Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

***Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: **"**Comments*".**

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Auto-Pedestrian Accident** on **12/16/YYYY,** the injuries and clinical condition of **XXXX** as a result of **Auto-Pedestrian Accident,** treatments rendered for the complaints and progress of the condition.*

- *Initial and final Physical Therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	**MM/DD/YYYY:** Patient was in yard and almost twisted ankle and in attempt to prevent fall patient put sudden weight on right leg in a squat position and felt immediate pain right thigh.
Date of injury	MM/DD/YYYY
Description of injury	Patient sustained in a motor vehicle versus pedestrian collision just prior to arrival. Per EMS, the patient was crossing the parking lot of a Casino when he was hit by a Sedan traveling 15-20 MPH. He was hit and fell onto the ground onto his right side. Report no loss of consciousness. The patient was ambulatory on scene after the incident. The patient does not recall the entire event but states his head hit the ground at some point when he sustained a laceration to the back of his head.
Injuries/Diagnoses	Traumatic injury Pedestrian injured in traffic accident involving motor vehicle Blunt head trauma Cephalohematoma Laceration of scalp (Right parietal region) Right shoulder pain, unspecified chronicity Injury of head Insomnia History of Adhesive capsulitis of right shoulder History of Frozen shoulder Right glenohumeral joint pain and stiffness AC joint arthritis
Treatments rendered	**Medications:** • Pain medications • Muscle relaxants • Anti-anxiety medications **Procedures:** **12/16/YYYY:** Repair of complex laceration on scalp with Staples **Rehabilitation sessions:** **01/02/YYYY – 02/11/YYYY:** Physical therapy for right shoulder pain and stiffness **Other procedures:** **04/29/YYYY:** Intra articular Steroid injection of Left Shoulder
Condition of the patient as per the last available record	*As on 04/29/YYYY,* patient presented for follow up on the right shoulder. Patient has seen some slight improvements but his motion is still very limited. He feels he should be farther along at this point. We discussed he had a frozen shoulder prior to his accident. His MVA did not cause the frozen shoulder, preexisting impingement/arthritis problems, or cause for any apparent fractures. As a result of the MVA he did have some time off of therapy/HEP due to the acuity of the MVA injury. This likely delayed some of his progress that could have been made in mobilizing the shoulder. Examination revealed visible AC joint degenerative joint disease, shoulder girdle muscle atrophy, limited and

	painful AROM at the shoulder joint. Still with end-feel consistent with frozen shoulder. Diagnosed with Adhesive capsulitis of right shoulder, showing limited interval improvement and AC joint arthritis. He underwent intra-articular Steroid injection of left shoulder. Follow-up in 6-8 weeks.

Patient History

Past Medical History: Bilateral dry eyes, floater, vitreous, hypertension, other left bundle branch block (09/19/YYYY), PVD (Posterior Vitreous Detachment), and unspecified disorder of refraction and accommodation (04/17/YYYY).

Surgical History: Repair of recurrent inguinal hernia, strang (YYYY).

Family History: Lung cancer in his mother.

Social History: As on 12/20/YYYY, patient reports that he quit smoking about 20 years ago. His smoking use included cigarettes. He has a 5.00 pack – year smoking history. He has never used smokeless tobacco. He reports that he drinks about 3.3 standard drinks of alcohol per week (1/2 glass wine nightly).

Allergy: No known allergies.

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
(Summary of medical records prior to MVA injury. Only the musculoskeletal and prior injury conditions have been elaborated. Other medical conditions are presented briefly.)			
06/17/YYYY	Hospital/ Provider	**Visit for Blood pressure check:** **Assessment and plan:** Frequent blood pressure checks. Decrease weight. Decrease sodium in diet. Increase aerobic exercise. Recheck lipids and chemistry panel. General surgical referral for right inguinal hernia.	1
03/08/YYYY	Hospital/ Provider	**Visit for Cough and UTI:** **Assessment:** Urinary tract infection with cough, likely viral. **Plan:** Symptomatic therapy. Phenergan/Codeine 1 teaspoon every 4 hours as needed for cough. He will contact me should he develop fever or any worsening of symptoms.	1-2
10/28/YYYY	Hospital/ Provider	**Visit for Abdominal pain:** **Assessment:** Mild right abdominal pain. I suspect this is a viral syndrome. **Plan:** Check CBC, sedimentation rate. Check PSA. Increase water intake. Have a very light diet, Suggest check lipids, chemistry-7, ALT in the relatively near future. We will just do a dip urinalysis today. It is completely normal. Specific	2

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		gravity is 1.025. Also suggest the need for increased fluid intake. Patient has a long history of worry about a large number of things and he tends to somatize somewhat. He does have a long history of mild hyperlipidemia as well as a family history of heart disease so this needs to be monitored closely. He remains off alcohol except rarely and off cigarettes.	
03/11/YYYY	Hospital/ Provider	**Visit for Hyperlipidemia:** **Assessment:** Mild hyperlipidemia. We discussed family history. In fact, he originally had said his brother had had myocardial infarction. **Plan:** Recheck lipids and hepatic function panel in July 2005 with vigorous changes in diet, exercise, weight, between now and then.	3
03/29/YYYY	Hospital/ Provider	**Visit for Left Ear Pain:** **Assessment:** Mild left otitis externa. Remotely, he could have some infection in the tissue between the ear and the throat. His symptoms sound like a component of serous otitis or eustachian tube dysfunction as well, though I see no fluid and he has good TM mobility with pneumatic otoscopy. **Plan:** Reassured. He should avoid using Q-tips. Use the Cortisporin Otic suspension until symptoms resolve. Suggest Amoxicillin 500 mg thrice daily for 10 days to ensure resolution.	3-4
02/08/YYYY	Hospital/ Provider	**Visit for Suture removal:** Patient is a 56 year old male here for suture removal from left wrist laceration 10 days ago. Getting better but did have a little serous discharge yet. **Examination:** Well healed wound left radial wrist Sutures removed Sterri strips. Does have a small 2 mm erythematous papule on one end but no evidence of pus. **Assessment/Plan:** Wrist laceration healed. Questionable etiology of abdominal tenderness – doubt significance if more than 2 years and no change.	4-5
03/26/YYYY	Hospital/ Provider	**Visit for Back pain:** **Chief complaint:** Acute back pain, triggered by falling asleep in recliner 2 weeks ago. Woke up with back pain, radiating down side of leg. Using topical alternating ice and heat, saw the Chiropractor, still bothering him. Also had a massage yesterday, has used couple of Ibuprofen with meals, again not much improvement. Worse with getting in and out of car. Left toes are some numb, no tingling or weakness of extremities. No loss of bowel control. Works at post office, bends lifts repetitively. Uses abdominal binder. No history of bad surgeries, specific injury, no fever or other joint problems. History of chronic back pain, better for quite a few years. **Examination:** Back normal lordotic curve non-tender to palpation, no deformity, no lesions, no redness or swelling.	5-6

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		Range of motion: Flexion to knees only extension to 10 degrees, lateral flexion right normal, lateral flexion left normal and painful at endpoint. Heel gait normal. Toe gait normal. DTRs 2 plus patellar and Achilles bilaterally. Sensation and pedal pulses normal. Straight leg raises to 60 degrees bilaterally without pain. **Assessment:** Low back pain syndrome (primary encounter diagnosis) **Plan:** Ibuprofen 800 mg 1 tablet 3 times daily with food/meals for 5 days. Flexeril 10 mg 1 tablet at night time for back muscle spasms. Relative rest for 1-2 weeks, topical ice as directed, stretching exercises as directed, may add Tylenol Extra-Strength tablets, alternating with Ibuprofen if needed for pain control. Use abdominal binder for support and pain control. Use of muscle relaxant causes drowsiness, no driving or operating heavy equipment. Recheck in 2 weeks, X-ray and PT if not improvement.	
06/18/YYYY	Hospital/ Provider	**Visit for Stomach upset and Cough:** Patient presented with stomach upset and cough for 1 week. Stopped smoking 15 years ago. **Exam:** **HEENT:** PERLA, EOMI, TMs normal bilaterally, Nose normal exam, no sinus pain, throat enlarged exudative tonsils, anterior cervical nodes, supple NK. **Extremities:** Full ROM **Outpatient prescriptions:** Ibuprofen 800 mg 1 tablet 3 times daily with food/meals for 5 days. **Discontinue:** Flexeril 10 mg	7
11/21/YYYY	Hospital/ Provider	**Visit for UTI:** **Assessment/Plan:** • Urinary tract infection versus low grade prostatitis – latter more likely • Essential hypertension • Hyperlipidemia Patient to set up CPx. Anticipated natural history and potential duration of the condition was discussed. Patient instructed to follow-up if symptoms worsen or fail to improve as expected.	7-8
12/22/YYYY	Hospital/ Provider	**Visit for Low back pain:** Patient is a 57 year old male here with low back pain, especially left side, after lifting a case of bottled water. Hurt a little 5 days ago and was worse the next day. Had spasms and used heat and then it got worse. Pain mainly in left low back with mild pain into the left high initially. No numbness into the legs. **Examination:**	8-9

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		Slight tender left low back with no deformity. ROM mildly limited by pain in paraspinous muscles. No spasm now. SLR negative at 60° bilaterally. Neuro intact. **Assessment:** Low back pain syndrome **Plan:** Light activity. No lifting (so no work) until healed. Return to work 12/29/YYYY.	
02/06/YYYY	Hospital/ Provider	**Visit for Right thigh pain:** Patient is a 57 year old male here with pain right thigh for about 2 months. Patient was in yard and almost twisted ankle and in attempt to prevent fall patient put sudden weight on right leg in a squat position and felt immediate pain right thigh. Iced it for a couple days and seemed to get a little better and soreness resolved. Patient with mild soreness but notes a defect in right anterior thigh. **Objective:** Patient with obvious large (approximately 2.5x4x1 inch) bulge of soft tissue proximal mid ant thigh with some defect central mid thigh and small amount extra swelling above knee in middle of distal thigh. No tenderness. No ecchymosis. Good strength. **Assessment/Plan:** Pain in limb (primary encounter diagnosis)-suspect partial quadriceps rupture/? rectus femoris or vastus intermedius **Plan:** Discussed with patient and then with Dr. Bergeson who will see patient in consultation. Anticipated natural history and potential duration of the condition was discussed. Patient instructed to follow-up if symptoms worsen or fail to improve as expected.	9-10
03/03/YYYY	Hospital/ Provider	**Visit for Right thigh pain:** Patient is a 58 year old male was seen at the request of Dr. Lee with the chief complaint of right thigh pain for about 2 months. Patient was in yard and almost twisted ankle and in attempt to prevent fall patient put sudden weight on right leg in a squat position and felt immediate pain right thigh. Iced it for a couple days and seemed to get a little better and soreness resolved. Patient with mild soreness but notes a defect in right anterior thigh. He is complaining of a knot in the anterior thigh by compartment. **Examination:** The right thigh is non-tender over the anterior compartment of the thigh. There is a palpable bump mid thigh. There is no significant defect at the quadriceps tendon. Scars are not present. Circulatory, motor and sensory exam is intact of the reminder of the lower extremity. The contralateral knee exhibits full ROM with good quadriceps and hamstring strength. There is no instability of the knee, no effusion, and CMS is intact of the contralateral lower leg.	10-12

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		X-ray of right knee: Bony mineralization is normal. No fracture or acute osseous abnormality is evident. Hip joint is well maintained. Very minor osteophyte formation is seen at the level of the knee. **Impression:** Right knee pain rectus femoris rupture **Plan:** Patient has normal range of motion and strength in the presence of a rectus femoris tendon rupture. Conservative versus surgical treatments were discussed in detail. Because of the chronicity of his injury and his ability to bear weight and function without difficulty or limitation. I recommended conservative treatment the observed at this time. If he should have increased weakness with pain in the anterior thigh compartment will revisit options for surgical treatment.	
04/24/YYYY	Hospital/ Provider	**Visit for Right thigh pain:** Patient is here for evaluation of his right thigh. She describes no increase in pain or discomfort. He is concerned that he might injure his leg with activity. **Objective:** Examination right thigh shows he is out we'll deformity of the rectus femoris. There is no noticeable weakness with extension comparing with the contralateral limb. He does have mildly positive patellar grind test. He is neurovascularly intact distally capillary refill is less than 3 seconds. **Impression:** Rectus femoris avulsion. Patellofemoral chondromalacia **Plan:** Patient may resume his activities keeping in mind that it will take some time to regain full strength of his right leg. Will have him follow up on as-needed basis.	12
09/25/YYYY	Hospital/ Provider	**Visit for Testicular pain:** **Assessment/Plan:** Orchitis/Epididymitis (primary encounter diagnosis) versus primary testicular mass **Plan:** Call with ultrasound. May also need scan and Urology consult.	12-13
10/27/YYYY	Hospital/ Provider	**Visit for Testicular pain:** **Assessment/Plan:** Orchitis/Epididymitis (primary encounter diagnosis) – Resolved Skin – Looks good.	14
01/05/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** Dysuria (primary encounter diagnosis) – Prostatitis Urinary frequency Erectile dysfunction – Options discussed	15-16
09/09/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:**	16-17

