Control No:

Medical Record - Indexing

Records of: <Name of the Patient>

Category	Date Range	Page Number
Arlington Fire District, NY	2/22/2014	1-4
Vassar Brothers Medical Center	2/22/2014 - 6/12/2015	5-40
Orthopedic Associates	2/28/2014 - 7/14/2015	41-65
Moriarty Physical Therapy P.C.	3/05/2014 – 4/02/2014 - 7/20/2015	66-90
Garner Chiropractic	3/05/2014 - 9/15/2014	91-96
Ulster Radiologic Associates, P.C.	4/22/2014	97-98
Unspecified	2/22/2014 – 6/12/2015	99-147

Control No:

Medical Record Review

Records Of:	<Name of the Patient>
Records Location:	YYYYYYY, M.D.
Service On/ Copied:	MM DD, YYYY
Social Security #:	xxx-xx-xxxx
Date of Birth:	MM DD, YYYY
Employer:	XXXXXXXX
Date of Injury:	2/22/2014
Method of Injury:	Slipped on ice falling backwards striking head on pavement
Injuries Incurred:	Head Injury

Medical Record Review

Provider /Document Title	Date of Service	Page #	Evaluation
Arlington Fire District, NY Patient Care Record Stephen Klauck, M.D.	2/22/2014	1-4	**Primary Imp:** Traumatic injury. **CC:** Head pain. **A:** Pain to back of neck, some pain in neck, back feels sore on palp. **Narrative:** Pt slipped on ice falling backwards striking head on pavement, c/o pain to back of head, back feels sore.
Vassar Brothers Medical Center ED Triage Note Joan Politi	2/22/2014	5-8	**Dx:** Closed head injury, nausea, shoulder injury, vomiting.
Vassar Brothers Medical Center ED Physician Note Stephanie Midgley, M.D.	2/22/2014	9-15	**CC:** Fell & hit head in parking lot, slipped on ice. **HPI:** Presents w/head injury related to fall, currently c/o N & V, SOB, headache, dizziness & neck pain. **ROS:** SOB, back & muscle pain, headache, dizziness, anxiety.
Vassar Brothers Medical Center ED Patient Summary Stephanie Midgley, M.D.	2/22/2014	16-22	**Dx:** Acute sprain or strain of cervical region, closed head injury w/concussion. Meds data. Pt educations materials.
Vassar Brothers Medical Center ED Clinic Summary Stephanie Midgley, M.D.	2/22/2014	23-31	Meds data. **Reason:** Shoulder injury, N & V, closed head injury, fall. **Dx:** Acute sprain or strain of cervical region, closed head injury w/concussion.
Vassar Brothers Medical Center Medication Profile Lawrence Kusior, M.D.	6/12/2015	32-34	Meds data.
Vassar Brothers Medical Center Operative Report Lawrence Kusior,	6/12/2015	35-40	**Preop & Postop Dx:** R shoulder impingement, bursitis, tendinopathy w/type 1 anterior superior labral tearing, synovitis as well as small

M.D.			focal full-thickness supraspinatus tendon tear. **Operation:** R shoulder arthroscopic rotator cuff tendon repair, arthroscopic decompression w/acromioplasty & bursectomy, arthroscopic debridement of labral tear & synovitis.
Orthopedic Associates Office Visit Report Nicholas Renaldo, M.D.	2/28/2014	41-44	**CC:** Fell on ice & injured R shoulder & neck. **HPI:** C/o neck pain & R shoulder pain, having difficulty lifting arm above shoulder, pain at night, taking motrin. **Imp:** Cervical spondylosis, LBP, neck pain, shoulder impingement. **P:** F/u 6 wks for eval.
Orthopedic Associates Office Visit Report Nicholas Renaldo, M.D.	4/14/2014	45-47	**CC:** F/u to neck & R shoulder pain. **HPI:** Pain in R shoulder. **Imp:** R shoulder impingement.
Orthopedic Associates Office Visit Report Nicholas Renaldo, M.D.	4/29/2014	48-50	**CC:** R shoulder MRI f/u. **HPI:** ↑ ROM. **Imp:** R shoulder impingement. **P:** Cont shoulder exercises at home, f/u in 3-4 once reeval.
Orthopedic Associates Office Visit Report Nicholas Renaldo, M.D.	5/29/2014	51-53	**CC:** R shoulder. **HPI:** R shoulder pain. **Imp:** R shoulder impingement, s/p 2 injections, failure of nonop treatment. **P:** F/u.
Orthopedic Associates Office Visit Report Lawrence Kusior, M.D.	6/24/2014	54-56	**CC:** R shoulder. **Imp:** Shoulder impingement. **P:** Follow back up.
Orthopedic Associates Office Visit Report Lawrence Kusior, M.D.	3/10/2015	57-59	**CC:** R shoulder pain. **Imp:** Shoulder impingement.

Orthopedic Associates Office Visit Report Lawrence Kusior, M.D.	4/28/2015	60-62	**CC:** R shoulder pain f/u. **Imp:** Shoulder impingement. **P:** R shoulder arthroscopy decompression debridement possible tendon surgery as needed.
Orthopedic Associates Office Visit Report Lawrence Kusior, M.D.	6/23/2015	63	**CC:** S/p R shoulder arthroscopy. **Imp:** Shoulder impingement, RCT. **P:** Follow back up in 3 wks & pop start formal PT at that time.
Orthopedic Associates Office Visit Report Lawrence Kusior, M.D.	7/14/2015	64-65	**CC:** R shoulder prob. **Imp:** R shoulder s/p rotator cuff repair.
Moriarty Physical Therapy P.C. Therapy Note John, Quinn, P.T. Nancy, Moriarty, P.T.	3/05/2014 – 4/02/2014	66-86	**Shoulder Dx:** S/p fall & concussion & R GH impingement, RC tendonitis, AC jt, sprain, along w/L shoulder RC tendonitis & cervical sprain. **Assessment of Impairments:** Difficulty to performing ADL's including anything w/cervical side bending, GH elevation or lifting heavy objects, presents w/↓ ROM, ↓ strength, pain, joint hypomobility.
Moriarty Physical Therapy P.C. Therapy Note John, Quinn, P.T. Nancy, Moriarty, P.T.	7/20/2015	87-90	**Dx:** Muscle weakness. **Shoulder Dx:** S/p fall & concussion & R GH impingement, RC tendonitis, AC jt, sprain, along w/L shoulder RC tendonitis & cervical sprain. **Assessment of Impairments:** As above. **Shoulder POC:** Duration: 6 wks. Frequency: 3 times weekly, home exercises.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	3/05/2014	91	Pt came for appt & doing much worse than doing on last visit, presented today for first time in wks after slipped & fell straight backwards on ice & hit head, dx w/shoulder injury,

			concussion, neck & upper back whiplash & myofascial pain, advised to rtn for next treatment.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	4/02/2014	92	Doing slightly worse, presented w/↓ lumbar flexion w/pain & extension w/pain, mod spasms noted neck & lower back, rtn for next treatment.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	4/18/2014	93	Doing slightly worse, ↓ cervical flexion w/pain, extension w/pain, L & R rotation w/pain, L & R lateral flexion w/pain, lumbar ROM showed ↓ lumbar flexion w/pain & extension w/pain, schedule next treatment.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	5/21/2014	94	Doing slightly worse, presented w/↓ cervical flexion w/pain, schedule next treatment.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	8/18/2014	95	Doing slightly worse, presented w/↑ neck & low back pain from doing yard work over weekend, noted low back pain & muscle spasms chronic & seem to be getting worse over last 2-3 wks w/not coming for regular care on monthly basis, restricted ROM, pain w/ortho testing, having problems preforming ADL's at home, schedule next treatment.
Garner Chiropractic Office Visit Report Gregory Garner, M.D.	9/15/2014	96	Doing slightly worse since last office visit, cervical ROM produced result of ↓ cervical flexion w/pain, noted mod spasms in neck & lower back, advised to rtn for next treatment.
Ulster Radiologic Associates, P.C. Radiology Report Jonathan Ahmadjian, M.D.	4/22/2014	97-98	**Clinical Hx:** Pain. **Exam:** MRI joint upr extreme w/o contrast R shoulder. **Imp:** Diffuse rotator cuff tendinitis, tendinitis of long head of biceps, small glenohumeral eff, small amount of synovitis or debris in subcutaneous coracoid recess.
Unspecified	2/22/2014 – 6/12/2015	99-147	Consent & Authorization. Orders. Duplicates Data.

Arlington Fire District, NY

Arlington Fire District NY

Patient Care Record

Name: [redacted]

Date: 02/22/2014 Patient 1 of 1

Patient Information			
Last	[redacted]	Address	[redacted]
First	[redacted]	Address 2	
Middle		City	Poughkeepsie
Gender	Female	State	NY
DOB	[redacted]	Zip	12603
Age	72 Yrs, 3 Months, 18 Days	Country	UNITED STATES
Weight		Tel	
Pedi Color		Physician	
[redacted]		Ethnicity	
Advanced Directive			
Resident Status			

Clinical Impression	
Primary Impression	Traumatic injury
Secondary Impression	
Protocol Used	
Anatomic Position	
Chief Complaint	head pain
Duration	Units
Secondary Complaint	
Duration	Units
Patient's Level of Distress	
Signs & Symptoms	Pain - Head
Injury	Fall - Fall from other slipping, tripping or stumbling - Other specified place - 02/22/2014
Medical/Trauma	Trauma
Barriers of Care	

[redacted]

Vital Signs

Time	AVPU	Side	POS	BP	Pulse	RR	SPO2	ETCO2	CO	BG	Temp	Pain	GCS(E+V+M)/Qualifier	RTS	PTS
0:02	A		Lay	170/90 M	86 R	20 R						8	15=4+5+6	12	

Initial Assessment

Category	Comments	Abnormalities	
Mental Status		Mental Status	⊕Event Oriented, Person Oriented, Place Oriented, Time Oriented
Skin		Skin	Not Assessed
HEENT	pt has pain to back of neck. some pain in neck	Head/Face	⊕Other
		Eyes	Not Assessed
		Neck	⊕Other
Chest		Chest	No Abnormalities
		Heart Sounds	Not Assessed
		Lung Sounds	Not Assessed
Abdomen		General	⊕Vomiting
		Left Upper	⊖Distension, Tenderness
		Right Upper	⊖Distension, Tenderness
		Left Lower	⊖Distension, Tenderness
		Right Lower	⊖Distension, Tenderness
Back	pt states back feels sore on palp	Cervical	⊕Pain on ROM
		Thoracic	⊕Other
		Lumbar/Sacral	Not Assessed
Pelvis/GU/GI		Pelvis/GU/GI	⊖Tenderness, Unstable
Extremities		Left Arm	No Abnormalities
		Right Arm	No Abnormalities
		Left Leg	No Abnormalities
		Right Leg	No Abnormalities
		Pulse	⊕Brachial: 2+ Normal
		Capillary Refill	Not Assessed
Neurological		Neurological	⊖Facial Droop, Seizures, Slurred Speech, Tremors, Weakness Left-Sided, Weakness Right-Sided

[redacted]

Electronically Signed by: KLAUCK, STEPHEN

Arlington Fire District NY

Patient Care Record

[redacted]

[redacted]

Date: 02/22/2014

Assessment Time: 02/22/2014 10:02

Narrative

pt found CAOx3 lying supine, non ambulatory in parking lot attended by FD eng crew. Pt slipped on ice falling backwards striking head on pavement. Pt c/o pain to back of head. Pt states back feels sore. Pt denies LOC. Neg chest pain, neg diff breathing. C collar applied, pt placed on backboard. pt had pos pms x 4 ext before and after backboarding. during last 5 mins of transport pt vomited twice, pt rooled onto right side to clear airway. unable to obtain second set of vitals due to vomiting. pt and report to er staff

Incident Details		Destination Details		Incident Times	
Location	parking lot	Disposition	Transported No Lights/Siren	PSAP Call	09:41:48
Address	[redacted]	Transport Due To	Patient	Dispatch Notified	09:41:48
Address 2		Transported To	Vassar Brothers Hospital	Call Received	09:41:48
City	Poughkeepsie	Requested By	Patient	Dispatched	09:45:21
State	NY	Destination	Hospital ER	En Route	09:45:51
Zip	12603	Address	45 Reade Place	Resp on Scene	
Medic Unit	3287	Address 2		On Scene	09:52:17
Run Type	911 Response (Emergency)	City	Poughkeepsie	At Patient	09:53:00
Priority Scene	Lights/Sirens	State	NY	Depart Scene	10:04:19
Shift	Group 4	Zip	12601	At Destination	10:19:00
Zone	ARLINGTON HQ (1363)	Zone	ARLINGTON HQ (1363)	Pt.Transferred	
Level of Service	Basic Life Support	Condition at Destination		Call Closed	11:12:09
EMD Complaint	Fall Victim	Destination Record #		In District	
EMD Card Number		Trauma Registry ID			

Crew Members

Personnel	Role	Certification Level
KLAUCK, STEPHEN	Lead	EMT-Basic (New York) -114569;
CARLON, JUSTIN	Driver	EMT-Paramedic (New York) -309452;

Insurance Details

Mileage		Delays		Additional Agencies
Scene		Category	Delays	
Destination				
Loaded Miles	0.0			
Start				
End				
Total Miles	0.0			

Transfer Details

PAN		Sending Physician	
PCS		Sending Record #	
ABN		Receiving Physician	
CMS Service Level		Condition Code	
ICD-9 Code		Condition Code Modifier	
Transfer Reason			
Other/Services			
Medical Necessity			

Billing Authorization

Language: en

Section I - Authorization for Billing

Enter Custom Billing Language Here

Signature

Billing Authorization	
HIPAA Acknowledgement	

Section II - Authorized Representative Signature

[redacted] 02/22/2014 11:47

Electronically Signed by: KLAUCK, STEPHEN

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

- Patient's Legal Guardian
- Patient's Medical Power of Attorney
- Relative or other person who receives benefits on behalf of the patient
- Relative or other person who arranges treatment or handles the patient's affairs
- Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for services rendered.

Signature

Printed Name	
Reason unable to sign	

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

Printed Name	
Reason unable to sign	

Facility Representative Signature

Printed Name	
Title of Representative	

Facility Signatures

Receiving Physician/Nurse: rn

Paperwork Recieved:

Airway Confirmation:

Provider Signatures

Lead Provider: STEPHEN KLAUCK | Certification Level: EMT-Basic (New York) -114569;

Provider: | Certification Level:

Provider: | Certification Level:

Provider: | Certification Level:

[redacted] 02/22/2014 11:47

Electronically Signed by: KLAUCK, STEPHEN

Vassar Brothers Medical Center

Emergency Documentation

Document Name: ED Triage Note Auth (Verified)
Performed By: Politi, Joan M 02/22/2014 10:27:25 EST
Authenticated By: Politi, Joan M 02/22/2014 10:27:25 EST

ED Triage Adult Entered On: 2/22/2014 10:37 EST
Performed On: 2/22/2014 10:27 EST by Politi, Joan M

Triage
Lynx Mode of Arrival : BLS/Ambulance
ED Vital Signs Assessed : Document
Pain Present : Yes actual or suspected pain
Document Allergies : Document Allergies
Emergency Severity : Document
Document Medications : Document Medications
ED Level of Care : Core
Chief Complaint : fell & hit head in parking lot. slipped on ice
Document Procedure History ED : Document
Languages : English
ED General Information Triage : Document
Triage Complete Indicator : Complete

Politi, Joan M - 2/22/2014 10:27 EST

Mode of Arrival/Transfer From
Arrived by EMS Service : Arlington Ambulance

Politi, Joan M - 2/22/2014 10:27 EST

Vitals/Ht/Wt
Heart Rate Monitored, Cuff : 77 bpm
Respiratory Rate : 18 br/min
Systolic/
Diastolic BP : 145 mmHg (HI)
Systolic/
Diastolic BP : 60 mmHg
O2 Therapy : Room air
SpO2 : 99 %
Height/Length Dosing : 167 cm(Converted to: 5 ft 6 inch, 5.48 ft, 65.75 inch)
Height/Inches : 66 inch
Weight/Lbs. : 186 lb
Clinical Weight : 84 kg(Converted to: 185 lb 3 oz, 185.188 lb)
Height Inches to CM : 167.6 cm
Weight Lbs. to Kg. : 84 kg

Politi, Joan M - 2/22/2014 10:27 EST

Pain Assessment
Preferred Pain Tool : Numeric rating scale
Primary Pain Intensity : 8
Pain Location : Head, Shoulder
Laterality : Left

Emergency Documentation

Document Name: ED Triage Note Auth (Verified)
Performed By: Politi, Joan M 02/22/2014 10:27:25 EST
Authenticated By: Politi, Joan M 02/22/2014 10:27:25 EST

Politi, Joan M - 2/22/2014 10:27 EST

[redacted]

ESI
DCP GENERIC CODE
Tracking Acuity : 3 -Urgent
Tracking Group : VB ED Tracking Group

Politi, Joan M - 2/22/2014 10:27 EST

Medication History
Medication List

(As Of: 2/22/2014 10:37:43 EST)

Prescription/Discharge Order
metoprolol : metoprolol ; *Status:* Prescribed ; *Ordered As Mnemonic:* metoprolol tartrate 25 mg oral tablet ; *Simple Display Line:* 25 mg, Oral, Daily, 30 day(s) ; *Ordering Provider:* Obi MD, Loretta; *Catalog Code:* metoprolol ; *Order Dt/Tm:* 8/3/2013 15:01:39

Emergency Documentation

Document Name: ED Triage Note Auth (Verified)
Performed By: Politi, Joan M 02/22/2014 10:27:25 EST
Authenticated By: Politi, Joan M 02/22/2014 10:27:25 EST

alpha-lipoic acid	: alpha-lipoic acid ; *Status:* Documented ; *Ordered As Mnemonic:* Alpha Lipoic Acid ; *Simple Display Line:* unknown, Oral, Daily ; *Catalog Code:* alpha-lipoic acid ; *Order Dt/Tm:* 8/2/2013 09:29:39
calcium-vitamin D	: calcium-vitamin D ; *Status:* Documented ; *Ordered As Mnemonic:* Calcium-Vitamin D 500 mg-200 units ; *Simple Display Line:* 1 tab, Oral, Daily ; *Catalog Code:* calcium-vitamin D ; *Order Dt/Tm:* 8/2/2013 09:27:57
magnesium oxide	: magnesium oxide ; *Status:* Documented ; *Ordered As Mnemonic:* magnesium oxide ; *Simple Display Line:* unknown, Oral, Daily ; *Catalog Code:* magnesium oxide ; *Order Dt/Tm:* 8/2/2013 09:28:51
multivitamin	: multivitamin ; *Status:* Documented ; *Ordered As Mnemonic:* multivitamin ; *Simple Display Line:* 1 tab, Oral, Daily ; *Catalog Code:* multivitamin ; *Order Dt/Tm:* 8/2/2013 09:26:22
omega-3 polyunsaturated fatty acids	: omega-3 polyunsaturated fatty acids ; *Status:* Documented ; *Ordered As Mnemonic:* Fish Oil ; *Simple Display Line:* 1,000 mg, Oral, Daily ; *Catalog Code:* omega-3 polyunsaturated fatty acids ; *Order Dt/Tm:* 8/2/2013 09:29:11

[redacted]

[redacted]

Diagnoses(Active)

Closed head injury without LOC*	*Date:* 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Closed head injury without LOC* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* 8D476BB6-C0C4-400D-8902-A9A50BF7E405
Nausea*	*Date:* 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Nausea* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* AHi9DQD9cNvfGolOn4waeg
Shoulder injury - Minor*	*Date:* 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Shoulder injury - Minor* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* C4C5CBF2-1CB2-473B-ACD8-05B5C9C06AF6
Vomiting*	*Date:* 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Vomiting* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* A9FB7B2F-63E4-4BAA-8832-6D1C58823B2D

Procedure History

(As Of: 2/22/2014 10:37:44 EST)

Anesthesia Minutes: 0 ; *Procedure Name:* Cholecystectomy ; *Procedure Minutes:* 0 ; *Comments:* 8/2/2013 12:29 - Mathews, Priya 2010 done at vassar

Emergency Documentation

Document Name: ED Note-Nursing Auth (Verified)
Performed By: Politi, Joan M 02/22/2014 10:52:17 EST
Authenticated By: Politi, Joan M 02/22/2014 10:52:17 EST

ED Assessment Adult Entered On: 2/22/2014 10:54 EST
Performed On: 2/22/2014 10:52 EST by Politi, Joan M

Respiratory
Respiratory Pattern Description : Regular

Politi, Joan M - 2/22/2014 10:52 EST

Neurological
Loss of Consciousness : No
Level of Consciousness : Alert
Pupils Equal, Round, Reactive to Light, and Accommodation : Yes
Characteristics of Speech : Clear

Politi, Joan M - 2/22/2014 10:52 EST

Morse Fall Risk
History of Fall in Last 3 Months Morse : Yes
Patient identified as risk for falls : At Risk for Falls
Presence of Secondary Diagnosis Morse : No
Use of Ambulatory Aid Morse : None, bedrest, wheelchair, nurse
IV/Heparin Lock Fall Risk Morse : Yes
Gait Weak or Impaired Fall Risk Morse : Normal, bedrest, immobile
Mental Status Fall Risk Morse : Oriented to own ability
Score : 45

Politi, Joan M - 2/22/2014 10:52 EST

Musculoskeletal
Musculoskeletal Joint Assessment Grid

Location :	Left Shoulder
	Politi, Joan M - 2/22/2014 10:52 EST

Musculoskeletal Abnormality Grid

Location :	pain to back of head
	Politi, Joan M - 2/22/2014 10:52 EST

Gastrointestinal
GI Symptoms : Nausea, Vomiting
Abdomen Description : Rounded

Politi, Joan M - 2/22/2014 10:52 EST

Emergency Documentation

Document Name: ED Note-Nursing Auth (Verified)
Performed By: Politi, Joan M 02/22/2014 10:52:17 EST
Authenticated By: Politi, Joan M 02/22/2014 10:52:17 EST

Integumentary
Skin Integrity : Intact, no abnormalities

Politi, Joan M - 2/22/2014 10:52 EST

Pain Assessment
Preferred Pain Tool : Numeric rating scale
Primary Pain Intensity : 8
Pain Location : Head, Occipital, Shoulder

Politi, Joan M - 2/22/2014 10:52 EST

Image 2 - Images currently included in the form version of this document have not been included in the text rendition version of the form.

