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  - Patient Letters/Call Log

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  - Procedure Report Writer with Image Management
  - Electronic Patient Consents and Forms
  - Quality Measures, Analysis and Reporting
  - Patient Instructions and Education
  - Medication Reconciliation, Referral Letters
  - Nurses Notes and Anesthesia Documentation

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- Electronic consents
- Patient Tracker

PRE-OP

- Template Driven History Taking
- Fall Risk Assessments
- Vital Sign capture
- All with minimum clicks

INTRA-OP

- Checklists
- Aldrete scores
- Medication Reconciliation
- Vital Sign interface
- Specimen labels
- Anesthesia meds dosage and timings

RECOVERY

- Safe Surgical Checklists
- Fall Risk Assessments
- Medication Reconciliation
- Vital Sign capture
- G-Code Generation

PATIENT CHECK OUT

- Discharge Instructions
- Referral Letter
- Plan and Patient Education
- Electronic consents

For further details please contact MD-Reports at 718.982.1315 or email sales@md-reports.com

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- Average withdrawal time
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- Cecal Intubation Rate
- Polyp Detection and Retrieval Rate
- Adenoma Detection Rate
- Time spent in Operating Room

... and many other reports based on Physicians, Procedure Type, Diagnosis, Indications, Instruments, etc.

Submit PQRS measures for authorized incentive pay outs of 0.5% for covered Medicare Part B fee schedule.
**SAMPLE COLONOSCOPY REPORT**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>PATIENT ID</th>
<th>DOB</th>
<th>AGE</th>
<th>SEX</th>
<th>EXAM DATE</th>
<th>PHYSICIAN</th>
<th>REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph R Smith</td>
<td>JOSSM1000</td>
<td>2/16/1935</td>
<td>60</td>
<td>M</td>
<td>01-05-2016</td>
<td>John W. Hart, M.D.</td>
<td>Keith Johnson, M.D.</td>
</tr>
</tbody>
</table>

**INDICATION**
- Patient with altered bowel habit with intermittent constipation with low abdominal pain. Encounter for screening for malignant neoplasm of colon - Z12.11

**CONSENT**
- Informed consent was obtained from the patient after providing any opportunity for questions.

**PREPARATION**
- EKG pulse, blood pressure and oxygen saturation monitored. Bowel preparation was given. Patient has no bleeding tendency. Has not used ASA or anticoagulation drugs for the last 5 days.

**INSTRUMENT**
- Olympus CFQ160 SN#: 2405565

**ANESTHESIA**
- As per anesthesia

**PROCEDURE**
- After placing the patient in the left lateral decubitus position, the colonoscope was gently inserted into the rectum and under direct visualization advanced to the Cecum which was identified by transillumination in the right lower quadrant. Identification of the ileum, appendiceal orifice, cecal strap. Color, texture, mucosa and anatomy of the colon were carefully examined with the scope. The patient tolerated the procedure well and there were no complications. After completion of the examination, patient was transferred to the recovery room.

**FINDINGS**

- Anal Canal
  - Anoscopy performed showed moderate hemorrhoids
  - Ulcerative colitis, unspecified, without complications

- Rectum
  - Mild rectal colitis. Biopsy obtained
  - Flat Polyp of size 0.4 cm. Polypectomy done using biopsy forceps
  - Sessile Polyp of size 0.6 cm. Polypectomy done using biopsy forceps

- Sigmoid Colon
  - Normal mucosa

- Descending Colon
  - Normal

- Splenic Flexure
  - Normal

- Transverse Colon
  - Normal

- Hepatic Flexure
  - Normal

- Ascending Colon
  - Normal

- Cecum
  - Normal

- Ileocecal Valve
  - Normal

- Ileum
  - Not Seen

**IMPRESSSION**
- Second degree hemorrhoids - K64.1
- Ulcerative colitis, unsp. w/o complications - K51.90
- Rectal polyp - K62.1

**PLAN**
- High fiber diet
- Wait for pathology report
- Repeat colonoscopy after 3-5 years for continue routine colorectal CA screening
- Sitz bath. Lidocaine ointment PR
- Canasa supp 1000 mg PR QHS PRN
- Colace 100 mg TID
- Hemorrhoid treatment with IRC to be scheduled

**CPT CODES**
- 45385 - Colonoscopy with polypectomy

This report has been reviewed by attending physician

Electronic Signature: John W. Hart, M.D.

Date: 1/6/2016 11:25:13 AM

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SAMPLE DISCHARGE INSTRUCTIONS FOR COLONOSCOPY

PATIENT ID/MRN : JOSSM0000 DOB: 2/16/1955 Date: 01/05/2016
PATIENT NAME : Joseph Smith

RESTRICTION ON ACTIVITY
1. Do not drive or operate machinery until the day after the procedure.
2. Following day - Return to usual activity, unless otherwise instructed.
3. Diet - Avoid alcohol for 24 hours after procedure; otherwise eat and drink as usual.

TREATMENT FOR COMMON AFTER EFFECTS
1. Mild abdominal pain and bloating - Rest and take liquids only.

SYMPTOMS TO WATCH FOR AND REPORT TO YOUR PHYSICIAN
1. Chills or fever occurring within 24 hours after procedure.
2. Rectal bleeding or dark stool.
3. Severe abdominal pain or bloating.
4. I.V. site swelling / redness.

DIET
☐ Resume normal diet
☐ Dietary restriction: 

MEDICATION
☐ Resume medications
☐ You may resume aspirin (Ecotrin) _____ Today _____ In _____ days
☐ You may resume blood Thinners (Coumadin/Plavix) _____ Today _____ In _____ days
☐ New medication(s): 

IMPRESSIONS:
Second degree hemorrhoids
Ulcerative colitis, unspecified, without complications
Rectal polyp

SPECIAL INSTRUCTIONS:
High fiber diet
Wait for pathology report
Repeat colonoscopy after 3-5 years for continue routine colorectal CA screening
Sitz bath. Lidocaine ointment PR
Canasa supp 1000 mg PR QHS PRN
Colace 100 mg TID
Hemorrhoid treatment with IRC to be scheduled

Signature: John W. Hart, M.D.

Signature (Patient/Responsible Party): Joseph Smith
January 5, 2016

Keith Johnson, M.D.
498 5th Avenue
Brooklyn NY 11219

In Reference to: Joseph Smith
ID No: JOSSM1000
DOB: 02/16/1955 AGE: 60
SEX: Male
Exam Date: 01-05-2016

Dear Dr. Johnson,

Thank you for referring Joseph Smith. I performed a Colonoscopy on Joseph Smith. Please find the enclosed reports which show my findings, impressions and recommendations. Patient is in good condition.

Indications
Patient with altered bowel habit with intermittent constipation with low abdominal pain. Colonoscopy to evaluate possible colitis and colorectal CA screening. Encounter for screening for malignant neoplasm of colon.

Impressions
Second degree hemorrhoids
Ulcerative colitis, unspecified, without complications
Rectal polyp

Plan/Assessment
High fiber diet
Wait for pathology report
Repeat colonoscopy after 3-5 years for continune routine colorectal CA screening
Sitz bath. Lidocaine ointment PR
Canasa supp 1000 mg PR QHS PRN
Colace 100 mg TID
Hemorrhoid treatment with IRC to be scheduled

Sincerely yours,

John W. Hart, M.D.
**Sample Esophagogastroduodenoscopy Report**

**Patient Name:** Amy W Armstrong  
**Patient ID:** AMYARM000  
**DOB:** 6/25/1968  
**Age:** 47  
**Sex:** F  
**Exam Date:** 01-05-2016  
**Physician:** John W. Hart, M.D.  
**Referral:** Keith Johnson, M.D.