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		Dysuria (primary encounter diagnosis) – probable mild prostatis again Due for recheck of lipids.	
09/30/YYYY	Hospital/ Provider	**Visit for Hyperlipidemia:** **Assessment:** • Hyperlipidemia • Impaired fasting glucose **Plan:** Diet discussed at length. Needs to get better aerobic exercise.	17-18
01/11/YYYY	Hospital/ Provider	**Visit for Prostatitis:** **Assessment:** • Prostatitis – recurrent • Nonspecific urethritis (primary encounter diagnosis) • Dysuria **Plan:** Encourage more fluids, less caffeine. Take longer course of Doxycycline which has been effective in the past.	18-19
05/17/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** Dysuria (primary encounter diagnosis) – This time patient has evidence of prostatitis. Long discussion with patient. He is quite anxious. Umbilical hernia – Discussed patient is asymptomatic. Some weight loss recommended. Reassured patient that, although his recurrent symptoms are very annoying, they are not serious or dangerous. Offered Urologic referral if symptoms do not improve.	19-21
08/23/YYYY	Hospital/ Provider	**Visit for Right thigh pain:** Patient is a 60 year old male here with persistent trouble with intermittent Charley horse like pain in proximal anterior thigh since rectus femoris rupture approximately 3/2 years ago (was seen 02/06/YYYY with symptoms for 2 months at that time). Patient notes occasional soreness right quadrant area. Patient has right foot bunion and will have upcoming surgery for that and wonders if something needs to be done to the thigh if it could be done around the same time. Activity is also limited by the right foot evertor tendon. Patient does some stretching but no strengthening. **Objective:** Patient still with palpable defect mid anterior thigh slightly more distally and then a soft tissue prominence proximal to that suggestive of partial rectus femoris rupture. Patient has good overall quadrant strength and is able to do a deep squat and get up with power from either leg alone. Good leg extension strength.	21-22

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		Assessment/Plan: Pain in limb (primary encounter diagnosis) – status post 2½ year old rupture of part of rectus femoris. Discussed with patient. He really has no functional loss and I do not believe the risks of surgery are worth the ltd benefit he might achieve from surgery (if any). Ortho referral offered.	
09/19/YYYY	Hospital/ Provider	**Visit for Pre operative medical clearance:** Patient is a 60 year old male here for preoperative medical clearance for upcoming bunion surgery right foot (bunion and tendon problem). Discussed foot pain which is quite limiting. Patient is medically clear for surgery. **Assessment/Plan:** • Preoperative cardiovascular exam (primary encounter diagnosis) • Pain in limb • Elevated blood pressure without hypertension • LBBB discussed	22-23
11/16/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** • Dysuria (primary encounter diagnosis) – Prostatitis • Essential hypertension – Patient should monitor home BPs • Anxiety	23-24
02/16/YYYY	Hospital/ Provider	**Visit for Hypertension:** **Assessment:** Essential hypertension (primary encounter diagnosis) **Plan:** Comprehensive Metabolic Panel with GFR Lipid profile Urinalysis, macro with micro if indicated Lisinopril 10 mg Take 1 tablet by mouth daily.	25
03/16/YYYY	Hospital/ Provider	**Visit for Low back pain:** Patient is a 61 year old male who presents for low back pain. Started having left sided back pain about 3-4 days ago. Had done some lifting of water containers the day before. Getting worse No radiation of pain, No numbness or tingling. No bowel or bladder changes. Feels like a spasm. Transition seem to cause more pain. Walking okay. Norco 10/325 helped a little. Unclear if Motrin helping. Has seen chiropractor a few times which helps momentarily. Had similar 15 years ago. Muscle relaxers worked well then and would like to try some now. **Examination:** **Musculoskeletal:** Back is without rash, some decreased lordosis, he is tender	26-27

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		over the left greater than right paraspinal region, non-tender over the lumbar spinal processes, straight leg test negative, flexion very limited. **Assessment and plan:** Backache (primary encounter diagnosis) Comment: Acute pain/spasm Walking as tolerated, increase fluids. Watch Motrin use. Will do some Flexeril. Follow up if worse or changing. Plan: Cyclobenzaprine (Flexeril) 10mg	
04/17/YYYY	Hospital/ Provider	**Visit for Dysuria and Shoulder pain:** Patient is a 61 year old male here with recurrent dysuria and for follow-up on BP. Patient did note a little soreness in the low back. Patient also mentions soreness in the left shoulder for perhaps 6 months. No injury. Does home exercise program with light weight (5 lbs Barbells) including overhead lifting. Discussed need to avoid impingement. **Objective:** **Left Shoulder:** ROM good, normal exam except minor pain with FROM and resisted abduction. **Assessment/Plan:** • Dysuria (primary encounter diagnosis) • Prostatitis • Anxiety • Shoulder pain	27-28
10/24/YYYY	Hospital/ Provider	**Visit for Shoulder pain:** Patient also with some shoulder pain since last here. Left side problems now for about a year. Has avoided overhead exercise. Can't sleep on the left side as it wakes him up. Adequate ROM but with some pain. Patient occasionally uses Tylenol or Ibuprofen (infrequent). **Objective:** Pain with range of motion of the left shoulder at >90 abduction with motion overall is good some pain with internal rotation. Strength OK. Positive speed test. Mildly tender bicipital groove, no crepitus, no apprehension, no subacromial tenderness. Strength and sensation normal. **Assessment/Plan:** • Pain in limb – possible left biceps tendonitis • Abdominal pain, other specified site – suspect viral • Need for prophylactic vaccination and inoculation against influenza	28-29

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		Plan: Lose weight.	
01/09/YYYY	Hospital/ Provider	**Visit for Left Shoulder pain:** Patient is a 61 year old male was seen at the request of Dr. Gerry Lee with the chief complaint of left shoulder pain. Patient is right hand dominant. The pain is located in the anterior region. It does radiate to the trapezius and periscapular, upper arm region. The severity of the pain is 8 out of 10. Patient is employed as a mailman for the last 35 years. He has difficulty with his job specifically when he has to lift anything about waist height. He's had no Physical Therapy nor has he had any horizontal injections. His pain began about one year ago. Cannot recall any trauma or injury. Symptoms have worsened in recent 5 months. **Physical examination:** The left shoulder is tender over the supraspinatus and AC joint. There are no palpable masses over the shoulder girdle. There is acromioclavicular crepitus. Positive cross arm test. Testing for impingement: Positive for O'Brien's test, positive Hawkin's test. Testing the biceps: Negative Yergason's test, negative Speed's test. Rotator cuff: Positive drop sign. Shoulder ROM in degrees for forward elevation 90, abduction 75, external rotation 40, internal rotation L1, extension 25. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. Skin is warm without erythema. Scars are not present. The remainder of the CMS is intact of the upper extremity. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. **X-rays of Left Shoulder:** No fracture, dislocation or bony destructive lesion is seen. Acromioclavicular degenerative disease with downward pointing osteophyte. Small focal area of calcific tendinitis superimposed with the humeral head on the external rotation view but evidently distinct from it at internal rotation partly. **Impression:** • Left shoulder pain, rule out internal derangement • Left shoulder impingement syndrome with calcific tendinitis • Moderate acromioclavicular arthritis **Plan:** After discussion of diagnoses, therapy options, it was elected to proceed with an MRI of the shoulder to rule out internal derangement. The procedure was discussed and the patient will be scheduled and return for further evaluation. In the meantime patient may continue his activity as tolerated letting pain be his guide.	30-31
02/07/YYYY	Hospital/ Provider	**Visit for Left Shoulder pain:** Patient is a 61 year old male was seen at the request of Dr. Gerry Lee with the chief complaint of left shoulder pain. Patient is right hand dominant. The pain is located in the anterior region. It does radiate to the trapezius and periscapular, upper arm region. The severity of the pain is 8 out of 10. Patient is employed as a	32-34

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		mailman for the last 35 years. He has difficulty with his job specifically when he has to lift anything about waist height. He's had no Physical Therapy nor has he had any Cortisone injections. His pain began about one year ago. Cannot recall any trauma or injury. Symptoms have worsened in recent 5 months. Patient is here for review of MRI results and to evaluate his left shoulder. There has been no interval change in his pain or discomfort. **Physical examination:** The left shoulder is tender over the supraspinatus and AC joint. There are no palpable masses over the shoulder girdle. There is acromioclavicular creptus. Positive cross arm test. Testing for impingement: Positive O'Brien's test, positive Hawkin's test. Testing the biceps: Negative Yergason's test, negative Speed's test. Rotator cuff: Positive drop sign. Shoulder ROM in degrees for forward elevation 90, abduction 75, external rotation 40, internal rotation L1, extension 25. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. Skin is warm without erythema. Scars are not present. The remainder of the CMS is intact of the upper extremity. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. **X-ray of Left Shoulder:** No fracture, dislocation or bony destructive lesion is seen. Acromioclavicular degenerative disease with downward pointing osteophyte. Small focal area of calcific tendinitis superimposed with the humeral head on the external rotation view but evidently distinct from it at internal rotation partly. **MRI of Left Shoulder:** Degenerative labral tear with biceps tendinosis. Partial tearing of supraspinatus at interval. *(*Comment: The above mentioned X-ray and MRI reports of Left Shoulder are not available.)* **Impression:** • Left shoulder pain degenerative labral tear with biceps tendinosis and partial rotator cuff tear • Left shoulder impingement syndrome with calcific tendinitis • Moderate acromioclavicular arthritis **Plan:** Lengthy discussion was had with patient regarding conservative versus surgical treatment for his symptomatic shoulder pain given that he has little improvement in his symptomatic shoulder pain. There is pathology identified on the MRI. Recommendation is for left shoulder arthroscopy with subacromial decompression, distal clavicle excision, mini open biceps tenodesis with rotator cuff repair. He agreed with this treatment plan and was consented for the procedure. The risks of the procedure were explained to him in detail which include but are not limited to incomplete resolution of pain, injury to adjacent neurovascular structures, deep venous thrombosis, pulmonary embolism and	

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		possible respiratory failure. He understood these risks and wished to proceed.	
02/25/YYYY	Hospital/ Provider	**Visit for Preoperative examination:** **Assessment/Plan:** Pre-operative cardiovascular examination (primary encounter diagnosis) Acute upper respiratory infections of unspecified site--viral	34-35
04/01/YYYY	Hospital/ Provider	**Visit for Cough:** **Assessment/Plan:** Cough (primary encounter diagnosis) – Right lower lobe pneumonia	35-36
04/10/YYYY	Hospital/ Provider	**Visit for Pneumonia:** **Assessment/Plan:** Pneumonia, organism unspecified (primary encounter diagnosis) – resolved clinically	36-37
04/16/YYYY	Hospital/ Provider	**Visit for Left Shoulder pain:** Patient with the chief complaint of left shoulder pain. He is right hand dominant. The pain is located in the anterior region. It does radiate to the trapezius and periscapular, upper arm region. The severity of the pain is 8 out of 10. He is employed as a mailman for the last 35 years. He has difficulty with his job specifically when he has to lift anything above waist height. He's had no physical therapy nor has he had any Cortisone injections. His pain began about one year ago. Cannot recall any trauma or injury. Symptoms have worsened in recent 5 months. Patient is here for evaluation of the shoulder as well as to review questions he may have regarding surgery. There has been no interval change in his pain or discomfort. **Physical exam:** The left shoulder is tender over the supraspinatus and AC joint. There are no palpable masses over the shoulder girdle. There is acromioclavicular creptus. Positive cross arm test. Testing for impingement: Positive O'Brion's test, positive Hawkin's test. Testing the biceps: Negative Yergason's test, negative Speed's test. Rotator cuff: Positive drop sign. Shoulder ROM in degrees for forward elevation 90, abduction 75, external rotation 40, internal rotation L1, extension 25. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. *X-ray of Left Shoulder reviewed.* *MRI of Left Shoulder reviewed.* **Impression:** • Left shoulder pain degenerative labral tear with biceps tendinosis and partial rotator cuff tear • Left shoulder impingement syndrome with calcific tendinitis	37-39