Procedure History

Procedure History

(As Of: 2/22/2014 10:54:53 EST)

Anesthesia Minutes: 0 ; *Procedure Name:* Cholecystectomy ; *Procedure Minutes:* 0 ; *Comments:* 8/2/2013 12:29 - Mathews, Priya 2010 done at vassar

[redacted]

Diagnoses(Active)
Closed head injury without LOC*

Date: 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Closed head injury without LOC* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ;

Diagnosis Code: 8D476BB6-C0C4-400D-8902-A9A50BF7E405

Nausea*

Date: 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Nausea* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* AHi9DQD9cNvfGolOn4waeg

Shoulder injury - Minor*

Date: 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Shoulder injury - Minor* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* C4C5CBF2-1CB2-473B-ACD8-05B5C9C06AF6

Vomiting*

Date: 2/22/2014 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Vomiting* ; *Classification:* Medical ; *Clinical Service:* Emergency medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:* A9FB7B2F-63E4-4BAA-8832-6D1C58823B2D

Document Name: ED Note-Physician Auth (Verified)
Performed By: Filewicz, Larysa 02/22/2014 10:56:48 EST
Authenticated By: Midgley MD, Stephanie G. 02/22/2014 13:44:57 EST

Closed head injury without LOC*, Shoulder injury - Minor*
Health Quest
[redacted]
Associated Diagnoses: **None**
Author: **Filewicz, Larysa**

Basic Information
History source: Patient.
Arrival mode: Ambulance-ALS.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.
2/22/2014 10:27 EST Chief Complaint fell & hit head in parking lot. slipped on ice

History of Present Illness
72 year old female presents to the ED with head injury related to a fall. Patient states that she fell this morning and slipped on ice landing directly on her head and back. Prior to the fall she states that she was "perfectly fine" and denies any previous dizziness or weakness. The patient is currently complaining of nausea, vomiting, shortness of breath, headache, dizziness, and neck pain. She denies any change in vision, chest pain, numbness, tingling, syncope, palpitation, or loss of consciousness.

Review of Systems
Constitutional symptoms: No fever, no chills, no weakness, no fatigue.
Skin symptoms: No rash, no lesion.

[redacted]

ROOM: ED23
ADMIT DATE 02/22/2014
DISCHARGE DATE 02/22/2014
Midgley MD, Stephanie G.

Emergency Documentation

Document Name: ED Note-Physician Auth (Verified)
Performed By: Filewicz, Larysa 02/22/2014 10:56:48 EST
Authenticated By: Midgley MD, Stephanie G. 02/22/2014 13:44:57 EST

Eye symptoms: Vision unchanged.
ENMT symptoms: No ear pain, no sore throat, no nasal congestion, no sinus pain.
Respiratory symptoms: Shortness of breath, No cough,
Cardiovascular symptoms: No chest pain, no palpitations, no syncope.
Gastrointestinal symptoms: Nausea, vomiting, constipation, no abdominal pain, no diarrhea.
Genitourinary symptoms: No dysuria, no hematuria.
Musculoskeletal symptoms: Back pain, Muscle pain, No Joint pain, , Reports: Neck, pain, stiffness.
Neurologic symptoms: Headache, dizziness, no numbness, no tingling.
Psychiatric symptoms: Anxiety, No depression,

[redacted]

Physical Examination

Vital Signs

Vitals View.

2/22/2014 10:44 EST	Temperature Oral	97.5 DegF
2/22/2014 10:27 EST	Height/Length Dosing	167 cm
	Clinical Weight	84 kg
	Heart Rate Monitored	77 bpm
	Respiratory Rate	18 br/min
	[redacted]	[redacted]
	Diastolic Blood Pressure	60 mmHg
	Primary Pain Location	Head, Shoulder
	Primary Pain Laterality	Left
	Primary Pain Intensity	8
	Oxygen Therapy	Room air
	SpO2	99 %

General: Alert, moderate distress.
Skin: Warm, dry, intact.
Head: Normocephalic, atraumatic.
Neck: Immobilized, Tenderness: C Spine Tenderness.
Cardiovascular: Regular rate and rhythm, No murmur, Normal peripheral perfusion, No edema.

Emergency Documentation

Document Name: ED Note-Physician Auth (Verified)
Performed By: Filewicz, Larysa 02/22/2014 10:56:48 EST
Authenticated By: Midgley MD, Stephanie G. 02/22/2014 13:44:57 EST

Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion.
Gastrointestinal: Soft, Nontender, Non distended, Normal bowel sounds.
Back: Nontender, Normal alignment, no step-offs.
Musculoskeletal: Normal ROM, no tenderness, no swelling, no deformity.
Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, normal speech observed.
Psychiatric: Cooperative, Mood and affect: Anxious.

Medical Decision Making
Radiology results:

* Final Report *

Reason For Exam
Traumas

Report
PROCEDURE: Computed Tomography Cervical Spine Without Contrast

CLINICAL HISTORY: Traumas

COMPARISON: None.

TECHNIQUE:
Computed Tomography transaxial scans of the entire cervical spine were performed without the administration of contrast. Thin section, high-resolution images of the cervical spine were obtained. In addition, 3D images were post processed on an independent workstation to assist in interpretation.

FINDINGS:
CRANIAL VAULT/SOFT TISSUE/SKULL BASE:
The visualized intracranial and prevertebral soft tissues are grossly unremarkable. The visualized skull base structures, mastoid air cells and paranasal sinuses are unremarkable.

VERTEBRAL BODIES/ALIGNMENT/MINERALIZATION:
There is no evidence for fracture.
Vertebral alignment is within normal limits.
Bony mineralization is within normal limits.

DISC SPACES/NEURAL FORAMINA:
The disc spaces are well preserved without significant canal or foraminal stenosis. There is minor C5-C6 disc space narrowing.

Emergency Documentation

Document Name: ED Note-Physician Auth (Verified)
Performed By: Filewicz, Larysa 02/22/2014 10:56:48 EST
Authenticated By: Midgley MD, Stephanie G. 02/22/2014 13:44:57 EST

FACET JOINTS:
There is moderate left-sided facet joint arthritic change at the C4-5, 56 and C7 levels.

PARASPINAL/PREVERTEBRAL SOFT TISSUES:
The paraspinal and prevertebral soft tissues are unremarkable.

LUNG APICES:
The visualized lung apices are clear.

IMPRESSION:
There is no sign of acute bony injury. Moderate to severe left-sided facet arthritic change.

Thank you for allowing us to participate in the evaluation of this patient.

Signature Line
***** Final *****

Dictated: Amatulle MD, Philip 02/22/14 11:49

Signed: Amatulle MD, Philip 02/22/14 11:52
Transcribed by: PA

* Final Report *

Reason For Exam
Trauma

Report
PROCEDURE: Computed Tomography Brain Without Contrast

CLINICAL HISTORY: Trauma

[redacted]

TECHNIQUE:
Computed Tomography of the brain was performed without the administration of intravenous contrast.

FINDINGS:
VENTRICLES/CISTERNS/SULCI:

Emergency Documentation

Document Name: ED Note-Physician Auth (Verified)
Performed By: Filewicz, Larysa 02/22/2014 10:56:48 EST
Authenticated By: Midgley MD, Stephanie G. 02/22/2014 13:44:57 EST

The ventricles, cisterns, and sulci are normal in size and configuration.

MASS EFFECT:
There is no evidence for mass effect or midline shift.

HEMORRHAGE/EXTRAAXIAL FLUID:
There is no acute intracranial hemorrhage or extraaxial fluid collection.

ISCHEMIA:
There is no acute lobar infarct.
No significant white matter disease is identified.

ORBITS/CALVARIA/SKULL BASE:
The visualized portions of the orbits are within normal limits.
The calvaria and skull base structures are unremarkable.

PARANASAL SINUSES/MASTOIDS:
The sinuses are unremarkable.
The mastoid air cells are well developed and aerated.

IMPRESSION:
Normal noncontrast CT scan of the brain.

Thank you for allowing us to participate in the evaluation of this patient.

Signature Line
***** Final *****

Dictated: Amatulle MD, Philip 02/22/14 11:48

Signed: Amatulle MD, Philip 02/22/14 11:50
Transcribed by: PA

72 y/o F presents after a mechanical fall due to ice, landing on her back and striking her head with active vomiting apon arrival. Concern for ICH/traumatic SAH, SDH, given c spine tenderness will check ct c spine in addition to ct brain, check cxr, ivf, zofran, ambulatory challenge, PO challenge, d/c home if work up neeg.

Reexamination/ Reevaluation
Patient is ambulating and has a steady gait. She is tolerating P.O. well.

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

ED Patient Summary

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

Vassar Brothers Medical Center – Emergency Department
Department Phone: 845-431-5680
Work/School Release Note

[redacted] was seen in our Emergency Department on 2/22/2014 10:24 AM

This patient may return to:

Thank you for choosing Vassar Brothers Medical Center for your medical care.

Patient Signature: _____

Signature of RN/Provider: _____

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

Vassar Brothers Medical Center
EMERGENCY DEPARTMENT
45 Reade Place
Poughkeepsie, NY 12601
845-431-5680

Patient Information:

[redacted]

Arrival Time: 2/22/2014 10:24 AM ED Provider: Midgley MD, Stephanie G.
Primary Care Physician: Hoffman MD, Daniel P.

We are pleased to have been able to provide you with care today. Please review these instructions when you return home in order to better understand your diagnosis and the necessary further treatment and precautions related to your condition.
In most cases, treatment in an Emergency Department is intended to be temporary in nature. In general, any additional treatment is to be given by your family doctor, or the physician to whom you have been referred upon discharge from the Emergency Department.

I understand that the medical care which I have received is care of an emergent nature. This care may not be a complete diagnosis or complete medical care. Follow-up is important to your health. Conditions may change in the course of hours and new complications may occur.
RETURN IMMEDIATELY TO THE EMERGENCY DEPARTMENT IF NEW SYMPTOMS DEVELOP, YOUR PRESENT SYMPTOMS PERSIST, OR YOUR CONDITION BECOMES WORSE. I have provided an accurate phone number and address so that I may be contacted for further health information or questions about my care.
X-rays do not always show injury or disease. Fractures (breaks in the bones), or other abnormalities are not always revealed on initial x-rays but may be revealed on subsequent x-rays. Your x-ray has been read on a preliminary basis. The final reading will be made by the radiologist. You will be notified of any additional findings.

Diagnosis:
Acute sprain or strain of cervical region; Closed head injury with concussion

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

[redacted]

Medication Information:
Vassar Brothers Hospital ED Physicians provided you with a complete list of medications post discharge, if you have been instructed to stop taking a medication please ensure you also follow up with this information to your Primary Care Physician.
Unless otherwise noted, patient will continue to take medications as prescribed prior to the Emergency Room visit. Any specific questions regarding your chronic medications and dosages should be discussed with your physician(s) and pharmacist.

Prescription

ibuprofen (Motrin 800 mg oral tablet) 800 mg Oral 3 times a day as needed for for pain

ondansetron (Zofran 4 mg oral tablet) 4 mg Oral every 8 hours as needed for as needed for nausea/vomiting

Medication Given in the Emergency Department:

Medications Given

Name	Dose
ondansetron	4 mg
acetaminophen	1000 mg
ketorolac	30 mg

Emergency Documentation

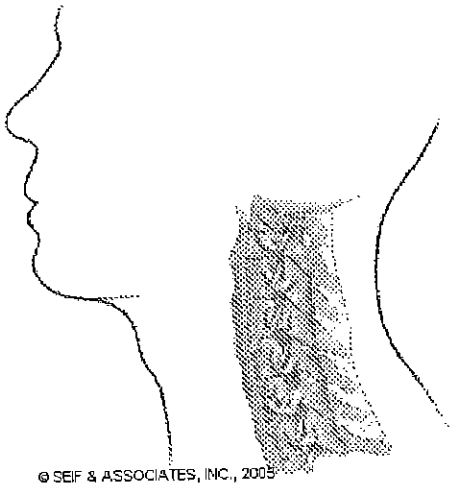
Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

[redacted] as been given the following list of patient education materials

Patient Education Materials:

Cervical Sprain

A cervical sprain is when the ligaments in the neck stretch or tear. The ligaments are the tissues that hold the neck bones in place.



HOME CARE

- Put ice on the injured area.
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 15 to 20 minutes, 3 to 4 times a day.
- Only take medicine as told by your doctor.
- Keep all doctor visits as told.

Emergency Documentation

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Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

- Keep all physical therapy visits as told.
- If your doctor gives you a neck collar, wear it as told.
- **Do not** drive while wearing a neck collar.
- Adjust your work station so that you have good posture while you work.
- Avoid positions and activities that make your problems worse.
- Warm up and stretch before being active.

GET HELP RIGHT AWAY IF:

- You are bleeding or your stomach is upset.
- You have an allergic reaction to your medicine.
- Your problems (*symptoms*) get worse.
- You develop new problems.
- You lose feeling (*numbness*) or you cannot move (*paralysis*) any part of your body.
- You have tingling or weakness in any part of your body.
- Your pain is not controlled with medicine.
- You cannot take less pain medicine over time as planned.
- Your activity level does not improve as expected.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Concussion and Brain Injury

A blow to the head can stop the brain from working normally (*concussion*). It is usually not life-threatening. However, the results of the injury can be serious. Problems caused by the injury might show up right away or days or weeks later. Getting better might take some time.

Emergency Documentation

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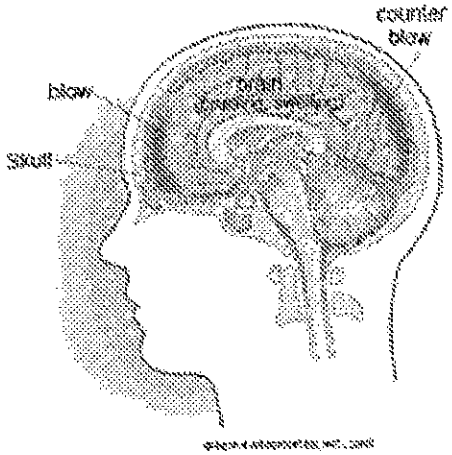

HOME CARE

- Rest your body. Ways to rest your body include:
  - Getting plenty of sleep at night.
  - Going to sleep early.
  - Taking naps during the day when you feel tired.
- Limit activities that require a lot of thought. This includes:
  - Time spent with homework.
  - Time spent with work related to a job.
  - TV watching.
  - Computer use.
- Return to normal activities (driving, work, school) only when your doctor says it is okay.
- Avoid high impact activity and sports until your doctor says it is okay.
- Take medicines only as told by your doctor.
- **Do not** drink alcohol until your doctor says it is okay.
- **Do not** make important decisions without help until you feel better.
- Follow up with your doctor as told.

GET HELP RIGHT AWAY IF:

You, your family, or your friends notice that:

Emergency Documentation

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- You have bad headaches, or they get worse.
- You have weakness, loss of feeling (*numbness*), or you feel off balance.
- You keep throwing up (*vomiting*).
- You feel tired or pass out (*faint*).
- One black center of your eye (*pupil*) is larger than the other.
- You twitch or shake (*seize*).
- Your speech is not clear (*slurred*).
- You are confused, restless, easily angered (*agitated*), or annoyed (*irritable*).
- You cannot recognize or respond to people or activities.
- You have neck pain.
- You have trouble being woken up.
- Your behavior changes.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 12/06/2010 Document Revised: 12/06/2012 Document Reviewed: 12/06/2010
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Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

ED Clinical Summary
VBMC Clinical Discharge Summary

Vassar Brothers Medical Center

EMERGENCY DEPARTMENT
45 Reade Place
Poughkeepsie, NY 12601

PERSON INFORMATION:

[redacted]

MedService:Emergency Room Arrival:2/22/2014 10:27 AM [redacted]D, Daniel P.
Address:30 CRAMER RD Phone #:(845) 473-3793
POUGHKEEPSIE NY 126036301

PROVIDER INFORMATION:

Provider	Role	Assigned	Unassigned
Politi, Joan M	ED Nurse	2/22/2014 10:27 AM	2/22/2014 11:22 AM
Midgley MD, Stephanie G.	ED Physician	2/22/2014 10:31 AM	
Filewicz, Larysa	ED Scribe	2/22/2014 10:45 AM	
Mitschow, Jillian Morgan	ED Registration	2/22/2014 11:00 AM	
Mehar, Amrita Celine	ED Nurse	2/22/2014 11:19 AM	
Baksh, Zafrulla	ED Technician	2/22/2014 12:34 PM	

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

[redacted]

Prescriptions

ibuprofen (Motrin 800 mg oral tablet) 800 mg, = 1 tab, Oral, TID, # 30 tab, 0 Refill(s), for pain

ondansetron (Zofran 4 mg oral tablet) 4 mg, = 1 tab, Oral, q8hr (specified start), # 10 tab, 0 Refill(s), as needed for nausea/vomiting

metoprolol (metoprolol tartrate 25 mg oral tablet) 25 mg, Oral, Daily, Supply 30 day(s), 0 Refill(s), called to pharmacy (Rx)

ED Medications Given:

Medication	Dose	Route	Performed By
ondansetron	4 mg	IV Push	Politi, Joan M
acetaminophen	1000 mg	IV	Politi, Joan M
ketorolac	30 mg	IV Push	Mehar, Amrita Celine

Home Medications List:

alpha-lipoic acid (Alpha Lipoic Acid) , unknown, Oral, once a day, Refills: 0

calcium-vitamin D (Calcium-Vitamin D 500 mg-200 units) 1 tab, Oral, once a day, Refills: 0

ibuprofen (Motrin 800 mg oral tablet) 1 tab, Oral, 3 times a day, As Needed, for pain, Refills: 0

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

magnesium oxide , unknown, Oral, once a day, Refills: 0

metoprolol (metoprolol tartrate 25 mg oral tablet) 25 mg, Oral, once a day, 30 day(s), 30 day(s), Refills: 0

multivitamin 1 tab, Oral, once a day, Refills: 0

omega-3 polyunsaturated fatty acids (Fish Oil) 1,000 mg, Oral, once a day, Refills: 0

ondansetron (Zofran 4 mg oral tablet) 1 tab, Oral, every 8 hours, As Needed, as needed for nausea/vomiting, Refills: 0

REASON FOR VISIT:
Shoulder injury - Minor*; Vomiting*; Nausea*; Closed head injury without LOC*; Fall
DISPOSITION:
Home or Self Care
DIAGNOSIS:
Acute sprain or strain of cervical region; Closed head injury with concussion
PATIENT EDUCATION INFORMATION:
Follow up:

With:	Address:	When:
Daniel Hoffman	375 Hooker Avenue Poughkeepsie, NY 12603 (845) 454-5000 Business (1)	Within 2 to 4 days

Comments:

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

Discharge Instructions:
Cervical Sprain, Easy-to-Read; Concussion and Brain Injury, Easy-to-Read
Medication Leaflets:

DIAGNOSTIC ORDERS:

Laboratory Orders

Name	Status	Details
Auto Diff	Completed	Blood, Stat, ST - Stat, Collected, 02/22/14 11:30:00 EST, Once 24, 02/22/14 11:30:00 EST, 02/22/14 11:30:00 EST, 13639780.000000
CBC w/ Auto Diff	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
CMP	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
PT	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
PTT	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N

Radiology Orders

Name	Status	Details
CT Cervical Spine WOC	Completed	02/22/14 10:45:00 EST, Stat, Traumas, N/A, Rad Type
CT Head/Brain	Completed	02/22/14 10:45:00 EST, Stat, Trauma, N/A, Rad Type

WOC

XR Chest Portable Ordered 02/22/14 10:45:00 EST, Stat, Trauma Injury, N/A, Rad Type

PHYS DOC NOTES:
Health Quest

[redacted]

Associated Diagnoses: **None**
Author: **Filewicz, Larysa**

Basic Information
History source: Patient.
Arrival mode: Ambulance-ALS.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.
2/22/2014 10:27 EST Chief Complaint fell & hit head in parking lot. slipped on ice

History of Present Illness
[redacted] presents to the ED with head injury related to a fall. Patient states that she fell this morning and slipped on ice landing directly on her head and back. Prior to the fall she states that she was "perfectly fine" and denies any previous dizziness or weakness. The patient is currently complaining of nausea, vomiting, shortness of breath, headache, dizziness, and neck pain. She denies any change in vision, chest pain, numbness, tingling, syncope, palpitation, or loss of consciousness.

Review of Systems
Constitutional symptoms: No fever, no chills, no weakness, no fatigue.
Skin symptoms: No rash, no lesion.
Eye symptoms: Vision unchanged.
ENMT symptoms: No ear pain, no sore throat, no nasal congestion, no sinus pain.
Respiratory symptoms: Shortness of breath, No cough,
Cardiovascular symptoms: No chest pain, no palpitations, no syncope.
Gastrointestinal symptoms: Nausea, vomiting, constipation, no abdominal pain, no diarrhea.
Genitourinary symptoms: No dysuria, no hematuria.
Musculoskeletal symptoms: Back pain, Muscle pain, No Joint pain, , Reports: Neck, pain, stiffness.
Neurologic symptoms: Headache, dizziness, no numbness, no tingling.
Psychiatric symptoms: Anxiety, No depression,

[redacted]

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

Surgical history: Cholecystectomy .
Social history: Married.

Physical Examination

Vital Signs
Vitals View.

