15

BONDHOLDER KOSHI PADNANI

pkopd@aol.com

855 East Broadway Apt. 5C
Long Beach, New York 11561.

Telephone: (917) 584-8382

FILED
OCT 22 2026
UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF CALIFORNIA

TJOF

UNITED STATES BANKRUPTCY COURT

EASTERN DISTRICT OF CALIFORNIA

DIABLO GRANDE COMMUNITY FACILITIES DISTRICT NO 1 Debtor.	Case No. 25-26635 -A -9 DCN BWS-1 Chapter 9.

BONDHOLDER KOSHI PADNANI'S MOTION TO EXTEND TIME TO FILE OBJECTION TO DIABLO GRANDE COMMUNITY FACILITIES DISTRICT NO. 1'S CHAPTER 9 PETITION.

2526635261022000000000013

Request for extension of time to file Objection.

I am writing to request an extension of time to file my objection which was due on April 3rd 2026 I apologize for the delay in filing the objection and any inconvenience it may cause to the court and the opposing party the reason for the delay is due to medical issues that have prevented me from completing the necessary tasks within the prescribed timeline I have attached relevant medical documentation such as doctors note and disability statement supporting my claim of being unable to meet the deadline due to medical reasons these documents provide a detailed explanation of my medical condition and the period during which I was unable to fulfill my obligations.

The severity of knee and ankle pain, asthma and anxiety insomnia impaired my cognitive and physical functioning, preventing me from managing daily responsibilities and processing complex information or completing this filing within the prescribed deadline.

Now that my condition has stabilized sufficiently to allow me to function normally I am submitting this objection immediately. I kindly request that you grant a retroactive extension based on these unavoidable medical grounds so that my objection may be considered on its merits.

Thank you for your time, understanding, and consideration of this request

Sincerely,

Koshi Padnani.
855 East Broadway apartment 5c Long Beach New York 11561
email address pkopd@aol.com

Case number 25-26635-A-9

Koshi Padnani

Additional documents.
- notary stamped letter
- & 12 pages medical documentation

NEW YORK ALL-PURPOSE ACKNOWLEDGMENT
REAL PROPERTY LAW §309-a

State of New York
County of Nassau } ss.

On the 10th day of September in the year 2026 before me,
Day Month Year

the undersigned personally appeared Koshi Padhan,
Name of Signer

(and N/A) personally known to me or
Name of Additional Signer, if Any

proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Signature of Notary Public
Notary Public — State of New York

Place Seal Below OR Complete Lines Below

JOSE G JARA
Notary Public - State of New York
NO. 01JA6244710
Qualified in Nassau County
My Commission Expires Jul 11, 2027

Name of Notary

Name of County in Which Originally Qualified

Commission Expiration Date

Name of County in Which Certificate of Official Character Filed (if required)

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Letter

Document Date: N/A Number of Pages: 1

Signer(s) Other Than Named Above: N/A

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Case # 25-26635-A-9

Reason For Visit

KOSHI PADNANI is being seen for a follow-up pain management visit.

History of Present Illness

10/13/2025: Was supposed to have Genicular nerve block but was denied bc didn't have referral from the orthopedist. Now she has the referral. Uses lidocaine patch, diclofenac gel, ice PRN

Initial HPI 12/20/2024:
WC 6/7/07 Internal Medicine Physician - lab coat got coat against chair and fell forward and twisted
Pain had knee replacement with Dr. Gerber on 10/30/124 and has been having left medial knee pain and posterior knee pain described as a sharp shooting stabbing pain. Taking Mobic 15 mg daily with no relief. Pt interested in Genicular nerve blocks.