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		• Moderate acromioclavicular arthritis **Plan:** Patient is scheduled for left shoulder arthroscopy with subacromial decompression, distal clavicle excision, mini open biceps tenodesis with rotator cuff repair. He agreed with this treatment plan and was consented for the procedure.	
05/08/YYYY	Hospital/ Provider	**Post operative visit for Left Shoulder surgery:** Patient is here for evaluation of the left shoulder. He is now 2 weeks out from left shoulder arthroscopic subacromially decompression and distal clavicle excision with mini open biceps tenodesis. Presents to the office today wearing postoperative sling and currently has mild to moderate pain controlled with oral medication. *(*Comment: The operative report for left shoulder arthroscopy with subacromial decompression, distal clavicle excision, mini open biceps tenodesis with rotator cuff repair is not available for review.)* **Objective:** Examination of the shoulder shows that the wound incisions are healing nicely. There is no evidence of infection. He is neurosensory intact distally capillary refill less than 3 seconds. The sutures removed in the office today. Motion of the elbow is uninhibited. **Impression:** Status post left shoulder arthroscopy with subacromial decompression, distal clavicle excision and mini open biceps tenodesis. **Plan:** Patient will begin outpatient physical therapy for passive range of motion. Postoperative wound care instructions as well as activity limitations and restrictions were discussed in detail. Return follow-up in 4 weeks for reevaluation.	40
06/06/YYYY	Hospital/ Provider	**Post operative visit for Left Shoulder pain:** Patient is here for evaluation of the left shoulder. He is now 6 weeks out from left shoulder arthroscopic subacromially decompression and distal clavicle excision with mini open biceps tenodesis. Making improvement with range of motion. Currently participating in outpatient physical therapy. **Objective:** Examination of the shoulder shows that the surgical incisions have healed completely. There is no evidence of infection. He is neurosensory intact distally capillary refill less than 3 seconds. Forward elevation 90° abduction 70° external rotation 40° internal rotation to L1. Motion of the elbow is uninhibited. **Impression:** Status post left shoulder arthroscopy with subacromial decompression, distal clavicle excision and mini open biceps tenodesis. **Plan:** He will continue with outpatient physical therapy focusing on range of motion. Stretching exercises were reviewed today in the office. Return follow-up in 6 weeks for reevaluation.	40

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06/11/YYYY	Hospital/ Provider	**Visit for UTI:** **Assessment:** Urinary tract infection **Plan:** Referral to Urology Planned urinalysis. Ciprofloxacin 500 mg twice daily.	41
07/12/YYYY	Hospital/ Provider	**Visit for skin rashes:** **Assessment/Plan:** • Rash and other nonspecific skin eruption (primary encounter diagnosis) • Contact dermatitis and other eczema due to plants (except food)	41-42
07/22/YYYY	Hospital/ Provider	**Follow-up visit for Left Shoulder pain:** Patient is here for evaluation of the left shoulder. He is now just under 12 weeks out from left shoulder arthroscopic subacromially decompression and distal clavicle excision with mini open biceps tenodesis and RCR. Making improvement with range of motion. Currently participating in outpatient physical therapy. His most recent therapy note state IR to T12, he is not currently this far around. His FF and IR continue to frustrate him, he notes gradual improvement in both since last visit. No longer taking oral medications for pain. He works in the Auburn Post office, feels he could perform approx 60-70% of his typical job With the exception of heavy/large parcel handling. Has additional PT visits upcoming. Examination of the shoulder shows that the surgical incisions have healed completely. There is no evidence of infection. He is neurosensory intact distally capillary refill less than 3 seconds. Forward elevation 90° abduction 85° external rotation 50° internal rotation to L1, Extension: 40°. Deltoid/biceps/triceps intact. End ROM is tight consistent with capsular adhesions. Motion of the elbow is uninhibited. FROM of the hand/wrist/digits. **Impression:** Status post left shoulder arthroscopy with subacromial decompression, distal clavicle excision and mini open biceps tenodesis. **Plan:** Patient will continue with outpatient physical therapy and daily HEP focusing on range of motion. Stretching exercises were reviewed today in the office. Return follow-up in 6 weeks for reevaluation. Off work for 4weeks. Discussed return to work at that point if he has made adequate progress with PT. Discussed avoidance of repetitive over shoulder and heavy lifting.	42-44
09/06/YYYY	Hospital/ Provider	**Visit for Rashes:** **Assessment/Plan:** Rash and other nonspecific skin eruption (primary encounter diagnosis) Stop deodorant. Use Nystatin topically and then use Lidex after each treatment.	44-45

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
11/21/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** Dysuria (primary encounter diagnosis)-etiology unclear but patient may have low grade prostatitis Difficult or painful urination Abdominal pain, other specified site Anxiety – Discussed with patient In view of possible prostatitis will initiate treatment now. Discussed Urology referral if he wishes.	45-47
11/27/YYYY	Hospital/ Provider	**Visit for Right Shoulder pain:** Patient was seen at the request of Dr. Gerry Lee with the chief complaint of right shoulder pain. The pain is located in the anterior region. It does radiate to the trapezius and periscapular, upper arm region. The severity of the pain is 3 out of 10 activity. The pain is non related to work and is non related to a motor vehicle accident. He works as a mail carrier and has difficulty lifting anything of weight. Previous left shoulder arthroscopy in April 2013. Doing well postoperatively. **Examination:** The right shoulder is tender over the supraspinatus. There are no palpable masses over the shoulder girdle. There is no acromio-clavicular creptus. Negative cross arm test. Testing for impingement: Positive O'Brien's test, positive Hawkin's test. Testing the biceps: Negative Yergason's test, negative Speed's test. Rotator cuff: Negative drop sign. Shoulder ROM in degrees for forward elevation 160, abduction 150, external rotation 45, internal rotation L1, extension 25. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. Skin is warm without erythema. Scars are not present. The remainder of the CMS is intact of the upper extremity. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. **Impression:** Right shoulder pain bursitis versus tendinitis **Plan:** Recommend as both diagnostic and treatment for persistent shoulder pain. He agreed with plan and wished to proceed with injection of the right shoulder having received and signed or verbally given a full informed consent for this procedure. He understood the risks, benefits, and advantages of the procedure and wishes to proceed. **<u>Intra-articular Steroid injection:</u>** A small wheal of 3 ml 2% plain Xylocaine was made in the skin at the injection site. A syringe with an 22 gauge 1.5 inch needle was used to enter the joint space. The joint was injected with Dexamethasone 4 mg/ml and 5 cc of 0.25% Marcaine. Patient tolerated the procedure well and there were no complications. Range of motion of the joint resulted in some relief of pain. Follow-up in 4 months for recheck.	47-49

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
06/11/YYYY	Hospital/ Provider	**Follow-up visit for right shoulder pain:** Patient is here for follow-up evaluation of his right shoulder. He did receive a cortisone injection at the last office visit. States his shoulder pain has resolved. Currently works full time for the post office without disability or limitation. **Physical examination:** The right shoulder is tender over the supraspinatus. There are no palpable masses over the shoulder girdle. There is no acromio-clavicular creptus. Negative cross arm test. Testing for impingement: Negative O'Brion's test, Negative Hawkin's test. Testing the biceps: Negative Yergason's test, Negative Speed's test. Rotator cuff: Negative drop sign. Shoulder ROM in degrees for forward elevation 160, abduction 150, external rotation 45, internal rotation L1, extension 25. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. **Impression:** Right shoulder pain bursitis improved **Plan:** May continue his activity as tolerated without limitation restriction. Follow-up as needed.	49-51
07/30/YYYY	Hospital/ Provider	**Visit for Low back pain:** Patient is a 63 year old male here with complaints of: Low back pain His back was bothering him a week or two in the middle part of the back on both sides. Now it is resolved there and is more in the lower back. Work has been busy (works at the post office), but "I didn't file anything like that" Working overtime He did some lifting of boxes at home in the garage, moving stuff around. Is sore the lower part of the spine and the Lumbar muscles mostly, but sore all over. There are "3 vertebrae in there" that are really sore. It feels like it is "Inflamed" at the lower part of the spine, it goes all the way across. Thinks the pain has gotten a little bit better, but he needs some back rest. He is requesting a letter off work. He has been off Monday and Tuesday; He has today off, but is supposed to work Thurs, Fri and Sat. Then he would be back to work on Monday. He has had this same symptom before, takes usually a week to heal, but it will resolve completely in the interim. He attributes the pain coming from a lack of exercise for the last month and a half because he had messedup his Achilles tendon, then restarting again. He is going to go to the gym and a personal trainer. Aggravating factors is twisting movements, and the way he lays on his back: Left side and lower part of the spine. Ibuprofen has helped, and icing has helped it. Icing 3 times per day, 10-15 minutes at a time. Tried Ibuprofen 400-600mg four times per day -it is "hard on his stomach". He has been icing since Monday or Tuesday. He has been resting at home, too. This time it feels like it is taking longer to heal than when he has had this in the past. The pain is not better or	51-55

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		worse after sitting down. He feels better to lay down. Pain rated 5/10, described as aching pain Midline versus paravertebral? All across low back Sharp or aching? Ache Night pain? Only he turns over onto the left **Physical examination:** **Low back:** There is pain to palpation across the lower back/sacral area and pen-spinal musculature. There is no deformity, erythema, edema, or ecchymosis. The range of motion is decreased for L lateral flexion, and decreased extension. Straight leg raise is negative bilateral (feels pulling pain in back of thighs at 70 degrees; no back pain, paresthesias or radicular pain). Muscle strength of the bilateral lower extremities is 5/5. **Assessment/Plan:** Backache, unspecified Low back strain Cyclobenzaprine (Flexeril) 10mg three times daily as needed. Referral To Physical Therapy Ibuprofen (Motrin) 800mg three times daily with food. Essential hypertension: Comp Metabolic Panel with GFR; Future Lumbago Ibuprofen (Motrin) 800mg three times daily with food.	
11/06/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Examination:** **Extremities** – No edema. Patient has trace tenderness of right Achilles tendon with no defect. **Assessment/Plan:** Dysuria (primary encounter diagnosis) Umbilical hernia – symptomatic Achilles tendonitis-mild, right – Rehab discussed Hypertension – Doing great	55-56
11/20/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** Dysuria (primary encounter diagnosis) Abdominal pain, other specified site Umbilical hernia Questionable NSU or psychological dysuria. Declines Urologic referral.	56-57
01/06/YYYY	Hospital/ Provider	**Pre operative medical clearance visit:** Patient here for preoperative EKG and medical clearance for upcoming umbilical	57-59

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		hernia repair scheduled tomorrow. Also bothered by left elbow pain for the past month or more (? two). Does recall hitting the elbow on a latch at work. Does wear tennis elbow band. Does some stretching, ice has not helped. Taking limited Ibuprofen. **Examination:** Mildly tender lateral epicondyle. FROM mild pain with full extension and with resisted supination and grip. **Assessment/Plan:** Pre-operative cardiovascular examination (primary encounter diagnosis) EKG shows LBBB as before. Patient is medically clear for surgery. Lateral epicondylitis left elbow	
04/01/YYYY	Hospital/ Provider	**Visit for Hypertension and Neck pain:** Patient is noting some tightness in his posterior neck. **Exam:** Neck: Mild paracervical tender. **Assessment/Plan:** Essential hypertension (primary encounter diagnosis) well controlled. Plan: Comprehensive Metabolic Panel CBC with automated differential Floaters – Follow-up with his Ophthalmolgoist. Cervicalgia mild, muscular – Offered PT if persists.	60-61
04/02/YYYY	Hospital/ Provider	**Visit for ear pain:** **Examination:** **Musculoskeletal:** Mild pain with palpation of the left TMJ. Some crepitus with opening/closing of jaw. **Assessment/Plan:** TMJ arthralgia (primary encounter diagnosis), left side. Start wearing mouth guard daily. Take the Ibuprofen 600 mg every 8 hours for 7 days. Follow up with PCP if symptoms don't improve.	61-63
11/25/YYYY	Hospital/ Provider	**Visit for Dysuria:** **Assessment/Plan:** Dysuria (primary encounter diagnosis) – Also symptoms of decreased stream, nocturia Abdominal pain, unspecified abdominal location Actinic keratoses Abdominal pain, unspecified site Polyuria	63-65