2/22/2014 10:44 EST	Temperature Oral	97.5 DegF
2/22/2014 10:27 EST	Height/Length Dosing	167 cm
	Clinical Weight	84 kg
	Heart Rate Monitored	77 bpm
	Respiratory Rate	18 br/min
	[redacted]	
	Diastolic Blood Pressure	60 mmHg
	Primary Pain Location	Head, Shoulder
	Primary Pain Laterality	Left
	Primary Pain Intensity	8
	Oxygen Therapy	Room air
	SpO2	99 %

General: Alert, moderate distress.
Skin: Warm, dry, intact.
Head: Normocephalic, atraumatic.
Neck: Immobilized, Tenderness: C Spine Tenderness.
Cardiovascular: Regular rate and rhythm, No murmur, Normal peripheral perfusion, No edema.
Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion.
Gastrointestinal: Soft, Nontender, Non distended, Normal bowel sounds.
Back: Nontender, Normal alignment, no step-offs.
Musculoskeletal: Normal ROM, no tenderness, no swelling, no deformity.
Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, normal speech observed.
Psychiatric: Cooperative, Mood and af[redacted]

Medical Decision Making
Radiology results:

* Final Report *

Reason For Exam
Traumas

Report
PROCEDURE: Computed Tomography Cervical Spine Without Contrast

CLINICAL HISTORY: Traumas

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

COMPARISON: None.

TECHNIQUE:
Computed Tomography transaxial scans of the entire cervical spine were performed without the administration of contrast. Thin section, high-resolution images of the cervical spine were obtained. In addition, 3D images were post processed on an independent workstation to assist in interpretation.

FINDINGS:
CRANIAL VAULT/SOFT TISSUE/SKULL BASE:
The visualized intracranial and prevertebral soft tissues are grossly unremarkable. The visualized skull base structures, mastoid air cells and paranasal sinuses are unremarkable.

VERTEBRAL BODIES/ALIGNMENT/MINERALIZATION:
There is no evidence for fracture.
Vertebral alignment is within normal limits.
Bony mineralization is within normal limits.

DISC SPACES/NEURAL FORAMINA:
The disc spaces are well preserved without significant canal or foraminal stenosis. There is minor C5-C6 disc space narrowing.

FACET JOINTS:
There is moderate left-sided facet joint arthritic change at the C4-5, 56 and C7 levels.

PARASPINAL/PREVERTEBRAL SOFT TISSUES:
The paraspinal and prevertebral soft tissues are unremarkable.

LUNG APICES:
The visualized lung apices are clear.

IMPRESSION:
There is no sign of acute bony injury. Moderate to severe left-sided facet arthritic change.

Thank you for allowing us to participate in the evaluation of this patient.

Signature Line
***** Final *****

Dictated: Amatulle MD, Philip 02/22/14 11:49

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

Signed: Amatulle MD, Philip 02/22/14 11:52
Transcribed by: PA

* Final Report *

Reason For Exam
Trauma

Report
PROCEDURE: Computed Tomography Brain Without Contrast

CLINICAL HISTORY: Trauma

[redacted]

TECHNIQUE:
Computed Tomography of the brain was performed without the administration of intravenous contrast.

FINDINGS:
VENTRICLES/CISTERNS/SULCI:
The ventricles, cisterns, and sulci are normal in size and configuration.

MASS EFFECT:
There is no evidence for mass effect or midline shift.

HEMORRHAGE/EXTRAAXIAL FLUID:
There is no acute intracranial hemorrhage or extraaxial fluid collection.

ISCHEMIA:
There is no acute lobar infarct.
No significant white matter disease is identified.

ORBITS/CALVARIA/SKULL BASE:
The visualized portions of the orbits are within normal limits.
The calvaria and skull base structures are unremarkable.

PARANASAL SINUSES/MASTOIDS:
The sinuses are unremarkable.
The mastoid air cells are well developed and aerated.

Emergency Documentation

Document Name: ED Clinical Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:33 EST

IMPRESSION:
Normal noncontrast CT scan of the brain.

Thank you for allowing us to participate in the evaluation of this patient.

Signature Line
***** Final *****

Dictated: Amatulle MD, Philip 02/22/14 11:48

Signed: Amatulle MD, Philip 02/22/14 11:50
Transcribed by: PA

72 y/o F presents after a mechanical fall due to ice, landing on her back and striking her head with active vomiting apon arrival. Concern for ICH/traumatic SAH, SDH, given c spine tenderness will check ct c spine in addition to ct brain, check cxr, ivf, zofran, ambulatory challenge, PO challenge, d/c home if work up neeg.

Reexamination/ Reevaluation
Patient is ambulating and has a steady gait. She is tolerating P.O. well.

Discharge Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Medication Profile

[redacted]

[redacted]

Medication Profile - Historical Meds

[redacted]

Facility : AMB Surg VASC

Discharge Date: 06/12/2015

PRN

---

acetaminophen-oxycodone(Percocet 5/325 oral tablet) 1 tab (Order Id = 643236363)
1 tab, Oral, q4hr (specified start), # 40 tab, 0 Refill(s), for pain, other reason (Rx)
Order Entered By: Kusior MD, Lawrence J.

ACTION(S)	ACTION TIME(S)
Status Change	**06/20/15 09:01 EDT**

Performed By: SYSTEM

Hx--alpha-lipoic acid(Alpha Lipoic Acid) 1 tab (Order Id = 643126971)
= 1 tab, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000**
Order Entered By: Mowbray, Lisa M

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/02/15 00:00 EDT

Hx--amlodipine(Norvasc 5 mg oral tablet) 1 tab = 5 mg (Order Id = 642610681)
5 mg, = 1 tab, Oral, Daily, 0 Refill(s), every other day
Scheduled: **830 1000 830 1000**
Order Entered By: Wood-Hellmuth, Jeanna

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/11/15 09:00 EDT

Hx--ascorbic acid(Vitamin C) 500 mg (Order Id = 643125059)
500 mg, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000**
Order Entered By: Mowbray, Lisa M

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/05/15 00:00 EDT

Hx--cholecalciferol(Vitamin D3 2000 intl units oral tablet) 1 tab = 2,000 IntUnit (Order Id = 643127203)
2,000 IntUnit, = 1 tab, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000 830 1000**
Order Entered By: Mowbray, Lisa M

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/05/15 00:00 EDT

Hx--meloxicam(meloxicam 15 mg oral tablet) 1 tab = 15 mg (Order Id = 642610977)
15 mg, = 1 tab, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000 830 1000**
Order Entered By: Wood-Hellmuth, Jeanna

Compliance status: Still taking, as prescribed

[redacted]

[redacted]

Compliance Information Source: Patient
Last Dose Dt Tm: 05/29/15 00:00 EDT

Hx--omega-3 polyunsaturated fatty acids(Fish Oil 1000 mg oral capsule) **1 cap = 1,000 mg** **(Order Id = 643126729)**
1,000 mg, = 1 cap, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000 830 1000**
Order Entered By: Mowbray, Lisa M

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/02/15 00:00 EDT

[redacted]

Facility : .Emergency VB Discharge Date: 08/03/2013

SCHEDULED MEDS

Hx--calcium-vitamin D(Calcium-Vitamin D 500 mg-200 units) **1 tab** **(Order Id = 217169995)**
1 tab, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000**
Order Entered By: Fried, Rebecca Ann

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/11/15 12:00 EDT

Hx--multivitamin **1 tab** **(Order Id = 217169427)**
1 tab, Oral, Daily, 0 Refill(s)
Scheduled: **830 1000**
Order Entered By: Fried, Rebecca Ann

Compliance status: Still taking, as prescribed
Compliance Information Source: Patient
Last Dose Dt Tm: 06/05/15 00:00 EDT

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

OPERATIVE REPORTS

[redacted]

Admit Date: 06/12/2015

Unit/Room/Bed: Unit 501 AV(VBMC)/

Discharge Date: 06/12/2015

Physician: Kusior, Lawrence

[redacted]

DICTATED BY: Lawrence J. Kusior, M.D.

SURGERY DATE:
06/12/2015

PREOPERATIVE DIAGNOSIS:
Right shoulder impingement, bursitis, tendinopathy.

POSTOPERATIVE DIAGNOSIS:
Right shoulder impingement, bursitis, tendinopathy with type 1 anterior superior labral tearing, synovitis as well as small focal full-thickness supraspinatus tendon tear.

OPERATION PERFORMED:
Right shoulder arthroscopic rotator cuff tendon repair, arthroscopic decompression with acromioplasty and bursectomy, arthroscopic debridement of the labral tear and synovitis.

SURGEON:
Lawrence J. Kusior, M.D.

ASSISTANT SURGEON:
Courtney Tosi, P.A.

ANESTHESIA:
General endotracheal with a block.

ANESTHESIOLOGIST:

ESTIMATE BLOOD LOSS:
Minimal.

FLUIDS:
Crystalloid.

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

[redacted]

OPERATIVE REPORTS

Admit Date: 06/12/2015

Unit/Room/Bed: Unit 501 AV(VBMC)/

Discharge Date: 06/12/2015

Physician: Kusior, Lawrence

[redacted] whose right shoulder has been painful and sore for a year after an accident. She had pain, discomfort, difficulty with arm elevation. She tried conservative treatment without much relief. Because of persistent pain, she presents for surgical intervention. MRI did not show obvious rotator cuff tear, but did have some tendinopathy. Options for operative and nonoperative interventions discussed, operative intervention chosen. Risks and benefits were reviewed. Informed consents were obtained.

SUMMARY OF PROCEDURE PERFORMED:
The patient was taken to the operating room. She received preop antibiotics. She was positioned supine on the operating room table. She was sedated, intubated and positioned in the beach-chair position, neck in neutral positioning. Examination of the right shoulder under anesthesia was unremarkable. The patient was given preop antibiotics, preop scalene block. The right upper extremity was prepped and draped in the standard fashion using ChloraPrep. A time-out was called. The patient's shoulder was injected with 60 mL of saline with a weak backflow. The arthroscope was inserted in the posterior portal. The intra-articular portion of the shoulder showed intact glenohumeral articular surfaces. The biceps tendon was intact. The patient had anterior labral and superior labral tearing, which was debrided arthroscopically with a shaver. The patient had synovitis of the shoulder, which was debrided. Undersurface of the rotator cuff showed an obvious small focal full-thickness supraspinatus tendon tear with some retraction, arthroscopic debridement was performed of the undersurface of the rotator cuff. At this point then, the arthroscope was inserted into the subacromial space. Arthroscopic bursectomy, CA ligament release, acromioplasty was performed. The acromioclavicular joint was visualized, but not violated. At this point, using accessory portals, the patient had the greater tuberosity gently shaved to get punctate bleeding. A 5.5 Bio-Suture anchor was placed into the greater tuberosity footprint and then 2 sutures were passed through the rotator cuff preparing the rotator cuff back to the greater tuberosity footprint in anatomic fashion. Excellent anatomic repair was achieved. At this point, the instruments were removed. The rotator cuff appeared to be intact. The undersurface of the acromion appeared to be intact. Good hemostasis was achieved. The wound was closed with nylon suture. A dry sterile bulky dressing and sling was applied. The patient was awakened, extubated and transferred back to her hospital bed, back to recovery room in stable condition, breathing on her own. There were no complications, drains, or specimens.

LJK/NTS/197903754/rh/1/06/12/2015 12:38:25
D: 06/12/2015 08:46:01T: 06/12/2015 09:46:42 [redacted]

Electronically signed by

Kusior MD, Lawrence J. 06/23/2015 12:32 EDT

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

[redacted]

OPERATIVE REPORTS

Admit Date: 06/12/2015

Unit/Room/Bed: Unit 501 AV(VBMC)/

Discharge Date: 06/12/2015

Physician: Kusior, Lawrence

[redacted]

VASC

Medical Record

VASC

[redacted]

Medical Record

VASC

Orthopedic Associates

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
02/28/2014

[redacted]

Chief Complaint
Fell on ice and injured her right shoulder and neck.

History of Present Illness
Patient slipped on the ice 1 week ago. Complaining of neck pain and right shoulder pain. She's having difficulty lifting her arm above her shoulder. She has pain at night. She has no radiating pain in her arms or legs. [redacted] She has no saddle paresthesias. She's been taking Motrin.

[redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
28Feb2014 01:03PM
Heart Rate: 60
Blood Pressure: 190 / 80, RUE, Sitting
BMI Calculated: 29.41
BSA Calculated: 1.93
Height: 5 ft 6 in
Weight: 183 lb
Pain Scale: 8

Review of Systems

Eyes: currently wearing eyeglasses.
Skin:. Skin negative.
ENT:. Ear/nose/throat negative.
[redacted]
Endocrine:. Endocrine negative.
Genitourinary:. Genitourinary negative.
Pulmonary/Respitory:. Pulmonary/respiratory negative.
Hematologic/Lymphatic: a tendency for easy bruising.
Psychologic:. Psychologic negative.
Gastrointestinal: nausea and vomiting was observed.
Constitutional:. Constitutional negative.
Oncologic:. Oncologic negative.
Musculoskeletal: joint pain .
Other:. Pregnant negative.

Physical Exam

Cervical spine exam: Flexion 50 degrees, extension 40 degrees, right rotation and lateral bending 80 degrees, left rotation and lateral bending 80 degrees. No tenderness over the midline or facet region.
No spasm.
Elbow flexion test is negative bilateral. Tinel's and Phalen's tests at wrist and elbow are negative.
Shoulder exam: Range of motion full. Negative impingement sign. Negative apprehension sign.
Thoracic spine: No deformity and no tenderness.

RIGHT:
Deltoid: C5 of 5/5
Biceps: C6 of 5/5.
Triceps: C7 of 5/5.
Wrist extension: C6 of 5/5.
Finger extension: C7 of 5/5.
Finger adduction and abduction: C8, T1 of 5/5.

LEFT
Deltoid: C5 of 5/5.
Biceps: C6 of 5/5.
Triceps: C7 of 5/5.
Wrist extension: C6 of 5/5.
Finger extension: C7 of 5/5.
Finger adduction and abduction: C8, T1 of 5/5.

LOWER EXTREMITY MOTOR EXAM:
RIGHT
Hip flexors: L2-L3 (5/5).
Quad: L2, L3, L4 (5/5).
Tibialis anterior: L4, L5, (5/5).
EHL: L5 (5/5).
Peronei: L5-S1 (5/5)

LEFT
Hip flexors: L2-L3 (5/5).
Quad: L2, L3, L4 (5/5).
Tibialis anterior: L4, L5, (5/5).
EHL: L5 (5/5).
Peronei: L5-S1 (5/5).

SENSORY EXAM:
Light touch/pinprick/position: normal
C4 through T1: Right normal and left normal.
T1-T12: Right normal and left normal.
L1-S1: Right normal and left normal.

REFLEXES:
Upper extremities 2+ symmetrical.
Lower extremities 2+ symmetrical.
Hoffmann sign absent bilaterally.
Plantar: Clonus absent.

Spurling's test is negative bilateral.
No Long Tract Findings

Other Findings:

Right Shoulder Exam:

ROM: Full and painless
No Deltorid or rotator cuff weakness or atrophy
Radial pulse palpable
Sensation grossly intact
No obvious effusion or deformity
No instability or apprehension
Positive impingement

Other:

Constitutional
General appearance: Normal.
Musculoskeletal

Examination of gait and station: Normal.
Examination of digits and nails: Normal.
Inspection/palpation of joints, bones, and muscles: Abnormal.
Assessment of muscle strength/tone: Normal.

Cardiovascular
Pulses: Normal.
Examination of extremities for edema and/or varicosities: Normal.

Lymphatic
Palpation of lymph nodes in neck: Normal.
Palpation of lymph nodes in axillae: Normal.
Palpation of lymph nodes in groin: Normal.
Palpation of lymph nodes in other areas: Normal.

Abdomen
Examination of the abdomen: Soft and non-tender.

Skin
Inspection of skin and subcutaneous tissue: Normal.
Palpation of skin and subcutaneous tissue: Normal.

Neurologic
Examination of cranial nerves: Normal.
Examination of reflexes: Normal.
Examination of sensation: Normal.

Psychiatric
Orientation to person, place and time: Normal.
Mood and affect: Normal.

Imaging Studies

CT scan cervical spine illustrates left-sided facet arthritis.

Impression

1. [redacted]
2. Cervical Spondylosis 721.0
3. Lower Back Pain 724.2
4. Neck Pain 723.1
5. Shoulder Impingement 726.2

Neck sprain, Right shoulder impingement.

Plan

1. Physical Therapy Referral Evaluation and Treatment PT/OT Referral Requested for: 28Feb2014
2. BMI recorded today was greater than 25. We recommend follow up with your PCP regarding weight management. Done: 28Feb2014
3. Metoprolol Tartrate TABS; Status: DISCONTINUED

Anti-inflammatories. Physical therapy. Follow up 6 weeks for evaluation. X-rays on arrival right shoulder. Consider injection. Consider MRI at that time.

Signatures

Electronically signed by : Nicholas Renaldo, M.D.; Feb 28 2014 1:34PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
04/14/2014

Patient Information

[redacted]

Chief Complaint
Follow up to neck and right shoulder pain; xrays taken today.

History of Present Illness

[redacted] comes to OADC today for a follow up. Patient seems to have pain in her right shoulder. Physical therapy was not effective. She has difficulty lifting her arm overhead. She feels clicking and crepitus when prompted to move her shoulder. She has no radicular pain.

[redacted]

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded by : Renaldo, Nicholas at 14Apr2014 11:30AM
Blood Pressure: 148 / 82
Height: 5 ft 6 in
Weight: 185 lb
BMI Calculated: 29.86
BSA Calculated: 1.93
Pain Scale: 8

Physical Exam

Right Shoulder Exam:

ROM: Full and painless
No Deltoid or rotator cuff weakness or atrophy
Radial pulse palpable
Sensation grossly intact
No obvious effusion or deformity
No instability or apprehension
There is impingement with resistance agains forward flexion and abduction

Other:

Procedure

Subacromial injection performed into the right shoulder.The procedure was performed utilizing the SonoSite M-MSK ultrasound device with HFL38x Transducer. Ultrasound gel was applied to the skin at the desired location for the probe. The appropriate anatomic landmarks were identified and images captured. The skin was prepped in the normal fashion. The needle was guided down to the desired anatomic location and injection provided under live ultrasound. Ultrasound images were captured with the needle in place and stored for later review.

Imaging Studies
Shoulder x-rays demonstrate mild osteoarthritis.

Impression
1. Shoulder impingement (726.2)

Right shoulder impingement. Injection performed.

Plan
1. Administer: Administer: Bupivacaine HCl - 0.25 % Injection Solution (Marcaine 0.25 % Injection Solution); INJECT 7 ML Injection; To Be Done: 14Apr2014
2. Administer: Administer: Kenalog 40 MG/ML Injection Suspension (Triamcinolone Acetonide); INJECT 40 MG Injection; To Be Done: 14Apr2014

MRI to evaluate rotator cuff pathology. MRI to discuss further treatments including injections and arthroscopy. All questions were answered to the patient's satisfaction.

Signatures
Electronically signed by : Nicholas Renaldo, M.D.; Apr 14 2014 1:22PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
04/29/2014

Patient Information

[redacted]

Chief Complaint
Right shoulder MRI follow up.

History of Present Illness

[redacted] comes to OADC today for a follow up.

Patient states that the injection was extremely helpful. She is also doing physical therapy. She is completely 15 sessions. He has occasional soreness on her outer arm. She is able to move her arm overhead. She has increased range of motion.

[redacted]

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded by : Todd, Melinda at 29Apr2014 10:06AM
Heart Rate: 65
Blood Pressure: 196 / 90, RUE, Sitting
Height: 5 ft 6 in
Weight: 185 lb
BMI Calculated: 29.86
BSA Calculated: 1.93
Pain Scale: 3

Physical Exam

Right Shoulder Exam:

ROM: Full and painless
No Deltorid or rotator cuff weakness or atrophy
Radial pulse palpable
Sensation grossly intact
No obvious effusion or derformity
No instability or apprehension
No impingment type symptoms

Other:

Imaging Studies

MRI of the right shoulder demonstrates rotator cuff tendinitis. No tear.

Impression

1. [redacted] (278.02)
2. Shoulder impingement (726.2)

Right shoulder impingement. Improved injection therapy.

Plan

1. BMI recorded today was greater than 25. We recommend follow up with your PCP regarding weight management. Status: Complete - Retrospective Authorization Done: 29Apr2014

Weightbearing as tolerated. Continue shoulder exercises at home. Follow-up in 3-4 once reevaluation. We discussed a series of injections over the course of the year. We also discussed arthroscopy for bursectomy and cleaned out should injections failed to provide long-standing relief. All questions were answered to the patient's satisfaction.

Signatures

Electronically signed by : Nicholas Renaldo, M.D.; Apr 29 2014 10:25AM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
05/29/2014

[redacted]

Chief Complaint
Right shoulder.

History of Present Illness
Patient is to have right shoulder pain. Previous injection was helpful. Therapy has been ineffective Medications been ineffective. She is requesting an injection.

[redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded by : Haegler, Jessica at 29May2014 12:53PM
Blood Pressure: 165 / 80
Height: 5 ft 6 in
Weight: 185 lb
BMI Calculated: 29.86
BSA Calculated: 1.93
Pain Scale: 7

Physical Exam

Right Shoulder Exam:

ROM: Full and painless
No Deltoid or rotator cuff weakness or atrophy
Radial pulse palpable
Sensation grossly intact
No obvious effusion or deformity
No instability or apprehension
There is impingement with resistance against forward flexion and abduction

Other:

Procedure

7 cc of quarter percent Marcaine with 1 cc of 40 mg Kenalog injected sterilely into the subacromial space of the right shoulder.The procedure was performed utilizing the SonoSite M-MSK ultrasound device with HFL38x Transducer. Ultrasound gel was applied to the skin at the desired location for the probe. The appropriate anatomic landmarks were identified and images captured. The skin was prepped in the normal fashion. The needle was guided down to the desired anatomic location and injection provided under live ultrasound.

