Patient Name ***DOB: MM/DD/YYYY***

Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

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

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

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

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

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

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

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

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

General Instructions:

- *The medical summary focuses on **Motor Vehicle Accident** on **MM/DD/YYYY**, the injuries and clinical condition of **XXXX** as a result of accident, treatments rendered for the complaints and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*
- *Unrelated visits for prior medical conditions have been captured briefly.*

Patient Name ***DOB: MM/DD/YYYY***

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	Neck strain Headaches Cervical disc disease Right arm paresthesias Cervical radiculopathy Brachial neuritis Left arm pain and paresthesias Cervicalgia Lumbago
Date of injury	MM/DD/YYYY
Description of injury	The patient was a restrained driver of a vehicle that was rear ended while stopped at a red light. There was no air bag deployment.
Injuries as a result of accident	• Cervical sprain with radiculopathy involving the right C7 nerve root • Thoracic sprain • Lumbosacral sprain • Internal derangement of left knee • Right hip sprain • Left knee sprain • Left knee meniscus tear • Left knee pain from bone marrow edema at the medial tibial plateau with subcortical cyst formation • Right hip pain with underlying osteoarthritis • Chondromalacia in the medial and lateral compartments of left knee • Derangement of medial meniscus of left knee due to old tear/injury • Left knee medial meniscus tear and aggravation of left knee primary, localized osteoarthritis • Cervicogenic headaches • Dizziness • Anxiety disorder
Treatments rendered	• Pain medications • Physical therapy • Trigger point injections (lower back) • T1-T2 interlaminar epidural injection • Left knee arthroscopic partial medial meniscectomy. • Right hip steroid injection
Condition of the patient as per the last available record	**As of 10/16/YYYY:** She's had continued complaints of medial and lateral sided knee pain. Follow-up MRI scan after surgery demonstrated edema in her medial, proximal tibial plateau. In addition, moderate chondromalacia in the medial and lateral compartments were noted. She is clinically improved at this point. I think she would benefit from continued Diclofenac as needed. She may use the unloader brace as

	needed. Follow up as needed.

Patient History

Past Medical History: Asthma, depression, obesity

Surgical History: Hysterectomy, low transverse cesarean sectionx3, appendectomy

Family History: Significant for Alzheimer's and hypertension

Social History: Denies smoking, alcohol, and drug use.

Allergy: Citalopram Hydrobromide

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Summary of prior injury records	
07/17/YYYY	Hospital/Provider Name	**Office Visit for annual exam:** *(Illegible notes)* **Complaints**: • Headaches, frontal • Insomnia **Impression**: • Emotional depression • Headaches-tension • Family planning • PE (physical exam) WNL (Within Normal limits) **Plan**: • Tylenol • Referred to Behavioral health	1237
06/17/YYYY	Hospital/Provider Name	**Office Visit for lump in head and neck pain:** *(Illegible notes)* **Chief complaints**: Lump to the left side of head, stiff neck, feels like all she wants to do is sleep. Depressed appearance **Neck**: Very stiff Palpable muscle tension in cervical and thoracic spine. Positive __ swelling on to left side of head.	1236

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment: • Tension cephalgia • Cervical myalgia **Plan**: • Motrin 600 mg • Flexeril 10 mg • Warm compresses, __ heat • Follow up	
06/11/YYYY	Hospital/Provider Name	**Bilateral digital screening mammogram with CAD:** **Reason:** Screening. **Impression**: Negative. Bi-Rads category 1 negative	1410-1411
09/11/YYYY	Hospital/Provider Name	**Office Visit for vaccination:** *(Illegible notes)* Presented to clinic for MMR vaccination. Vaccine given to patient. RTC as needed.	1235
03/02/YYYY	Hospital/Provider Name	**Follow-up Visit for cough:** *(Illegible notes)* Dry cough and right ear pain. **Assessment**: • Otitis media • Asthma acute exacerbation **Treatment**: • Albuterol • Prednisone • Amox Follow up in 3 weeks.	1234
05/24/YYYY	Hospital/Provider Name	**Office Visit for pregnancy results:** Positive.	1232-1233
09/09/YYYY	Hospital/Provider Name	**Office Visit for pregnancy test:** **Assessment:** Amenorrhea – rule out pregnancy	1098
04/21/YYYY	Hospital/Provider Name	**Operative report:** **Preoperative diagnoses:** Term intrauterine pregnancy at 39+ weeks. Two previous cesarean sections. Undesired fertility. **Postoperative diagnoses:**	1264-1268, 1260-1263, 1272-1275, 1283-1290, 1277-1281, 1291, 1260-1263