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Check fasting labs and get more exercise, drink more water earlier in the day. Patient recalled trying samples of Flomax for about a week or so but does not recall if it helped.	
11/21/YYYY	Hospital/ Provider	**Visit for nonspecific urethritis:** **Assessment/Plan:** NSU (Nonspecific Urethritis) Discussed with Dr. Licata. Several similar episodes in the past, last seen for similar symptoms by Dr. Lee on 11/25/YYYY. Ordered urinalysis, urine culture Doxycycline 100 mg twice daily for 10 days. 12/05/YYYY: Repeated Doxycycline 100 mg twice daily for 10 days. Tender prostate Mild prostate tenderness on exam. CBC with differential PSA Total; Future Urine culture; Future	65-67
02/16/YYYY	Hospital/ Provider	**Visit for Annual physical examination:** Patient with arm pain – Right upper arm sore muscle. Complains of pain in lateral right shoulder and upper arm for 1 month. Feels like muscle pain. Using heat, then stretches, then ice which has improved but not resolved symptoms. History of bursitis in that shoulder that required corticosteroid injection. Dr Bergeson did surgery on the left shoulder and is requesting referral back to him. Not taking anything for pain now. **Exam:** **Musculoskeletal:** Right shoulder with normal ROM, tenderness in area of subacromial bursa. **Assessment/Plan:** Right shoulder pain, unspecified chronicity – Suspect subacromial bursitis. Recommended short course of OTC NSAIDs, stretches/exercises. Discussed Corticosteroid injection if pain is not improving. Essential hypertension Hyperlipidemia, unspecified hyperlipidemia type Chronic urethritis Chronic prostatitis Eustachian tube dysfunction, left Solar lentigo Elevated fasting glucose Former tobacco use Screening for malignant neoplasm of colon Screening for endocrine, nutritional, metabolic and immunity disorder Need for pneumococcal vaccination Need for hepatitis C screening test	67-70

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
04/25/YYYY	Hospital/ Provider	**Visit for prostatitis:** **Impression/Plan:** Chronic prostatitis (primary encounter diagnosis) Try adding Finasteride 5 mg to the Flomax 0.4 mg daily. Reevaluation in 3 months. Ordered urinalysis, urine culture. Abnormal urine Possible hematuria workup with cystoscopy if positive.	70-73
09/18/YYYY	Hospital/ Provider	**Visit for Dysuria and Proteinuria:** **Assessment/Plan:** Dysuria This is most likely a recurrence of chronic prostatitis. Do Sitz baths 20-30 minutes at least daily while symptoms persist Use Ibuprofen 400 – 600 mg up to every 6 hours Ordered urinalysis Proteinuria, unspecified type On urine dip. Microalbumin/Creatinine ratio Periumbilical abdominal tenderness without rebound tenderness No sign of hernia or other pathology at this time If this worsens or persists, it can be evaluated further with ultrasound. Screening colonoscopy is scheduled in 4 days Viral URI with cough This has nearly completely resolved.	73-76
03/09/YYYY	Hospital/ Provider	**Visit for annual Physical examination:** **Shoulder** – Patient notes chronic persistent right anterior shoulder pain as well as a posterior pack. Notes no problems with some weakness or numbness distally but does have some tenderness to palpation over his right elbow on occasion. That is usually worse when turning to grip something. Both of these are achy in nature but not limiting his range of motion. No distal weakness or numbness. No known injury. **Assessment:** • Essential hypertension (primary encounter diagnosis) • Hyperlipidemia, unspecified hyperlipidemia type • Chronic right shoulder pain • Lateral epicondylitis of right elbow • Left bundle branch block (LBBB) • Acromioclavicular joint arthritis • Solar lentigo	76-80

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: New orders ordered on this visit: X-ray of shoulder 2 or more views, right Referral to Orthopedics CBC with automated differential Comprehensive metabolic panel with GFR Lipid profile Microalbumin/Creatinine Ratio urine, random Thyroid Screen (TSH) with reflex Free T4	
03/09/YYYY	Hospital/ Provider	**X-ray of Right Shoulder:** **Clinical indication:** Right shoulder pain and AC joint. **Findings:** Marginal spurring noted along the acromioclavicular and glenohumeral articulations. Small 1 mm soft tissue calcification noted near the coracoid process. Subcortical lucency noted in the right humeral head. No dislocations **Impression:** Right acromioclavicular and glenohumeral joint degenerative changes. 1 mm dystrophic calcification versus tiny avulsion near the coracoid process.	81
04/04/YYYY	Hospital/ Provider	**Visit for Right Shoulder pain:** Patient is a 67 year old male was seen at the request of Dr. Oglivie with the chief complaint of right shoulder pain. His right shoulder pain is intermittent and can get up to a pin level of 4/10. The pain is located on the top of the shoulder that radiates down the bicep. He has pain with reaching behind his back and across his chest. He takes Ibuprofen 400 mg for pain and discomfort. He has no prior history surgery on the right shoulder, Physical Therapy or Cortisone injections. **Examination:** The right shoulder is tender over the supraspinatus. There are no palpable masses over the shoulder girdle. There is acromioclavicular crepitus. Positive cross arm test. Testing for impingement: Positive O'Brien's test. Positive Hawkin's test. Testing the biceps: Positive Yergason's test, Positive Speed's test. Rotator cuff: Negative drop sign. Shoulder ROM in degrees for forward elevation 170, abduction 160, external rotation 70, internal rotation T12, extension 20. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. *X-ray of right shoulder reviewed.* **Impression:** • Right shoulder impingement • Right shoulder moderate AC osteoarthritis	82-84

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: Recommend Cortisone injection as both diagnostic and treatment for persistent shoulder pain. Patient agreed with plan and wished to proceed with injection of the right shoulder having received and signed or verbally given a full informed consent for this procedure. He understood the risks, benefits, and advantages of the procedure and wishes to proceed. **Intra-Articular Steroid injection:** The right shoulder was prepped with Betadine and the injection site was wiped clean with an alcohol swab. A small wheal of 3ml 2% plain Xylocaine was made in the skin at the injection site. A syringe with a 22 gauge 1.5 inch needle was used to enter the joint space. The joint was injected with Betamethasone 6 mg/ml and 5 cc of 0.25% Marcaine. The needle and syringe were then withdrawn. Range of motion of the joint resulted in some relief of pain. If pain does not improve with cortisone injection. He will call the office and I will order and MRI.	
06/11/YYYY	Hospital/ Provider	**Visit for Anemia:** **Assessment:** Macrocytic anemia (primary encounter diagnosis) Essential hypertension, benign – At goal BPH with obstruction/lower urinary tract symptoms – Controlled on medications **Plan:** New orders ordered on this visit: CBC with automated differential Comprehensive metabolic panel with GFR Vitamin B12 Folate (Folic Acid) Electrophoresis protein with reflex	84-88
01/16/YYYY	Hospital/ Provider	**Visit for annual physical examination:** **Assessment/Plan:** Difficult or painful urination Dysuria Urinalysis is normal. Patient with prior history of prostatitis. States he has tremendous pressure at the tip of his penis when he has to urinate. No pain with urination. Exam is normal – No redness, swelling or discharge from penis. Will start antibiotics empirically but patient understands that antibiotics may not be helpful if no infection is present. Ordered urinalysis Referral to Urology Ciprofloxacin 500mg every 12 hours for 7 days Annual physical exam Has upcoming appointment with Dr. Ogilvie. Would like to have labs done before visit.	89-91

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Last PSA was 2 years ago. Ordered Lipid profile CBC with automated differential Comprehensive metabolic panel PSA, Prostate Specific Antigen Vitamin B12: Future Toenail fungus Right great toe has a hole in upper middle nail. Some separation of nail from bed. Slightly tender with downward pressure. Discussed fungus and treatment options. Patient would like to discuss removal of nail with Dr. Ogilvie.	
03/28/YYYY	Hospital/ Provider	**Visit for left thumb pain:** **Chief complaint:** Patient presents with: Thumb pain: Left thumb one month Back pain: Right side muscle pain Thumb – 1 month of pain. Notes was working hard and felt something but kept working. Pain since. No swelling no weakness or numbness. Back – Pinched something last week and awoke/ stiff. Limits mobility. **Examination:** Chest: Tenderness to palpation over the 10-12 ribs, no skin changes. Extremities: Tenderness to palpation over the CMC and mild arthritis. **Assessment:** • Pain of left thumb (primary encounter diagnosis) • Acute right-sided low back pain without sciatica **Plan:** New orders ordered on this visit: X-ray finger specify digits left 2 or more views Referral to Surgery Hand Splints, all types DME X-ray ribs right with Chest PA 3 views **Prescription:** Meloxicam (Mobic) 15 mg. **Discussion:** Routine review of concerns, findings and pathophysiology. Splint Trial of Mobic. X-rays. Hand referral. Work note. Consider further management as indicated. **Follow-up:** Recheck in 2 weeks, sooner should new symptoms or problems arise.	91-94
03/28/YYYY	Hospital/	**X-ray of Right Ribs with Chest:**	95

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider	**Clinical indication:** Right 10-12 rib pain. **Findings:** **Lungs and pleura:** There is no evidence of airspace disease. The pulmonary vasculature is unremarkable. There is no pleural effusion. There is no pneumothorax. Interstitial prominence again noted. **Mediastinum and hila:** Heart is not enlarged. Remaining mediastinal and hilar structures are unremarkable. The trachea is midline. **Bones and soft tissues:** The visualized bones are grossly unremarkable. Soft tissues are within normal limits. Plate in the proximal left humerus. No acute displaced rib fracture. **Impression:** No evidence of acute cardiopulmonary process. No acute displaced rib fracture.	
03/28/YYYY	Hospital/ Provider	**X-ray of Left Thumb finger:** **Clinical indication:** Pain of left thumb. **Findings:** **Bones:** No distinct acute displaced fractures identified. 2 mm calcification is seen projecting at the lateral aspect of the first IP joint, which is nonspecific and might represent sequel of remote trauma, dystrophic capsuloligamentous calcification or ununited articular marginal osteophyte, as incidental finding. **Joints:** Articular alignment is anatomic. Mild to moderate degenerative changes of the first IP joint and moderate to severe degenerative changes of the first CMC joint are seen. **Soft tissues:** No significant soft tissue abnormality is seen. **Impression:** No definite acute injury. Moderate to severe osteoarthritis of the first CMC joint and mild to moderate osteoarthritis of the first IP joint.	96
05/07/YYYY	Hospital/ Provider	**Visit for Dysuria and Vertigo:** **Assessment/Plan:** Benign paroxysmal positional vertigo of left ear Dix-Hallpike testing positive on left. Nystagmus present. Epley maneuver repositioning performed. Cautioned patient keep head at midline for 3-4 hours. Sleep in recliner tonight if possible. Advised patient not to lay back into bed with face upward. Always get into bed on one shoulder. Try not to roll over in bed, roll under. Advised patient that vertigo usually resolves in 4-5 days however if dizziness continues he should return to clinic. Meclizine (Antivert) 25 mg three times daily as needed. Ondansetron (Zofran) 4 mg 1-2 tablets every 12 hours as needed.	97-99

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Difficult or painful urination Complaints of burning with urination. Occasional burning pain in abdomen at level of bladder. Had same complaint in January of 2019. Urinalysis normal both times. Has history of prostatitis. PSA- normal in January 2019. Was referred to Dr. Janiga but cancelled appointment. Stressed to patient that he needs to be seen by Urology to determine if there is a structural problem. Ordered urinalysis. Referral to Urology.	
06/04/YYYY	Hospital/ Provider	**Visit for prostatitis:** **Impression/Plan:** Patient with chronic prostatitis/prostadynia with BPH with a normal PSA and erectile dysfunction. BPH with obstruction/lower urinary tract symptoms (primary encounter diagnosis) Continue with Flomax 0.4 mg and Finasteride 5 mg daily. Plan: Urinalysis and Urine culture. Prostadynia Start Finasteride 5 mg daily Screening PSA (prostate specific antigen) Annual PSA with his PCP ED (Erectile Dysfunction) of organic origin No new treatment. He is aware that Finasteride can make this worse. Microscopic hematuria Stable for him. No new evaluation.	99-102
09/24/YYYY	Hospital/ Provider	**X-ray of Right Shoulder:** **Clinical indication:** Right shoulder pain. **Findings:** Diffuse osteopenia. Stable degenerative changes of the right acromioclavicular and glenohumeral joints. No fractures, cortical erosions or dislocations. No significant soft tissue swelling. Visualized lung fields show no focal infiltrates. **Impression:** Stable degenerative osteoarthrosis of the right acromioclavicular and glenohumeral joints without acute abnormalities.	103-104