Conservative Care: has been doing PT
Pain Medications: Mobic PRN
Past Injections: none
Spine surgery: none
Blood thinners: none

Injury Details:
Location of Problem:. lt knee.
Cause of Accident/Injury: work related.
Date of Accident/Injury: 6/7/07.
On a scale of 0-10, patient rated 7 for pain when active.
On a scale of 0-10, patient rated 5 for pain at rest.
Pain Quality: dull/aching, sharp, shooting.
Pain is Radiating: yes. LT KNEE
Pain is constant.
Pain affects the following activities: household chores, leisure, sleep, social interactions.
Pain improves with: Nothing helps with pain getting better.
Pain worsen with: standing, walking, exercising, stairs, lying in bed.
Patient needs support to ambulate: no.
Patient has had surgery for this problem in the past: no.
Patient has had physical therapy for this in the past: yes.
Patient has completed studies for this problem? yes.
Completed Test/Imaging Studies: LT KNEE MRI.

Surgical History

History of Cesarean section
History of Knee arthroscopy

Current Meds

Albuterol Sulfate HFA 108 (90 Base) MCG/ACT Inhalation Aerosol Solution
Calcitonin (Salmon) 200 UNIT/ACT Nasal Solution; INSERT 1 SQUIRT IN ONE NOSTRIL EVERY DAY, ALTERNATING EACH NOSTRIL
Cromolyn Sodium Powder
Diclofenac Sodium 1 % External Gel; Apply sparingly to affected area twice a day
Diclofenac Sodium 3 % External Gel; APPLY SPARINGLY TO THE AFFECTED AREA(S) TWICE DAILY
Etodolac 200 MG Oral Capsule; 1 TAB PO Q 6-8 PRN SEVERE PAIN WITH FOOD
Gabapentin 300 MG Oral Capsule; TAKE 1 CAPSULE 3 TIMES DAILY
Meloxicam 15 MG Oral Tablet; Take 1 tablet daily
methylPREDNISolone 4 MG Oral Tablet Therapy Pack; TAKE 4 MG As Directed
Naloxone HCl - 0.4 MG/ML Injection Solution Prefilled Syringe; USE AS DIRECTED
Naloxone HCl - 4 MG/0.1ML Nasal Liquid; USE AS DIRECTED
Naloxone HCl - 4 MG/0.1ML Nasal Liquid; USE AS DIRECTED
oxyCODONE HCl - 10 MG Oral Tablet; 1 tab q 6 to 8 hours PRN FOR SEVERE PAIN ONLY MDD:3 tabs
oxyCODONE HCl - 5 MG Oral Tablet; 1 tab every 4-6 hours as needed for pain MDD:5 tabs

Allergies

Hyaluronic Acid CAPS

Review of Systems

Constitutional, Eyes, ENT, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Integumentary, Neurological, Psychiatric, Endocrine and Heme/Lymph review of systems are otherwise negative except as noted in HPI.

Vitals

Vital Signs

	Recorded: 13-Oct-2025 01:07 pm

Filed 10/22/26 Case 25-26635 Doc 138

Height	5 ft 2 in
Weight	116 lb
BMI Calculated	21.22 kg/m2
BSA Calculated	1.52 m2

Physical Exam

Constitutional; Appears well, no apparent distress
Ability to communicate: Normal
Respiratory: non-labored breathing
Skin: No rash noted
Head: Normocephalic, atraumatic
Neck: no visible thyroid enlargement
Eyes: Extraocular movements intact
Neurologic: Alert and oriented x3
Psychiatric: normal mood, affect and behavior

Examination of the left knee is as follows:
Inspection:. midline scar.
Palpation: tenderness, medial joint line tenderness, posterior tenderness.
ROM: pain with flexion, pain with extension, posterior pain with flexion, posterior pain with extension, ROM is limited secondary to pain.

Assessment

Primary osteoarthritis of left knee (715.16) (M17.12)

Discussion/Summary

After discussing various treatment options with the patient including but not limited to oral medications, physical therapy, exercise modalities as well as interventional spinal injections, we have decided with the following plan:

- Continue Home exercises, stretching, activity modification, physical therapy, and conservative care.
- Recommend LEFT Genicular Nerve Block under fluoroscopic guidance with image.
- The risks, benefits and alternatives of the proposed procedure were explained in detail with the patient. The risks outlined include but are not limited to infection, bleeding, nerve injury, a temporary increase in pain, failure to resolve symptoms, allergic reaction, symptom recurrence, and possible elevation of blood sugar in diabetics. All questions were answered to patient's apparent satisfaction and he/she verbalized an understanding.
- The pain has not responded to conservative care including NSAID therapy and/or physical therapy. There is no bleeding tendency, unstable medical condition, or systemic infection.
- Follow up in 1-2 weeks post injection for re-evaluation.