Ultrasound images were captured with the needle in place and stored for later review.

Imaging Studies

Previous MRI demonstrates rotator cuff tendinitis. She reports further detail.

Impression

1. [redacted] (278.02)

Right shoulder impingement. Status post 2 injections. Failure of nonoperative treatment.

Plan

1. BMI recorded today was greater than 25. We recommend follow up with your PCP regarding weight management. Status: Complete - Retrospective Authorization Done: 29May2014

Injection performed good result. Recommend ice and rest for the next week. Saws and pendulums encouraged. Follow-up with Dr. Kusior to consider arthroscopy. All questions were answered to the patient's satisfaction.

Signatures

Electronically signed by : Nicholas Renaldo, M.D.; May 29 2014 1:04PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
06/24/2014

Patient Information

[redacted]

Chief Complaint
Right shoulder.

[redacted]

4/24/15 12:21:49 PM

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded by : Cronk, Leslie at 24Jun2014 10:10AM

Blood Pressure: 189 / 93
Height: 5 ft 6 in
Weight: 185 lb
BMI Calculated: 29.86
BSA Calculated: 1.93
Pain Scale: 8

Review of Systems

Eyes: currently wearing eyeglasses.
Skin:. Skin negative.
ENT:. Ear/nose/throat negative.
Neurologic: dizziness and fainting.
Infectious Disease: [redacted].
Cardiovascular: [redacted].
Endocrine:. Endocrine negative.
Genitourinary:. Genitourinary negative.
Pulmonary/Respitory:. Pulmonary/respiratory negative.
Hematologic/Lymphatic: a tendency for easy bruising.
Psychologic:. Psychologic negative.
Gastrointestinal:. Gastrointestinal negative.
Constitutional:. Constitutional negative.
Oncologic:. Oncologic negative.
Musculoskeletal:. Musculoskeletal negative.
Other:. Pregnant negative.

Physical Exam

Patient states she injured her right shoulder when she slipped and fell in a parking lot in February of this year. She had a concussion had shoulder pain afterwards. No prior problems with her shoulder. She comes in for evaluation and states that the shoulder is painful and sore she's tried 2 cortisone shots and is tried physical therapy. On exam her right shoulder has full range of motion. There is some mild impingement-like findings noted. She does have good rotator cuff strength. Distal clavicle is nontender elbow wrist finger thumb range of motion are intact sensation is intact to the hand and pulses are present there is no signs of any scapular wingin her neck is supple good range of motiong

Constitutional
General appearance: Normal.
Musculoskeletal
Examination of gait and station: Normal.
Examination of digits and nails: Normal.
Inspection/palpation of joints, bones, and muscles: Abnormal.
Assessment of muscle strength/tone: Normal.
Upper extremity compartments: Normal.
Cardiovascular
Pulses: Normal.
Examination of extremities for edema and/or varicosities: Normal.

Lymphatic
Palpation of lymph nodes in other areas: Normal.
Skin
Inspection of skin and subcutaneous tissue: Normal.
Neurologic
Examination of sensation: Normal.
Upper extremity peripheral vascular exam: Normal.
Psychiatric
Orientation to person, place and time: Normal.
Mood and affect: Normal.

Imaging Studies

MRI was reviewed does appear to show shoulder bursitis tendinitis no signs of rotator cuff labral tearing

Impression

1. [redacted]
2. Shoulder impingement (726.2)

Right shoulder chronic tendinitis bursitis of the shoulder no definite tears

Plan

1. BMI recorded today was greater than 25. We recommend follow up with your PCP regarding weight management. Status: Complete - Retrospective Authorization Done: 24Jun2014

Patient has been having pain discomfort for 4 months after her fall. She's try cortisone and therapy. I offered her surgery as the next reasonable treatment however she is reluctant to consider any surgery at this time. I do not see any definite need for surgical intervention. Try to stay away from further cortisone shots. If she has no improvement over the next 2 months she should follow back up.

Thank you for allowing me to participate in the care o[redacted] you have any questions, please do not hesitate to contact me.

Signatures

Electronically signed by : Lawrence Kusior, M.D.; Jun 24 2014 12:35PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
03/10/2015

Patient Information

[redacted]

Chief Complaint
Right shoulder pain.

[redacted]

4/15 12:21:45 PM

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded: 10Mar2015 02:18PM
Height: 5 ft 6 in
Weight: 185 lb
BMI Calculated: 29.86
BSA Calculated: 1.93

Review of Systems

Eyes: currently wearing eyeglasses.
Skin:. Skin negative.
ENT: nasal discharge and epistaxis.
Neurologic:. Neurologic negative.
[redacted]
Endocrine:. Endocrine negative.
Genitourinary:. Genitourinary negative.
Pulmonary/Respitory:. Pulmonary/respiratory negative.
Hematologic/Lymphatic:. Hematological/lymphatic negative.
Psychologic:. Psychologic negative.
Gastrointestinal:. Gastrointestinal negative.
Constitutional:. Constitutional negative.
Oncologic:. Oncologic negative.
Musculoskeletal: joint pain .
Other:. Pregnant negative.

Physical Exam

Patient is follow-up her right shoulder is still painful and sore. I last seen her last year for 1 visit. She was diagnosed at the time with a rotator cuff tendinitis. She had treatment with cortisone and therapy. She still has had persistent pain and problems to the shoulder. On exam she has no bruising. She states she can elevate the arm past 90° but has pain discomfort in doing so. Her rotator cuff strength is grossly appear to be intact. Bicep triceps appear to be intact. Does appear to have impingement-like findings. Distal clavicle is nontender elbow wrist finger thumb range of motion are intact

Impression

1. Shoulder impingement (726.2)

Right shoulder pain chronic patient states she had a fall that aggravated the shoulder. At this point I told the patient mentions is been well over 6 months and she has not had result from conservative care of anti-inflammatory cortisone and therapy. I think surgical intervention would be reasonable to consider. I gave her copies shoulder arthroscopy handout to review. She will contemplate this with her husband and she will follow back up if she decides to proceed with surgery.

Plan

1. XRAY Shoulder 2 or more views; Status:Complete - Retrospective Authorization; Done: 10Mar2015 02:06PM

Patient: [redacted]
Encounter: [redacted]

Thank you for allowing me to participate in the care of [redacted] you have any questions, please do not hesitate to contact me.

Signatures
Electronically signed by : Lawrence Kusior, M.D.; Mar 10 2015 4:40PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
04/28/2015

Patient Information

[redacted]

Chief Complaint
RIGHT SHOULDER PAIN F/U.

History of Present Illness

[redacted]comes to OADC today for a follow up.

[redacted]

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded: 28Apr2015 01:29PM

Heart Rate: 69
Blood Pressure: 194 / 80
Height: 5 ft 6 in
Weight: 183 lb
BMI Calculated: 29.54
BSA Calculated: 1.93
Pain Scale: 8-9

Physical Exam

Patient is follow-up she's had persistent right shoulder pain. She has not been doing well with physical therapy. She still has pain and 8 - 9/10. She impingement like findings at 90°. Her rotator cuff strength does appear to be intact distal clavicle is nontender. She is neurologically intact to the hand and pulses are present

Imaging Studies

Prior MRI showed rotator cuff tendinitis bursitis impingement, no definite rotator cuff tears

Impression

1. Never a smoker
2. [redacted]
3. Shoulder impingement (726.2)

Right shoulder persistent shoulder pain unresponsive conservative care

Plan

Plans for right shoulder arthroscopy decompression debridement possible tendon surgery as needed. Informed consents were signed. This benefits were reviewed. Questions were asked and answered. We'll set up surgery near future. Handouts given

Discussion/Summary

The indications for surgery, nature of surgical treatment, alternative methods of treatment, including nonoperative

or no treatment were discussed at length. The possibility of failure of surgical outcome, surgical risks, including but not limited to: death, paralysis, infection, injury to nerve or blood vessel, blood clot, excessive bleeding requiring transfusion, stroke and damage to adjacent structures were discussed as well. No guarantees were given or implied. The patient understands and accepts the surgical risks and wishes to proceed. The patient understands all risks of nonoperative treatment and is willing to have the procedure performed.

Thank you for allowing me to participate in the care of [redacted] ou have any questions, please do not hesitate to contact me.

Signatures

Electronically signed by : Lawrence Kusior, M.D.; Jun 9 2015 12:30PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
06/23/2015

Patient Information

[redacted]

Chief Complaint
S/P Right shoulder arthroscopy 6/12/15.

Vitals
Vital Signs [Data Includes: Current Encounter]
Recorded: 23Jun2015 10:55AM
Height: 5 ft 6 in
Weight: 183 lb
BMI Calculated: 29.54
BSA Calculated: 1.93
Pain Scale: 1

Physical Exam
Patient is follow-up she is status post a right shoulder arthroscopic decompression debridement rotator cuff tendon surgery overall she is doing well. Her incisions are healing well. There is no signs of any infection. Her elbow wrist finger thumb range of motion are intact sensation is intact to the hand and pulses are present. Arthroscopy pictures were reviewed with her copies given

Impression
1. [redacted]
2. Shoulder Impingement (726.2)
3. Rotator cuff tear (840.4)

Right shoulder status post rotator cuff tendon surgery debridement

Plan
1. Stop: Meloxicam 15 MG Oral Tablet
2. BMI recorded today was greater than 25. We recommend follow up with your PCP regarding weight management.; Status:Complete - Retrospective Authorization; Done: 23Jun2015

Patient will continue with immobilization in her sling. No lifting, no sports. She'll follow back up in 3 weeks and pop start formal physical therapy at that time. I did tell her that the expected length to recover be close to 4-6 months.

Thank you for allowing me to participate in the care of [redacted] f you have any questions, please do not hesitate to contact me.

Signatures
Electronically signed by : Lawrence Kusior, M.D.; Jun 23 2015 12:07PM EST (Author)

Orthopedic Associates
OF DUTCHESS COUNTY
1910 South Road
Poughkeepsie, NY, 12601
(845)454-0120

Date of Service
07/14/2015

Patient Information

[redacted]

Chief Complaint
Right shoulder problem.

History of Present Illness

[redacted] comes to OADC today for a follow up.

[redacted]

8/21/15 10:32:08 AM

Patient: [redacted]
Encounter: [redacted]

[redacted]

Vitals

Vital Signs [Data Includes: Current Encounter]
Recorded: 14Jul2015 03:03PM

Height: 5 ft 6 in
Weight: 183 lb
BMI Calculated: 29.54
BSA Calculated: 1.93
Pain Scale: 4

Physical Exam

Patient is follow-up right shoulder does have some pain some discomfort. She has been using her sling. Her incisions look good. No signs of infection. Elbow wrist and finger thumb range of motion are intact

Impression

1. Complete rupture of rotator cuff (727.61)
2. Shoulder impingement (726.2)

Right shoulder status post rotator cuff repair

Plan

Patient will wean out of her sling, work on formal range of motion physical therapy exercises be reevaluated 6-8 weeks.

Thank you for allowing me to participate in the care o[redacted] you have any questions, please do not hesitate to contact me.

Signatures

Electronically signed by : Lawrence Kusior, M.D.; Jul 14 2015 5:20PM EST (Author)

Moriarty Physical Therapy P.C.

Moriarty Physical Therapy P.C.
301 Manchester Road
Suite 101
Poughkeepsie, NY 12603-2587
Phone: (845) 454-4137
Fax: (845) 454-6457

[redacted]
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	Measure	Note	CPT	Mod
Physical Therapy Evaluation	30			97001	
PROM	8	min		97140	
Manual Stretching	6	min		97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment	0			G8539	
Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented	0			G6730	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

[redacted]

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)

UEFS

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)

Medical History

Dominant Hand: Right.

General Health Questions

[redacted]

ADL Problems

ADL Problems: Automobile Use, Changing and Making Bed, Household Maintenance, Housework, Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint, Bicipital groove, Coracoid process, Subacromial.

	Result	Note
Cervical Active ROM		
Cervical Extension AROM	30 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	5 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	

[redacted]

Cervical R. Rotation AROM	70 degrees		
Cervical Passive ROM			
Cervical Extension PROM	40 degrees		
Cervical Flexion PROM	85 degrees		
Cervical L. Lateral Flexion PROM	10 degrees		
Cervical L. Rotation PROM	75 degrees		
Cervical R. Lateral Flexion PROM	25 degrees		
Cervical R. Rotation PROM	75 degrees		

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	90 degrees	160 degrees	
Shoulder Abduction AROM	75 degrees	150 degrees	
Shoulder External Rotation AROM	50 degrees	70 degrees	
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	115 degrees	170 degrees	
Shoulder Abduction PROM	100 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	2+ /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3 /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

Skilled Intervention: The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below. **As a result of these impairments, the patient has difficulty:** performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility.

Daily Assessment

Treatment Response: Pt. has a good understanding of diagnosis and HEP. PT. demonstrated an increase in GH flexion bilateral post-session compared to initial measurements.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching, Pulley AAROM exercises, Rotator cuff strengthening, Shoulder girdle strengthening, Wand AAROM exercises. **Supervised Exercises:** Body blade exercises, Plyo ball exercises, Rotator cuff strengthening, Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs, Ice Packs, TENS, Ultrasound. **Treatment Procedures:** Joint Mobilization, Manual Stretching, Massage, Myofascial Release, IASTM.

Electronically signed by:

[redacted]

[redacted]

Michael Stranges, PT
03/05/14 11:34 am
038504

John Quinn, PT, DPT
03/05/14 1:32 pm
License: 026945-1

[redacted]

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moriarty PHYSICAL THERAPY

[redacted]

Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	Measure	Note	CPT	Mod
PROM	5	min		97140	
Manual Stretching	6	min		97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min		97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)	

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)	

Medical History

Dominant Hand: Right

[redacted]

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	30 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	5 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	40 degrees	
Cervical Flexion PROM	85 degrees	
Cervical L. Lateral Flexion PROM	10 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	110 degrees	160 degrees	
Shoulder Abduction AROM	85 degrees	150 degrees	
Shoulder External Rotation	50 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	130 degrees	170 degrees	
Shoulder Abduction PROM	100 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	2+ /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3 /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

Skilled Intervention: The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below. **As a result of these impairments, the patient has difficulty:** performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility.

Daily Assessment

Treatment Response: Pt. demonstrates an improved in R GH flexion and abduction AROM and PROM.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
03/07/14 10:27 am
038504

PT DPT

John Quinn, PT, DPT
03/07/14 11:07 am
License: 026945-1

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[redacted]
03/12/14
Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	Measure	Note	CPT	Mod
PROM	8	min		97140	
Manual Stretching	6	min		97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min		97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

Spinal Symptom Rating		
Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)	

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. PL had concussion, along with neck, bilateral shoulder and R elbow pain. PL was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)	

Medical History

Dominant Hand: Right.

[redacted]

Shoulder Surgery: N/A

ADL Problems

ADL Problems: Automobile Use, Changing and Making Bed, Household Maintenance, Housework, Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint, Bicipital groove, Coracoid process, Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	30 degrees	
Cervical Flexion AROM	60 degrees	
Cervical L. Lateral Flexion AROM	5 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	40 degrees	
Cervical Flexion PROM	85 degrees	
Cervical L. Lateral Flexion PROM	10 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	110 degrees	160 degrees	
Shoulder Abduction AROM	85 degrees	150 degrees	
Shoulder External Rotation	50 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	130 degrees	170 degrees	
Shoulder Abduction PROM	100 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	2+ /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3 /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. tolerates session with no increase in pain.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching, Pulley AAROM exercises, Rotator cuff strengthening, Shoulder girdle strengthening, Wand AAROM exercises. **Supervised Exercises:** Body blade exercises, Plyo ball exercises, Rotator cuff strengthening, Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs, Ice Packs, TENS, Ultrasound. **Treatment Procedures:** Joint Mobilization, Manual Stretching, Massage, Myofascial Release, IASTM.

Electronically signed by:

Michael Stranges, PT
03/12/14 10:53 am
038504

John Quinn, PT, DPT
03/12/14 11:37 am
License: 026945-1

[redacted]

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[redacted]
Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	6	min		97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min		97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)

Medical History

Dominant Hand: Right.

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use, Changing and Making Bed, Household Maintenance, Housework, Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint, Bicipital groove, Coracoid process, Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	30 degrees	
Cervical Flexion AROM	60 degrees	
Cervical L. Lateral Flexion AROM	5 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	40 degrees	
Cervical Flexion PROM	85 degrees	
Cervical L. Lateral Flexion PROM	10 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	110 degrees	160 degrees	
Shoulder Abduction AROM	85 degrees	150 degrees	
Shoulder External Rotation	50 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	130 degrees	170 degrees	
Shoulder Abduction PROM	100 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	2+ /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3 /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: PL presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. demonstrates an increase in UE muscular endurance over baseline measures.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching, Pulley AAROM exercises, Rotator cuff strengthening, Shoulder girdle strengthening, Wand AAROM exercises. **Supervised Exercises:** Body blade exercises, Plyo ball exercises, Rotator cuff strengthening, Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs, Ice Packs, TENS, Ultrasound. **Treatment Procedures:** Joint Mobilization, Manual Stretching, Massage, Myofascial Release, IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
03/14/14 11:20 am
038504

PT DPT

John Quinn, PT, DPT
03/14/14 11:54 am
License: 026945-1

[redacted]

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moriarty PHYSICAL THERAPY

[redacted]

03/17/14
Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	7	min		97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min		97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)	

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)

Medical History

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	30 degrees	
Cervical Flexion AROM	60 degrees	
Cervical L. Lateral Flexion AROM	5 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	40 degrees	
Cervical Flexion PROM	85 degrees	
Cervical L. Lateral Flexion PROM	10 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	120 degrees	160 degrees	
Shoulder Abduction AROM	95 degrees	150 degrees	
Shoulder External Rotation	70 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	150 degrees	170 degrees	
Shoulder Abduction PROM	120 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3- /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. continues to demonstrate an increase in R GH AROM/PROM over baseline measures. Pt. was able to perform all therapeutic exercises with no rest breaks, demonstrating an increase in UE muscular endurance.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

Michael Stranges, PT
03/17/14 1:25 pm
038504

John Quinn, PT, DPT
03/17/14 1:44 pm
License: 026945-1

[redacted]

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[redacted]

Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: Nancy Moriarty, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	Measure	Note	CPT	Mod
PROM	8	min		97140	
Manual Stretching	7	min	UT,LS,GH	97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min	GH, cervical	97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G842 7	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)	

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)	

Medical History

Dominant Hand: Right.

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	40 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	15 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	50 degrees	
Cervical Flexion PROM	65 degrees	
Cervical L. Lateral Flexion PROM	20 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	120 degrees	160 degrees	
Shoulder Abduction AROM	95 degrees	150 degrees	
Shoulder External Rotation	70 degrees	70 degrees	

[redacted]

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	150 degrees	170 degrees	
Shoulder Abduction PROM	120 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3- /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. tolerates session with a decrease in pain and an increase in cervical ROM. Pt. demonstrates a decrease in tightness in R UT post-IASTM.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
03/19/14 10:52 am
038504

PT, DPT

Nancy Moriarty, PT, DPT
03/19/14 11:04 am
License: 016739-1

[redacted]

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moriarty
PHYSICAL THERAPY

[redacted]

03/24/14
Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	7	min	UT,LS,GH	97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min	GH, cervical	97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Current medications not documented by the eligible professional, reason not given	0			G8427	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)

UEFS

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS

[redacted]

Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	7 - Severe Pain (7 - 9)

Medical History

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	40 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	15 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	50 degrees	
Cervical Flexion PROM	85 degrees	
Cervical L. Lateral Flexion PROM	20 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	125 degrees	160 degrees	
Shoulder Abduction AROM	100 degrees	150 degrees	
Shoulder External Rotation	90 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	16 degrees	170 degrees	
Shoulder Abduction PROM	140 degrees	170 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3- /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3- /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. continues to demonstrate an increase in R GH AROM/PROM compared to baseline measures. Pt. has no increase in pain post-session.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
03/24/14 1:45 pm
038504

PT DPT

John Quinn, PT, DPT
03/24/14 1:52 pm
License: 026945-1

[redacted]

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moriarty PHYSICAL THERAPY

[redacted]

03/26/14
Diagnosis: Posterior soft tiss impg
Joint pain-shlder
Therapist: John Quinn, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	7	min	UT,LS,GH	97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min	GH, cervical	97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G842 7	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)	

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. PL was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	6 - Moderate Pain (4 - 6)	

Medical History

Dominant Hand: Right.

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	40 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	15 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	50 degrees	
Cervical Flexion PROM	65 degrees	
Cervical L. Lateral Flexion PROM	20 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Positive	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	140 degrees	160 degrees	
Shoulder Abduction AROM	110 degrees	150 degrees	
Shoulder External Rotation	90 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	175 degrees	175 degrees	
Shoulder Abduction PROM	175 degrees	175 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3 /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3 /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. demonstrates full PROM in R and L GH joints today for the first time since initial injury. PL also demonstrates a slight increase in UE strength compared to IE.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
03/26/14 10:55 am
038504

PT DPT

John Quinn, PT, DPT
03/26/14 11:16 am
License: 026945-1

[redacted]

Moriarty Physical Therapy P.C.
301 Manchester Road
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Poughkeepsie, NY 12603-2587
Phone: (845) 454-4137
Fax: (845) 454-6457

[redacted]

03/31/14
Diagnosis: Posterior soft tiss impg
Joint pain-shider
Therapist: Nancy Moriarty, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	7	min	UT,LS,GH	97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min	GH, cervical	97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	

Subjective

Spinal Symptom Rating

Neck Disability Index	68 - Moderate activity causes significant pain (40 - 69)

UEFS

[redacted]

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	6 - Moderate Pain (4 - 6)	

Medical History

Dominant Hand: Right.

[redacted]

Shoulder Surgery: N/A.