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/27/YYYY	Hospital/ Provider	**Visit for Right Shoulder pain:** Patient is seen today for a follow up right shoulder pain. Last seen on *04/04/YYYY (Must be 04/04/YYYY)* for a cortisone injection. Patient reports injections are working well, and he would like to repeat one to the right shoulder joint today Patient is a 68 year old male was seen at the request of Dr. Oglivie with the chief complaint of right shoulder pain. His right shoulder pain is intermittent and can get up to a pain level of 4/10. The pain is located on the top of the shoulder that radiates down the bicep. He has pain with reaching behind his back and across his chest. He takes Ibuprofen 400 mg for pain and discomfort. He has no prior history surgery on the right shoulder, physical therapy or cortisone injections. **Examination:** The right shoulder is tender over the supraspinatus. There are no palpable masses over the shoulder girdle. There is acromioclavicular creptus. Positive cross arm test. Testing for impingement: Positive O'Brien's test, positive Hawkin's test. Testing the biceps: Positive Yergason's test, Positive Speed's test. Rotator cuff: Negative drop sign. Shoulder ROM in degrees for forward elevation 170, abduction 160, external rotation 70, internal rotation T12, extension 20. There is no anterior, posterior, inferior instability without clunk. There is negative apprehension sign. The contralateral shoulder demonstrates full ROM, no instability, good abductor and flexor muscle strength. *X-ray of right shoulder reviewed.* **Impression:** • Right shoulder impingement • Right shoulder moderate AC osteoarthritis **Plan:** Recommend a repeat glenohumeral cortisone injection as treatment for persistent shoulder pain. Patient agreed with plan and wished to proceed with injection of the right shoulder having received and signed or verbally given a full informed consent for this procedure. **<u>Intra-articular Steroid injection:</u>** The right shoulder was prepped with alcohol and the injection site was wiped clean with an alcohol swab. A small wheal of 3ml 2% plain Xylocaine was made in the skin at the injection site. A syringe with an 22 gauge 1.5 inch needle was used to enter the joint space. The joint was injected with 12 mg Betamethasone 6 mg/ml and 5 cc of 0.25% Marcaine. The needle and syringe were then withdrawn. The wound was covered with a Bandaid after washing away the antiseptic. Patient	105-108

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		tolerated the procedure well and there were no complications. Range of motion of the joint resulted in some relief of pain. If pain does not improve with cortisone injection patient will call the office and I will order and MRI.	
11/02/YYYY	Hospital/ Provider	**MRI of Right Shoulder without contrast:** **Clinical indication:** Primary osteoarthritis of right shoulder. **Findings:** **Supraspinatus Outlet:** Mild to moderate degenerative changes of the AC joint are present and there is associated narrowing, marginal hypertrophy and minimal effusion of the joint. Type I acromion present. No subacromial spur is seen. Mild subacromial-subdeltoid and subcoracoid bursal effusions are present. **Rotator cuff:** No distinct partial thickness or full-thickness rotator cuff tendon tears identified. Moderate to severe tendinosis and diffuse degenerative bursal sided fraying of the supraspinatus and infraspinatus tendons is seen. Mild to moderate subscapularis tendinosis is seen. **Long head of biceps tendon:** The long head of biceps tendon maintains normal position in the bicipital groove. There is heterogeneous intermediate signal thickening of the biceps pulley complex compatible with degeneration/degenerative complex tear, which is associated with small subcortical enthesopathic fibrocystic lesion in the subjacent anterior humeral head at the proximal aspect of the medial bicipital ridge that corresponds to ovoid lucency with indistinct sclerotic rim in the midline anterior humeral head on the prior shoulder radiographs. Tendinosis and probable longitudinal split tear of the intracapsular segment of long head of biceps tendon is seen. **Labroligamentous structures:** Global mild degenerative intermediate intrasubstance signal of the labrum is seen with no distinct labral tear identified. No paralabral cyst is seen. **Glenohumeral joint:** Articular alignment is normal. The articular cartilage is maintained. No focal chondral lesion or significant cartilage fissuring is seen. No glenohumeral joint effusion is seen. **Osseous structures:** The bones are intact. No suspicious bone lesions are seen. Small focus of tiny superficial enthesopathic fibrocystic foci is seen at the posterior superolateral humeral head, as incidental finding. **Musculature/Soft tissues:** No significant muscle atrophy is appreciated. Visualized soft tissues are unremarkable. **Impression:** Intact rotator cuff. Moderate to severe tendinosis and diffuse degenerative bursal sided fraying of the supraspinatus and infraspinatus tendons.	109-112

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Mild to moderate subscapularis tendinosis. Tendinosis and probable longitudinal split tear of the intracapsular segment of long head of biceps tendon and degeneration/degenerative complex tear of the biceps labral pulley complex, which is associated with small subcortical enthesopathic fibrocystic lesion in the subjacent anterior humeral head at the proximal aspect of the medial bicipital ridge. Global degenerative signal alteration of the labrum with no distinct labral tear identified. Mild to moderate osteoarthritis of the AC joint. Mild subacromial-subdeltoid and subcoracoid bursal effusions compatible with bursitis. *Related records: MRI screening form*	
11/08/YYYY	Hospital/ Provider	**Visit for Right Shoulder pain:** Patient is seen today for right shoulder MRI follow up. Was last seen 09/27/YYYY, received an injection and reports it only offered about 2 weeks of good pain relief. Patient increased pain, and worsening/limited motion. Patient reports Ibuprofen 800mg is not offering much relief. Adding Tylenol did not help either. Pain limiting sleep. Has not been able to stretch use the shoulder due to pain. Has otherwise been feeling well, no fever/malaise/chills. Has completed an MRI on the shoulder. **Examination:** Holds right arm/shoulder at side/favored. Elbow/wrist/hand ROM appear full. **Right shoulder:** No gross effusion. There is general tenderness to palpation about the shoulder, without any focal bony tenderness to palpation. Shoulder is painful/stiff to PROM. FF 35, abduction 30, Extension 35, ER 20 with end-feel consistent with frozen shoulder. Unable to test stability and/or cuff/biceps function. *MRI of right shoulder dated 11/02/YYYY reviewed.* **Impression:** • Right shoulder pain, adhesive capsulitis. • AC joint OA. **Plan:** Discussed etiology/adhesive capsulitis at length. Need for PROM with TERM using table glides with sustained stretches for one minute in forward flexion and abduction to gradually improve his ROM and break through the adhesions. Continue with OTC meds for pain control, Ibuprofen and Tylenol dosing reviewed. Heat with stretching, icing for 20min prior to bed/night.	113-116

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Manipulation under anesthesia if not improving. Unable to repeat injection on the shoulder for 3 months. Handout on frozen shoulder provided. Exercises demonstrated for weighted pendulum and table glides. Follow-up in approximately 6 weeks.	
12/04/YYYY	Hospital/ Provider	**Visit for Prostadynia:** **Impression/Plan:** Patient with improved prostadynia on Finasteride 5 mg daily. He doesn't want to continue taking as many medications as he currently is and wants to know if he can stop any of the medications. Prostadynia (primary encounter diagnosis): He is on Flomax 0.4 mg and Finasteride 5 mg daily. I want him to stop the Finasteride 5 mg daily to see if that makes any difference. BPH with obstruction/lower urinary tract symptoms: Continue on Flomax 0.4 mg daily ED (Erectile Dysfunction) of organic origin: He is fine with his current situation. No new treatment at this time unless his erectile dysfunction gets significantly worse.	116-118
12/12/YYYY	Hospital/ Provider	**Intake Functional Status Summary:** **Risk Adjustment criteria:** **Severity:** Severe (Intake FS: 41) **Condition:** Shoulder **Functional Status Measure:** **Patient's Physical FS primary measure** – Intake score: 41 **Interpretation:** This FS measure places the patient in Stage 2 and means the patient has poor shoulder function. **Risk Adjusted Statistical FOTO** – Intake score: 48 **Interpretation:** Given the patient's risk adjustment variables, like patients nationally had a FS score of 48, Stage 3 at intake. **Rehabilitation Resource Predictor:** **Points of Physical FS change** – Predicted value: 25 **Discharge FS score** – Predicted value: 66 **Interpretation:** Given the patient's risk adjustment variables, and the actual intake FS score, FOTO predicts the patient will experience at least an increase on function of 25 points (to 66 or higher) putting them in the Stage 4 level or higher at discharge. **Visits per episode:** 14 **Duration of episodes in days:** 56 **Average Satisfaction Score:** 97.4% **CMS Impairment/Limitation/Restriction for FOTO Shoulder Survey:**	119-121

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th></th><th>Status</th><th>Limitation</th><th>G-Code</th><th>CMS Severity Modifier</th></tr>
<tr><td>Intake</td><td>41%</td><td>59%</td><td>Current status</td><td>CK – At least 40% but less than 60%</td></tr>
<tr><td>Predicted</td><td>66%</td><td>34%</td><td>Goal status</td><td>CJ – At least 20% but less than 40%</td></tr>
<tr><td></td><td></td><td></td><td>D/C Status</td><td>CK – Only report if this is discharge survey</td></tr>
</table>
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<tr><td>12/13/YYYY</td><td>Hospital/ Provider</td><td>
Physical therapy for right shoulder pain and stiffness – Initial evaluation:

Patient is a 68 year old right handed male (occupation: retired Mail carrier) referred to Physical Therapy with the medical diagnosis of Adhesive capsulitis of right shoulder. The patient is complaining of intermittent right glenohumeral joint pain and stiffness which began 2 weeks after a cortisone injection about month ago. Symptoms began about a month ago insidiously but has been a mail carrier that recently retired but has a long history of right shoulder pain and left rotator cuff repair years ago. Pain ranges from 0-7/10 and is mechanical and inflammatory nociception and musculoskeletal in nature. There is a previous history of right glenohumeral joint pain for years. The patient has received anti inflammatories and cortisone treatment for right glenohumeral joint pain with Mixed benefit.

Signs and symptoms are suggestive of right stage 1/2 adhesive capsulitis . The patient will benefit from a course of physical therapy treatment to address their current limitations detailed below.

The screen for fear avoidance is low. The three-question depression screen is negative.

Prior level of function: Home activities of daily living and recently retired.

Unable to sleep without glenohumeral joint pain.
Unable to reach any where
Resting pain: 0/10

Objective Examination:
Cervical: AROM – Flexion increase glenohumeral joint pain.
Rotation Right limited and with glenohumeral joint pain.

Shoulder: AROM – Right versus Left:
Flexion: 55 no arching of back versus 165 degrees – comparable pain
Abduction: 34 versus 144 degrees – comparable pain
External rotation: 47 versus 77 degrees – comparable pain
Hand behind back waist versus lateral T8.