Plan

Primary osteoarthritis of left knee

OC PM Procedure Booking Form Outpatient Not required Status: Active Requested for: 13-Oct-2025

Electronically signed by : BRIAN GOLDSTEIN, D.O.; Oct 13 2025 1:18PM Eastern Standard Time (Author)

Health Record from FollowMyHealth®

From: FollowMyHealth <noreply@followmyhealth.com>
To: pkopd@aol.com
Date: Jan 12, 2026, 2:55 AM

Name: KOSHI Padnani
Date of Birth: 15-Aug-1955
Gender Identity: Female

Documents

1/6/2026Ayal Segal, MD - Portal Note

Reason For Visit

KOSHI PADNANI is a 70 year old female being seen for a follow-up visit for. This visit is related to worker's compensation. Date of Injury: 6/7/2007 retired. Left TKR 10/30/2024.

History of Present Illness

History of Present Illness

Patient is a 70-year-old female who presents today for an evaluation regarding her left knee. Patient is status post left total knee replacement performed on October 30, 2024 by Dr. Gerber. She states that following her knee replacement she did fairly well but always had a feeling of stiffness with a lack of extension. She did follow-up with Dr. Gerber following the surgery numerous times. I was offered a manipulation under anesthesia. This was approved before receiving the manipulation. She decided to seek a second opinion. She did present to the office and it was discussed that she did have an extension lag as well as stiffness within her knee. She was advised to try physical therapy and continuing strengthening exercises at home. This was to include and improve her range of motion but particularly for improvement and strengthening of her extensor mechanism. She states that this has been for several months and although she does feel a little more stable. She does have a lack of extension with active range of motion. She states that due to this she feels discomfort weakness stiffness and a feeling of buckling at times. She also states that she must use a cane when ambulating due to the uncertainty when walking. And still has discomfort which is worse at night. She states that she has tried all conservative measures including anti-inflammatories and pain medications. Along with topical diclofenac gel and lidocaine with no relief. Currently she is on meloxicam. She presents today for an evaluation regarding her left knee. As this is a Worker's Compensation case which began on June 7, 2007. The board has asked for a percentage of loss. And is therefore here to discuss further medical options and her required

percentage of loss for her left knee. She denies any history of new or recent injury. And is currently not working in her profession

Physical Exam

On physical examination of the left knee. Patient is status post left total knee replacement. There is a well-healed surgical scar with no evidence of infection superficial or deep. There is no redness heat or discharge noted. However there is some joint effusion still noted. There is some diffuse pain and tenderness particularly with in the patellofemoral compartment as well as the medial femoral-tibial compartment. She does have a marked decrease range of motion. Particularly with extension. She is able to to extend her knee to a -5 degrees at passive extension. However actively she has a lack of extension of 30 degrees. This was measured 3 times using a goniometer. Passively it was measured from -5 degrees to 95 degrees the second reading was -6 degrees to 90 degrees. And the third and final measurement was -5 degrees to 90 degrees. However performing these range of motion actively it was also measured 3 times using a goniometer. It was noted with the first measurement as being -35 degrees to 90 degrees. The second reading was -30 degrees to 95 degrees. And the third and final reading of 32 degrees to 90 degrees. Therefore indicating she has a significant active decreased range of motion both passive and actively. During evaluating ligamentous laxity. An anterior posterior drawer test as well as varus and valgus stress testing were performed. Which shows some stability. With approximately 5 degrees of laxity when performing the varus and valgus stress test. There is some joint effusion noted. With muscle atrophy. This was measured using a tape measure and comparing it to the opposite knee. At 5 cm above the patella it is noted that on the nonsurgical knee it was 33 cm. Whereas the left was 35 cm. Indicating some joint effusion. But when measuring the knee 10 cm above the patella. It is noted that the right knee has her circumference of 39 cm with the left being 36 indicating muscle atrophy. This was measured 3 times using the tape measure. The first reading measured 36 cm the second reading was 35 cm and the third and final reading was 36 cm. Whereas the right was consistently at 39 cm. There is some crepitus during the evaluation at the patellofemoral compartment. She is neurovascularly intact with good distal pulses and no calf tenderness.