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	40 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	15 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	50 degrees	
Cervical Flexion PROM	65 degrees	
Cervical L. Lateral Flexion PROM	20 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

[redacted]

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	7 - Severe Pain (7 - 9)

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	
Bilateral Upper Extremity	*Right*	*Left*	
Shoulder: Acromioclavicular			
Shear Test	Positive	Negative	

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*
Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	140 degrees	160 degrees	
Shoulder Abduction AROM	110 degrees	150 degrees	
Shoulder External Rotation	90 degrees	70 degrees	

[redacted]

AROM			
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	175 degrees	175 degrees	
Shoulder Abduction PROM	175 degrees	175 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3 /5	3+ /5	
Shoulder External Rotation Strength	3 /5	3+ /5	
Shoulder Flexion Strength	3 /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. continues to tolerate therapy with no increase in pain. PL still has restrictions in bilateral paraspinals and deltoids.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. TENS. Ultrasound. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage. Myofascial Release. IASTM.

Electronically signed by:

Michael Stranges, PT
03/31/14 10:53 am
038504

Nancy Moriarty, PT, DPT
03/31/14 11:11 am
License: 016739-1

[redacted]

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301 Manchester Road
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Phone: (845) 454-4137
Fax: (845) 454-6457

[redacted]

04/02/14
Diagnosis: Posterior soft tiss impg
Joint pain-shider
Therapist: Nancy Moriarty, PT, DPT
Referred by: Nicholas Renaldo, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
PROM	8	min		97140	
Manual Stretching	7	min	UT,LS,GH	97140	
Shoulder Overhead Pulley Active Range of Motion	4	sets reps		97110	
Shoulder ER (Rubber Tubing)	4	sets reps color		97110	
Shoulder IR (Rubber Tubing)	4	sets reps color		97110	
Mid Rows (rubber tubing)	4	sets reps color		97110	
Shoulder Extension (Rubber Tubing)	4	sets reps color		97110	
Shoulder Flexn with Wand Passive Range of Motion	4	sets reps		97110	
Joint Mobilization	10	min	GH, cervical	97140	
Hot Pack	10	min	pre-session	97010	
Other Shoulder Exercise	4	sets reps	AROM GH flexion, scaption in standing	97110	
Physical Therapy ReEval	15			97002	59
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	
Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment	0			G8539	
Pain assessment documented as positive utilizing a standardized tool	0			G8730	

[redacted]

AND a follow-up plan is documented				

Subjective

Spinal Symptom Rating

Neck Disability Index	40 - Moderate activity causes significant pain (40 - 69)	

UEFS

The Upper Extremity Functional Score is reported below. At subsequent evaluations, we will report on the UEFS Score Change.: A change of 9 points or more in the UEFS indicates a significant change in function. 25/80.

Right Shoulder

Onset

Date of Onset: 02/22/14. **Description:** Pt. fell on ice and hit back of head. Pt. had concussion, along with neck, bilateral shoulder and R elbow pain. Pt. was transported to hospital with cervical collar in ambulance. **Mechanism of Shoulder Injury:** Trauma/fall.

Current Complaints

Patient reports: pain in neck, bilateral shoulders, and R elbow. Pain is worse with GH elevation, looking up or to the side, or lifting objects.

Pain Rating

Visual Analog Scale Numeric Pain Rating	4 - Moderate Pain (4 - 6)	

Medical History

[redacted]

ADL Problems

ADL Problems: Automobile Use. Changing and Making Bed. Household Maintenance. Housework. Shopping. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to rotate/sidebend head, raise arms overhead, or carry heavy objects without significant pain.

Medical History

Current Medications: See intake.

Objective

Tender Structures

Tender Shoulder Joint Structures: (R) AC joint. Bicipital groove. Coracoid process. Subacromial.

	Result	*Note*
Cervical Active ROM		
Cervical Extension AROM	40 degrees	
Cervical Flexion AROM	80 degrees	
Cervical L. Lateral Flexion AROM	15 degrees	
Cervical L. Rotation AROM	70 degrees	
Cervical R. Lateral Flexion AROM	20 degrees	
Cervical R. Rotation AROM	70 degrees	
Cervical Passive ROM		
Cervical Extension PROM	50 degrees	
Cervical Flexion PROM	65 degrees	
Cervical L. Lateral Flexion PROM	20 degrees	
Cervical L. Rotation PROM	75 degrees	
Cervical R. Lateral Flexion PROM	25 degrees	
Cervical R. Rotation PROM	75 degrees	

PQRS Measures

Functional Outcome Assessment Performed: Results of standardized outcomes measures included in evaluation.
Current Medications: See medication list scanned into record.

Pain Rating

Verbal Pain Rating at Present	4 - Moderate Pain (4 - 6)	

Neck

Posture and Alignment

Head and Neck Posture: Forward head.

Right Upper Extremity	*Right*	*Left*	*Note*
Upper Extremity Neurovascular Screening			
Biceps Tendon Reflex (C5,6)	Normal (2+)	Normal (2+)	
Brachioradialis Tendon Reflex (C6)	Normal (2+)	Normal (2+)	
Triceps Tendon Reflex (C7)	Normal (2+)	Normal (2+)	
Elbow Strength Testing			
Elbow Extension Strength	3+ /5	3+ /5	
Elbow Flexion Strength	3+ /5	3+ /5	
Forearm Pronation Strength	3+ /5	3+ /5	
Forearm Supination Strength	3+ /5	3+ /5	
Wrist Strength Testing			
Wrist Extension Strength	3+ /5	3+ /5	
Wrist Flexion Strength	3+ /5	3+ /5	
Wrist Radial Deviation Strength	3+ /5	3+ /5	
Wrist Ulnar Deviation Strength	3+ /5	3+ /5	

Bilateral Upper Extremity	*Right*	*Left*
Shoulder: Acromioclavicular		
Shear Test	Negative	Negative

Right Shoulder

Posture and Alignment

Shoulder Deformity: Rounded shoulders. **Shoulder Girdle:** slight scapular winging.

	Right	*Left*	*Note*

[redacted]

[redacted]

Joint Integrity Testing of Shoulder			
Impingement	Positive	Negative	
Shoulder: Muscle and Tendon Pathology Tests			
Empty Can/Supraspinatus Test - RC Tear, Impingement Syndrome	Positive	Negative	
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	150 degrees	170 degrees	
Shoulder Abduction AROM	135 degrees	170 degrees	
Shoulder External Rotation AROM	90 degrees	90 degrees	
Shoulder Internal Rotation AROM	90 degrees	90 degrees	
Shoulder Passive ROM			
Shoulder Flexion PROM	175 degrees	175 degrees	
Shoulder Abduction PROM	175 degrees	175 degrees	
Shoulder External Rotation PROM	90 degrees	90 degrees	
Shoulder Internal Rotation PROM	90 degrees	90 degrees	
Shoulder Strength Testing			
Shoulder Abduction Strength	3+ /5	3+ /5	
Shoulder External Rotation Strength	3+ /5	3+ /5	
Shoulder Flexion Strength	3+ /5	3+ /5	
Shoulder Internal Rotation Strength	3+ /5	3+ /5	

Assessment

Right Shoulder

Assessment

Contraindications to Therapy: none. **Precautions to Therapy:** none.

Diagnosis

Shoulder Diagnosis: Pt. presents to physical therapy s/p fall and concussion and now likely has R GH impingement, RC tendonitis, and AC jt. sprain, along with L shoulder RC tendonitis and cervical sprain.

Assessment of Impairments

As a result of these impairments, the patient has difficulty: performing ADLs including anything with cervical sidebending, GH elevation or lifting heavy objects. **Patient presents with:** decreased ROM, decreased strength, pain, joint hypomobility. **Skilled Intervention:** The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below.

Daily Assessment

Treatment Response: Pt. has demonstrated improvements with ROM, strength, muscular endurance, pain levels, and overall function. Pt. continues to demonstrate deficiencies, that can be seen above, that should be addressed with additional skilled PT.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** Pectoral stretching. Pulley AAROM exercises. Rotator cuff strengthening. Shoulder girdle strengthening. Wand AAROM exercises. **Supervised Exercises:** Body blade exercises. Plyo ball exercises. Rotator cuff strengthening. Shoulder girdle muscle strengthening. **Treatment Modalities:**

[redacted]

Hot Packs, Ice Packs, TENS, Ultrasound. **Treatment Procedures:** Joint Mobilization, Manual Stretching, Massage, Myofascial Release, IASTM.

Electronically signed by:

PT, DPT

Michael Stranges, PT
04/02/14 10:35 am
038504

PT, DPT

Nancy Moriarty, PT, DPT
04/02/14 10:50 am
License: 016739-1

[redacted]

Moriarty Physical Therapy P.C.
301 Manchester Road
Suite 101
Poughkeepsie, NY 12603-2587
Phone: (845) 454-4137
Fax: (845) 454-6457

[redacted]

07/20/15
Diagnosis: Muscle weakness-general
Joint pain-shlder
Rotator cuff dis NEC
Orthopedic aftercare NEC
Therapist: John Quinn, PT, DPT
Referred by: Lawrence Kusior, MD
Total Visits: 1

Summary

Thank you for this referral. My initial evaluation follows.

Procedures

	Minutes	*Measure*	*Note*	*CPT*	*Mod*
Physical Therapy Evaluation	30			97001	
Therapeutic Exercise	15	min	Wand AAROM, Pulleys, UT stretch	97110	
Manual Therapy	15	min	STM to (R) UT, Biceps, Pec insertion, deltoid.	97140	
Patient Education/Self Care Management	15	min	Pt provided with HEP and demonstrated understanding of exercises.	97535	
Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability	0			G8427	
Falls plan of care documented	0			0518F	
Falls risk assessment documented	0			3288F	
Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year	0			1100F	
Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment	0			G8539	
Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented	0			G8730	

Subjective

Right Shoulder

Onset

[redacted]

Date of Onset: 2/22/14. **Mechanism of Shoulder Injury:** Slip and fall on ice in stop & shop parking lot.

Current Complaints

Patient reports: Pt is a 73 yo female s/p (R) RTC repair and debridement via arthroscopy 6/12/15. Pt reports falling on ice 2/22/14 and hurting her (R) shoulder. Pt attempted PT prior to surgery with no benefits/decrease in symptoms. Pt then had (R) RTC repair and debridement on 6/12/15, relieving some symptoms, but leaving the pt in pain with decrease ROM and strength. Pt reports that she was in a sling for the first 4 weeks after surgery and this is the first week she is not using it. At this point in time the patient would like to be pain free, have her full ROM and strength back, and be able to garden again.

Pain Rating

Visual Analog Scale Numeric Pain Rating	5 - Moderate Pain (4 - 6)

[redacted]

ADL Problems

ADL Problems: Automobile Use. Bathing and Showering. Bed Mobility. Changing and Making Bed. Cleaning Bathroom. Clothing Care. Dressing. Feeding and Eating. Hair Care. Health Maintenance. Housework. Meal Preparation. Oral Hygiene. Shopping. Yard work. **Prior Level of Function:** Prior to this injury/episode, patient had no difficulty with ADL.

Functional Deficits

Primary Functional Limitation: Patient is unable to garden 2* to significant pain, decreased ROM and strength. **Second Functional Limitation:** Patient is unable to lift 2* to weakness and pain and precautions. **Third Functional Limitation:** Patient is unable to use the RUE to groom her hair 2* to decreased ROM, weakness and pain. **Fourth Functional Limitation:** Patient is unable to perform housework such as clean 2* to pain, weakness and decreased ROM.

Outcomes Scores Correlated to Medicare Impairment Rating

Upper Extremity Functional Scale Modified for Medicare Impairment Ratings	21 - CL: 60 to 79% Impaired (17 - 31)

Medical History

Current Medications: Norvasc (5mg).

Objective

Objective

Note: Pt presented with limited (R) shoulder ROM, strength and increased tension in muscles surrounding the shoulder. Pt has 4 incision scars with tenderness to touch of all 4. Pt also has tenderness in the (R) UT, biceps, pecs, and deltoid.

Neck

Posture and Alignment

Head and Neck Posture: FHP, elevated (L) shoulder, slight winging of (B) scapulae, rounded shoulders.

Right Shoulder	*Right*	*Left*	*Note*
Shoulder Active ROM			
Shoulder Flexion Active Range of Motion	50 degrees	180 degrees	N/T on (L) but WFL - Soreness
Shoulder Abduction AROM	45 degrees	180 degrees	N/T on (L) but WFL - Pain in superior

[redacted]

			shoulder
Shoulder External Rotation AROM	43 degrees	90 degrees	N/T on (L) but WFL
Shoulder Internal Rotation AROM	45 degrees	90 degrees	Blocked by body.
Shoulder Passive ROM			
Shoulder Flexion PROM	85 degrees	180 degrees	N/T on (L) but WFL - Soreness
Shoulder Abduction PROM	73 degrees	180 degrees	N/T on (L) but WFL - Pain in superior shoulder
Shoulder External Rotation PROM	52 degrees	90 degrees	N/T on (L) but WFL
Shoulder Internal Rotation PROM	45 degrees	90 degrees	Blocked by body. N/T on (L) but WFL

Assessment

Right Shoulder

Assessment

Precautions to Therapy: Pt on RTC surgery protocol.

Diagnosis

Shoulder Diagnosis: (R) RTC repair and debridement via arthroscopy 6/12/15

Assessment of Impairments

Skilled Intervention: The patient requires skilled intervention by a physical therapist in order to achieve the LTG stated below. **As a result of these impairments, the patient has difficulty:** performing ADLs including those listed above. **Patient presents with:** decreased ROM. decreased strength. joint hypomobility. pain.

Daily Assessment

Treatment Response: Pt tolerated session well with increased tenderness in the (R) UT, Biceps, Pec insertion, and deltoid. Pt able to perform HEP within tolerable ROM, with proper form. Pt able to tolerate gentle STM to (R) UT, Biceps, Pec insertion, deltoid.

Plan

Right Shoulder

Shoulder Plan of Care

Duration: Six weeks. **Frequency:** Three times weekly. **Home Exercises:** See enclosed patient handout. **Supervised Exercises:** Rotator cuff strengthening. **Treatment Modalities:** Hot Packs. Ice Packs. Interferential Electrical Stimulation. **Treatment Procedures:** Joint Mobilization. Manual Stretching. Massage.

Daily SOAP Note

SUBJECTIVE

Note: Pt is a 73 yo female s/p (R) RTC repair and debridement via arthroscopy 6/12/15. Pt reports falling on ice 2/22/14 and hurting her (R) shoulder. Pt attempted PT prior to surgery with no benefits/decrease in symptoms. Pt then had (R) RTC repair and debridement on 6/12/15, relieving some symptoms, but leaving the pt in pain with decrease ROM and strength. Pt reports that she was in a sling for the first 4 weeks after surgery and this is the first week she is not using it. At this point in time the patient would like to be pain free, have her full ROM and strength back, and be able to garden again.

OBJECTIVE

Note: See procedures.

ASSESSMENT

Note: Pt tolerated session well with increased tenderness in the (R) UT, Biceps, Pec insertion, and deltoid. Pt able to perform HEP within tolerable ROM, with proper form. Pt able to tolerate gentle STM to (R) UT, Biceps, Pec insertion, deltoid.

PLAN

Note: Progress POC as tolerable and within protocol.

Electronically signed by:

[redacted]

Donna DeMilio, PT, DPT
07/20/15 5:31 pm
034724-1

John Quinn, PT, DPT
07/20/15 8:01 pm
License: 026945-1

[redacted]

Garner Chiropractic

Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted]

Wednesday, March 05, 2014

The patient came in for her appointment and stated that she is doing much worse than she was doing on her last visit. [redacted] presented today for the first time in weeks after she slipped and fell straight backwards on ice and hit her head. [redacted] was taken via ambulance to the local ER and had a head CT scan and was diagnosed with a shoulder injury, consussion, neck and upper back whiplash and myofascial pain. [redacted] was examined by her PCP and sent to an ortho who referred her back to my office to treat the spinal injuries as he treats her shoulder. The patient rated her lower back a 5, neck an 8, mid back an 8 and left sacro-iliac articulation a 4 on a scale of 0 to 10 with 0 being nothing and 10 being her original intensity. The patient explained that her problems continue to be aggravated when she does nothing in particular because it is always there. The patient also stated her symptoms are still improved when she uses heat and rests. Observation of [redacted] revealed decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. Observation of the patient's active range of motion revealed decreased lumbar flexion with pain and extension with pain. I noticed moderate spasms in [redacted]'s neck and lower back. While palpating the patient, I found moderate tender taut fibers over her neck. While I had the patient in the prone position, I noticed she had a functionally short right leg length. To decrease the patient's discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up the patient's healing process, massage therapy was applied to [redacted]'s cervical musculature and mid thoracic musculature (97124). A hydrocollator pack was utilized to create moist heat over [redacted]'s cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). To increase the motion in her spine and to relax the paraspinal musculature, mechanical traction was performed over [redacted]'s cervical spine (97012). Using motion palpation, the Diversified manual adjusting technique was performed over all restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each manipulation (98941). An upper posture exercise was taught to and done with the patient in to build the flexibility and strength of the her neck, shoulder and upper back musculature and bring her head over her shoulders with her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). P.N.F. stretches were performed over the patient's cervical and traps musculature (97112). I did trigger point therapy over trigger points found in her traps regions to further relax her musculature and decrease her discomfort (97530). When leaving, the patient informed me that she felt slightly better. The patient has been advised to return for her next treatment on an as needed basis. As of today, the patient's prognosis is guarded because she is currently acute and has not had enough treatments to correctly evaluate a prognosis.

Dr. Gregory Garner

The patient has been advised to return for her next treatment on an as needed basis.

CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted] Wednesday, April 02, 2014

As the patient came into the office, she informed me that she is doing slightly worse. The patient rated her lower back a 5, neck an 8, mid back an 8 and left sacro-iliac articulation a 4 on a scale of 0 to 10 with 0 being nothing and 10 being her original intensity. The patient's aggravating activities are unchanged and are when she does nothing in particular because it is always there. [redacted] also let me know that her problems continue to become better when she uses heat and rests. The patient's active range of motion revealed decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. The patient presented with decreased lumbar flexion with pain and extension with pain. Moderate spasms were noticed in [redacted]s neck and lower back. Palpation of the patient revealed moderate tender taut fibers over her neck. Examination of the patient in the prone position revealed a functionally short right leg length. To speed up the healing process through decreasing her discomfort, decreasing the muscle tone, decreasing any swelling, breaking up any adhesions, and increasing the vascular flow, therapeutic massage was applied to [redacted]s cervical musculature and mid thoracic musculature (97124). A hydrocollator pack was utilized to create moist heat over the patient's cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). I used mechanical traction over [redacted]s cervical spine to increase the motion in her spine and to relax the associated paraspinal musculature through stretching the individual intersegmental muscles and ligaments (97012). The Diversified adjusting technique was performed over all restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each adjustment (98941). An upper posture exercise was taught to and done with the patient in to build the strength and flexibility of the patient's neck, shoulder and upper back musculature and bring her head over her shoulders with her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). P.N.F. stretches were applied to the patient's cervical and traps musculature (97112). Trigger point therapy was done over trigger points found in her traps regions to relax her musculature and decrease her discomfort (97530). Before the visit was over, [redacted] stated that she felt slightly better. [redacted] has been informed to return for her next recommended treatment on an as needed basis. The patient's prognosis is guarded because she is currently acute and has not had enough treatments to correctly evaluate a prognosis.

Dr. Gregory Garner

[redacted] has been informed to return for her next recommended treatment on an as needed basis.

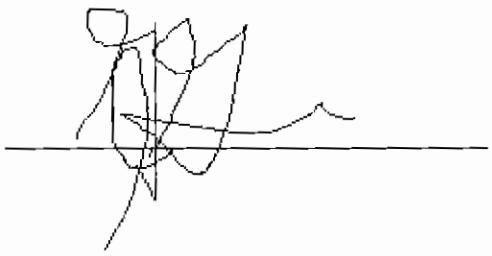
CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted] Friday, April 18, 2014

As the patient came into the office, she informed me that she is doing slightly worse. When I asked the patient to rate her intensity on a scale of 0 to 10 with 0 being nothing and 10 being her original intensity, [redacted] gave her lower back a 5, neck an 8, mid back an 8 and left sacro-iliac articulation a 4 since her last office visit. The patient's aggravating activities remain unchanged. As previously noted, they are when she does nothing in particular because it is always there. [redacted] also stated that her problems still become better when she uses heat and rests. Observation of the patient revealed decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. The patient's lumbar range of motion showed decreased lumbar flexion with pain and extension with pain. I noticed moderate spasms in [redacted]'s neck and lower back. Palpation of the patient revealed moderate tender taut fibers over her neck. I observed the patient had a functionally short right leg length while she was in the prone position. To decrease the patient's discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up the patient's healing process, massage therapy was applied to [redacted]'s cervical musculature and mid thoracic musculature (97124). A hydrocollator pack was used to create moist heat to decrease the discomfort of the [redacted]'s cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). Mechanical traction was applied over [redacted]'s cervical spine to increase the motion in her spine and to relax the associated paraspinal musculature through stretching the individual intersegmental muscles and ligaments (97012). Using motion palpation, the Diversified manual adjusting technique was performed over all restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each manipulation (98941). An upper posture exercise was taught to and performed with the patient in to build the flexibility and strength of the her neck, shoulder and upper back musculature and bring her head over her shoulders with her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). Proprioceptive nerve facilitation stretches were done so the patient's cervical and traps musculature (97112). To relax the patient's musculature and decrease her discomfort, trigger point therapy was done over trigger points found in her traps regions (97530). After the treatment, [redacted] stated that she felt slightly better. I have instructed the patient to schedule her next treatment on an as needed basis. The prognosis for this patient at this time is guarded because she is currently acute and hasn't received enough treatments to determine a prognosis.



Dr. Gregory Garner

I have instructed the patient to schedule her next treatment on an as needed basis.

CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

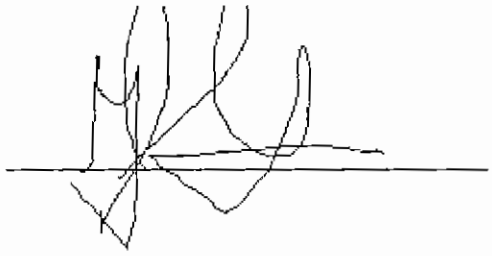
Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted]

Wednesday, May 21, 2014

The patient came in today stating that since her last office visit, she is doing slightly worse. On a scale of 0 to 10, with 0 being nothing and 10 being her original intensity, the patient rated her lower back a 5, neck a 6, mid back a 6 and left sacro-iliac articulation a 4. The patient explained to me that her problems continue to be aggravated when she does nothing in particular because it is always there. The patient stated that her symptoms continue to be relieved when she uses heat and rests. The patient presented with decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. Observation of the patient showed decreased lumbar flexion with pain and extension with pain. Moderate spasms were observed in the patient's neck and lower back. The patient had moderate tender taut fibers over her neck. I observed the patient had a functionally short right leg length while she was in the prone position. Therapeutic massage was applied over the patient's cervical musculature and mid thoracic musculature to decrease her discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up her healing process (97124). I applied a hydrocollator pack to create moist heat over the patient's cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). To increase the motion in her spine and to relax the paraspinal musculature, mechanical traction was used over [redacted]'s cervical spine (97012). Using motion palpation, the Diversified manual adjusting technique was performed over all restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each manipulation (98941). An upper posture exercise was taught to and performed with the patient in to build the flexibility and strength of the patient's neck, shoulder and upper back musculature so that she can bring her head over her shoulders and bring her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). P.N.F. stretches were performed over the patient's cervical and traps musculature (97112). I performed trigger point therapy over trigger points found in the patient's traps regions to further relax her musculature and decrease her discomfort (97530). After the treatment, [redacted] informed me that she felt slightly better. The patient has been instructed to return for her next treatment on an as needed basis. Currently, the patient's prognosis is guarded because the patient is currently acute and hasn't received enough treatments to determine a prognosis.



Dr. Gregory Garner

The patient has been instructed to return for her next treatment on an as needed basis.

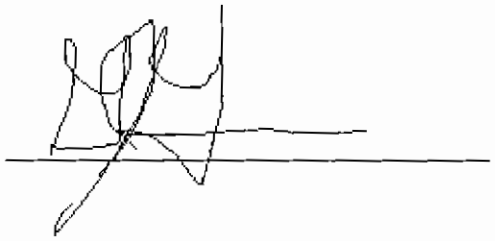
CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted] Monday, August 18, 2014

When the patient came into the office, she informed me that she is doing slightly worse. [redacted] presented with increased neck and low back pain from doing yard work over the weekend. She noted the low back pain and muscle spasms have been chronic and seem to be getting worse over the last 2-3 weeks with not coming for regular care on a monthly basis. Upon exam she had restricted ranges of motion, pain with ortho testing, and was having problems preforming ADL's at home. The patient gave her lower back a 6, neck a 6, mid back a 2 and left sacro-iliac articulation a 4 on a scale of 0 to 10 with 0 being nothing and 10 being her original intensity. The patient stated that her problems are still aggravated when she does nothing in particular because it is always there. The patient also informed me that her symptoms continue to improve when she uses heat and rests. Observation of the patient showed decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. The patient's lumbar range of motion showed decreased lumbar flexion with pain and extension with pain. Moderate spasms were noted in [redacted]'s neck and lower back. Palpation of the patient showed moderate tender taut fibers over her neck. I noticed the patient had a functionally short right leg length while she was in the prone position. Therapeutic massage was applied to the patient's cervical musculature and mid thoracic musculature to decrease her discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up her healing process (97124). A hydrocollator pack was used to create moist heat to decrease the discomfort of the patient's cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). I applied mechanical traction over [redacted]'s cervical spine to increase the motion in her spine and to relax the associated paraspinal musculature through stretching the individual intersegmental muscles and ligaments (97012). I used the Diversified adjusting technique over all of the patient's restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each adjustment (98941). An upper posture exercise was taught to and performed with the patient in to build the strength and flexibility of the patient's neck, shoulder and upper back musculature and bring her head over her shoulders with her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). Trigger point therapy was performed over trigger points found in her traps regions to relax her musculature and decrease her discomfort (97530). After the treatment, the patient told me that she felt slightly better. I have instructed the patient to schedule her next treatment on an as needed basis. Currently, the prognosis for this patient is guarded because she is currently acute and has not had enough treatments to correctly evaluate a prognosis.



Dr. Gregory Garner

I have instructed the patient to schedule her next treatment on an as needed basis.

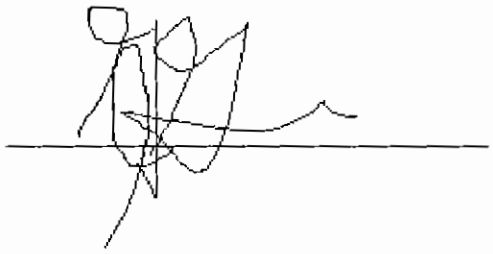
CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

Office Visit

Garner Chiropractic
4 Tucker Drive
Poughkeepsie, NY 12603
845-471-8400

[redacted] Monday, September 15, 2014

The patient informed me that she is doing slightly worse since her last office visit. The patient rated her lower back a 6, neck a 6, mid back a 2 and left sacro-iliac articulation a 4 on a scale of 0 to 10 with 0 being nothing and 10 being her original intensity. The patient's aggravating activities have not changed. As previously noted, they are when she does nothing in particular because it is always there. The patient also let me know that her symptoms still improve when she uses heat and rests. Testing of the patient's cervical range of motion produced the result of decreased cervical flexion with pain, extension with pain, left rotation with pain, right rotation with pain, left lateral flexion with pain and right lateral flexion with pain. Observation of the patient revealed decreased lumbar flexion with pain and extension with pain. I noted moderate spasms in [redacted]'s neck and lower back. The patient had moderate tender taut fibers over her neck. While I had the patient in the prone position, I observed she had a functionally short right leg length. To decrease the patient's discomfort, decrease the muscle tone, decrease any swelling, break up any adhesions, increase the vascular flow, and speed up the patient's healing process, massage therapy was applied to [redacted]'s cervical musculature and mid thoracic musculature (97124). I applied a hydrocollator pack to create moist heat over the patient's cervical musculature and lumbar musculature to increase the blood flow, decrease the discomfort, and relax the associated musculature (97010). I performed mechanical traction over [redacted]'s cervical spine to increase the motion in her spine and to relax the associated paraspinal musculature through stretching the individual intersegmental muscles and ligaments (97012). Diversified manual adjustments were performed over all restricted vertebral segments. All segments moved well, and appropriate audible releases were heard with each adjustment (98941). An upper posture exercise was taught to and performed with the patient in to build the flexibility and strength of the her neck, shoulder and upper back musculature so that she can bring her head over her shoulders and bring her shoulders back to reduce her forward head posture and decrease the risk of future problems associated with it. The patient has been instructed to perform the exercises at least once daily (97110). P.N.F. stretches were done to the patient's cervical and traps musculature (97112). To relax the patient's musculature and decrease her discomfort, trigger point therapy was performed over trigger points found in her traps regions (97530). Before the visit was over, the patient told me that she felt slightly better. I have advised the patient to return for her next treatment on an as needed basis. Currently, the prognosis for this patient is guarded because she is currently acute and hasn't received enough treatments to determine a prognosis.



Dr. Gregory Garner

I have advised the patient to return for her next treatment on an as needed basis.

CPT codes: CMT 3-4 Regions 98941, Hot/Cold Packs 97010, Mechanical Traction 97012 1 Units, Therapeutic Exercise 97110 1 Units, Neuromuscular Re-Ed 97112 1 Units, Massage 97124 and Therapeutic Activities 97530 1 Units

Ulster Radiologic Associates, P.C.

Ulster Radiologic Associates, P.C.

P.O. Box 2270
Kingston, NY 12402
Phone: (845) 339-7582
Fax: (845) 338-5616

Jonathan Ahmadjian, MD
Bruce B. Moor, MD
Susan K. Connors, MD
Thomas Koshy, MD
Gi Suk Song, MD
Steven Schwartz, MD
Jaime L. Parent, MD

Nicholas J Renaldo MD
1910 South Road
Poughkeepsie, NY 12601

[redacted]

Date of Service: 04/22/2014

MRI JOINT UPR EXTREM W/O CONTRAST right shoulder

CLINICAL HISTORY: Pain

COMPARISON: None

TECHNIQUE: Multiple sequences of the RIGHT shoulder were performed on a 1.5 Tesla magnet including axial PD and PD fat sat, oblique coronal PD and T2 fat sat, and sagittal T1 and PD fat sat sequences.

FINDINGS: There is infraspinatus and supraspinatus tendinitis. There is probably an element of subscapularis tendinitis. Increased signal and thickening of the intra-articular portion of the long head of the biceps is present without rupture. No complete rotator cuff tear. Mild degenerative change of the a.c. joint. The acromiohumeral space measures 6-7 mm. No atrophy of the musculature of the rotator cuff. Small amount of subacromial subdeltoid fluid is present. Small joint effusion in the glenohumeral joint. Small amount of fluid in the subcoracoid recess which appears to contain some debris or synovitis.

No labral tear. No labral cysts. No Hill-Sachs deformity. No acute fracture. No soft tissue mass.

IMPRESSION: Diffuse rotator cuff tendinitis. Tendinitis of the long head of the biceps.

Small glenohumeral effusion. There may be a small amount of synovitis or debris in the subcutaneous coracoid recess.

Electronically signed by:Nicholas Renaldo M.D. Apr 29 2014 8:32AM EST 4/29/2014

[redacted]

Jonathan Ahmadjian, MD
JA/ja/04/23/14

Electronically Signed - JONATHAN AHMADJIAN, MD 04/23/14 9:48

Unspecified

Consents

Document Name: Consent Forms Auth (Verified)
Performed By: CPDI User 10/31/2014 11:22:38 EDT
Authenticated By:

[redacted]

[redacted]

ACKNOWLEDGEMENT OF BILL OF RIGHTS/ ADVANCE DIRECTIVES / NOTICE OF PRIVAC[redacted]

I have received a copy of the Patient's Bill of Rights, as required by New York State l[redacted]
had an opportunity to receive assistance in understanding and exercising these rights. Attn: Midgley MD, Stephanie G.
Privacy Practices as required by the Health Insurance Portability and Accountability A[redacted]

23 50[redacted]

Medical Record

To be completed by the Vassar Brothers Medical Center

If Signature was not obtained, it was because:

- ☐ Patient is unable and unaccompanied by a representative and the Bill of Rights and information on how to understand and exercise these rights was left with the patient for his/her representative.
- ☐ The Bill of Rights was given, but patient/representative declined to sign.
- ☐ Other (specify)

IMPORTANT – READ CAREFULLY

Federal Laws (18 U.S.C. ss 287 & 1001) and other federal and state law provide for criminal and/or civil penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States or any state agency. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of Medicare and/or Medicaid claims. By signing this form, I certify that to the best of my knowledge, any information provided by me including, but not limited to, eligibility and enrollment information is complete and accurate.

PERSONAL BELONGINGS

I understand and have been advised by a representative of the Vassar Brothers Medical Center that no personal property should be kept on the premises of the Vassar Brothers Medical Center. In regard to those personal items that I deem to be necessary, I have been informed that the Vassar Brothers Medical Center maintains a safe for the safekeeping of money, personal effects and other valuables. Understanding that any personal items brought into the Vassar Brothers Medical Center have the potential to become lost or misplaced, I hereby release the Vassar Brothers Medical Center from any and all liability resulting from the loss of disappearance of said items. Any personal property which I keep with me shall be at my own risk and the Vassar Brothers Medical Center shall not be liable for any loss of damage to it.

[FINANCIAL OBLIGATIONS]

[For and in consideration of services rendered or to be rendered by Vassar Brothers Medical Center, I agree to be fully and totally responsible to the Vassar Brothers Medical Center for all charges as submitted by Vassar Brothers Medical Center on my account and to make payment in accordance with the Vassar Brothers Medical Center policy for payment of bills. I understand that if I have not provided the Vassar Brothers Medical Center with accurate and correct information regarding my insurer, HMO or other health benefit plan which provides me with health care coverage, I will be personally responsible for the cost of all care rendered to me by the Vassar Brothers Medical Center. It is further agreed that the charges incurred represent the fair and reasonable value of the services rendered and are in accordance with the posted charges of the Vassar Brothers Medical Center, which are available upon request. Payment may be demanded at any time, and the demand for payment shall not be a prerequisite to my immediate responsibility for payment. In the event I fail to pay my bill, I agree to pay, in addition to the amount of the bill, any reasonable attorney's fees the Vassar Brothers Medical Center incurs in collecting the bill.

I understand that financial assistance is available for those with qualifying needs and I can contact 845-431-5699 for more information.]

I have read all of the above, have been offered an opportunity to ask questions and my signature below indicates my understanding and agreement to the above.

[redacted] 2/22/14

[redacted]ATIVE [redacted] DATE

DATE

SIGNATURE OF INTERPRETER (if required) PRINT NAME DATE

[redacted] Number: 2

[redacted]

VASSAR BROTHERS MEDICA[redacted]

Medical Record

Patient Name: _____

CONSENT AND AUTHORIZATION FOR THE FOLLOWING:

A. Treatment B. Payment C. Release of Information D. Personal Valuables

CONSENT FOR TREATMENT (Please check one) **Outpatient** ☐ **Inpatient** ☐

I consent to be admitted/treated by Vassar Brothers Medical Center and its related health care providers, medical staff and affiliates (collectively, "the Vassar Brothers Medical Center") for the purpose of receiving medical care and treatment and/or diagnostic procedures which may include administering of medications, blood and blood products. I understand that I have the right to consent or refuse any procedure or therapeutic treatment and that a discussion of the risks, benefits and alternatives to each procedure will be made available to me. For obstetrical service, this includes care of the newborn. To the extent that this form is signed by a legally authorized representative of an incapacitated person (e.g., an unemancipated minor), the terms "I", "me" and "my" shall be read to refer to the above-referenced patient, as applicable.

I am aware that there are certain risks and hazards connected with any treatment that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment and surgery because the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees or assurances have been made to me concerning my treatment at the Vassar Brothers Medical Center. I am aware that unforeseen conditions may arise during my treatment by the Vassar Brothers Medical Center which would require more treatment than originally anticipated.

PRUDENT LAYPERSON-EMERGENCY SERVICES

I am aware of my rights as a prudent layperson under federal and state law (where applicable). I attest that I possess at least average knowledge of health and medicine. I believe that the delay and absence of immediate medical care could result in serious jeopardy to my health, serious impairment of bodily functions and/or serious dysfunction of any bodily organ part.

SIGNATURE ON FILE (For Medicare and/or Medigap Beneficiaries)

I request that payment of authorized Medicare and/or Medigap benefits, as applicable be made to me or on my behalf for services rendered at the Vassar Brothers Medical Center including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicaid and Medicare Services or its agents any information needed to determine these benefits or benefits for related services.

PAYMENT & UNIFORM ASSIGNMENT OF BENEFITS

I hereby authorize payment to the Vassar Brothers Medical Center or its assignees, all monies and /or benefits to which I may be entitled from third party payors, including, government agencies (e.g., Medicare, Medicaid, TRICARE) insurance carriers, HMOs or other who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered. I understand that my assignment of any benefits that I may be due does not relieve me of any obligations to pay the Vassar Brothers Medical Center for any charges not covered by this assignment. I authorize the Vassar Brothers Medical Center to utilize my Medicare Part A lifetime day coverage, when necessary. If Medicaid assistance is denied I understand that I may request Special Assistance from the Vassar Brothers Medical Center under TITLE VI OF THE PUBLIC HEALTH SERVICE ACT.

GENERAL CONSENT TO RELEASE INFORMATION

By signing this document, I authorize the Vassar Brothers Medical Center to release my personal health information: (a) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operations purposes; (b) to any person or entity which may be responsible for billing and/or collection of claims for medical services or products provided by the Vassar Brothers Medical Center under an insurance or other contract or obligation; (c) to any person or entity which is, or may be liable to the Vassar Brothers Medical Center or me for all or part of the Vassar Brothers Medical Center charges, including, but not limited to, insurance companies, health maintenance organizations, workers' compensation carriers, or other third party; (d) to any governmental agency or other organization responsible for oversight of the Vassar Brothers Medical Center or third party payor; (e) to the health department or the Centers for Disease Control and Prevention for requirements to disclose information regarding any reportable diseases; or (f) for the Vassar Brothers Medical Center normal health care operations. In the event that I am to be considered for placement in an alternate care facility, I hereby authorize the Vassar Brothers Medical Center to release my medical record to such facility for the purpose of discharge planning and/or continuation of post hospital care.

Consents

Document Name: Consent Forms Auth (Verified)
Performed By: Mitschow, Jillian Morgan 02/22/2014 11:25:52 EST
Authenticated By:

Consent Forms

[redacted]

[redacted]

VASSAR BROTHERS MEDICAL CENTER

HealthQuest affiliate

Patient Name: _____ Medical Record: _____

CONSENT AND AUTHORIZATION FOR THE FOLLOWING:

A. Treatment B. Payment C. Release of Information D. Personal Valuables

CONSENT FOR TREATMENT (Please check one) | **Outpatient** ☐ | **Inpatient** ☐

I consent to be admitted/treated by Vassar Brothers Medical Center and its related health care providers, medical staff and affiliates (collectively, "the Vassar Brothers Medical Center") for the purpose of receiving medical care and treatment and/or diagnostic procedures which may include administering of medications, blood and blood products. I understand that I have the right to consent or refuse any procedure or therapeutic treatment and that a discussion of the risks, benefits and alternatives to each procedure will be made available to me. For obstetrical service, this includes care of the newborn. To the extent that this form is signed by a legally authorized representative of an incapacitated person (e.g., an unemancipated minor), the terms "I", "me" and "my" shall be read to refer to the above-referenced patient, as applicable.

I am aware that there are certain risks and hazards connected with any treatment that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment and surgery because the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees or assurances have been made to me concerning my treatment at the Vassar Brothers Medical Center. I am aware that unforeseen conditions may arise during my treatment by the Vassar Brothers Medical Center which would require more treatment than originally anticipated.

PRUDENT LAYPERSON-EMERGENCY SERVICES

I am aware of my rights as a prudent layperson under federal and state law (where applicable). I attest that I possess at least average knowledge of health and medicine. I believe that the delay and absence of immediate medical care could result in serious jeopardy to my health, serious impairment of bodily functions and/or serious dysfunction of any bodily organ part.

SIGNATURE ON FILE (For Medicare and/or Medigap Beneficiaries)

I request that payment of authorized Medicare and/or Medigap benefits, as applicable be made to me or on my behalf for services rendered at the Vassar Brothers Medical Center including physician services. I authorize any holder of medical or other information about me to release to the Center for Medicaid and Medicare Services or its agents any information needed to determine these benefits or benefits for related services.

PAYMENT & UNIFORM ASSIGNMENT OF BENEFITS

I hereby authorize payment to the Vassar Brothers Medical Center or its assignees, all monies and/or benefits to which I may be entitled from third party payors, including, government agencies (e.g., Medicare, Medicaid, TRICARE) insurance carriers, HMOs or other who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered. I understand that my assignment of any benefits that I may be due does not relieve me of any obligations to pay the Vassar Brothers Medical Center for any charges not covered by this assignment. I authorize the Vassar Brothers Medical Center to utilize my Medicare Part A lifetime day coverage, when necessary. If Medicaid assistance is denied I understand that I may request Special Assistance from the Vassar Brothers Medical Center under TITLE VI OF THE PUBLIC HEALTH SERVICE ACT.

GENERAL CONSENT TO RELEASE INFORMATION

By signing this document, I authorize the Vassar Brothers Medical Center to release my personal health information: (a) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operations purposes; (b) to any person or entity which may be responsible for billing and/or collection of claims for medical services or products provided by the Vassar Brothers Medical Center under an insurance or other contract or obligation; (c) to any person or entity which is, or may be liable to the Vassar Brothers Medical Center or me for all or part of the Vassar Brothers Medical Center charges, including, but not limited to, insurance companies, health maintenance organizations, workers' compensation carriers, or other third party; (d) to any governmental agency or other organization responsible for oversight of the Vassar Brothers Medical Center or third party payor; (e) to the health department or the Centers for Disease Control and Prevention for requirements to disclose information regarding any reportable diseases; or (f) for the Vassar Brothers Medical Center normal health care operations. In the event that I am to be considered for placement in an alternate care facility, I hereby authorize the Vassar Brothers Medical Center to release my medical record to such facility for the purpose of discharge planning and/or continuation of post hospital care.

[redacted]

[redacted]

ACKNOWLEDGEMENT OF BILL OF RIGHTS/ ADVANCE DIRECTIVES / NOTICE OF PRIVACY PRACTICES

I have received a copy of the Patient's Bill of Rights, as required by New York State law, a Notice of Privacy Practices, and have had an opportunity to receive assistance in understanding and exercising these rights. I have also received a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

23

[redacted]

To be completed by the Vassar Brothers

If Signature was not obtained, it was because:

☐ Patient is unable and unaccompanied by a representative and the Bill of Rights and information on how to understand and exercise these rights was not with the patient for his/her representative.

☐ The Bill of Rights was given, but patient/representative declined to sign.

☐ Other (specify):

IMPORTANT – READ CAREFULLY

Federal Laws (18 U.S.C. ss 287 & 1001) and other federal and state law provide for criminal and/or civil penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States or any state agency. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of Medicare and/or Medicaid claims. By signing this form, I certify that to the best of my knowledge, any information provided by me including, but not limited to, eligibility and enrollment information is complete and accurate.

