PATIENT MEDICAL RECORD — SUMMARY CHART

Patient Demographics

Field	Value
Name	James Robert Patterson
DOB	March 3, 1963 (Age 63)
Sex	Male
MRN	SUN-2024-33201
Insurance	Aetna — AET-W92-550183746
PCP	Dr. Michael Torres, MD — Bayshore Family Practice
Endocrinologist	Dr. Ananya Desai, MD — Sunshine Endocrinology & Diabetes Center

---

Chief Complaint

"My blood sugars are all over the place. I wake up with lows in the middle of the night and don't feel them. My wife found me confused at 3 AM twice last month."

History of Present Illness (HPI)

Mr. Patterson is a 63-year-old male with a **14-year history of Type 2 diabetes mellitus**, currently managed with basal insulin (glargine), metformin, and empagliflozin. He presents for endocrinology follow-up with worsening glycemic variability and **recurrent nocturnal hypoglycemia**.

Key concerns:

- HbA1c: 7.8% (target <7.0%) — up from 7.2% six months ago
- Fingerstick logs show fasting glucose range of 52–210 mg/dL over past 30 days
- **Two episodes of severe nocturnal hypoglycemia** in past 4 weeks (glucose 38 mg/dL and 42 mg/dL per bedside fingerstick)
- Wife reports patient was confused, diaphoretic, and unresponsive to verbal commands during both episodes
- Patient reports **no prodromal symptoms** (no shakiness, no palpitations) — consistent with **hypoglycemia unawareness**
- Currently checking fingerstick glucose 2× daily (fasting and bedtime) — insufficient to detect nocturnal patterns

Treatment History

Date	Treatment	Provider	Outcome
2012	Diagnosed T2DM; Metformin 500mg BID	Dr. Torres	Controlled for 5 years

2017	Added Glipizide 10mg daily	Dr. Torres	HbA1c improved to 6.9%
2020	Glipizide discontinued, started Lantus 20u QHS	Dr. Desai	Better control, HbA1c 7.0%
2022	Added Empagliflozin 25mg daily	Dr. Desai	HbA1c 6.8%, cardiovascular benefit
2025	Lantus titrated to 32u QHS; Metformin 1000mg BID	Dr. Desai	HbA1c rising, hypoglycemia emerging
Mar 2026	CGM (Dexcom G7) prescribed	Dr. Desai	**Claim denied by Aetna**

Physical Examination (March 15, 2026)

Vitals: BP 142/88, HR 68, BMI 31.4, Weight 214 lbs

Relevant findings:

- Decreased vibratory sensation bilateral feet (tuning fork test)
- Monofilament: absent sensation 3/10 sites right foot, 2/10 sites left foot
- Pedal pulses: palpable bilaterally but diminished
- Fundoscopic: mild nonproliferative diabetic retinopathy (per last ophthalmology note, Jan 2026)

Laboratory Results (March 10, 2026)

Test	Result	Reference
HbA1c	7.8%	<7.0%
Fasting glucose	168 mg/dL	70-100
Creatinine	1.4 mg/dL	0.7-1.3
eGFR	52 mL/min	>60
Urine albumin/creatinine	88 mg/g	<30
Total cholesterol	198 mg/dL	<200
LDL	102 mg/dL	<100

Medications

Medication	Dose	Frequency	Start Date
Insulin glargine (Lantus)	32 units	QHS	2020
Metformin	1000 mg	BID	2012
Empagliflozin (Jardiance)	25 mg	Daily	2022

Lisinopril	20 mg	Daily	2018
Atorvastatin	40 mg	QHS	2019

Comorbidities

- Type 2 DM with complications (retinopathy, nephropathy, neuropathy)
- Hypertension (controlled)
- Hyperlipidemia (controlled)
- Stage 3a CKD (eGFR 52)
- Peripheral neuropathy with hypoglycemia unawareness
- Mild nonproliferative diabetic retinopathy

Provider Notes

Dr. Desai, March 15, 2026:

> *Mr. Patterson has documented hypoglycemia unawareness with two severe nocturnal episodes in the past month. His current 2×/day fingerstick monitoring is inadequate to detect nocturnal hypoglycemia patterns. CGM is the standard of care for patients with hypoglycemia unawareness regardless of insulin regimen complexity — this is supported by ADA Standards of Care 2026, Section 7 ("CGM should be offered to all adults with diabetes on insulin who are at risk for hypoglycemia") and the Endocrine Society Clinical Practice Guidelines. The distinction between basal-only and intensive insulin regimens is clinically irrelevant when the primary indication is hypoglycemia unawareness and patient safety. I am prescribing Dexcom G7 CGM and will appeal the denial.*

> *Additionally, I am considering transitioning Mr. Patterson to a basal-bolus regimen given his rising HbA1c, which would independently satisfy the payer's coverage criteria. However, CGM should not be contingent on escalating to a more complex regimen — CGM data is needed FIRST to safely titrate any insulin changes.*