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Term intrauterine pregnancy at 39+ weeks. Two previous cesarean sections. Undesired fertility. Uterine atony. Immediate postpartum hemorrhage. **Procedures performed:** Repeat low transverse cesarean section, bilateral tubal ligation, subsequent hysterectomy and right salpingo-oophorectomy.	
04/21/YYYY	Hospital/Provider Name	**Procedure report:** **Preoperative diagnosis:** Intraoperative bleeding. **Postoperative diagnosis:** Intraoperative bleeding. **Procedures performed:** • Abdominal exploration. • Oversewing of bleeding veins.	1257-1259
04/25/YYYY	Hospital/Provider Name	**Urology consultation report:** **Chief complaint/reason for consultation:** Right hydronephrosis and hydroureter without excretion. **Assessment**: This is a 37-year-old female post op day #4 from a C-section, right salpingo-oophorectomy, bilateral tubal ligations complicated by a 22-L blood loss, with large amount of blood loss from the right vaginal cuff. Patient now has evidence of a complete obstruction or partial obstruction, versus ligated right distal ureter with right hydroureteral nephrosis. Patient also has evidence of a possible ileus versus small bowel obstruction.	1269-1271
04/25/YYYY	Hospital/Provider Name	**Procedure report:** **Preoperative diagnosis:** Right ureteral distal obstruction. **Postoperative diagnosis:** Right ureteral distal obstruction. **Procedures performed:** Rigid cystoscopy with attempted retrograde pyelogram and ureterogram along with attempted stent placement.	1276, 1282, 1301-1304, 1305-1320
04/26/YYYY	Hospital/Provider Name	**CT of liver/spleen and CT pelvis:** **Impression**: • New right percutaneous nephrostomy tube. No right hydronephrosis. • Small hematoma in the hysterectomy bed unchanged from the prior study. No enlarging or new retroperitoneal or intra abdominal	1292-1294

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		hematoma is seen. • Small amount of fluid and air in the hysterectomy bed site. • Free intra abdominal fluid as on the prior study. • Diffusely dilated and fluid/air-filled stomach and small bowel loops most likely representing postoperative ileus. A very distal small bowel obstruction would not be excluded. The wall thickening involving a loop of small bowel is not as well appreciated on the current study, however, this was done without contrast and so evaluation of the bowel wall is suboptimal. The colon is decompressed. • Bilateral pleural effusions and bibasilar lung consolidation/atelectasis.	
04/26/YYYY	Hospital/Provider Name	**X-Ray of chest:** **Impression**: Increasing basilar atelectasis and right pleural effusion. The possibility of infection is not excluded. There is a PICC line remaining in the superior vena cava. Other lines have been withdrawn.	1300
04/27/YYYY	Hospital/Provider Name	**Ultrasound CD external veins left:** **Clinical indication:** Left upper extremity swelling distal to elbow. **Impression**: • Occlusive, non-compressible thrombus in the left the level of the antecubital fossa. • Patent left upper extremity venous system proximal to antecubital fossa.	1295
04/27/YYYY	Hospital/Provider Name	**Portable abdomen series:** **Clinical indication:** ileus. **Impression**: Multiple air-fluid levels and dilated loops of small bowel. A mechanical obstruction cannot be excluded. It is possible that this is a severe ileus related to the recent surgery.	1296
04/27/YYYY	Hospital/Provider Name	**Portable chest X-ray:** **Clinical indication**: Evaluation effusion **Impression**: Slight improvement in the basilar atelectasis. There is probably a small effusion remaining on the right.	1297
04/28/YYYY	Hospital/Provider Name	**Portable chest X-ray:** **Clinical indication**: SOB (Shortness of Breath) **Impression**: • Cardiomegaly with pulmonary edema. • Stable bilateral pleural effusions.	1298