PERSONAL BELONGINGS

I understand and have been advised by a representative of the Vassar Brothers Medical Center that no personal property should be kept on the premises of the Vassar Brothers Medical Center. In regard to those personal items that I deem to be necessary, I have been informed that the Vassar Brothers Medical Center maintains a safe for the safekeeping of money, personal effects and other valuables. Understanding that any personal items brought into the Vassar Brothers Medical Center have the potential to become lost or misplaced, I hereby release the Vassar Brothers Medical Center from any and all liability resulting from the loss of disappearance of said items. Any personal property which I keep with me shall be at my own risk and the Vassar Brothers Medical Center shall not be liable for any loss of damage to it.

[FINANCIAL OBLIGATIONS]

[For and in consideration of services rendered or to be rendered by Vassar Brothers Medical Center, I agree to be fully and totally responsible to the Vassar Brothers Medical Center for all charges as submitted by Vassar Brothers Medical Center on my account and to make payment in accordance with the Vassar Brothers Medical Center policy for payment of bills. I understand that if I have not provided the Vassar Brothers Medical Center with accurate and correct information regarding my insurer, HMO or other health benefit plan which provides me with health care coverage, I will be personally responsible for the cost of all care rendered to me by the Vassar Brothers Medical Center. It is further agreed that the charges incurred represent the fair and reasonable value of the services rendered and are in accordance with the posted charges of the Vassar Brothers Medical Center, which are available upon request. Payment may be demanded at any time, and the demand for payment shall not be a prerequisite to my immediate responsibility for payment. In the event I fail to pay my bill, I agree to pay, in addition to the amount of the bill, any reasonable attorney's fees the Vassar Brothers Medical Center incurs in collecting the bill.

I understand that financial assistance is available for those with qualifying needs and I can contact 845-431-5600 for more information.]

I have read all of the above, have been offered an opportunity to ask questions and my signature below indicates my understanding and agreement to the above.

[redacted]

Spouse / Son — 2/22/14

RELATIONSHIP WITH PATIENT — DATE

DATE

SIGNATURE OF INTERPRETER (if required) — PRINT NAME — DATE

Number: 6

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

Name of QIO (in bold)

IPRO

Telephone Number of QIO

1-800-446-2447; TTY: 1-866-446-3507

  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is:

Hospital Name	Provider ID Number
VASSAR BROTHERS MEDICAL CENTER	330023

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4:** The QIO will review your medical records and other important information about your case.
- **STEP 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

ADDITIONAL INFORMATION:

[redacted]

[redacted]

Patient Name: [redacted]

Patient ID Number: [redacted]

Physician: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

IPRO

Telephone Number of QIO

1-800-446-2447; TTY: 1-866-446-3507

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call Case Management - 845-437-3101

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Patient Representative (see 1)

[redacted]

Date

3/20/14

Number: 8

Emergency Documentation

Document Name: Pre-Arrival Note Auth (Verified)
Performed By: Baker, Domonique Lauryn 02/22/2014 10:24:40 EST
Authenticated By: Baker, Domonique Lauryn 02/22/2014 10:24:40 EST

Pre-Arrival Note

Pre-Arrival Summary

Name: arlington,
Gender:

Current Date: 2/22/2014 10:24:40 EST

Age:
Pre-Arrival Type: EMS
ETA: 2/22/2014 10:22:00 EST

Presenting Problem:
Pre-Arrival User: Spiers, Tanya A
Referring Source:
Bed Assignment: .

Vassar Brothers Medical Center

Pre-Arrival Communication Form

Vital Signs:

Miscellaneous Info:

[redacted]

P[redacted]

Health Quest

APC Patient Summary

Print Date: 06/16/2015 9:06 am

[redacted]

Seq/Ep	Procedure		Modifiers 1 2 3 4 5	Start	End	Provider	Role
						00014815 Breckenridge,Matthew, MD	AN
2 11	04.81	Anesth injec periph nerv		6/12/2015			
						00014815 Breckenridge,Matthew, MD	SUR
3 10	29826	SHOULDER ARTHROSCOPY/SURGER	RT	6/12/2015			
						00090023 Kusior, Lawrence	SUR
						00014815 Breckenridge,Matthew, MD	AN
4 10	29827	ARTHROSCOP ROTATOR CUFF REPR	RT	6/12/2015			
						00090023 Kusior, Lawrence	SUR
						00014815 Breckenridge,Matthew, MD	AN
5 11	64415	N BLOCK INJ BRACHIAL PLEXUS	RT XP	6/12/2015			
						00014815 Breckenridge,Matthew, MD	SUR
6 2	J0690	CEFAZOLIN SODIUM INJECTION		6/12/2015			
7 5	J1885	KETOROLAC TROMETHAMINE INJ		6/12/2015			
8 6	J2405	ONDANSETRON HCL INJECTION		6/12/2015			
9 1	J2704	INJ, PROPOFOL, 10 MG		6/12/2015			
10 3	J2704	INJ, PROPOFOL, 10 MG		6/12/2015			
11 4	J7120	RINGERS LACTATE INFUSION		6/12/2015			
12 7	J7120	RINGERS LACTATE INFUSION		6/12/2015			

Consult Performed By

[redacted]

[redacted]

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To be completed by the Vassar Brothers Medical Center

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☐ Patient is unable and unaccompanied by a representative and the Bill of Rights and information on how to understand and exercise these rights was left with the patient for his/her representative to review.

☐ The Bill of Rights was given but patient representative declined to sign acknowledgement.

☐ Other (specify): [redacted]

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I understand that financial assistance is available for those with qualifying needs and I can contact 845-475-9940 for more information.]

I have read all of the above, have been offered an opportunity to ask questions and my signature below indicates my understanding and agreement to the above.

[redacted]

Self
RELATIONSHIP WITH PATIENT

6/12/15
DATE

[redacted]

SIGNATURE OF INTERPRETER (if required)

6/12/15
[redacted]

0000 AM/PM
TIME

Medical Record
TE

Number: 6

Discharge Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

[redacted] [redacted]

-Keep operative site clean and dry-Do not remove any dressings, if applicable, unless instructed so by your surgeon

-NOTIFY YOUR PHYSICIAN: Call your physician if you are experiencing any of the following: difficulty breathing, bleeding that you feel is excessive, persistent nausea and vomiting, any unusual pain, swelling, or temperature greater than 101F.

Smoking:

Smoking increases you risk for stroke, vascular, and lung disease. It is never too late to quit smoking. If you currently smoke, or have only quit smoking within the last year, you are advised to use the educational material given to you regarding quitting. **In addition, you may call the New York State Smokers' Quit-line (1-866-697-8487) for help quitting smoking. By consenting to the release of your information, you also authorize the NYS Smokers' Quitline to share and make available to PHC patient activity reports of your outcome and quit status, and eligibility for nicotine replacement therapy.**

Follow-up Instructions

[redacted]

Medical Record

[redacted]

6-12-15 — Date/Time — Relationship to Patient

Escort Signature

6-12-15 — Date/Time — Relationship to Patient

Registered Nurse

6-12-15 — Date/Time

Person Full [redacted] 06/12/2015 09:13:46 3 of 5

Number: 10

History and Physical Reports

t Name: History and Physical Auth (Verified)
d By: CPDI User 06/15/2015 13:01:46 EDT
ated By:

[redacted]

ROOM:
ADMIT DATE 06/12/2015
DISCHARGE DATE 06/12/2015
Kusior MD, Lawrence J.

Procedure History

Date	Procedure	Status	Provider	Location
f1	Cholecystectomy	Active		
	colonoscopy x 2	Active		

f1: Comment added by Mathews, Priya on 08/02/2013 12:29:09 EDT
2010 done at vassar

[redacted]

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

[redacted]

[redacted]

Health Quest

VASSAR BROTHERS MEDICAL CENTER

[redacted]

Medical Record

IMPLANT RECORD

6/12/2015

Anatomical Site: RIGHT SHOULDER

Service: ☒ Orthopedics ☐ General ☐ Vascular ☐ Cardiac ☐ Ophthalmology ☐ Spinal/Pain ☐ Urology ☐ Cosmetics/Plastics
☐ Gyn ☐ Podiatry ☐ Wound/Skin ☐ GI/Endo ☐ Other _____

IMPLANT INFORMATION - AFFIX ALL IMPLANT LABELS BELOW- If no label exists please fill out the entry below

Sticker	Charge Code	Sticker	Charge Code
[redacted] Expiration Date _____		Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____	
Manufacturer _____ Site _____ Ref # _____ Lot # _____ _____ Qty _____ Expiration Date _____		Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____	
Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____		Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____	
Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____		Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____	
Manufacturer _____ Site _____ Ref # _____ Lot # _____ _____ Qty _____ Expiration Date _____		Manufacturer _____ Site _____ Ref # _____ Lot # _____ Desc _____ Qty _____ Expiration Date _____	

R.N. Signature: _____ Charges Entry Date _____ Charge Entry Signature _____

Page 1: Medical Record Page 2: Charge Vehicle Page 3: Implant Log

[redacted]

[redacted]

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

VBMC Boarding Pass /Universal Protocol Checklist - Surgical Services

☐ Start OR VBMC ☒ Start OR

Date of Procedure: 6/12/15

BOARDING PASS ISSUED :

@ TIME 0650 DATE: 6/12/15
BY: [redacted]
(SIGNATURE)

	Scheduler Date: 6/3 Time: 11:30 Sign: [redacted]	Pre Surgical Testing (PST) Date: 6/11 Time: 1400 Sign: [redacted]	Pre-op RN: Sign: [redacted] Time: [redacted] Date:	Hand-off from Preop Rn to OR
Correct Patient: Verified by name, date of birth & MRN				
Allergies noted: NKDA, Eggs				
Blood band on and verified if applicable				
Correct Procedure (R) shoulder	RR			
Pre-Op Diagnosis Noted	RR			
Correct Site / Side / Level / Digit	RR			
Surgical/Medical Consent				
Blood Consent				
Anesthesia Consent				
Correct History and Physical / H&P Update				
MD Available @ OR				
Site Marked #1 (R) Shoulder				
Site Marked #2				
Last time voided: time: 600 Amount:				
Antibiotic Available: ☒ Yes ☐ Not Applicable Ancef-2gm				
Metal Implants/devices document only if Present: Location of implant (if applicable): NONE		na [redacted]		
Relevant Image Report/Diagnostic Study Report available (Report and/or PACs) If applicable MRI				
Mobility limitations that may affect patient positioning (R) Shoulder pain	RR	na [redacted]		
DNR suspension N/A				
Interperter needed N/A				
Isolation Precautions N/A if yes Circle the type Contact Airborne				

Pre-Op RN Signature: [redacted] Date: 6/12 Time: 0650

OR RN Signature: [redacted] Date: Time:

[redacted]

[redacted]

Medical Record

[redacted]

[redacted]

VASSAR BROTHERS MEDICAL CENTER
Health Quest affiliate

Count Sheet **Date** 6/12/15

Item	Initial	Added	2 nd	Closing	Skin
Raytex	10			10	10
Lap Pads	5			5	5
Needles	2			2	2
Reels	—			—	—
Sharps	1			1	1
Tips/scratch	—			—	—
Hypo needles					
Peanuts					
FRED					
Scissor tip/ band					
Umb. Tapes					
Bulldog					
Vessel Loops					
Booties					
Fogarty insert					
Neuro Paddies					
Neuro Strips					
Raney Clips					
Safety Pin					
Tonsil Sponges					
Spinal	1				

Any count sheet(s) utilized are to be included as part of the patient's permanent record.

RN: In: TM	RN: Out: [redacted]
Scrub: In: BW	Scrub: Out: [redacted]

Count (s) Correct: ☒ Yes ☐ No

If No: ☐ X-ray taken per policy ☐ MD notified: ☐ Yes ☐ No

X-Ray read by: _____ Results: _____

Transfer count performed: ☐ N/A ☐ Yes

RN: _____

Scrub: _____

[redacted]

Medical Record

Number: 19

[redacted]

ROOM:
ADMIT DATE 06/12/2015
DISCHARGE DATE 06/12/2015
Kusior MD, Lawrence J.

Operative Documentation

nent Name: Document Name Result Status
rmed By: Performed Physician Name Performed Date/Time
nticated By: Authenticated By Authenticated Date/Time

ument Signatures
ied By:
Mowbray, Lisa M 06/12/15 07:36
nent Name: Document Name Result Status
rmed By: Performed Physician Name Performed Date/Time
nticated By: Authenticated By Authenticated Date/Time

)R Intraoperative Nursing Record

:OR Intraoperative Nursing Record Summary
[redacted]
Female
[redacted]
sician: Kusior MD, Lawrence J.
[redacted]
Type: S
m/Bed: /
it/Disch: 06/12/15 05:58:02 -
titution:

[redacted]

[redacted]

ted By: Lettieri, Chelsea

Operative Documentation

nt Name: Document Name Result Status
ed By: Performed Physician Name Performed Date/Time
icated By: Authenticated By Authenticated Date/Time

nt In Room Time	06/12/15 07:30:00	Patient Out Room Time	06/12/15 08:49:00
y			
ry Start Time	06/12/15 08:01:00	Surgery Stop Time	06/12/15 08:32:00
ial for	Yes		
y/Knowledge			
t related to			
al experience			
esia			
hesia Start	06/12/15 07:30:00		

Modified By: Dean, John T 06/12/15 08:48:41

Care Text:
Expected Outcomes: **Patient verbalizes orientation to environment** **Patient expresses feelings, ,
and asks questions** **Patient demontrates/restates instructions given**

Times - VSCOR Audit

2/15 08:48:41 Owner: TMARZAHL Modifier: JDEAN
+> 1 Patient Out Room Time
+> 1 Surgery Stop Time
2/15 08:02:56 Owner: TMARZAHL Modifier: TMARZAHL
+> 1 Surgery Start Time

ts - VSCOR

are Text:
Interventions: 1. All sponge, sharps, and instuments counts done as per policy

	Entry 1		
dure	Arthroscopy	By	Dean, John T,
s,			
	Shoulder(Right), Decompression Shoulder(Right)		Bobby R
es Correct?	Yes	Instruments Correct?	N/A
s Correct?	Yes	Other Correct?	Yes
tial for	Yes		
cal injury			

Modified By: Marzahl, Tobyjean M 06/12/15 07:50:43

Care Text:
Expected Outcomes: **Patient is free of signs and symptoms of nerve and joint injury or circulatory ent**

rture from OR - VSCOR

	Entry 1		
of Transport	Stretcher/Bed	Post-op Destination	PACU Phase I
ef			
fication that	Yes	Special Post-op	No
l count is		Considerations	

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Last Modified By: Marzahl, Tobyjean M
06/12/15 07:51:18
Post-Care Text:
Expected Outcomes: **Patient's skin integrity maintained / no signs fo burns, bruises or injuries**

Skin Prep/Drape - VSCOR

Pre-Care Text:
Interventions: 1. Prevent pooling of solutions

	Entry 1		
Procedure	Arthroscopy Shoulder(Right), Decompression Shoulder(Right)	**Prep Area**	right shoulder
Prep Agents	Chloraprep		
Hair Removal			
By	Kusior MD, Lawrence J.		
Last Modified By:	Marzahl, Tobyjean M 06/12/15 07:57:38		

Post-Care Text:
Expected Outcomes: **Patient's skin integrity maintained / no signs of burns, bruises or injuries**

Special Equipment - VSCOR

Pre-Care Text:
Interventions: 1. Cover warming blanket with sheet / make sure sheets under patient are smooth

	Entry 1		
Equipment Setting	mfg settings	**Equipment Type**	SCD
Last Modified By:	Marzahl, Tobyjean M 06/12/15 08:00:51		

Post-Care Text:
Expected Outcomes: **Patient's skin integrity maintained / no signs of burns, bruises or injuries**

Surgical Irrigation - VSCOR

	Entry 1		
Irrigant	Normal saline	**Irrigant Volume In**	3000 mL
Last Modified By:	Marzahl, Tobyjean M 06/12/15 07:52:32		

General Comments:
with epi

Surgical Procedures - VSCOR

	Entry 1	Entry 2
Procedure Description		
Procedure	Arthroscopy Shoulder	Decompression Shoulder
Modifiers	Right	Right
Procedure Description per Surgeon	right shoulder arthroscopy	W/ DEBRIDEMENT, POSS TENDON SURGERY
Primary Procedure	Yes	No
Primary Surgeon	Kusior MD, Lawrence J.	Kusior MD, Lawrence J.
Start	06/12/15 08:01:00	06/12/15 08:01:00

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Stop	06/12/15 08:32:00	06/12/15 08:32:00
Anesthesia Type	General	General
Surgical Service	SN - Orthopedics	SN - Orthopedics
Wound Class	I - Clean	I - Clean
Last Modified By:	Dean, John T 06/12/15 08:50:43	Dean, John T 06/12/15 08:48:48

Surgical Procedures - VSCOR Audit

06/12/15 08:50:43	Owner: JDEAN		Modifier: JDEAN
1	<*> Procedure	Arthroscopy Shoulder	
1	<+> Procedure Description per Surgeon		
06/12/15 08:48:48	Owner: JDEAN		Modifier: JDEAN
<+> 1	Stop		
<+> 2	Stop		
06/12/15 08:48:26	Owner: TMARZAHL		Modifier: JDEAN
<+> 1	Start		
<+> 2	Start		

[redacted]

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Time Out - VSCOR Audit
06/12/15 08:00:12 Owner: TMARZAHL Modifier: TMARZAHL
1 <+> Date/Time
1 <*> Procedure Arthroscopy Shoulder(Right), Decompression Shoulder(Right)

Case Comments
<None>

Finalized By: Dean, John T

Document Signatures
Signed By:
Dean, John T 06/12/15 08:52

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

[redacted]

[redacted]

Medical Record

Brief Op Note

Date/Time	
	Post-op Diagnosis:
	Procedure:
	Findings:
	Surgeon:
	Assistant:
	Specimens:
	Complications:
	EBL:
	Wound Classification: Class 1 ☑ Class 2 ☐ Class 3 ☐ Class 4 ☐
	Other
	Signature: Date/Time

[redacted]

1PON1003 (C2/15)

SR_printed 03/26/2015 06:59 AM

Number: 29

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Anesthesia Pre-Operative Evaluation
Health Quest

[redacted]

Associated Diagnoses: **None**
Author: **Breckenridge MD, Matthew**

[redacted]

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

08/02/2013 **Use:** Past
Frequency: 1-2 times per month
Started at age: 17 Years
Has alcohol use interfered with work or home life? No
Do you ever drink more than intended? No
Has anyone been hurt or at risk by your drinking? No
Ready to change: No

Employment/School
08/02/2013 **Risk Assessment:** N/A

Exercise
08/02/2013 **Risk Assessment:** Occasional exercise

Home/Environment
08/02/2013 **Risk Assessment:** N/A

Sexual
08/02/2013 **Risk Assessment:** N/A

Substance Abuse
08/02/2013 **Risk Assessment:** N/A

Tobacco
08/02/2013 **Risk Assessment:** N/A

Results review: Lab results (data)

6/12/2015 6:13 EDT	Type and Cross Match Completed	N/A
	Type and Screen Completed	N/A

Assessment

Procedure Information
Procedure Rt shoulder arthroscopy.
Performing Provider: Kusior MD, Lawrence J..
NPO: Since Midnight.

Anesthesia Evaluation
Current Medications: Documented and Reviewed.
Risks/Benefits: Risks, benefits and alternatives discussed with patient/guardian who wishes to proceed with plan..
Anesthesic Plan: General, Block.
Airway Assessment: Mallampati Classification: II.
Dentition/Dental Evaluation: Normal.
ASA Physical Status: II.
Mental Status: Alert and Oriented

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Anesthesia Post Anesthesia Evaluation
Health Quest

[redacted]

Associated Diagnoses: **None**
Author: **Breckenridge MD, Matthew**

Post Procedure Assessment
Anesthesia Post Anesthesia Evaluation:
Mental Status: Patient Participation: Awake.
Airway Patency: Satisfactory.
Oxygen:: Room Air.
Vital Signs: Vitals from Flowsheet

6/12/2015 9:50 EDT	Heart Rate Monitored	64 bpm
	Respiratory Rate	19 br/min
	Systolic Blood Pressure	**134 mmHg HI**
	Diastolic Blood Pressure	**58 mmHg <LLOW**
	Mean Arterial Pressure, Cuff	83 mmHg
	SpO2	**92 % <LLOW**
	Oxygen Therapy	Room air
6/12/2015 9:40 EDT	Heart Rate Monitored	69 bpm
	[redacted]	
	Mean Arterial Pressure, Cuff	113 mmHg
	SpO2	100 %
	Oxygen Flow Rate	2 L/min
	Oxygen Therapy	Room air
6/12/2015 9:30 EDT	Heart Rate Monitored	81 bpm
	[redacted]	
	Mean Arterial Pressure, Cuff	92 mmHg
	SpO2	95 %
	Oxygen Therapy	Room air
6/12/2015 9:20 EDT	Heart Rate Monitored	79 bpm
	Respiratory Rate	20 br/min
	[redacted]	
	SpO2	99 %
	Oxygen Flow Rate	4 L/min
	Oxygen Therapy	Nasal cannula
6/12/2015 9:10 EDT	Heart Rate Monitored	67 bpm
	Respiratory Rate	**21 br/min HI**
	Systolic Blood Pressure	125 mmHg

[redacted]

	Diastolic Blood Pressure	61 mmHg
	Mean Arterial Pressure, Cuff	82 mmHg
	SpO2	100 %
	Oxygen Flow Rate	4 L/min
	Oxygen Therapy	Nasal cannula
6/12/2015 9:00 EDT	**Temperature Temporal**	**95.8 DegF LOW**
	Heart Rate Monitored	65 bpm
	Respiratory Rate	19 br/min
	[redacted]	
	SpO2	100 %
	Oxygen Flow Rate	4 L/min
	Oxygen Therapy	Nasal cannula

Hydration Status: Satisfactory.
Nausea/Vomiting: None noted.
Pain: Controlled with current regimen.