Musculoskeletal: antalgic and ambulates with cane.

DTRs: Biceps, brachioradialis, triceps, patellar, ankle and plantar 2+ and symmetric bilaterally. Pulses: dorsalis pedis, posterior tibial, femoral, popliteal, and radial 2+ and symmetric bilaterally.

Imaging: X-rays of the left knee were taken in the office today. This includes all 3 views. The AP, lateral and sunrise views. They reveal a status post left total knee replacement. The hardware is in perfect placement and fixated well. There is excellent alignment. There is no evidence of any fracture, dislocation or loosening of any hardware.

Discussion/Summary

Medication risks reviewed. Surgical risks reviewed. After thorough history full examination and review of the x-rays. It was explained to the patient that she does have a functioning left total knee replacement. However she does present with significant stiffness/range of motion within the knee. This has been noted numerous times since her surgery and acknowledge with Worker's Compensation board as she did have

approval for a manipulation. This is noted during passive but mostly during active range of motion. She also presents with a weakness with muscle atrophy and the feeling of instability during ambulation and muscles ambulate with the use of a cane. According to the New York State guidelines she does have a percentage of loss which is permanent according to the New York State guidelines. According to table 7.5 on page 44. The patient did have a total knee replacement which is equivalent to 35% schedule of loss. However due to her range of motion. The outcome matched the column of being considered poor (C). When assessing the overall grade it is considered poor due to the fact that she has an extension lag during active range of motion of 30 degrees which is greater then 20 degrees in the guidelines. This would add an additional 30% to her schedule. When measuring the stability she does have a stable joint therefore not any additional percentage. And the buckling is mostly due to to the muscle atrophy and lack of range of motion. When measuring the muscle atrophy it is an additional 5% as the guidelines on table 7.5 reads 1.5 to 2.5 inches of muscle atrophy adds an additional 5%. So according to the New York State guidelines on table 7.5 on page 44. It is come to the conclusion that she has a total schedule loss of 70/%. This is based on the 35% due to her surgery and the additional 30% due to the poor outcome of her range of motion and additional 5% due to her muscle atrophy. It was explained to the patient that she should continue with her exercise program to hopefully regain more strength but also to improve her range of motion. She is advised to continue with ice packs/moist heat and to continue with anti-inflammatories/pain medications as needed. Currently the patient is not working as she is unable to return back to work as she is still disabled. It is recommended that she follow with this office accordingly in the next 2 to 3 months for reevaluation and to discuss further medical management.

35 minutes were spent, face to face, in direct consultation with the patient. This includes reviewing the natural history of their Dx., eliciting the history, performing an orthopedic exam, review of the x-ray findings, forming a differential Dx and discussing all treatment options. This Includes both surgical and non-surgical treatments. I also reviewed all the risks and benefits of non-operative & operative Tx options, future impact into orthopedic functions/problems, activity restrictions both at home and at work, and all follow up requirements.