**Indication:** Functional dyspepsia - K30  
Abnormal findings on diagnostic imaging of other parts of digestive tract - R93.3  
Dysphagia, although currently resolved on PPI and also s/p balloon dilation of a Schatzki's ring to 20 mm about 4 months ago - R13.10

**Consent:** Informed consent was obtained from the patient after providing any opportunity for questions.

**Preparation:** EKG pulse, blood pressure and oxygen saturation monitored.

**Instrument:** Olympus GIF-H180 SN# 2809885

**Anesthesia:** As per anesthesia

**Procedure:** Appropriate time-out protocol was followed: the correct patient, the correct procedure and the correct equipment in the room were confirmed. The Gastroscope was gently passed through the incisoral orifice into the oral cavity and under direct visualization the esophagus was intubated. The endoscope was passed down the esophagus, through the stomach and into the 2nd Portion. Color, texture, mucosa and anatomy of esophagus, stomach and duodenum were carefully examined with the scope. The patient tolerated the procedure well and there were no complications. After completion of the examination, patient was transferred to the recovery room.

**Findings**

| Oropharynx | Normal |
| Esophagus | Mild distal esophagitis  
| EG Junction | Lower: Biopsy taken for GERD symptoms  
| Cardia | Normal  
| Fundus | Normal  
| Body | Normal  
| Antrum | Gastritis, unspecified, without bleeding  
| Pylorus | Normal  
| Duodenum Bulb | Normal  
| 2nd Portion | Normal  
| 3rd Portion | Normal  

**Impression:** Esophagitis, unspecified - K20.9  
Gastritis, unspecified, without bleeding - K29.70

**Plan:** Wait for pathology report  
Raise the head of bed by 30 degrees at night  
Anti reflux diet  
Continue present medications  
Follow up in office in 2 weeks  
Further recommendations pending the results of biopsies

**CPT Codes:** 43239 - EGD with biopsy, single or multiple

This report has been reviewed by attending physician:  
Electronic Signature: [Signature]  
Date: 1/5/2016 2:38:50 PM
SAMPLE DISCHARGE INSTRUCTIONS FOR EGD

PATIENT ID/MRN: AMYARM000  DOB: 6/25/1968  Date: 01/05/2016
PATIENT NAME: Amy W Armstrong

RESTRICTION ON ACTIVITY
1. Do not drive or operate machinery until the day after the procedure.
2. Following day - Return to usual activity, unless otherwise instructed.
3. Diet - Avoid alcohol for 24 hours after procedure; otherwise eat and drink as usual.

TREATMENT FOR COMMON AFTER EFFECTS
1. Mild abdominal pain and bloating - Rest and take liquids only.

SYMPTOMS TO WATCH FOR AND REPORT TO YOUR PHYSICIAN
1. Chills or fever occurring within 24 hours after procedure.
2. Rectal bleeding or dark stool.
3. Severe abdominal pain or bloating.
4. I.V. site swelling / redness.

DIET
x Resume normal diet
__ Dietary restriction: ____________________________

MEDICATION
x Resume medications
__ You may resume aspirin (Ecotrin) _____Today _____In _____days
__ You may resume blood Thinners (Coumadin/Plavix) _____Today _____In _____days
__ New medication(s): ____________________________

IMPRESSIONS:
Esophagitis, unspecified
Gastitis, unspecified, without bleeding

SPECIAL INSTRUCTIONS:
Wait for pathology report
Raise the head of bed by 30 degrees at night
Anti reflux diet
Continue present medications
Follow up in office in 2 weeks
Further recommendations pending the results of biopsies.

Signature: ____________________________
John W. Hart, M.D.

Signature (Patient/Responsible Party): ____________________________
Amy W Armstrong
January 5, 2016

Keith Johnson, M.D.
498 5th Avenue
Brooklyn NY 11219

In Reference to:  Amy W Armstrong  
                ID No: AMYARM000  
                DOB: 06/25/1968  AGE: 47  
                SEX: Female  

Exam Date: 01-05-2016

Dear Dr. Johnson,

Thank you for referring Amy W Armstrong. I performed an upper endoscopy on the patient. Please find the enclosed reports which show my findings, impressions and recommendations.

Indications
Functional dyspepsia
Abnormal findings on diagnostic imaging of other parts of digestive tract
Dysphagia, although currently resolved on PPI and also s/p balloon dilation of a Schatzki's ring to 20 mm about 4 months ago

Impression
Esophagitis, unspecified
Gastritis, unspecified, without bleeding

Plan
Wait for pathology report
Raise the head of bed by 30 degrees at night
Anti reflux diet
Continue present medications
Follow up in office in 2 weeks
Further recommendations pending the results of biopsies

Truly yours,

John W. Hart, M.D.
## Patient List

10/05/2015  Monday  

**Total no. of patients:** 5

**For John W Hart M.D.**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>(SEX)</th>
<th>PATIENT ID/MRN</th>
<th>TYPE</th>
<th>DOB</th>
<th>REFERRING PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thompson, Ryan</td>
<td>(M)</td>
<td>117191</td>
<td>COL</td>
<td>05/26/1984</td>
<td>Dr. R Gold M.D.</td>
</tr>
</tbody>
</table>

**SEDATION**

As Per Anesthesia

**INDICATIONS**

- Encounter for screening for malignant neoplasm of colon - Z12.11
- Family history of malignant neoplasm of digestive organs - Z80.0
- Family history of colonic polyps - Z83.71

**FINDINGS**

- Normal (Anus Canal)
- Internal Hemorrhoids (Rectum)
- POLYP (Rectum)
- Sessile Polyp - Polypectomy done using biopsy forceps (Rectum)
- Normal (Sigmoid Colon)
- Colon polyp (Descending Colon)
- Sessile Polyp - Polypectomy done by snare (Descending Colon)
- Normal (Splenic Flexure)
- Normal (Transverse Colon)
- Normal (Hepatic Flexure)
- Normal (Ascending Colon)
- Normal (Ileum)
- Not Seen (Ileum)

**ICD CODES**

- First degree hemorrhoids - K64.0
- Benign neoplasm of descending colon - D12.4
- Benign neoplasm of rectum - D12.8

**PLAN**

- High fiber diet
- Wait for pathology report
- Continue present diet
- No ASA or NSAID’s for 2 weeks
- Follow up in office in 2 weeks
- Follow up colonoscopy in 3 years

**CPT Codes**

- 45385 - Colonoscopy with polypectomy by snare
- 45380 - Colonoscopy with biopsy

| Longhorn, Terrence | (M)   | 75168 | EGD  | 03/26/1938  | Dr. Herman M.D.     |