Treatments/Procedures Forms

Preoperative Checklist Entered On: 6/12/2015 6:35 EDT
Performed On: 6/12/2015 6:13 EDT by Mowbray, Lisa M

Pre-op Checklist
RN Who Verified Site : Mowbray, Lisa M

Mowbray, Lisa M - 6/12/2015 7:33 EDT

Last Fluid Intake : 6/11/2015 21:00 EDT
Last Food Intake : 6/11/2015 21:00 EDT
Last Void : 6/12/2015 6:05 EDT

Mowbray, Lisa M - 6/12/2015 6:13 EDT

Surgery Prep Grid
Home Prep Complete : No
Surgical Prep (clippers) Performed/Verified : No

Mowbray, Lisa M - 6/12/2015 6:13 EDT

DCP GENERIC CODE
Anesthesia Consent : Yes
H & P Updated Day of Surgery : Yes
Site Verified by Physician : Yes

Mowbray, Lisa M - 6/12/2015 7:33 EDT

ID Band on and Verified : Yes
Allergy Indicator on and Verified : Yes
Blood Band on and Verified : N/A
Surgical Consent Complete : Yes
Blood Consent : N/A
Current ECG in Medical Record : No

Treatments/Procedures Forms

Cardiac Clearence : No
Medical Clearance : No
Relevant Images in Available : Yes
Review of Labs : Yes
Type and Screen Completed : N/A
Type and Cross Match Completed : N/A
MRSA Nasal Swab Prophylaxis Administered : N/A
Autologous Blood Available : N/A
Site Verified by Patient/Family : Yes
Site Verified by RN : Yes
Prosthesis/Metal Implant : No
Anti-embolic Stockings : Yes
Cardiac Implant/Other : No
Pre Op Shower with Chlorhexadine : N/A
DNR Suspension : N/A
Urine Pregnancy Dipstick : N/A
(Comment:

Normal Value = Negative

[SYSTEM - 6/12/2015 6:35 EDT])

SYSTEM - 6/12/2015 6:35 EDT

Valuables/Belongings
At Bedside : Clothes, Shoes, Glasses, Cell phone, Purse, Wallet
Important Valuables at Bedside : None

Mowbray, Lisa M - 6/12/2015 6:13 EDT

Procedure Documentation

Document Name: Anesthesia Regional Block Procedure Auth (Verified)
Performed By: Breckenridge MD, Matthew 06/12/2015 08:07:33 EDT
Authenticated By: Breckenridge MD, Matthew 06/12/2015 08:07:33 EDT

Anesthesia Regional Block Procedure
Health Quest

[redacted]

Associated Diagnoses: None
Author: **Breckenridge MD, Matthew**

Procedure Documentation

Document Name: Anesthesia Regional Block Procedure Auth (Verified)
Performed By: Breckenridge MD, Matthew 06/12/2015 08:07:33 EDT
Authenticated By: Breckenridge MD, Matthew 06/12/2015 08:07:33 EDT

Procedure

Block Pre-Procedure Information

Block Performed: Interscalene Block.
Indication: The block(s) was/were placed for post-operative pain control.
Consent: Verified that Anesthesia/Block procedure consent has been obtained and documented.
Standard ASA monitors applied to patient.
Block site verification and Time Out conducted at 6/12/2015 7:25:00 AM.

Regional Block Procedure

Skin prep with: Chloraprep.
Sedation: midazolam 2 mg, fentanyl 100 mcg.
Blocking Agent administered: 0.5% Bupivacaine with Epi 20 mL.
Needle type used: 22 Gauge short bevel block needle 40 mm.
Injection Narrative: Needle inserted, Under ultrasound guidance, Negative Aspiration, No sharp pain or paresthesia during injection, Easy to inject, Needle clearly visualized throughout block procedure, injection was made incrementally with aspiration every 5 cc's..
Time interval for block placement: start time: 0725, end time: 0729.
Vital signs: pre-procedure (blood pressure: 158/72, heart rate: 85, oxygen saturation: 100), post-procedure (blood pressure: 160/75, heart rate: 83, oxygen saturation: 100).
Procedure: I peformed the procedure myself.

Professional Services

Block Procedures: Single Shot brachial plexus block (any approach) - 64415.

EKG Results

[redacted]

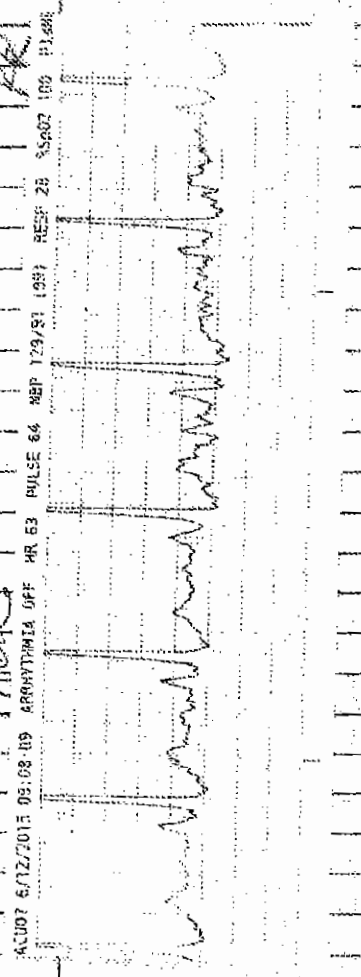
[redacted]

Date/Time
Discipline

Multidisciplinary Progress Notes

"DO NOT USE THESE ABBREVIATIONS": Q.D., Q.O.D., MS, MSO4, MgSO4, U or u, IU
Do not use a trailing Zero (X.0) - Write Xmg. Use leading Zero - Write 0.Xmg.

Please print name/dictation # after signature.



VASSAR BROTHERS MEDICAL CENTER [redacted]

MULTIDISCIPLINARY PROGRESS NOTES

Form# VBMC65 (R/2012)

Medical Record

Number: 43

Perioperative Documentation

Perioperative Documentation

Collected Date Collected Time Charted by Procedure	06/12/2015 09:50:00 EDT Ryan, Katherine	Units	Ref Range
Discharged to the Care of Responsible Ad	Family member		
Discharge Instructions Given	Patient		
Medication Reconciliation Reviewed/Given	Yes		
Prescription Given	Yes		
Mode of Departure (Phase II)	Wheelchair		
Discharge Destination	Home		
PADSS - Vital Signs	See Below T1		
PADSS - Activity, mental status	2 - Oriented and steady gait		
PADSS - Pain, nausea, vomiting	2 - Minimal		
PADSS - Surgical bleeding	2 - Minimal		
PADSS - Intake / Output	See Below T2		
PADSS - TOTAL	10		

T1: 06/12/2015 09:50:00 EDT (PADSS - Vital Signs)
2 - Within 20% of preoperative value
T2: 06/12/2015 09:50:00 EDT (PADSS - Intake / Output)
2 - Oral fluid intake and voiding

Collected Date Collected Time Charted by Procedure	06/12/2015 06:13:00 EDT Mowbray, Lisa M	Units	Ref Range
Pre Op Shower with Chlorhexadine	N/A		

Perioperative Documentation

PACU Departure

Collected Date	06/12/2015		
Collected Time	09:50:00 EDT		
Charted by	Ryan, Katherine		
Procedure		Units	Ref Range
Discharged to the Care of Responsible Ad	Family member		
Discharge Instructions Given	Patient		
Medication Reconciliation Reviewed/Given	Yes		
Prescription Given	Yes		
Mode of Departure (Phase II)	Wheelchair		
Discharge Destination	Home		

PADSS

Collected Date	06/12/2015		
Collected Time	09:50:00 EDT		
Charted by	Ryan, Katherine		
Procedure		Units	Ref Range
PADSS - Vital Signs	See Below [T1]		
PADSS - Activity, mental status	2 - Oriented and steady gait		
PADSS - Pain, nausea, vomiting	2 - Minimal		
PADSS - Surgical bleeding	2 - Minimal		
PADSS - Intake / Output	See Below [T2]		
PADSS - TOTAL	10		

T1: 06/12/2015 09:50:00 EDT (PADSS - Vital Signs)
2 - Within 20% of preoperative value
T2: 06/12/2015 09:50:00 EDT (PADSS - Intake / Output)
2 - Oral fluid intake and voiding

Procedures

Warming/Cooling Information

Collected Date	06/12/2015	06/12/2015	06/12/2015		
Collected Time	09:50:00 EDT	09:40:00 EDT	09:30:00 EDT		
Charted by	Ryan, Katherine	Ryan, Katherine	Ryan, Katherine		
Procedure				Units	Ref Range
Cooling Measures	Ice packs	Ice packs	Ice packs		

Collected Date	06/12/2015	06/12/2015	06/12/2015		
Collected Time	09:20:00 EDT	09:10:00 EDT	09:00:00 EDT		
Charted by	Ryan, Katherine	Ryan, Katherine	Ryan, Katherine		
Procedure				Units	Ref Range
Warming Measures	-	-	See Below [T3]		
Cooling Measures	Ice packs	Ice packs	Ice packs		

T3: 06/12/2015 09:00:00 EDT (Warming Measures)
Warm blankets, Warming blanket/Bair Hugger

Procedure Time Out

Collected Date	06/12/2015		
Collected Time	07:34:00 EDT		
Charted by	Mowbray, Lisa M		
Procedure		Units	Ref Range
Time Out Date & Time	06/12/2015 07:25:00		
Procedure Time Out Procedure	See Below [T4]		
Procedure Time Out	See Below [T5]		
Physician	Kusior MD, Lawrence J.		
Anesthesiologist	Breckenridge MD, Matthew		
Nurse	Mowbray, Lisa M		

T4: 06/12/2015 07:34:00 EDT (Procedure Time Out Procedure)
Block (also choose other below and specify)
T5: 06/12/2015 07:34:00 EDT (Procedure Time Out)
Correct Patient Identifiers, Allergies Reviewed, Correct Procedure Site & Sides, Verify Site Marked/Special

Procedures

Procedure Time Out

T5: 06/12/2015 07:34:00 EDT (Procedure Time Out)
Purpose Wrist Band, Correct Position, Special Equipment / Implants / Requirements Available, Relevant Diagnostic Tests Available, Relevant Diagnostic Images Displayed, Fire Risk Assessment Performed, Team Confirmation - Nothing is unsafe, and it is safe to pro

Procedures Checklist

Collected Date	06/12/2015		
Collected Time	06:13:00 EDT		
Charted by	Mowbray, Lisa M		
Procedure		Units	Ref Range
Blood Band on and Verified	N/A		
Patient ID Band on and Verified	Yes		
ECG (Current) in Medical Record	No		
Site Verified by Patient/Family	Yes		
Site Verified by RN	Yes		
Site Verified by Physician	Yes		
RN Who Verified Site	Mowbray, Lisa M		
Surgical Prep Verified	No		
Last Fluid Intake	06/11/2015 21:00:00		
Last Void	06/12/2015 06:05:00		
Home Prep Complete	No		
Last Food Intake	06/11/2015 21:00:00		

***** This print request includes documents that are images not included in this print out. *****

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

These are the tests that were performed during your Emergency Department visit:

Laboratory Orders

Name	Status	Details
Auto Diff	Completed	Blood, Stat, ST - Stat, Collected, 02/22/14 11:30:00 EST, Once 24, 02/22/14 11:30:00 EST, 02/22/14 11:30:00 EST, 13639780.000000
CBC w/ Auto Diff	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
CMP	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
PT	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N
PTT	Completed	Blood, Stat, ST - Stat, 02/22/14 10:45:00 EST, Once 24, 02/22/14 10:45:00 EST, Print label Y/N

Radiology Orders

Name	Status	Details
CT Cervical Spine WOC	Completed	02/22/14 10:45:00 EST, Stat, Traumas, N/A, Rad Type
CT Head/Brain WOC	Completed	02/22/14 10:45:00 EST, Stat, Trauma, N/A, Rad Type
XR Chest Portable	Ordered	02/22/14 10:45:00 EST, Stat, Trauma Injury, N/A, Rad Type

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

Patient Care Orders

Name	Status	Details
ED Critical Care Assessment	Ordered	
Fall Risk Protocol	Ordered	02/22/14 10:54:54 EST
Rotate IV Site	Ordered	02/26/14 11:11:18 EST, Once, 02/26/14 11:11:18 EST
Saline Lock	Completed	02/22/14 10:45:00 EST

Cardiology Orders
No cardiology orders were placed.

These are the procedures that were performed during your Emergency Department visit:

Patient Education Materials:
Cervical Sprain, Easy-to-Read; Concussion and Brain Injury, Easy-to-Read

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

Follow-Up Instructions:

[redacted]

With:	Address:	When:
Daniel Hoffman	375 Hooker Avenue Poughkeepsie, NY 12603 (845) 454-5000 Business (1)	Within 2 to 4 days

Comments:

Emergency Documentation

Document Name: ED Patient Summary Auth (Verified)
Performed By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST
Authenticated By: Mehar, Amrita Celine 02/22/2014 13:50:35 EST

Vassar Brothers Medical Center
EMERGENCY DEPARTMENT
45 Reade Place
Poughkeepsie, NY 12601

[redacted]

Arrival Time: 2/22/2014 10:24 AM ED Provider: Midgley MD, Stephanie G.
Primary Care Physician: Hoffman MD, Daniel P.

My signature below indicates that I have received and understand the oral instructions regarding my medical problem. I acknowledge receipt of this written instruction sheet. I will arrange for follow-up care as indicated.
My signature below also indicates that I have received a printed copy of my medication reconciliation form, record of tests performed, and education on any major procedure that was completed during my visit.
I understand I should take the forms to my personal physician for follow-up and the signed original will be kept in my medical record.

2/22/2014 13:50:34

Patient or Responsible Person

ED Nurse/Provider

[redacted]

[redacted]

[redacted]

Medical Record

Vassar Brothers Medical Center
EMERGENCY DEPARTMENT
45 Reade Place
Poughkeepsie, NY 12601

Patient Information:

[redacted]

ED Provider: Midgley MD, Stephanie G.

Primary Care Physician: Hoffman MD, Daniel P.

My signature below indicates that I have received and understand the oral instructions regarding my medical problem. I acknowledge receipt of this written instruction sheet. I will arrange for follow-up care as indicated.
My signature below also indicates that I have received a printed copy of my medication reconciliation form, record of tests performed, and education on any major procedure that was completed during my visit.
I understand I should take the forms to my personal physician for follow-up and the signed original will be kept in my medical record.

[redacted]

2/22/2014 13:45:30

Celine Mehar, RN
ED Nurse/Provider

Orthopedic Associates
of Dutchess County

1910 South Rd
Poughkeepsie
NY 12601
845-454-0120

400 Westage Business
Center Dr
Fishkill
NY 12524
845-897-4600

454 Springbrook Ave
Rhinebeck
NY 12572
845-876-9707

918 Ulster Ave
Kingston
NY 12401
845-338-8900

455 Route 82
Hopewell Junction
NY 12533
845-227-5070

126 Laurel Ave
Suite 200
Cornwall
NY 12518
845-534-5768

Family & Sports
Chiropractic
258 Hurleyville Rd
Poughkeepsie
NY 12603
845-454-0909

www.orthodade.com

To Whom It May Concern:

The information contained in this mailing is physician privileged and confidential. It is intended only for the use of the individual or entity named as the recipient. Be hereby notified that any dissemination, distribution or copy of the communication is strictly prohibited as a matter of law. **If you have received this communication in error please notify us immediately by telephone or return the original mailing to us at the above address via the US Postal Service.**

Sincerely,

Health Information Department
1910 South Road
Poughkeepsie, NY 12601
Phone 845-454-0120
Fax 845-471-7888

**PLEASE NOTE: You will be receiving an invoice for this X-ray/MRI CD from our copying service, Health Port.

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

VSCOR Phase II Nursing Record

VSCOR Phase II Nursing Record Summary

Primary Physician: Kusior MD, Lawrence J.

[redacted]

Female

[redacted]

Lawrence J.

[redacted]

Room/Bed: /
Admit/Disch: 06/12/15 05:58:02 -
06/12/15 10:27:00

Institution:

[redacted]

Printed By: Letteri, Chelsea

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Last Modified By: Ryan, Katherine
06/12/15 10:27:42

Finalized By: Ryan, Katherine

Document Signatures
Signed By:
Ryan, Katherine 06/12/15 10:27

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

VSCOR Phase I Nursing Record

VSCOR Phase I Nursing Record Summary
Primary Physician: Kusior MD, Lawrence J.
[redacted]
Room/Bed: /
Admit/Disch: 06/12/15 05:58:02 -
Institution:
[redacted]

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Case Times - PACU I - VSCOR Audit
06/12/15 09:37:54 Owner: KRYAN Modifier: KRYAN
<+> 1 Ready for PACU I Discharge
<+> 1 Discharge from PACU I

Case Attendees - PACU I

	Entry 1
PACU I - Case Attendee	Ryan, Katherine
PACU I - Role Performed	Nurse - Postop
Last Modified By:	Ryan, Katherine 06/12/15 09:37:50

Finalized By: Ryan, Katherine

Document Signatures
Signed By:
Ryan, Katherine 06/12/15 09:38

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

OPERATIVE REPORTS

DICTATED BY: Lawrence J. Kusior, M.D.

[redacted]

SURGERY DATE:
06/12/2015

PREOPERATIVE DIAGNOSIS:
Right shoulder impingement, bursitis, tendinopathy.

POSTOPERATIVE DIAGNOSIS:
Right shoulder impingement, bursitis, tendinopathy with type 1 anterior superior labral tearing, synovitis as well as small focal full-thickness supraspinatus tendon tear.

OPERATION PERFORMED:

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

Right shoulder arthroscopic rotator cuff tendon repair, arthroscopic decompression with acromioplasty and bursectomy, arthroscopic debridement of the labral tear and synovitis.

SURGEON:
Lawrence J. Kusior, M.D.

ASSISTANT SURGEON:
Courtney Tosi, P.A.

ANESTHESIA:
General endotracheal with a block.

ANESTHESIOLOGIST:

ESTIMATE BLOOD LOSS:
Minimal.

FLUIDS:
Crystalloid.

INDICATIONS FOR PROCEDURE:
[redacted] is a pleasant 73-year-old female whose right shoulder has been painful and sore for a year after an accident. She had pain, discomfort, difficulty with arm elevation. She tried conservative treatment without much relief. Because of persistent pain, she presents for surgical intervention. MRI did not show obvious rotator cuff tear, but did have some tendinopathy. Options for operative and nonoperative interventions discussed, operative intervention chosen. Risks and benefits were reviewed. Informed consents were obtained.

SUMMARY OF PROCEDURE PERFORMED:
The patient was taken to the operating room. She received preop antibiotics. She was positioned supine on the operating room table. She was sedated, intubated and positioned in the beach-chair position, neck in neutral positioning. Examination of the right shoulder under anesthesia was unremarkable. The patient was given preop antibiotics, preop scalene block. The right upper extremity was prepped and draped in the standard fashion using ChloraPrep. A time-out was called. The patient's shoulder was injected with 60 mL of saline with a weak backflow. The arthroscope was inserted in the posterior portal. The intra-articular portion of

Operative Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

the shoulder showed intact glenohumeral articular surfaces. The biceps tendon was intact. The patient had anterior labral and superior labral tearing, which was debrided arthroscopically with a shaver. The patient had synovitis of the shoulder, which was debrided. Undersurface of the rotator cuff showed an obvious small focal full-thickness supraspinatus tendon tear with some retraction, arthroscopic debridement was performed of the undersurface of the rotator cuff. At this point then, the arthroscope was inserted into the subacromial space. Arthroscopic bursectomy, CA ligament release, acromioplasty was performed. The acromioclavicular joint was visualized, but not violated. At this point, using accessory portals, the patient had the greater tuberosity gently shaved to get punctate bleeding. A 5.5 Bio-Suture anchor was placed into the greater tuberosity footprint and then 2 sutures were passed through the rotator cuff preparing the rotator cuff back to the greater tuberosity footprint in anatomic fashion. Excellent anatomic repair was achieved. At this point, the instruments were removed. The rotator cuff appeared to be intact. The undersurface of the acromion appeared to be intact. Good hemostasis was achieved. The wound was closed with nylon suture. A dry sterile bulky dressing and sling was applied. The patient was awakened, extubated and transferred back to her hospital bed, back to recovery room in stable condition, breathing on her own. There were no complications, drains, or specimens.

LJK/NTS/197903754/rh/1/06/12/2015 12:38:25
D: 06/12/2015 08:46:01 T: 06/12/2015 09:46:42
[redacted]

Electronically signed by

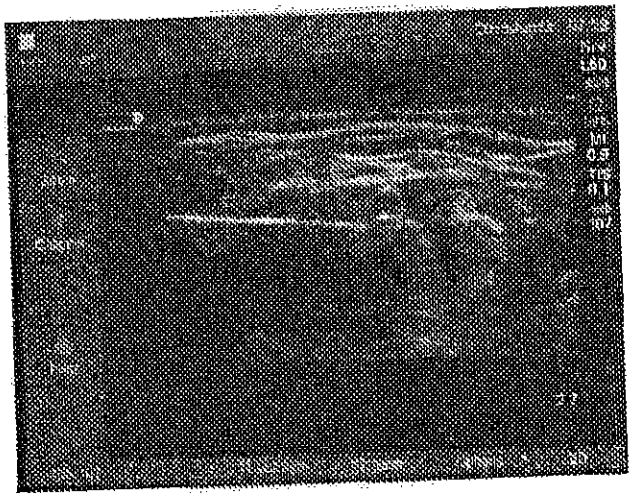
Kusior MD, Lawrence J. 06/23/2015 12:32 EDT

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time

[redacted]

[redacted]

Medical Record



Discharge Documentation

Document Name: Document Name Result Status
Performed By: Performed Physician Name Performed Date/Time
Authenticated By: Authenticated By Authenticated Date/Time