Assessment

Postoperative stiffness of total knee replacement (996.77) (T84.89XA,M25.669,Z96.659)

Status post total left knee replacement (V43.65) (Z96.652)

Plan

Status post total left knee replacement

Xray Knee 3 Views, Left; Status:Complete; Done: 06-Jan-2026

Electronically signed by : WILLIAM SZABO, PA; Jan 10 2026 10:43AM Eastern Standard Time (Author)
Electronically signed by : AYAL SEGAL, MD; Jan 10 2026 11:15AM Eastern Standard Time (Author)

Case 25-26635-A-9

John Bedell, DO
Joseph Vitoulis, DO
Olivia McColgan, PA
Rayven Mason, NP
Sther Charlot, NP
Temima Leiser, NP

Family Medicine

265 West Park Ave, Long Beach, NY 11561
T: (516) 431-3600 | F: (516) 431-4107

271 Doughty Blvd, Inwood, NY 11096
T: (516) 371-6884 | F: (516) 371-6083

1000 Atlantic Ave, Baldwin, NY 11510
T: (516) 371-6083 | F: (516) 371-6083

342 Beach 54th St, Arverne, NY 11692
T: (718) 634-5448 | F: (718) 318-2247

Catholic Health
Physician Partners

RE: Koshi Padnani

To whom ever it may concern,

This letter is to inform you that my patient Koshi Padnani was seen on July 20,2026. At the time of the visit, she complained of insomnia and ankle pain.

Sincerely,

Temima Leah Leiser, NP
Electronically signed by Temima Leah Leiser, NP on 9/2/2026

Case 25-26635-A-9

Padnani, Koshi

MRN: E4715941

Office Visit 7/20/2026
Family Medicine, Long Beach

Provider: Leiser, Temima Leah, NP (Nurse Practitioner)
Primary diagnosis: Ankle pain, unspecified chronicity, unspecified laterality
Reason for Visit: Fatigue • Sleeping Problem • Ankle Pain

Progress Notes

Leiser, Temima Leah, NP (Nurse Practitioner) • Nurse Practitioner

Patient ID: Koshi Padnani is a 70 y.o. female
Chief Complaint: Fatigue, Sleeping Problem (Pt reports she has not able to sleep well), and Ankle Pain

Subjective:
70-year-old female with a past medical history significant for anxiety, insomnia, and hypertension presents today with complaints of persistent insomnia and chronic left ankle pain.

The patient reports ongoing difficulty sleeping, describing both difficulty falling asleep and maintaining sleep throughout the night. She states that her insomnia has progressively worsened and is affecting her daytime functioning, energy level, and overall quality of life. She denies any recent acute stressors or changes in her daily routine that would explain the worsening of her symptoms. A thorough medication reconciliation was performed during today's visit. Review of her medical record revealed that the last prescription for Ambien issued by this office was on 02/26/2025. The New York State I-STOP Prescription Monitoring Program was reviewed prior to prescribing, with no unexpected controlled substance prescriptions identified. Given her previous response to therapy and the absence of concerning findings on review of the prescription monitoring program, a refill of Ambien was prescribed.

A comprehensive discussion was held regarding insomnia and its potential contributing factors. Sleep hygiene measures were reviewed in detail, including maintaining a consistent sleep schedule, limiting caffeine and alcohol intake, reducing screen time before bedtime, avoiding daytime naps, and creating an optimal sleep environment. Additional medical causes of insomnia, including thyroid dysfunction, metabolic abnormalities, anemia, and vitamin deficiencies, were discussed. Routine laboratory studies were obtained today to evaluate for potential underlying causes contributing to her sleep disturbances. The patient verbalized understanding of the plan.

The patient also reports left ankle pain that has been present for approximately four months. She denies any known trauma or specific injury preceding the onset of pain. She has attempted conservative treatment at home, including the use of an ACE bandage for compression and topical Voltaren gel, without significant improvement in her symptoms. She continues to experience persistent discomfort despite these measures. She denies numbness, tingling, open wounds, redness, drainage, fever, or other systemic symptoms. Given the chronicity of her symptoms and failure of conservative treatment, an X-ray of the left ankle was ordered for further evaluation to assess for underlying degenerative changes, occult injury, or other bony abnormalities.

The patient was advised that she is also due for her annual physical exam and routine preventive health maintenance. She was encouraged to schedule this appointment at her earliest convenience so that age-appropriate screenings, preventive care, and chronic disease management can be comprehensively reviewed.