**SEDATION**

As Per Anesthesia

**INDICATIONS**

- Gastro-esophageal reflux disease with esophagitis - K21.0

**FINDINGS**

- Normal (Oropharynx)
- Multiple biopsies taken. Biopsy taken with forceps. (Esophagus)
- Normal (EG-Junction)
- Normal (Cardia)
- Normal (Fundus)
- MULTIPLE POLYPS (Body)
- Multiple polyps Polyp - Polypectomy done using biopsy forceps (Body)
- Mild gastritis (Antrum)
- Multiple biopsies taken. Biopsy taken with forceps. (Antrum)
- Normal (Pylorus)
- Multiple biopsies taken. Biopsy taken with forceps. (Duodenum Bulb)
- Duodenitis (2nd Portion)
- Multiple biopsies taken. Biopsy taken with forceps. (2nd Portion)
- Not Seen (3rd Portion)
**Patient List**

10/05/2015  Monday  Total no. of patients 5

**ICD CODES**
- Duodenitis, without evidence of hemorrhage - 535.60
- Mild gastritis - 535.40
- Polyp of stomach - D11.1
- Benign neoplasm of stomach - D13.1
- Duodenitis without bleeding - K29.80

**PLAN**
- Wait for pathology report.
- Avoid: citrus juices, cigarettes, chocolate, tight fitting clothing, coffee and other caffeinated beverages, carbonated beverages, fatty and fried foods, anticholinergic medications, medications which decrease LES tone (Ca channel blockers, theophylline preparations).
- Strict antireflux diet
- Omeprazole 20 mg daily
- Follow up in the office in 2 weeks

**CPT Codes**
- 43239 - EGD with biopsy, single or multiple

3. JAMISON, MARY K  (F)  82365  EGD  05/14/1955  Dr. Shetty M.D.

**INDICATIONS**
- Bariatric surgery status - Z98.84

**FINDINGS**
- Normal (Oropharynx)
- Normal (Esophagus)
- Normal (EG-Junction)
- Normal (Cardia)
- Normal (Fundus)
- Evidence of Billroth II anastomosis (Body)
- afferent and efferent loops entered nI appearance (Body)
- gastric pouch normal bx obtained (Body)
- Not seen (Antrum)
- Not seen (Pylorus)
- Not seen (Duodenum Bulb)
- Not seen (2nd Portion)
- Not Seen (3rd Portion)
- No evidence of inflammation, ulcer or lesion noted (Gastric Pouch)
- Normal. Biopsy taken. Biopsy taken with forceps. (Gastric Pouch)

**ICD CODES**
- s/p gastric bypass
- History of Bariatric surgery - Z98.84

**PLAN**
- Wait for pathology report

**CPT Codes**
- 43239 - EGD with biopsy, single or multiple

4. PERRY, SUSAN  (F)  92699  COL  09/30/1956  Dr. Chandri M.D.

**INDICATIONS**
- Encounter for screening for malignant neoplasm of colon - Z12.11
- Personal history of other malignant neoplasm of large intestine - Z95.038

---

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Patient List

10/05/2015  Monday  Total no. of patients 5

FINDINGS
Normal (Anal Canal)
Anastomosis (Rectum)
suture present (Rectum)
Multiple biopsies taken. Biopsy taken with forceps. (Rectum)
Diverticulosis of large intestine without perforation or abscess without bleeding
(Sigmoid Colon)
Normal (Descending Colon)
Normal (Splenic Flexure)
Normal (Transverse Colon)
Normal (Hepatic Flexure)
Normal (Ascending Colon)
Normal (Cecum)
Normal (Ileocecal Valve)
Not Seen (Ileum)

ICD CODES
First degree hemorrhoids - K64.0
S/P Ca of colon resection rectal anastomosis - 945.72
S/p colon resection with rectal anastomosis
Diverticulosis of large intestine without perforation or abscess without bleeding-K57.36

PLAN
Wait for pathology report
High fiber diet
Continue present diet
Follow up in office in 2 weeks

CPT Codes
45380 - Colonoscopy with biopsy.

J. Smith, Robert  (M)  117659  COL  12/15/1964  Dr Thompson M.D.

SEDATION
As Per Anesthesia

INDICATIONS
Change in bowel habit - K19.4
Constipation, unspecified - K59.00

FINDINGS
Normal (Anal Canal)
Internal Hemorrhoids (Rectum)
Second degree hemorrhoids (Rectum)
Diverticulosis of large intestine without perforation or abscess without bleeding
(Sigmoid Colon)
Normal (Descending Colon)
Normal (Splenic Flexure)
Normal (Transverse Colon)
Normal (Hepatic Flexure)
Normal (Ascending Colon)
Normal (Cecum)
Normal (Ileocecal Valve)
Not Seen (Ileum)

ICD CODES
Internal Hemorrhoids - 455.0

PLAN
High fiber diet
Follow up colonoscopy in 3 years

CPT Codes
45378 - Colonoscopy, diagnostic (separate procedure)
SAMPLE CONSULTATION REPORT

PATIENT NAME: Lynn Grevas
PATIENT ID: LYNGRE000
DATE OF BIRTH: 8/25/1955
AGE: 60 SEX: Female

ATTENDED BY: John W. Hart, M.D.
REFERRED BY: Peterson, Mark M.D.
EXAM DATE: 10/14/2015

CHIEF COMPLAINT:
Evaluation for colonoscopy

PRESENT ILLNESS:
The patient is referred for a colonoscopy. Last colonoscopy 25 years ago for shigella infection. No repeat procedure noted. Patient has a baseline history of anemia. Patient presently receiving iron infusions. Denied melena, rectal bleeding, nausea, emesis, change in bowel habits. Prior EGD for duodenal ulcer 10 years ago.

MEDICATIONS:
Iron
Lantus
Aspirin 81 mg
Vitamin B
Vitamin D
Vitamin C
Metformin
Glipizide
Metoprolol
Furosemide
Simvastatin

ALLERGIES:
Latex
Cipro
Dust mite extract

MEDICAL HISTORY:
DM, anemia, occipital migraines, renal insufficiency

HOSPITALIZATION AND SURGERY:
Cardiac cath, C-section, left foot surgery

FAMILY HISTORY:
Skin CA (Father), Bone CA (Father), Liver cancer (Mother)

SOCIAL HISTORY:
SMOKING: Patient denies smoking.
ALCOHOL: Patient denies drinking alcohol.
DRUGS: Patient denies taking drugs.

SYSTEMS REVIEW:
GENERAL: No weakness, weight change, fever, chills, heat/cold, intolerance.
SKIN: No rashes, yellow skin/jaundice.
ENDOCRINE: Normal tolerance to cold. Normal tolerance to heat.
EYES: Cataract surgery (bilateral).
HEENT: No headaches, visual changes, photophobia, nosebleeds, hoarseness, sinus.
CARDIAC/RESPIRATORY: No cough, shortness of breath, sputum production, chest pain, orthopnes/edema.
MUSCULOSKELETAL: No back pain, joint pain.
NEUROLOGICAL: No weakness, altered coordination/sensation, memory/mood change.

PHYSICAL EXAMINATION:
BP: 140/90 mmHg Height: 64.0 inches Weight: 300.0 lbs BMI: 51.5
GENERAL: Morbid obesity, soft, nontender, no rebound. Non cachetic. No stigmata of CLD.

NEUROLOGICAL: Alert. Grossly non focal.


LYMPHATICS: No lymphadenopathy.

EYES: No evidence of conjunctivitis, discharge or visual abnormalities.

ENT: Hearing seems normal. Tongue in mid line, no fasciculation seen. Tonsils not enlarged.