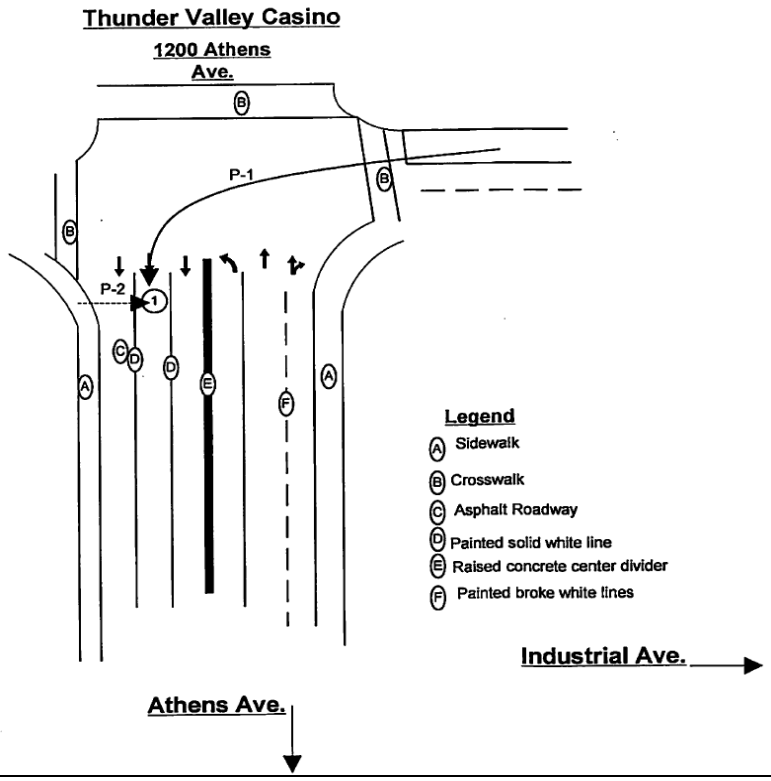
PROM:
Right flexion 65 first resistance – Pain
Abduction 55 first resistance
External rotation 25 first resistance – no pain
</td><td>122-128</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Strength – Not tested. **Diagnosis:** Right glenohumeral joint pain and stiffness **Therapy rendered:** Therapeutic exercise **Response to treatment:** **Subjective:** I feel a little better. Numeric Pain rating scale: 0/10 **Objective:** Flexion 58°, external rotation 55°, abduction 50° **Plan:** Manual therapy for joint mobilization. **Therapy plan:** • Therapeutic exercise • Neuromuscular re-education • Gait training • Manual Therapy • Therapeutic activity • Self care management/Patient education • Modalities like hot pack or cold pack, mechanical traction, electrical stimulation, iontophoresis Frequency: Once a week Duration: 8 weeks.	
Date of MVA injury: 12/16/YYYY *(Summary of medical records post MVA injury)*			
12/16/YYYY	Hospital/ Provider	**Traffic collision report:** **Crash date:** 12/16/YYYY **Time of crash:** 0010 hours **Crash identifiers:** **County**: Placer **City**: Unincorporated **Judicial district:** Santucci Justice **Crash occurred on:** 1200 Athens Ave **Latitude:** 38.840086° **Longitude:** -121.314112° **At/ from intersection with street, road:** 308 Feet North of Athens Ave **Party #1:**	129-137

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Driver Name: Victor Alberto Cornado Barraz **License Number**: D3128620 **State**: CA **Address:** 32, Water Glen CIR, Sacramento, CA – 95826 **Direction of Travel:** South **On Street or highway:** Private Parking Lot **Speed limit:** NA **Vehicle year:** 2017 **Make:/Model/Color:** Nissan Ultima Grey **License plate number:** 7XOE847 **State**: CA **Disposition of vehicle:** Driven **Vehicle type:** 01 **Vehicle Damage**: None **Party #2:** **Name**: Gary Michael Clark **Address:** 1449, Blur Squirrel Street, Roseville, CA – 95747 **Direction of Travel:** East **On Street or highway:** Private Parking Lot **Speed limit:** NA **Vehicle type:** 60 **Primary Collision Factor:** Improper driving of Party 1 **Weather**: Clear **Lightings condition**: Dark – No street lights **Roadway surface**: Dry **Roadway conditions**: No unusual conditions **Traffic control devices:** No controls present **Type of collision:** Vehicle/Pedestrian **Motor Vehicle involved with:** Pedestrian **Pedestrian's action:** Crossing – Not in cross walk **Special information:** **Cell phones not in use:** Both the Parties 1 and 2 **Other associated factors:** None apparent **Movement preceding collision:** Making left turn of Party 1 **Sobriety – Drug Physical:** Had not been drinking – Both the parties 1 and 2 **Injury:** **Injured:** Pedestrian **Extent of injury:** Possible injury **Name**: Gary Michael Clark **Address:** 1449, Blur Squirrel Street, Roseville, CA – 95747 **Transported by:** AMR Ambulance **Taken to:** Sutter Roseville Medical Center **Describe injuries:** Bump to head **Narrative:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Notification: I received a radio call of a vehicle collision with unknown injuries from the Sacramento CHP Dispatch Center, at approximately 0018 hours. I responded from 1-80 East at SR-49 and arrived on scene at approximately 0027 hours. All times, speeds and measurements are approximations. All measurements were obtained by estimation, patrol vehicle odometer and roll meter. **Scene description:** This collision occurred at the address of 1200 Athens Ave. in the private parking lot of the Thunder Valley Casino. Thunder Valley Casino is west of Industrial Ave. in an unincorporated area of Placer County. The parking lot at this location is straight, multi-lane in each direction, asphalt paved roadway, bordered by raised concrete curbs. Refer to the Factual Diagram for further scene details. **Parties:** Party #1 (P-1/Barraz) was contacted at the scene standing on the west curb of the parking lot near the entrance. He was identified by his California Driver License and was determined to be the driver of V-1 by his statement. P-1 stated he was wearing his seatbelt and had no injuries as a result of this collision. P-1 was a solo occupant in V-1. Vehicle #1 (V-1/Nissan) V-1 was located at the scene and had been moved from its place of rest prior to CHP arrival. V-1 sustained no visible damage from this collision. P-1 drove V-1 from the scene. No prior mechanical defects were noted or claimed. Party #2 (P-2/Clark) was contacted at the scene in the rear of an AMR ambulance being attended to by emergency personnel. He was identified by his valid California Driver License (A0623966) and determined to be P-2 by his statement and injuries sustained. P-2 had a bump to the back of his head and complained of pain to her chest and face. P-2 was transported from the scene by AMR and taken to Sutter Auburn Faith Hospital for treatment of his injuries. **Other Factual Information:** This collision was recorded by Thunder Valley Casino Security video cameras. I watched the recording of this traffic collision at the Thunder Valley Casino Security office. A copy of the video recording has been requested. Should a copy of the video come available it will be added to this report via a supplemental. **Statements:** Party #1 (P-1/Barraz) P-1 related in essence the following information; He was driving V-1 (Nissan) westbound in the parking lot making a left turn towards Athens Ave. at approximately 5 miles per hour. P-1 stated P-2 ran in front of V-1 causing the front of V-1 to impact him. P-2 fell to the ground and P-1 immediately exited and checked on P-2. Party #2 (P-2/Clark) P-2 related in essence the following information; He was walking in an easterly direction towards the parking lot. He admitted to not using the crosswalk, but stated he thought P-1 could see him. Next, the front of V-1	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		struck P-2. The impact caused P-2 to fall to the ground and hit his head. **Opinions and Conclusions:** **Summary:** P-1 (Barraz) was driving V-1 (Nissan) in a westerly direction in the Thunder Valley Casino parking lot. He was in the process of making a left turn towards Athens Ave. at approximately 5 MPH. P – 2 (Clark) was a pedestrian who was walking in an easterly direction and crossing the traffic lanes, approximately 48 feet south of the crosswalk. This collision occurred as a result of P-1 driving at an unsafe speed and failing to yield the right way to P-2. Although P-2 was not in the crosswalk, he was well within the traffic lane when he was struck by V-1. P-1 failed to stop/yield as he approached P-2 and continued towards P-2 at an unsafe speed until the front of V-1 struck P-2. P-2 was struck by V-1 which caused him to go airborne and hit the hood of V-1. P-1 exited V-1 and attended to P-2. Both parties remained at the scene until CHP arrival. Summary is based upon the statements provided at the scene, injuries sustained by P-2 and the video footage I viewed which was provided by Thunder Valley Casino Security. **Area of Impact (AOI):** The AOI, where the front of V-1 (Nissan) struck P-2 was located approximately 198 feet north of the north roadway edge line of Athens Ave. and 1343 feet west of the west roadway edge line of Industrial Ave. **Cause:** P-1 (Barraz) was determined to be the cause of this traffic collision by driving V-1 at a speed unsafe for conditions. Due to V-1's unsafe speed, P-1 was unable to stop V-1 in time and caused the front of V-1 to collide into P-2. **Recommendations:** None **Sketch Diagram:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
			
12/16/YYYY	Hospital/ Provider	**Emergency Medical Services (EMS) record following Auto Pedestrian Accident:** **Call information:** Call received: 00:15:18 hours Dispatched: 00:15:18 hours En route: 00:15:24 hours At scene: 00:19:29 hours At patient side: 00:19:34 hours Transport: 00:35:30 hours Arrival: 00:50:17 hours Care transferred: 00:55:00 hours Available: 01:08:13 hours **From:** 1200, Athens Ave Lincoln, CA – 95648 (Business/Commercial) **To:** Sutter Roseville Medical Center 1 Medical Plaza Dr Roseville, CA – 95661 (Hospital – ED)	138-150

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chief complaint: Right sided head pain Onset: Acute Cause of injury: MVC – Vehicle versus Pedestrian Type of other vehicle: Car Speed: 20 MPH **Vitals:** BP: 195/130 mm Hg Pulse: 129 bpm Respirations: 20 breaths per minute SpO_2: 96% Pain scale: 4/10 **Physical assessment:** **Head:** Right Parietal Skull/Scalp: Positive: Edema/Swelling – Traumatic Bleeding – Controlled Incision/Laceration, And Pain **Impression:** Trauma – Traumatic injury **Narrative** C3 response for vehicle versus pedestrian. Arrived scene with Cal Fire E77 to find 68 year old male sitting on the curb with a towel pressed against the right side of his head. Patient alert and oriented and walking around. Patient was advised to remain seated. Patient states he was crossing the street when a car making a turn approx 15 MPH per driver, struck the patient causing him hit the ground with his right side/shoulder and head. Patient denies LOC and is AOX4. Minor laceration to right parietal region with a golf ball sized hematoma. Patient also with complaint of right shoulder pain, chronic 2/10 tonight 4/10 no deformity, bruising or pain with palpation. Patient denies blurred vision, no headache, not dizzy or lightheaded. Patient placed in modified c-spine with a collar. Vital signs obtained and secondary unremarkable unless otherwise noted. Monitored patient en route C2 to SRMC ER. TOC to staff without incident. **Disposition:** Transported to Hospital ER. *Related records: EMS bills, acknowledgement, audit trial*	
12/16/YYYY	Hospital/ Provider	**Emergency Department (ED) Record following Auto-Pedestrian accident :** Patient is a 68 year old male with a history of hypertension who presents with a head injury sustained in a motor vehicle versus pedestrian collision just prior to arrival. Per EMS, the patient was crossing the parking lot of a Casino when he was hit by a Sedan traveling 15-20 MPH. Report no loss of consciousness. The	151-193

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		patient was ambulatory on scene after the incident. The patient does not recall the entire event but states his head hit the ground at some point when he sustained a laceration to the back of his head. Complains of mild, burning pain that is localized with no alleviating or exacerbating factors. Reports chronic, 2/10 right shoulder pain that exacerbated to 4/10 in severity since the incident. Denies use of blood thinners. Denies headache. Denies any other pain/injury. **Review of systems:** Skin: Positive for wound. **Vitals:** BP: 188/110 mm Hg Pulse: 109 bpm Respirations: 21 breaths per minute SpO_2: 97% **Physical examination:** **HENT:** 6 cm cephalohematoma on the right, with 2.5 – 3 cm laceration over the cephalohematoma. **ED medication administration:** Lidocaine/Epinephrine/Tetracaine (LET) topical solution **ED Procedures:** **Laceration Repair – Complex:** Laceration length 2.5 cm Wound anesthetized with LET. After copious irrigation with normal saline, wound explored and debrided. Skin wound closed with Staples x2. Wound well approximated, tolerated well, no complications. Patient/family given explicit wound care, surveillance, and follow up instructions. **Response to interventions/ED course/consults:** **@ 01:55 AM:** Patient feeling well, no complained of – requests discharge home. Advised to follow up in 3-5 days for staple removal. Strict return precautions provided. **Medical Decision Making:** Differential Diagnosis includes but is not limited to: Intracranial hemorrhage, neck/back strain, ligamentous injury, fracture, dislocation, myocardial contusion, spinal cord injury, soft tissue contusion, pneumothorax, solid organ or hollow viscous injury, peritoneal bleeding, laceration, abrasion, imbedded foreign body, ocular injury, hemothorax. **Diagnoses:** • Pedestrian injured in traffic accident involving motor vehicle, initial encounter (primary encounter diagnosis) • Blunt head trauma, initial encounter • Cephalohematoma	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Laceration of scalp, initial encounter **Imaging orders:** CT Head, CT Cervical spine and X-ray of Chest **Discharge:** Patient presents with blunt head trauma status post auto vomiting pedestrian without intracranial injury – no bony injury or solid organ/hollow viscous injury. Patient stable throughout the course of their ED visit without any evidence of deterioration. Discussed with patient plans for discharge as well as return precautions and follow up plan. Patient agrees to the plan. Patient discharged home and will follow up with PMD. **Disposition:** Discharge **Condition:** Stable and improved. *Related records: ED labs, ED nursing assessments, ED Orders, ED medication records, flow sheets, consent, agreement, authorization, patient information and history* **Comment: The patient name was mentioned as Oceanbb Tra only in this ED record. But in the header it was given as Gary Clark. Also the DOB in the header matches with the patient's age in the record. Kindly consider this.*	
12/16/YYYY	Hospital/ Provider	**X-ray of Chest:** **Clinical indication:** Injury. **Findings:** Cardiac silhouette is normal in size. Mild uncoiling of aorta. Pulmonary vasculature is within normal limits. No focal consolidations, pleural effusions, or large pneumothoraces. Degenerative changes of both shoulders and the thoracic spine. **Impression:** No radiographic evidence of acute cardiopulmonary pathology.	194-196
12/16/YYYY	Hospital/ Provider	**CT of Brain without contrast:** **Clinical indication:** Injury. **Findings:** There is no hydrocephalus. Basilar cisterns are patent. There are no acute abnormal extra axial fluid collections. There is no acute hemorrhage or midline shift. There is no acute depressed calvarial fracture. Imaged paranasal sinuses and mastoid air cells are predominantly clear. Right parietal scalp hematoma. **Impression:** No acute intracranial hemorrhage.	197-200