All questions and concerns were addressed during today's visit. The patient verbalized understanding of the treatment plan and agrees with the recommendations. She was instructed to follow up after imaging and laboratory results are available or sooner if her symptoms worsen or new concerns arise.

Ankle Pain
Pertinent negatives include no numbness.

Ex. 25-26635-A-9

History reviewed. No pertinent past medical history.

Filed 10/22/26 Case 25-26635 Doc 138

Most Recent Immunizations

Administered	Date(s) Administered
• COVID-19MRNA BIVAL VAC(MODERNA)50 MCG/0.5ML IM SUSP	06/12/2023
• COVID-19MRNA VACC MODERNA (Spikevax)12yrs 50MCG/0.5ML IM SUSY	09/13/2024
• Covid-19 Mrna Vacc (Moderna) 100 Mcg/0.5ml Im Susp	11/24/2021
• Covid-19 Mrna Vaccine (Pfizer) 30 Mcg/0.3ml Im Susp	02/25/2021
• Influenza High Dose (IIV3) PF 0.5ML (FLUZONE HIGH DOSE)	09/25/2024
• Influenza High Dose (IIV4-HD)PF 0.7ML (Fluzone High Dose)	11/19/2022
• Influenza Quadrivalent MDV 0.5ML (FLUCELVAX)	10/14/2019
• Influenza Split Quad PF 0.5ML (FLUZONE PF, AFLURIA PF)	09/28/2018
• Influenza Vac IIV3 Adjuvanted (FLUAD)	11/16/2025
• Influenza Vac Subunit Quad (CCIIV4) 0.5ML (FLUCELVAX PF QUAD)	02/04/2018
• Influenza Vac aIIV4 Adjuvanted (Fluad)	10/15/2021
• MMR	08/06/2010
• Pneumococcal Conjugate (PCV20)(PREVNAR)	03/20/2023
• Pneumococcal polysaccharide (PPSV23) (PNEUMOVAX)	08/26/2020
• Tdap (ADACEL, BOOSTRIX)	08/04/2024
• Zoster (ZOSTAVAX)	11/30/2016
• Zoster Recombinant (SHINGRIX)	12/04/2019

Radiological Studies: No results found.
Diagnostic Studies:
Objective:
Vital Signs: BP 138/88 (BP Location: Right arm, BP Patient Position: Sitting) | Pulse 74 | Temp 98 °F (36.7 °C) (Oral) | Resp 18 | Ht 1.575 m (5' 2") | Wt 51.7 kg (114 lb) | SpO2 99% | BMI 20.85 kg/m²

PHQ 9 Total Score (Score < or =9 is negative screen. If Score is >9, the provider must complete follow up): 0

Physical Exam
Vitals reviewed.
Constitutional:
Appearance: Normal appearance.
HENT:
Head: Normocephalic.
Right Ear: Tympanic membrane normal.
Left Ear: Tympanic membrane normal.
Nose: Nose normal. No congestion.
Mouth/Throat:
Pharynx: No posterior oropharyngeal erythema.
Eyes:
Extraocular Movements: Extraocular movements intact.
Pupils: Pupils are equal, round, and reactive to light.
Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds.
Pulmonary:
Breath sounds: Normal breath sounds.
Abdominal:
General: Bowel sounds are normal. There is no distension.
Palpations: Abdomen is soft.

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History reviewed. No pertinent surgical history.

Review of Systems:

Review of Systems
Constitutional: Negative for appetite change, chills, fatigue, fever and unexpected weight change.
HENT: Negative for congestion, ear pain, facial swelling, hearing loss and sore throat.
Eyes: Negative for pain, discharge and visual disturbance.
Respiratory: Negative for cough, chest tightness, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Negative for abdominal pain, blood in stool, constipation, diarrhea, nausea and vomiting.
Genitourinary: Negative for difficulty urinating, dysuria, flank pain, frequency, hematuria and urgency.
Musculoskeletal: Negative for back pain and joint swelling.
Left ankle pain
Skin: Negative for color change and rash.
Neurological: Negative for dizziness, tremors, weakness, light-headedness, numbness and headaches.
Psychiatric/Behavioral: Negative for behavioral problems and suicidal ideas. The patient is nervous/anxious.
Endocrine: Negative for polyuria.
Hematological: Does not bruise/bleed easily.