HEAD & NECK: Thyroid gland not enlarged. Trachea central in position.


CARDIOVASCULAR: No Gallops S1 and S2 appear normal. No S3, S4 or murmur.

RECTAL: Deferred.

EXTREMITIES: No clubbing. No cyanosis. No pedal edema.

BACK: Patient does not complain of back pain. No CVA tenderness.

IMPRESSIONS:
- Anemia, unspecified - D84.9
- Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation - K26.9

COMORBIDITY:
- DM, occipital migraines, renal insufficiency

PLAN:
- High fiber diet
- Acquire blood work from PMD
  +/- capsule study

PROCEDURE:
- EGD - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.
- Colonoscopy Moviprep (diabetic) - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.

PROCEDURE CODE:
- L499204

Follow up in 1 month
Follow up for Colonoscopy

Signature: [Signature]
John W. Hart, M.D.

on 10/15/2015 10:55:26 AM signed off by John W. Hart, MD
January 5, 2016

Diana Bernard
276 Main Street
Staten Island, NY 11787

In Reference to: Lynn Grevas
   ID No: LYNGRE000
   DOB: 08/25/1955  AGE: 60
   SEX: Female

Exam Date: 01-05-2016

Dear Dr. Bernard,

Thank you for referring Lynn Grevas to me. Enclosed are my findings and recommendations for her.

Indications:
Evaluation for colonoscopy
The patient is referred for a colonoscopy. Last colonoscopy 25 years ago for shigella infection. No repeat procedure noted. Patient has a baseline history of anemia. Patient presently receiving iron infusions. Denied melena, rectal bleeding, nausea, emesis, change in bowel habits. Prior EGD for duodenal ulcer 10 years ago.

My Impressions are:
Anemia, unspecified
Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation

Plan/Recommendations:
High fiber diet
Acquire blood work from PMD
+/- capsule study
PROCEDURE:
EGD - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.
Colonoscopy Moviprep (diabetic) - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.

Truly Yours

John W. Hart
SAMPLE FOLLOW UP REPORT

PATIENT NAME: Miriam R Sandoval
PATIENT ID: 5214522
DATE OF BIRTH: 6/25/1947
AGE: 68 SEX: Female
ATTENDED BY: John W. Hart, M.D.
REferred BY: Johnson, Matthew M.D.
EXAM DATE: 10/14/2015

CHIEF COMPLAINT:
Patient has bloating and constipation
Capsule follow up

PRESENT ILLNESS:
Capsule with noted vascular ectasias, otherwise normal examination. Blood work noted for elevated serology for Crohn’s disease (IgG, IgA ASCA). Crohn’s subclinical presentation. Only complaint is bloating. Breath testing negative. Recommended entragam trial to see if symptoms improve. Patient denied allergy to beef. No melena, hematochezia, nausea, emesis.

MEDICATIONS:
Synthroid
NSAIDS
Duloxetine

ALLERGIES:
NKDA

MEDICAL HISTORY:
Hypothyroidism

HOSPITALIZATION AND SURGERY:
Right knee replacement, cholecystectomy

FAMILY HISTORY:
Stroke, Pacemaker

SOCIAL HISTORY:
SMOKING: Patient denies smoking.
ALCOHOL: drinks alcohol (1/week).
DRUGS: Patient denies taking drugs.

SYSTEMS REVIEW:
GENERAL: No weakness, weight change, fever, chills, heat/cold, intolerance.
SKIN: No rashes, yellow skin/jaundice.
ENDOCRINE: Normal tolerance to cold. Normal tolerance to heat.
EYES: No discharge. No other eye problems.
CHILDHOOD ILLNESS: Non significant.
HEENT: No headaches, visual changes, photophobia, nosebleeds, hoarseness, sinus.
CARDIAC/RESPIRATORY: No cough, shortness of breath, sputum production, chest pain, orthopnes/edema.
GENITOURINARY: No frequency, urinary problems, urgency, hematuria/incontinence.
MUSCULOSKELETAL: No back pain, joint pain.
NEUROLOGICAL: No weakness, altered coordination/sensation, memory/mood change.
INFECTION: No infection seen.

PHYSICAL EXAMINATION:
BP: 118/63 mmHg Pulse: 73 Height: 63.0 inches Weight: 148.0 lbs BMI: 26.2
GENERAL: Non cachetic. No stigmata of CLD. Not obese.
NEUROLOGICAL: Alert. Grossly non focal.
LYMPHATICS: No lymphadenopathy.
EYES: No evidence of conjunctivitis, discharge or visual abnormalities.
ENT: Hearing seems normal. Tongue in mid line, no fasciculation seen. Tonsils not enlarged.
HEAD & NECK: Thyroid gland not enlarged. Trachea central in position.
CARDIOVASCULAR: No Gallops S1 and S2 appear normal. No S3, S4 or murmur.
RECTAL: Deferred.
BACK: Patient does not complain of back pain. No CVA tenderness.
EXTREMITIES: No clubbing. No cyanosis. No pedal edema.

IMPRESSIONS:
Abdominal distension (gaseous) - R14.0
Dysphagia, unspecified - R13.10
Gastro-esophageal reflux disease without esophagitis - K21.9

COMORBIDITY:
Hypothyroidism

PLAN:
Enteragam trial Crohn's disease subclinical
Follow up 1 month
Miralax 1-2 times per day for recent constipation
Colonoscopy 2 years

MEDICATIONS:
EnteraGam 5 gram oral powder packet 5 gram 1 unit by mouth twice a day Refill 0: 10/14/2015

PROCEDURE CODE:
L3 99213
Follow up in 2 years
Follow up for Colonoscopy

Signature: [Signature]
John W. Hart, M.D.

on 10/14/2015 11:52:17 AM signed off by John W. Hart, M.D.
IMPRESSIONS / PLAN

PATIENT NAME: Lynn Grevas
PATIENT ID: LYNGRE000
DATE OF BIRTH: 8/25/1955
AGE: 60 SEX: Female
ATTENDED BY: John W. Hart
REFERRED BY: Dr Dara Brener
EXAM DATE: 1/5/2016

IMPRESSIONS:
Anemia, unspecified - D64.9
Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation - K26.9

PLAN:
High fiber diet
Acquire blood work from PMD
 +/- capsule study

PROCEDURE:
EGD - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.; Colonoscopy Moviprep (diabetic) - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.