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Right parietal scalp hematoma.	
12/16/YYYY	Hospital/ Provider	**CT of Cervical Spine without contrast:** **Clinical indication:** Injury. **Findings:** Please note that the contents of the spinal canal are not accurately evaluated by CT. There is no acute fracture of the cervical spine. Craniocervical junction is normal alignment. Atlantodens intervals normal allowing for degenerative changes. Failure of fusion of the posterior arch of C1 which is an anatomic variant. Cervical vertebra normal in height. Mild anterolisthesis of C2 upon C3. Mild retrolisthesis of C3 upon C4. Mild anterolisthesis of C5 upon C6. Vascular calcifications. **Axial images:** C2-3: No significant central spinal neural foraminal stenoses. C3-4: Left paracentral disc osteophyte complex with moderate central spinal stenosis. Severe left and moderate right neural foraminal stenoses. C4-5: Left paracentral disc osteophyte complex with moderate central spinal stenosis. Moderate bilateral neural foraminal stenoses. C5-6: Broad-based disc osteophyte complex without significant central spinal stenosis. Mild left neural foraminal stenosis. C6-7: Right paracentral disc osteophyte complex with mild-to-moderate central spinal stenosis. Moderate right neural foraminal stenosis. C7-T1: Limited evaluation on CT. Vascular calcifications. **Impression:** No acute fracture of the cervical spine. Multilevel degenerative changes.	201-204
12/20/YYYY	Hospital/ Provider	**Office visit following Auto-Pedestrian accident:** Patient is a 68-year-old male who was struck by a car in a parking lot on Monday sustaining blunt head trauma, and a laceration of parietal scalp. He was seen at Sutter Roseville Medical Center Emergency Department. Diagnosed with head injury with laceration. Had negative CT studies of head and neck. Has a laceration to his right parietal scalp with 2 staples in place. Has history of right shoulder adhesive capsulitis, and is working with Physical Therapy to increase his range of motion. He states since getting hit by Kari's having increased burning in his right shoulder. He states his range of motion is still equivocal to pre-injury, however burning pain is new. Denies numbness or tingling to his hands. He also exhibits a bruise over his left shoulder. States he has mild nausea but denies headaches, dizziness, or photophobia.	205-207

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Review of systems: Integumentary: Laceration right parietal scalp. Gastrointestinal: Positive for intermittent nausea since accident. **Physical examination:** **Skin:** 2.5 cm laceration to right parietal scalp. 2 staples in place. No surrounding redness or heat. No discharge from wound. No dehiscence of wound edges. **Musculoskeletal:** Bruising over her left anterior shoulder, and right lateral shoulder. Has decreased range of motion to right shoulder. Has known adhesive capsulitis, and is working with physical therapy to increase range of motion. **Assessment/Plan:** • Right shoulder pain, unspecified chronicity • Visit for wound check • Injury of head, subsequent encounter **Plan:** Will order X-ray of right shoulder. Continue brain rest. Reviewed ER report, and labs/imaging studies. Will remove staples on Monday as it has only been 4 days since they were placed. Aftercare instructions discussed.	
12/20/YYYY	Hospital/ Provider	**X-ray of Right Shoulder:** **Clinical indication:** Trauma. **Findings:** Mild hypertrophic changes of the AC joint. Diffuse osteopenia. No visualized acute fracture or dislocation evident. Degenerative changes at the glenohumeral articulation. Difficult to evaluate the glenohumeral joint. Recommend Grashey view and axillary view. Cystic change in the proximal humerus may relate to chronic rotator cuff pathology. **Impression:** Degenerative changes of the right shoulder as described above. No visualized acute fracture. In this osteopenic patient if fracture remains a clinical consideration recommend CT or MRI to correlate with prior study from 11/02/YYYY.	208
12/23/YYYY	Hospital/ Provider	**Follow-up visit:** Patient is here today for staple removal, and insomnia. Was involved in an auto pedestrian sustaining a 2 cm laceration right parietal scalp on December 16, 2019. Requesting suture removal. Denies redness, heat, or discharge from wound. Insomnia. Has had persistent insomnia for some time. He would like to try medication to	209-212

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		help him fall asleep. Denies headaches, dizziness, chest pain, shortness of breath, depression, or anxiety. **Review of systems:** **Integumentary:** Healing wound to right parietal scalp. 2 staples in place. Patient reports soft tissue swelling to both sides of anterior neck. **Physical examination:** **Skin:** Warm, dry, with 2 cm laceration to right parietal scalp. 2 staples in place. There is no redness, heat, or swelling around wound. Staples removed without incident. Soft tissue swelling anterior neck bilaterally. No palpable lymph nodes appreciated. **Assessment/Plan:** Insomnia, unspecified type Will do trial of Zolpidem for persistent insomnia. Patient advised to try half a pill before taking a whole one to ascertain if lower dose is effective. Patient also advised that if this is going to be a continuous medication we will need to initiate a contract for controlled substances, and do a drug screen with three-month visits. Zolpidem (Ambien) 10 mg; Take 1 Tab by mouth at bedtime as needed Dispense: 30 tablets. Encounter for staple removal 2 staples removed from right parietal scalp. No dehiscence of wound edges after staple removal. Patient advised to follow-up as needed.	
01/02/YYYY	Hospital/ Provider	**Physical Therapy visits for right shoulder pain and stiffness – Evaluation after Auto-Pedestrian Accident:** **Subjective:** My shoulder was starting to feel good after doing the PT exercises, but then I was hit by a car when I was crossing the street at Thunder Valley (12/16/YYYY). I put my right arm on the hood of the car to protect myself. Went by ambulance to Sutter ER and had X-rays done. Everything was fine except I had a hematoma on my head. My shoulder has been hurting more again since the accident. I am still doing the exercises. I think they help. My shoulder hurts the most when I move my arm across my body and when I reach and pull something. **Pain:** 3/10 at rest, last night it was a 7-8/10. **Objective:** FOTO: 44 in 2 visits **Active Range of Motion – Right Shoulder:** Flexion: 58 Abduction: 45 Hand behind back: Waist	212-217

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<tr><td></td><td></td><td>
Diagnosis: Right glenohumeral joint pain and stiffness

Treatment interventions:
• Therapeutic Exercise
• Manual Therapy
• Joint mobilization
• Soft tissue mobilization
• Modalities – Ice pack/Heat

Assessment:
Response to intervention: Patient felt better with distraction and soft tissue work, some soreness with joint mobilization. Passive flexion= 90 degrees.

Progress towards goals: Patient reported some improvement following his initial PT visit, however shortly after was hit by a car. Luckily he didn't get badly hurt, but his shoulder is more sore again.

Plan: Continue manual therapy as appropriate.
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<tr><td>01/02/YYYY</td><td>Hospital/ Provider</td><td>
Functional Status Summary:

Risk Adjustment criteria:
Severity: Severe (Intake FS: 41)
Condition: Shoulder

Functional Status Measure:
Patient's Physical FS primary measure – Intake score: 41
Patient's Physical FS primary measure – On 01/02/YYYY: 44
Interpretation: Patient's intake FS score was 41 placing the patient in Stage 2. Patient's FS score now is 44/100 (3 points of functional change since intake) placing the patient in Stage 3 and means the patient has fair shoulder function.
Risk Adjusted Statistical FOTO – Intake score: 48
Interpretation: Given the patient's risk adjustment variables, like patients nationally had a FS score of 48, Stage 3 at intake.

Additional Items:
<table>
<tr><th></th><th>FOTO Mean at Discharge</th><th>01/02/YYYY Value</th><th>Interpretation of Predicted Value</th></tr>
<tr><td>Points of Physical Change</td><td>25</td><td>3</td><td>Given the patient's risk adjustment variables, and the actual intake FS score, FOTO predicts the patient will experience at least an increase on function of 25 points (to 66 or higher) putting them in the Stage 4 level or higher at discharge.</td></tr>
<tr><td>Visits</td><td>14</td><td>2</td><td></td></tr>
<tr><td>Duration in</td><td>56</td><td>21</td><td></td></tr>
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</td><td>218-220</td></tr>
</table>

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<tr><td></td><td></td><td>
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<tr><td>days</td><td></td><td></td><td></td></tr>
<tr><td>Average satisfaction score</td><td>97.4%</td><td>100%</td><td></td></tr>
</table>

Additional Surveys:
Net Promoter Question Results on 01/02/YYYY – Score: 10.0
Scale: 0-10

CMS Impairment/Limitation/Restriction for FOTO Shoulder Survey:
<table>
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<tr><td>Intake</td><td>41%</td><td>59%</td><td></td><td></td></tr>
<tr><td>Predicted</td><td>66%</td><td>34%</td><td>Goal status</td><td>CJ – At least 20% but less than 40%</td></tr>
<tr><td>01/02/YYYY</td><td>44%</td><td>56%</td><td>Current Status</td><td>CK – At least 40% but less than 60%</td></tr>
<tr><td></td><td></td><td></td><td>D/C Status</td><td>CK – Only report if this is discharge survey</td></tr>
</table>
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<tr><td>01/07/YYYY</td><td>Hospital/ Provider</td><td>
Functional Status Summary:

Risk Adjustment criteria:
Severity: Severe (Intake FS: 41)
Condition: Shoulder

Functional Status Measure:
Patient’s Physical FS primary measure – Intake score: 41
Patient’s Physical FS primary measure – On 01/02/YYYY: 44
Patient’s Physical FS primary measure – On 01/07/YYYY: 47
Interpretation: Patient’s intake FS score was 41 placing the patient in Stage 2. Patient’s FS score now is 47/100 (6 points of functional change since intake) placing the patient in Stage 3 and means the patient has fair shoulder function.

Risk Adjusted Statistical FOTO – Intake score: 48
Interpretation: Given the patient’s risk adjustment variables, like patients nationally had a FS score of 48, Stage 3 at intake.

Additional Items:
<table>
<tr><th></th><th>FOTO Mean at Discharge</th><th>01/02/YYYY Value</th><th>01/07/YYYY Value</th></tr>
<tr><td>Points of Physical Change</td><td>25</td><td>3</td><td>6</td></tr>
<tr><td>Visits</td><td>14</td><td>2</td><td></td></tr>
<tr><td>Duration in days</td><td>56</td><td>21</td><td>26</td></tr>
<tr><td>Average satisfaction score</td><td>97.4%</td><td>100%</td><td>93.8%</td></tr>
</table>

Interpretation of Predicted value: Given the patient’s risk adjustment variables, and the actual intake FS score, FOTO predicts the patient will experience at least
</td><td>221-223</td></tr>
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Additional Surveys:
Net Promoter Question Results on 01/02/YYYY – Score: 10.0
Net Promoter Question Results on 01/07/YYYY – Score: 10.0
Scale: 0-10

CMS Impairment/Limitation/Restriction for FOTO Shoulder Survey:
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<tr><td>01/02/YYYY</td><td>44%</td><td>56%</td><td></td><td></td></tr>
<tr><td>01/07/YYYY</td><td>47%</td><td>53%</td><td>Current Status</td><td>CK – At least 40% but less than 60%</td></tr>
<tr><td></td><td></td><td></td><td>D/C Status</td><td>CK – Only report if this is discharge survey</td></tr>
</table></td><td></td></tr>
<tr><td>01/22/YYYY</td><td>Hospital/ Provider</td><td>Follow-up visit:

Patient was seen today for right shoulder pain. Patient is right hand dominant. The pain is located in the anterolateral region. The pain is nonrelated to work, but is related to a motor vehicle accident.