Social History

Tobacco Use
- Smoking status: Never
- Smokeless tobacco: Never

Vaping Use
- Vaping status: Never Used

Substance Use Topics
- Alcohol use: Yes
  Comment: socially
- Drug use: Never

Preventative Screenings:

Family History:

History reviewed. No pertinent family history.

Allergies as of 07/20/2026 - Review Complete 04/06/2026

Allergen	Reaction	Noted
• Hylan g-f 20	Swelling	05/22/2025

Current Medications:

Outpatient Encounter Medications as of 7/20/2026

Medication	Sig
• albuterol (PROVENTIL HFA;VENTOLIN HFA) 108 (90 Base) MCG/ACT inhaler	Inhale 2 puffs into the lungs every 6 (six) hours as needed for Wheezing..
• amLODIPine (NORVASC) 2.5 MG tablet	Take 2.5 mg by mouth in the morning.
• cetirizine (ZYRTEC ALLERGY) 10 MG tablet	Take 10 mg by mouth in the morning.
• montelukast (SINGULAIR) 10 MG tablet	Take 1 tablet (10 mg total) by mouth nightly..
• zolpidem (AMBIEN) 5 MG tablet	Take 1 tablet (5 mg total) by mouth nightly as needed for Sleep. Max Daily Amount: 5 mg.

No facility-administered encounter medications on file as of 7/20/2026.

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Tenderness: There is no abdominal tenderness.

Musculoskeletal:
General: No swelling. Normal range of motion.
Cervical back: Normal range of motion and neck supple.
Right lower leg: No edema.
Left lower leg: No edema.

Skin:
General: Skin is warm and dry.
Capillary Refill: Capillary refill takes less than 2 seconds.
Findings: No rash.

Neurological:
Mental Status: She is alert and oriented to person, place, and time.

Psychiatric:
Mood and Affect: Mood normal.

Assessment & Plan

Ankle pain, unspecified chronicity, unspecified laterality

Xray ordered

Orders:
- X-Ray Ankle 2 Views Left; Future

Insomnia, unspecified type

Refill ambien 5 mg nightly prn
Istop checked Reference #: 277541636
Labs drawn.
Orders:
- zolpidem (AMBIEN) 5 MG tablet; Take 1 tablet (5 mg total) by mouth nightly as needed for Sleep. Max Daily Amount: 5 mg.
- CBC and differential
- Comprehensive Metabolic Panel with Fibrosis-4 (FIB-4) Index
- Ferritin
- Folate
- Hemoglobin A1c
- Lipid panel
- Thyroid Panel + TSH
- Total Iron Binding Capacity (TIBC)
- Vitamin D 25 hydroxy
- Vitamin B12

Essential hypertension

Refill amlodipine 2.5 mg daily

Orders:
- amLODIPine (NORVASC) 2.5 MG tablet; Take 1 tablet (2.5 mg total) by mouth in the morning.

Chronic obstructive pulmonary disease, unspecified COPD type (HCC)

Refill montelukast 10 mg tab daily

Orders:
- montelukast (SINGULAIR) 10 MG tablet; Take 1 tablet (10 mg total) by mouth nightly..

Location of blood draw: Right antecubital

# of vials: 3

Dx: G47.00

Performed today by Temima Leah Leiser, NP, 07/20/2026 3:28 PM

I will be using documentation of time to charge for this visit.No

Leiser, Temima Leah, NP
Electronically Signed
07/20/26 1535

Instructions

After Visit Summary (English Snapshot) - Automatic Snapshot taken 7/20/2026

Additional Documentation

Vitals: BP 138/88 (BP Location: Right arm, BP Patient Position: Sitting) Pulse 74 Temp 98 °F (36.7 °C) (Oral) Resp 18 Ht 1.575 m (5' 2") Wt 51.7 kg (114 lb) SpO2 99% BMI 20.85 kg/m² BSA 1.51 m²