Follow up in 1 month for Follow up for colonoscopy

Signature

John W. Hart
# Patient List

**For John W Hart M.D.**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>(SEX)</th>
<th>PATIENT ID/MRN</th>
<th>TYPE</th>
<th>DOB</th>
<th>REFERRING PHYSICIAN</th>
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</thead>
<tbody>
<tr>
<td>1. Lemington, Martina</td>
<td>(F)</td>
<td>26370</td>
<td>FOL</td>
<td>05/16/1960</td>
<td>Paul Cohen</td>
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<tr>
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<td>INDICATIONS Procedure f/u</td>
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<tr>
<td></td>
<td>ICD CODES Gastritis, unspecified, without bleeding - K29.70</td>
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<tr>
<td></td>
<td>PLAN Benefiber daily</td>
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<td></td>
<td>Dietary modification (dyspepsia)</td>
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<td>TUMS as needed</td>
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<td>Colonoscopy 3 years</td>
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<td>CPT Codes L3 99213</td>
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<tr>
<td>2. Martinez, Joanna</td>
<td>(F)</td>
<td>31831</td>
<td>FOL</td>
<td>05/21/1964</td>
<td>Kristen O Brien M.D.</td>
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<td>PLAN Dietary modification (low fat, nonspicy food)</td>
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<td>ETCH avoidance</td>
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<td>TUMS, H2 blocker prn</td>
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<td>Surgical evaluation for cholecystectomy</td>
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<td>Colonoscopy 2 year (piecemeal removal, flat polyp (TA))</td>
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<td>3. Zubrera, Susan</td>
<td>(F)</td>
<td>SUSZUB000</td>
<td>FOL</td>
<td>06/25/1947</td>
<td>Bianco, Dr. M.D.</td>
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<td>INDICATIONS Capsule follow up</td>
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<td>PLAN Enteragam trial</td>
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<td>?? crohn's disease ? subclinical</td>
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<td>Follow up 1 month</td>
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<td>Miralax 1-2 times per day for recent constipation</td>
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<td>Colonoscopy 2 years</td>
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<td>EntereGum 5 gram oral powder packet 5 gram 1 unit by mouth twice a day Refill 0 : 10/14/2015 (M-ERxF)</td>
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<td>CPT Codes L3 99213</td>
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<tr>
<td>4. Ellington, Anne</td>
<td>(F)</td>
<td>ANNETEO00</td>
<td>CON</td>
<td>02/15/1960</td>
<td>Huxman, Dr M.D.</td>
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<td></td>
<td>INDICATIONS Bloating</td>
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<td>ICD CODES Abdominal distension (gaseous)-R14.0</td>
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<td>PLAN EGD - discussed the risks, benefits, and alternatives also provided written</td>
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<td>information regarding the procedure (F)</td>
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<td>Breath Test, SIBO, Lactulose (F)</td>
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<tr>
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<td>Stop probiotic</td>
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<td>CPT Codes L4 99214</td>
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<tr>
<td>5. Gunner, Loida B.</td>
<td>(F)</td>
<td>LOIGUND00</td>
<td>CON</td>
<td>04/15/1936</td>
<td>Korpi, Dr. M.D.</td>
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<tr>
<td></td>
<td>INDICATIONS Weight loss</td>
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</tbody>
</table>
Patient List
10/14/2015 Wednesday Total no. of patients 7

6. Grevas, Lynn (F) LYNGRE000 CON 08/25/1955 Bianco, Dr. M.D.
INDICATIONS Evaluation for colonoscopy

ICD CODES Anemia, unspecified - D64.9
Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation - K26.9

PLAN High fiber diet
Acquire blood work from PMD
EGD - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.
Colonoscopy Noliprep (diabetic) - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.
+- capsule study

CPT Codes L4 99204

7. Donald, Chris (F) CHRDON001 CON 04/15/1974 Thompson, Dr M.D.
INDICATIONS Abdominal pain

ICD CODES Slow transit constipation - K59.01

PLAN Fleet enema daily
Miralax BID-TID
Increase fluid intake
Colonoscopy - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.

CPT Codes L4 99204
## SAMPLE PATIENT HISTORY

**Patient ID**: 5214522  
**Patient Name**: Miriam R. Sandoval  
**Age**: 69  
**Gender**: Female

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Attending Physician</th>
<th>Report Type</th>
<th>Indications</th>
<th>Impressions</th>
<th>Plan</th>
<th>Referral</th>
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</thead>
<tbody>
<tr>
<td>11/13/2015</td>
<td>John W. Hart, M.D.</td>
<td>FOL</td>
<td></td>
<td>Abdominal distension (gaseous)-R.14.0</td>
<td>Enteragam trial Crohn's disease subclinical Follow up 1 month Miralax 1-2 times per day for recent constipation Colonoscopy 2 years Enteragam 5 gram oral powder packet 5 gram 1 unit by mouth twice a day Refill 0 : 10/14/2015(M-ERxF)</td>
<td>Natalie R Schmidt, M.D.</td>
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<tr>
<td>10/08/2015</td>
<td>John W. Hart, M.D.</td>
<td>CAP</td>
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<td>Continue PPI daily Celiac panel/IBD panel Colonoscopy in 2 years Pulmonology referral MR in 12 months of liver</td>
<td>Matthew W Johnson</td>
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<tr>
<td>09/11/2015</td>
<td>John W. Hart, M.D.</td>
<td>FOL</td>
<td>1 month fu</td>
<td>Abn radiology GI tract - 793.40 Bloating - 787.3</td>
<td>Continue PPI daily Celiac panel/IBD panel Colonoscopy in 2 years Pulmonology referral MR in 12 months of liver</td>
<td>Matthew W Johnson</td>
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<tr>
<td>08/21/2015</td>
<td>John W. Hart, M.D.</td>
<td>FOL</td>
<td>3 month fu</td>
<td>Bloating - 787.3</td>
<td>CT imaging abdomen/pelvis with oral contrast Follow up in 2 weeks</td>
<td>Natalie R Schmidt, M.D.</td>
</tr>
<tr>
<td>05/22/2015</td>
<td>John W. Hart, M.D.</td>
<td>Lac</td>
<td></td>
<td></td>
<td>Patient failed omeprazole, nexium and lansoprazole. Good effect with devilant Dietary modification Lifestyle modification Follow up in 3 months If not improved, consider CT imaging</td>
<td>Kristen O Brien, M.D.</td>
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<tr>
<td>05/22/2015</td>
<td>John W. Hart, M.D.</td>
<td>FOL</td>
<td>Lactose breath test</td>
<td>Gastritis - 535.00 Hiatal hernia - 553.30 Dyspepsia - 536.80</td>
<td>Continue PPI daily Celiac panel/IBD panel Colonoscopy in 2 years Pulmonology referral MR in 12 months of liver</td>
<td>Matthew W Johnson</td>
</tr>
</tbody>
</table>

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<th>Attending Physician</th>
<th>Report Type</th>
<th>Indications</th>
<th>Impressions</th>
<th>Plan</th>
<th>Referral</th>
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<tbody>
<tr>
<td>05/14/2015</td>
<td>John W. Hart, M.D.</td>
<td>EGD</td>
<td>Dysphagia - 787.2</td>
<td>Mild gastritis - 535.40</td>
<td>Wait for pathology report</td>
<td>Kristen O'Brien, M.D.</td>
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<td></td>
<td>GERD - 530.81</td>
<td>Bile gastritis, without evidence of hemorrhage - 535.40</td>
<td>Avoid greasy, spicy food</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Blouting - 787.3</td>
<td>Multiple Polyps in Stomach - 211.1</td>
<td>Avoid: citrus juices, cigarettes, chocolate, tight fitting clothing, coffee and other caffeine containing beverages, carbonated beverages, fatty and fried foods, anticholinergic medications, medications which decrease LES tone (Ca channel blockers, theophylline preparations). Follow up in the office in 2 weeks</td>
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<tr>
<td>05/11/2015</td>
<td>John W. Hart, M.D.</td>
<td>SIB</td>
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<td>Continue daily PPI</td>
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<td>05/11/2015</td>
<td>John W. Hart, M.D.</td>
<td>FOL</td>
<td>SIBO</td>
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<td>Bloating - 787.3</td>
<td>EGID planned</td>
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<td>Gerd - 530.81</td>
<td>Desylant daily</td>
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<td>Weight gain - 783.1</td>
<td>Dietary modification</td>
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<td>Bloating - 787.3</td>
<td>Lifestyle modification</td>
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<td>Diverticulosis - 562.10</td>
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<td>Hemorrhoids - 455.0</td>
<td>SIBO test</td>
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<td>Hiatal hernia - 553.30</td>
<td>Lactose breath test</td>
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<td>Poly - 211.3</td>
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<td>Calcium supplementation</td>
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<td>Abdominal sonogram</td>
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<td>06/12/2012</td>
<td>John W. Hart, M.D.</td>
<td>CON</td>
<td>Patient has bloating and constipation.</td>
<td>Gerd - 530.81</td>
<td>EGID - discussed the risks, benefits, and alternatives also provided written information regarding the procedure. (P)</td>
<td>Alfred Belding, M.D.</td>
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<td></td>
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<td>Dyspepsia - 536.8</td>
<td>Colonoscopy - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.</td>
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<td>Constipation - 564.0</td>
<td>Miralax</td>
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<td>Increase fiber and oral fluid intake.</td>
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<td>Pepcid OTC daily.</td>
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<td>Anti reflux diet.</td>
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## SAMPLE ENDOSCOPIC ULTRASOUND REPORT