Patient was seen at SAFH ER on 12/16/YYYY after he was involved in a pedestrian versus car accident. He was hit and fell onto the ground onto his right side.

Patient has been continuing the PT that was ordered at his last visit on 11/08/YYYY, reports his shoulder is sore all of the time, using Ibuprofen for pain relief.

Physical exam:
There is general tenderness to palpation about the shoulder, without any focal bony tenderness to palpation. No effusion or skin compromise.

Shoulder is painful/stiff to PROM. Forward flexion 75, Abduction 40, Extension 55, External rotation 35 with end-feel consistent with frozen shoulder.

Still unable to test stability and/or cuff/biceps function.

Imaging: X-ray of Right Shoulder dated 12/20/YYYY reviewed.

Impression/Plan:
Patient is a 68 year old male with adhesive capsulitis, he has apparently suffered a setback with falling onto the shoulder secondary to car versus pedestrian accident recently. We discussed given his X-ray findings he likely does have some</td><td>224-226</td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		degenerative change and/or chronic impingement issues with his rotator cuff. His current exam finding suggests that the adhesive capsulitis is still a predominant issue. He has shown some mild improvement despite his recent setback with this motor vehicle accident versus pedestrian incident. Discussed frozen shoulder, typical progress is slow, but consistent with regular stretches. Continue with Table glides thrice daily for Forward flexion and Abduction, holding at end ROM for 1 minute. Heat/ice/medications reviewed. Injection therapy be revisited at next appointment if he is showing limited improvement. Hold off on repeat MRI for now given the finding of frozen shoulder. Follow-up in 6-8 weeks.	
01/09/YYYY – 01/30/YYYY	Hospital/ Provider	**Summary of interim Physical Therapy visits for right shoulder pain and stiffness:** **Dates of visits:** 01/09/YYYY, 01/16/YYYY, 01/21/YYYY, 01/30/YYYY **Diagnosis:** Right glenohumeral joint pain and stiffness **Therapy plan:** • Therapeutic exercise • Neuromuscular re-education • Gait training • Manual Therapy • Therapeutic activity • Modalities like hot pack or cold pack, mechanical traction, electrical stimulation, iontophoresis • Self care management/Patient education **Comment: The interim Physical therapy visits are combined elaborating the initial and final evaluation to know the progress of the patient and to avoid repetition.*	227-255
02/11/YYYY	Hospital/ Provider	**Physical therapy for right shoulder pain and stiffness – Discharge evaluation:** **Subjective:** It's about the same. Effect of last treatment: Tolerated well. **Pain:** 0/10 **Objective:** Right glenohumeral joint active range of motion: Flexion: 65/75 Abduction:45/55	256-262

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hand behind back: Above waist laterally External rotation 36/37 **Treatment interventions:** Therapeutic Exercise Instructed in use of tennis ball for self massage to posterior right shoulder. May continue heat and massager to right upper trapezius. Educated and instructed in ice packs for shoulder. Manual Therapy: Long axis distraction right glenohumeral joint neutral and 80 degrees flexion/scaption Joint mobilization- posterior anterior, posterior anterior glides and inferior glides glenohumeral joint grade III Modality – Ice pack to right shoulder **Diagnosis:** Right glenohumeral joint pain and stiffness **Assessment:** **Response to intervention:** Tolerated well but minimal range of motion improvement. **Progress toward goals:** Treatment diagnosis – right stage 1/2 adhesive capsulitis and mobility is not improving much despite stretching daily x 3 and manual therapy. His gains in physical therapy do not maintain between visits indicating that manual therapy and the home exercise program are not helping his situation at it's current stage. He is trained in a home exercise program for stretching within his tolerance. Due to lack of significant improvement in last month we are stopping physical therapy for now. **Plan:** Discharge Physical Therapy for now.	
02/11/YYYY	Hospital/ Provider	**Functional Status Summary:** **Risk Adjustment criteria:** **Severity:** Severe (Intake FS: 41) **Condition:** Shoulder **Functional Status Measure:** **Patient's Physical FS primary measure** – Intake score: 41 **Patient's Physical FS primary measure** – On 01/07/YYYY: 47 **Patient's Physical FS primary measure** – On 02/11/YYYY: 53 **Interpretation:** Patient's intake FS score was 41 placing the patient in Stage 2. Patient's FS score now is 53/100 (12 points of functional change since intake) placing the patient in Stage 3 and means the patient has fair shoulder function. **Risk Adjusted Statistical FOTO** – Intake score: 48 **Interpretation:** Given the patient's risk adjustment variables, like patients nationally had a FS score of 48, Stage 3 at intake.	263-266

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
Additional Items:
<table>
<tr><th></th><th>FOTO Mean at Discharge</th><th>01/07/YYYY Value</th><th>02/11/YYYY Value</th></tr>
<tr><td>Points of Physical Change</td><td>25</td><td>6</td><td>12</td></tr>
<tr><td>Visits</td><td>14</td><td></td><td>7</td></tr>
<tr><td>Duration in days</td><td>56</td><td>26</td><td>61</td></tr>
<tr><td>Average satisfaction score</td><td>97.4%</td><td>93.8%</td><td>96.9%</td></tr>
</table>
Interpretation of Predicted value: Given the patient’s risk adjustment variables, and the actual intake FS score, FOTO predicts the patient will experience at least an increase on function of 25 points (to 66 or higher) putting them in the Stage 4 level or higher at discharge.

Additional Surveys:
Net Promoter Question Results on 01/02/YYYY – Score: 10.0
Net Promoter Question Results on 01/07/YYYY – Score: 10.0
Net Promoter Question Results on 02/11/YYYY – Score: 10.0
Scale: 0-10

CMS Impairment/Limitation/Restriction for FOTO Shoulder Survey:
<table>
<tr><th></th><th>Status</th><th>Limitation</th><th>G-Code</th><th>CMS Severity Modifier</th></tr>
<tr><td>Intake</td><td>41%</td><td>59%</td><td></td><td></td></tr>
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<tr><td>01/07/YYYY</td><td>47%</td><td>53%</td><td></td><td></td></tr>
<tr><td>02/11/YYYY</td><td>53%</td><td>48%</td><td>Current Status</td><td>CK – At least 40% but less than 60%</td></tr>
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</td><td></td></tr>
<tr><td>03/04/YYYY</td><td>Hospital/ Provider</td><td>
Follow-up visit:

Patient is a 69 year old male seen today for follow up on the right shoulder.

History reviewed.

Patient has been attending PT, exercising on his own regularly.
He has seen some slight improvements but his motion is still very limited.

Physical exam:
Shoulder ROM was painful/stiff to PROM.
Today's visit: FF 80, Abduction 55, extension 60, ER 40, IR thumb to PSIS.
Still with end-feel consistent with frozen shoulder.
</td><td>267-269</td></tr>
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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		No shoulder effusion. General tenderness to palpation about the shoulder. Moves elbow/wrist/digits well. **Impression/Plan:** Adhesive capsulitis of right shoulder, showing gradual improvement. **Plan:** I reviewed the etiology and expected timeframe of improvement with frozen shoulder. Expect approximately 10-15° of improvement about every 6-8 weeks as he continues his stretching on the shoulder. This will likely take the better part of a year time to resolve. Modalities reviewed along with over-the-counter medications as needed for pain and inflammation. Continued focus on forward flexion and abduction table glides stretches only at end range of motion for 1 minute time, performing these 3 times daily. He may advance his use and activity with the arm as tolerated otherwise. Discussed eventual referral back to outpatient physical therapy as his motion returns to work on strengthening. Follow up in roughly 2 months time to recheck motion. May return for intra-articular injection if he is seeing worsening symptoms or further loss of motion. Consider manipulation under anesthesia if full motion return is not present by 1 year.	
04/29/YYYY	Hospital/ Provider	**Follow-up visit:** Patient is a 69 year old male seen today for follow up on the right shoulder. *History reviewed.* Patient was last seen 03/04/YYYY when we discussed his apparent frozen shoulder, and that typical progress is slow, but consistent with regular stretches. Patient has been exercising on his own regularly. He has seen some slight improvements but his motion is still very limited. He feels he should be farther along at this point. He has retained an attorney for the pedestrian versus vehicle accident. He has a business card with him. He has not signed a records/information release that I have seen as of yet, we discussed him completing this today if he would like us to forward information/discuss his status with his attorney. **As a recap for his shoulder:** Patient has been seen in our clinic for his right shoulder as far back as 04/04/YYYY when Dr. Bergeson diagnosed him with impingement/AC joint arthritis and gave him a bursal injection. Next visit was 04/04/YYYY, and 09/27/YYYY with me where he had recurrence	270-275

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		of impingement/bursitis in the shoulder and had repeat injections. He only noted a week and a half of relief with that last injection, and a subsequent MRI was obtained on 11/02/YYYY that showed intact cuff with tendinosis/fraying, and biceps tendinosis, AC joint arthrosis and bursal effusions were noted and discussed. above was consistent with his previous diagnoses of impingement/bursitis/arthritis. Follow up appointment on 11/08/YYYY was notable for interval finding of a frozen shoulder. We discussed the merits of an intrarticular injection versus the previous subacromial injection that he had received x 2. He was working on home exercises to progress the shoulder motion and using OTC NSAIDS to help with pain and inflammation. He had established with Physical Therapy 12/13/YYYY and was noted there as well to have a frozen shoulder. 3 days later he was struck by a vehicle and treated in the ED. No known shoulder fracture at time of ED visit. Post MVA return visits to PCP's office and re-start of physical therapy during/after which he was showing some slow/continuous progress on his ROM noted at the 01/YYYY appointment with me. He has since struggled with return of ROM but states his pain is not as significant. Last visit 03/04/YYYY showed again some mild/limited improvement in ROM, but still a frozen shoulder, he wanted to consider/hold off on r a joint injection unless he was continuing to struggle despite re-doubling his home exercise efforts. We discussed he had a frozen shoulder prior to his accident. His MVA did not cause the frozen shoulder, preexisting impingement/arthritis problems, or cause for any apparent fractures. As a result of the MVA he did have some time off of therapy/HEP due to the acuity of the MVA injury. This likely delayed some of his progress that could have been made in mobilizing the shoulder. **Physical exam:** Skin intact/dry/warm over the shoulder. Visible AC joint Degenerative Joint Disease that is consistent with previous exam. General shoulder girdle muscle atrophy consistent with period of disuse. No shoulder joint effusion. He demonstrates AROM that is limited at the shoulder joint, maximal use of scaption with active attempts at shoulder FF/Abduction. Shoulder ROM is still painful/stiff to end of motion with PROM. Current visit: FF 80, Abduction 50. Extension 55. ER 25 degrees. IR thumb to right kidney. Still with end-feel consistent with frozen shoulder. No shoulder effusion. There is today less general tenderness to palpation about the shoulder. Moves elbow/wrist/digits well. **Impression:**	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Adhesive capsulitis of right shoulder, showing limited interval improvement. • AC joint arthritis. **Plan:** Intra articular injection to help with the frozen shoulder was recommended. **Procedure:** After a sterile prep of the left shoulder, 4cc of 1% Lidocaine was injected into the skin and subcutaneous tissues, syringe exchanged and 4 cc of 0.25% Bupivacaine and 80 mg of Depomedrol were injected into the subacromial bursal region. The patient tolerated the procedure without complications. Noted improved symptoms of pain to AROM within 5 minutes of injection. Still with solid/stiff end feel. Reviewed need for 3 times a day table glides focusing on forward flexion and abduction. ER/IR stretches also discussed. Etiology of adhesive capsulitis reviewed, along with typical slow resolution. Typical self limited nature of this process with conservative care discussed. Indication for manipulation under anesthesia at one year of frozen shoulder onset if not resolved by then. Discussed repeat imaging if not improving status post today's injection and continued efforts over the next 6-8 weeks of concerted efforts with HEP.	
09/24/YYYY – 06/02/YYYY	Hospital/ Provider	**Other records:** **PDF REF:** 276-332 EKG, lab reports, cover pages, affidavit forms **Comments: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.*	