitfield

CREDENTIALS
MD, FCCP

SPECIALTY
Pulmonology

DATE
10/28/2026

TIME
11:20