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<tr>
<th>PATIENT NAME</th>
<th>PATIENT ID</th>
<th>DOB</th>
<th>AGE</th>
<th>SEX</th>
<th>EXAM DATE</th>
<th>PHYSICIAN</th>
<th>REFERRAL</th>
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<tbody>
<tr>
<td>Minnie Mouse</td>
<td>MINMOU000</td>
<td>9/18/1926</td>
<td>87</td>
<td>F</td>
<td>01-18-2016</td>
<td>John Hart, M.D.</td>
<td>Kevin W Smith, M.D.</td>
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</tbody>
</table>

### INDICATION
- Epigastric pain - R10.13
- Abnormal findings on diagnostic imaging of liver and biliary tract - R93.2
- Dilated intra and extrahepatic ducts - R93.2

### CONSENT
- Informed consent was obtained from the patient after providing any opportunity for questions.

### PREPARATION
- EKG pulse, blood pressure and oxygen saturation monitored.

### INSTRUMENT
- Linear, UC30P, 180118

### ANESTHESIA
- As Per Anesthesia

### PROCEDURE
- The GastroScope was gently passed through the incisoral orifice into the oral cavity and under direct visualization the esophagus was intubated. The endoscope was passed down the esophagus, through the stomach and into the Ultrasound. Color, texture, mucosa and anatomy of Esophagus, Stomach and Duodenum were carefully examined with the scope. The patient tolerated the procedure well and there were no complications. After completion of the examination, patient was transferred to the recovery room.

### FINDINGS
- **Common Bile duct**: 8mm proximally to 7mm distally without retained stones or sludge
- **Pancreas**: Head of pancreas without calcifications, mass or lymphadenopathy. Duct about 4mm.
- **Stomach**: No celiac lymphadenopathy. Limited views of body and tail of pancreas because of significant hiatal hernia and shadowing foreign object.

### IMPRESSION
- Dilated common bile duct
- Gastroparesis - K31.84
- Limited views of body and tail of pancreas
- Diaphragmatic hernia without obstruction or gangrene - K44.9

### PLAN
- Follow up in clinic
- Low residue diet
- Acide blockade

### CPT CODES
- 43259 - Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate: with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate

This report has been reviewed by attending physician

![Image of endoscopic ultrasound]

Electronic Signature: 

Date: 1/19/2016 2:25:31 PM

John Hart, M.D.
SAMPLE BRONCHOSCOPY REPORT

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>PATIENT ID</th>
<th>DOB</th>
<th>AGE</th>
<th>SEX</th>
<th>EXAM DATE</th>
<th>PHYSICIAN</th>
<th>REFERRAL</th>
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</thead>
<tbody>
<tr>
<td>Mickey W. Mouse</td>
<td>MICM0004</td>
<td>12/5/1901</td>
<td>114</td>
<td>M</td>
<td>01-18-2016</td>
<td>John Hart, M.D.</td>
<td>Kevin W. Smith, M.D.</td>
</tr>
</tbody>
</table>

**INDICATION**: Cough - R05

**CONSENT**: Consent obtained before the procedure. It’s indications and potential complications and alternatives were discussed with the patient. The patient read and signed the provided consent form. The consent form was witnessed by the assisting nurse.

**PREPARATION**: EKG pulse, blood pressure and oxygen saturation monitored.

**INSTRUMENT**: Olympus BF-3C40 Fiber Optic Bronchoscope

**ANESTHESIA**: Versed 2 mg IV
Demerol 100 mg IV

**PROCEDURE**: The bronchoscope will be inserted through the nose or mouth. The scope will be passed down the throat and into the lungs. The images and the scope may be used to remove a small tissue sample. If a foreign body is present, it may be removed through the scope. If a lavage is planned, a water solution may be used to wash an area. The solution is then removed and sent to a lab for examination.

**FINDINGS**

<table>
<thead>
<tr>
<th>Site</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td>Narrow nasal passage</td>
</tr>
<tr>
<td>Pharynx</td>
<td>Lymphoid hyperplasia</td>
</tr>
<tr>
<td>Larynx</td>
<td>Normal</td>
</tr>
<tr>
<td>Vocal Cords</td>
<td>Normal vocal cords mobility</td>
</tr>
<tr>
<td>Trachea</td>
<td>Expiratory collapse of lower trachea</td>
</tr>
<tr>
<td>Main Carina</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**BRONCHIAL TREE**

<table>
<thead>
<tr>
<th>Lung</th>
<th>Side</th>
<th>Finding</th>
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</thead>
<tbody>
<tr>
<td>Left Lung</td>
<td>Left Main Stem</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Left Lower Lobe</td>
<td>Secretions</td>
</tr>
<tr>
<td></td>
<td>Left Upper Lobe</td>
<td>Thick mucous plugs</td>
</tr>
<tr>
<td>Right Lung</td>
<td>Right Main Stem</td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td>Right Upper Lobe</td>
<td>Secretions</td>
</tr>
<tr>
<td></td>
<td>Middle Lobe</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**COMMENTS**: Microbiology positive for S. Pneumonia as predominate organism with H. Influenza also identified in one of the two samples. Both are pan-sensitive.

Cytology positive for prominent neutrophils with some macrophages likely lipid laden based on secondary review, but no eosinophils.

**IMPRESSION**: Lymphoid hyperplasia of pharynx
Mucopurulent chronic bronchitis - J41.1
Congenital tracheomalacia - Q32.0

**PLAN**: Cefdinir 250 twice daily for 3 weeks
Follow up in office in 2 weeks

**CPT CODES**: 31624 - Bronchoscopy with bronchial lavage

This report has been reviewed by the attending physician.

Signature: [Signature]
Date: 1/19/2016 2:57:26 PM

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SAMPLE UROLOGY REPORT

PATIENT NAME: Donald Duck
PATIENT ID: DONDUC000
DOB: 06/09/1934
AGE: 81
SEX: M
EXAM DATE: 01-18-2016
PHYSICIAN: John Hart, M.D.
REFERRAL: Kevin W Smith, M.D.