Flowsheets: Social Determinants of Health, Patient Health Questionnaire, Allergy Visit Question

Communications

ⓘ

Media

From this encounter

Electronic signature on 7/20/2026 1:45 PM - E-signed

Pharmacy Benefits

PADNANI, KOSHI A - ELDER BB CDH-Y HPDMEDD (CVS|CAREMARK)

Covered: **Retail**, **Mail Order**, Specialty Unknown: Long-Term Care

Member ID:	01385170801	BIN:	004336	DOB:	8/15/1955
Group ID:	RX8585	PCN:	MEDDADV	Legal sex:	F
Group name:	ELDERPLAN MAPD H3347/EP26HMO16			Address:	855 EAST BROADWAY APT 5C LONG BEACH NY 11561

Orders Placed

Labs

CBC and differential (Resulted 7/20/2026, Abnormal)
Hemoglobin A1c (Resulted 7/20/2026, Abnormal)
Total Iron Binding Capacity (TIBC) (Resulted 7/20/2026, Abnormal)
Comprehensive Metabolic Panel with Fibrosis-4 (FIB-4) Index (Resulted 7/20/2026)
Ferritin (Resulted 7/20/2026)
Folate (Resulted 7/20/2026)

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Lipid panel (Resulted 7/20/2026)
Thyroid Panel + TSH (Resulted 7/20/2026)
Vitamin B12 (Resulted 7/20/2026)
Vitamin D 25 hydroxy (Resulted 7/20/2026)

Imaging
X-Ray Ankle 2 Views Left

Medication Changes

As of 7/20/2026 3:28 PM

	Refills	Start Date	End Date
Added: zolpidem (AMBIEN) 5 MG tablet	0	7/20/2026	9/1/2026
Take 1 tablet (5 mg total) by mouth nightly as needed for Sleep. Max Daily Amount: 5 mg. - Oral			
Prior authorization: Closed - Prior Authorization not required for patient/medication			

Medication List at End of Visit

As of 7/20/2026 3:28 PM

	Refills	Start Date	End Date
albuterol (PROVENTIL HFA;VENTOLIN HFA) 108 (90 Base) MCG/ACT inhaler	—		—
Inhale 2 puffs into the lungs every 6 (six) hours as needed for Wheezing.. - Inhalation			
Patient-reported medication			
amLODIPine (NORVASC) 2.5 MG tablet	0	7/20/2026	—
Take 1 tablet (2.5 mg total) by mouth in the morning. - Oral			
cetirizine (ZYRTEC ALLERGY) 10 MG tablet	—		—
Take 10 mg by mouth in the morning. - Oral			
Patient-reported medication			
montelukast (SINGULAIR) 10 MG tablet	0	7/20/2026	—
Take 1 tablet (10 mg total) by mouth nightly.. - Oral			
zolpidem (AMBIEN) 5 MG tablet	0	7/20/2026	9/1/2026
Take 1 tablet (5 mg total) by mouth nightly as needed for Sleep. Max Daily Amount: 5 mg. - Oral			
Prior authorization: Closed - Prior Authorization not required for patient/medication			

Visit Diagnoses

Primary: Ankle pain, unspecified chronicity, unspecified laterality M25.579
Insomnia, unspecified type G47.00
Essential hypertension I10
Chronic obstructive pulmonary disease, unspecified COPD type (HCC) J44.9

Patient Lines/Drains/Airways Status

Active PICC Line / CVC Line / PIV Line / Drain / Airway / Intraosseous Line / Epidural Line / ART Line / Line / Wound / Decubitus Ulcer / NG/OG Tube / Glucose Sensor

None

Inactive PICC Line / CVC Line / PIV Line / Drain / Airway / Intraosseous Line / Epidural Line / ART Line / Line / Wound / Decubitus Ulcer / NG/OG Tube / Glucose Sensor

None

Case 25-26635-A-9