PRE DIAGNOSIS:
- Urinary frequency - R35.0
- Peyronie's disease - N48.6
- Minimally elevated PSA with strong family history

POST DIAGNOSIS:
- Overactive bladder - N32.81
- Muscular disorders of urethra - N36.44

CONSENT:
After obtaining the history and performing physical examination, the procedure, indications, potential complications like bleeding, perforation, infection, adverse medication reaction and alternatives were explained to the patient. Patient appeared to understand the benefits and risks of this procedure. Informed consent was obtained from the patient after providing any opportunity for questions.

ANESTHESIA:
- Lidocaine 2% Jelly Topical

PROC. PERFORMED:
- URODYNAMICS-DSB

PROCEDURE:
Uroflow performed if bladder full and patient prepped. Pt then placed on exam table in frog leg position. Gentutia prepped, and lidocaine jelly administered. Urethral catheter placed. Abdominal catheter placed in rectum for male; and in vagina or rectum for female. Catheters calibrated and equalized. Infusion initiated at 50ml/min and notation made of filling landmarks. Valsalva maneuver performed for stress incontinence with or without urethral catheter. Presence of involuntary contractions noted. Patient allowed to void spontaneously. Graphs recorded. Catheters removed.

VOLUME VOIDED: 107 ml
PEAK FLOW: 15.1 ml/sec (with straining)
SONOGRAPHIC PVR: 16 ml
VOIDING CURVE MORPHOLOGY: small, bell-shaped, terminal dribble

CMG/pressure flow the bladder was then filled and should be mentioned that upon placement of the rectal catheter, a rectal swab was performed in the event patient decides on a prostate biopsy. The bladder was filled to a total of 200 mL and then patient had an involuntary contraction with equivocal findings for obstruction but voided to completion. The voiding pressure was approximately 50 cm's of water in the peak flow was 11 mL's per second. Voiding curve generally bell-shaped.

FINDINGS
- Prostate:
  - 10-15 g smooth symmetric benign
- Penis:
  - No discrete plaque appreciated

POST-OP:
- 1. Overactive bladder. Begin VESICARE 5 mg
- 2. Peyronie's disease. Patient reassured and will begin pentoxifylline 400 mg 3 times a day
- 3. PSA elevation 2.7, minimally elevated by age adjusted criteria with very strong family history

I did recommend a prostate biopsy as the patient is aware of my concern regarding his significant family history. At this point he is not ready to make that decision and we will address this again upon his return in 5 weeks.

This report has been reviewed by attending physician

Electronic Signature: John Hart, M.D.
Date: 1/18/2016 11:41:21 AM
SAMPLE NURSES REPORT FOR PRE PROCEDURE

Patient Name: Joseph R Smith
Date of birth: 2/16/1955
Age: 60
Sex: Male

Patient Id: JOSSM000

Attending Physician: John W. Hart, M.D.
Service Date: 01/05/2016

PROCEDURE: Colonoscopy

Allergies: NKDA
Time of Assessment: 9:51 AM
Time of Arrival: 9:50 AM
NPO: Yes
Bowel prep taken: Yes
Bowel prep result clear: Yes
Ride Available: Yes
Ambulatory: Yes

BP: 143/72 mmHg
HR: 65
RR: 25
SAO2: 98
Height: 68 in
Weight: 162 lbs
Temp: 98.5°F
BMI: 24.6

Aldrete Score:

| ACT | 2 |
| CRC | 2 |
| LOC | 2 |
| RSP | 2 |
| SKN | 2 |
| Tot.Par | 10 |

CHIEF COMPLAINT:
Change in bowel habit - R19.4
Constipation, unspecified - K59.00

MEDICATIONS:
Colace 100 mg TID
Lidocaine ointment PR

ALLERGIES:
NKDA

HABITS:
ETOH - No
Recreational Drugs - No
Tobacco - No

MEDICAL/SURGICAL HISTORY:
• Lung disease - Yes, COPD
• GI disease - Yes, Constipation, Abdominal pain on LLQ, Change in bowel habits

PREPROCEDURE CHECKLIST:
Side rails up - Yes
History & Physical Present - Yes
Arm Band Verified - Yes
Consent Signed - Yes

Electronic Signature: [Signature]
Mary Smith, R.N.
1/3/2016 9:56:00 AM
SAMPLE NURSES REPORT FOR INTRA PROCEDURE

Patient Name: Joseph R Smith
Date of Birth: 2/16/1955  Age: 60  Sex: Male

Attending Physician: John W. Hart, M.D.
Service Date: 01/05/2016

Procedure: Colonoscopy

Allergies: NKDA

Time into Procedure room: 10:05 AM ; Time out of Procedure room: 10:31 AM

Procedure Verified by: MD

Monitors applied: Preassessment H&P reviewed, IV in place and patent, Side Rails up

Patient evaluated immediately before anesthesia:

BP: 120/80 mmHg HR: 65 Heart Rhythm: Sinus Rhythm Resp. rate: 25 R.A:SAO2: 99 Time: 10:06 AM

Airway is clear: Yes

Procedure 1: Colonoscopy  Start Time: 10:07 AM Cecum reached Time: 10:22 AM End Time: 10:30 AM

Scope: Olympus PCEH180AL SN# 2802703

SPECIMEN SENT:
Specimen A: Biopsy Ascending Colon: Cold biopsy
Specimen B: Polyp Ascending Colon: Snare cold snare

Pre Procedure DX: Change in bowel habit - R19.4
Constipation, unspecified - K59.00

Post Procedure DX: See physician’s report

CLINICAL GUIDELINES:

Conscious sedation
Colonoscopy

EXPECTED:
No burns or red areas will be present on site of grounding pad post procedure
Patient breathes adequately and respiratory rate is within normal limits.

NURSES NOTES:
Saline lock patient; No filtration noted, no redness, no swelling noted, siderails up, fall precaution observed; No signs and symptoms related to respiratory distress noted; Patient tolerated procedure well - MD

Reported of last vital signs in procedure room; Patient transferred to recovery room via stretcher; Report given to recovery nurse - RN

Alarm limits set - Yes

Care plan - Yes

IV in place, patent - Yes

Monitors on - Yes

Pre assessment H&P reviewed - Yes

Side rails up - Yes

VITAL SIGNS RECORD

<table>
<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>RR</th>
<th>Sao2</th>
<th>Co2</th>
</tr>
</thead>
<tbody>
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<td>120/80</td>
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<td>64</td>
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<td>98</td>
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<td>10:21 AM</td>
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<td>22</td>
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<tr>
<td>10:25 AM</td>
<td>115/80</td>
<td>65</td>
<td>25</td>
<td>99</td>
</tr>
</tbody>
</table>

Electronic Signature: 
Mary Smith, R.N.  1/5/2016 10:32:00 AM

Electronic Signature: 
John W. Hart, M.D.  1/5/2016 10:32:00 AM

Report Sign Off Time: 1/5/2016 10:35:15 AM
SAMPLE NURSES REPORT FOR POST PROCEDURE

Patient Name: Joseph R Smith  
Date of birth: 2/16/1955  
Age: 60  
Sex: Male  
Attending Physician: John W. Hart, M.D.  
Service Date: 01/05/2016  
Procedure: Colonoscopy

RECOVERY ROOM:

Allergies: NKDA

Time In: 10:31 AM  
Patient Location/Bed: Room #1  
Alarms Set  
Brakes On  
Breath sounds normal  
HOB Flat  
HOB Up  
Monitor On  
Moves all extremities  
Siderails Up  

Pain Level: 5/10  
Action: Patient given percocet (5 mg)

Adlpre Score  

PRE  
INTRA  
POST

ACT 2 2 2
CRC 2 2 2
LOC 2 2 2
RSP 2 2 2
SKN 2 2 2
Tot, Par 10 10 10

Discharge Criteria  

POST

Activity 2
Vital Signs 2
Abdomen 2
Nausea & Vomiting 2
Pain 2
Tot, Par 10

Ambulating per preprocedure status
Discharge instruction sheet given and reviewed with patient and/or family
Patient or significant other verbalized understanding of instructions and explanations
Direct Physical Assessment by MD in Recovery
Indirect physical assessment of the patient reported to M.D. by recovery RN

Discharge Criteria (>8) Met: Yes  
Time: 10:52 AM
Final Discharge Score: 10@10

VITAL SIGNS RECORD

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<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>HR</th>
<th>RR</th>
<th>Sao2</th>
<th>EKG</th>
<th>Co2</th>
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<tbody>
<tr>
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<td>143/72</td>
<td>65</td>
<td>25</td>
<td>98</td>
<td>SR</td>
<td>2</td>
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<tr>
<td>10:37 AM</td>
<td>140/70</td>
<td>65</td>
<td>25</td>
<td>99</td>
<td>SR</td>
<td>3</td>
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<tr>
<td>10:42 AM</td>
<td>143/73</td>
<td>62</td>
<td>17</td>
<td>98</td>
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<td>2</td>
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<td>10:47 AM</td>
<td>135/74</td>
<td>63</td>
<td>18</td>
<td>99</td>
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<td>2</td>
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<tr>
<td>10:52 AM</td>
<td>142/70</td>
<td>64</td>
<td>19</td>
<td>97</td>
<td>SR</td>
<td>2</td>
</tr>
</tbody>
</table>

Electronic Signature  

Mary Smith, R.N.  
1/5/2016 10:50:00 AM

Report Sign Off Time: 1/5/2016 10:56:35 AM
SAMPLE PRE ANESTHESIA REPORT

Patient Name: Joseph R Smith
Date of birth: 02/16/1955
Attending Physician: John W. Hart, M.D.
Date of Service: 01/05/2016

Age: 60    Sex: M

Patient Id: JOSM1000
Referral: Johnson, Keith M.D.
Anesthesiologist: James P Perkins, M.D.

Procedure: Colonoscopy

ASA class: Level-II
Medications: Colace 100 mg TID
              Lidocaine ointment PR
Allergies: NKDA
Habits: ETOH-No,
         Recreational Drugs-No,
         Tobacco-No,

Proposed Anesthesia: IV deep sedation
Vital signs: BP: 143/72 mmHg  HR: 65  RR: 25  SpO2: 98  Height: 68.00 in  Weight: 162.00 lbs  Temp: 98.50 F  Time: 10:01 AM
DX: Change in bowel habit - R19.4
     Constipation, unspecified - K59.00

Medical History
From: Patient
Medical History: Lung disease-Yes, COPD
GI disease-Yes, Constipation, Abdominal pain on LLQ, Change in bowel habits

Physical Exam:
HEENT: Lips, teeth and gums showed normal mucosa. The oral mucosa, hard and soft palate, tongue and posterior pharynx were normal.
LYMPH NODES: No lymphadenopathy was appreciated in the neck.
LUNGS: Auscultation of the lungs revealed was appreciated in the neck, axillae or groin.
HEART: There was a regular rate and rhythm without any murmurs, gallops, rubs.
ABDOMEN: Soft and non-tender and no palpable organomegaly.
MENTAL STATUS: Alert and oriented.
H & P COMMENTS: Well developed, well nourished, in no acute distress.

Pre-Anesthesia Evaluation:
Discussed anesthesia risk and alternatives-Yes
Motion sickness-No
Patient evaluated-Yes

Signed Off by: James Perkins, CRNA
James P Perkins, CRNA  Jan 5 2016  10:06 AM
SAMPLE INTRA ANESTHESIA REPORT

Patient Name: Joseph R Smith  
Date of birth: 02/16/1955  
Age: 60  
Sex: M  
Attending Physician: John W. Hart, M.D.  
Date of Service: 01/05/2016  
Referral: Johnson, Keith M.D.  
Anesthetist / CRNA: James P Perkins, CRNA  
Patient Id: J0SSM1000

Procedure: Colonoscopy  
Anesthesia Start: 10:05 AM  
Anesthesia End: 10:29 AM  
Procedure Start: 10:09 AM  
Procedure End: 10:31 AM  
Procedure Timeout: 10:36 AM  
Propofol Start: 10:10 AM  
Propofol End: 10:29 AM

Monitors: NIBP, EKG, Pox, Oxygen

Type of Anesthesia: TIVA
Position: Left lateral
Airway: Nasal
Eyes: Closed
Fluids: Lactated Ringer
Checklist: Eye care
Monitors on VSS
O2 applied as indicated
PP checked and padded
To procedure room

More Checklist: Chart Reviewed
Equipment Check
ID Check
Pl. Re-Eval Pre-Ind

Signed Off by: James P Perkins, CRNA  
Jan 5 2016  10:43 AM
**FLUIDS AND AGENTS**

<table>
<thead>
<tr>
<th>Time</th>
<th>10:03 AM</th>
<th>10:08 AM</th>
<th>11:13 AM</th>
<th>11:18 AM</th>
<th>11:24 AM</th>
<th>Total</th>
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<tbody>
<tr>
<td>Demerol (mg)</td>
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<td>Fentanyl (mcg)</td>
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<td>Propofol (mg)</td>
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**VITALS**

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<td>150/120</td>
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<td>Heart Rate (HR)</td>
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<td>Resp Rate (RR)</td>
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**MONITORS**

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<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>99%</td>
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Signed Off By: [signature]

James P Perkins, CRNA  Jan 5 2016  10:43 AM
SAMPLE POST ANESTHESIA REPORT

Patient Name: Joseph R Smith
Date of birth: 02/16/1955
Attending Physician: John W. Hart, M.D.
Date of Service: 01/05/2016
Age: 60
Sex: M
Patient Id: JOSSM1000
Referral: Johnson, Keith M.D.
Anesthetist / CRNA: James P Perkins, CRNA

Procedure: Colonoscopy
Type of:
Anesthesia: Proposed (Pre OP); IV deep sedation
Performed (Intra OP): TIVA
Cond to Par: Awake & Alert
IV Fluids: Lactated Ringer
Anesthesia Start: 10:05 AM
Procedure Start: 10:09 AM
PACU Start: 10:29 AM
Anesthesia End: 10:29 AM
Procedure End: 10:31 AM

Vital Signs:
BP: 120/0  HR: 65  RR: 25  SpO2: 99  Height: 68.00 in  Weight: 162.00 lbs

Post Procedure:
Diagnosis: See physician's report
Discharge
Assessment:
Alert/Orient
Ambulatory
Stable
Notes: Patient is stable

Anesthesiologist: James P Perkins, M.D.

Signed off by: James Perkins CRNA

James P Perkins, CRNA Jan 5 2016 10:54 AM