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Increasing retrocardiac and basilar atelectasis. • Placement of nasogastric tube.	
04/28/YYYY	Hospital/Provider Name	**Portable KUB abdomen:** **Clinical indication:** Eval Ileus. **Impression**: • Gas-filled distended loops of small bowel. This may reflect ileus, however, a partial mechanical distal small bowel obstruction cannot be entirely excluded. Clinical correlation is recommended. • Nephrostomy tube and nasogastric tube in position.	1299
05/01/YYYY	Hospital/Provider Name	**Operative Report:** **Preoperative diagnosis:** Left hand compartment syndrome. **Postoperative diagnosis:** Left hand compartment syndrome. **Procedure performed**: Release, left hand intrinsic muscle compartments with fasciotomy. **Indications and findings:** Patient had undergone previous placement of a radial artery catheter with occlusion of the radial artery. Her hand at that point was soft; however, it was noted last evening that she had developed increased pain. This correlated with an improved signal in the radial artery. She was felt to have a reperfusion injury with severe compartment syndrome. Preoperative measurements confirmed the need for fasciotomy. At surgery, bulging of several of the muscles was noted once the fascia was release, confirming the clinical diagnosis. **Procedure**: Under satisfactory general anesthesia, patient was prepped and draped in the usual fashion. Over the metacarpals, between the index and middle and ring and little, 2 dorsal incisions were made on the dorsum of the hand and dissection carried down to the fascia. The 4 dorsal compartments were released. The muscle was seen to bulge significantly on each. Incision was made along the thenar eminence and severe swelling noted in this area. For this reason, a 2nd small counter incision was made on the dorsum of the web space. Through this, the 1st dorsal interosseous was released further, as was the adductor compartment. The final incision was made along the hypothenar eminence. This muscle was also noted to swell severely. Following this, the tourniquet was then deflated and hemostasis obtained. The wounds were closed very loosely with interrupted 4-0 nylon sutures. She was placed back into intrinsic plus splint. Overall prognosis is good, as the appearance of the muscle showed good perfusion post release of the	1238-1239

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		tourniquet.	
05/05/YYYY	Hospital/Provider Name	**Discharge Summary:** **Admission diagnosis:** Desire for repeat low transverse cesarean section and permanent sterility. **Discharge diagnosis:** Status post repeat low transverse cesarean section, subsequent hysterectomy and right salpingo-oophorectomy with multiple postoperative complications, including placement of right nephrostomy tube, fasciotomy to the left hand and post op ileus.	1240-1243
05/22/YYYY	Hospital/Provider Name	**CT of liver spleen with contrast:** **Clinical indication:** Abdominal pain. **Impression**: • Resolving pelvic hematoma. No findings to suggest an abscess. • Persistent dilatation of the right ureter to the level of the mid pelvis at the site of the previously noted hematoma.	1321
05/22/YYYY	Hospital/Provider Name	**CT of pelvis with contrast:** **Clinical indication:** Abdominal pain. **Impression**: Combined report examination. (CT liver/spleen)	1322
05/16/YYYY-05/30/YYYY	Hospital/Provider Name	**Occupational Therapy status post-surgery for left hand compartmental syndrome:** *(Illegible notes)* Patient underwent surgery for left hand compartment syndrome. Moderate hand edema Notes tingling to left thenar and intrinsic flexors. Therapeutic exercises **Frequency:** 2 times per week for 8 weeks.	1244-1245, 1323
05/22/YYYY-06/14/YYYY	Hospital/Provider Name	**Summary of interim Occupational Therapy visits:** *Illegible notes* Positive edema **Treatment rendered:** • Soft tissue mobilization • Electrical stimulation • Cold packs • Therapeutic exercises **Reviewer's comments: The interim visits are summarized with significant*	1332-1337

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		events.	
06/15/YYYY	Hospital/Provider Name	**CT of kidney, adrenal, and pelvis:** **Impression**: • No significant change in right hydronephrosis and hydroureter, which is probably due to stenosis in the distal ureter in the region of the hysterectomy. • Continued resolution of hematoma from hysterectomy. • Persistent fluid collection superior to the bladder which is unchanged.	1246-1247, 1248-1249
07/02/YYYY	Hospital/Provider Name	**Emergency room visit for abdominal pain:** **Chief complaints:** • Abdominal tube not draining • Mild adnominal pain • Left flank pain • Urinary incontinence **Diagnosis**: • Obstructive nephrostomy tube • UTI	1325-1329
07/10/YYYY	Hospital/Provider Name	**Procedure Report:** **Procedure**: Nephrostomy tube change **Impression**: Uncomplicated 10-French nephrostomy tube exchange.	1250, 1330-1331
07/28/YYYY	Hospital/Provider Name	**Procedure Report:** **Preoperative diagnosis:** Distal right ureteral stricture. **Postoperative diagnosis**: Distal right ureteral stricture. **Procedures performed:** • Excision of right distal ureteral stricture. • Right uretero neocystotomy. **Related records**: Ultrasound KUB report	1251-1256, 1338
08/02/YYYY	Hospital/Provider Name	**CT of liver/spleen, pelvis:** **Clinical History**: Patient who had hysterectomy and right ureteral injury. She has had a distal right ureterectomy and ureterocystostomy. Evaluate for extravasation.	1339-1343
08/10/YYYY	Hospital/Provider	**Cystogram report:**	1344-1345

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	**Clinical indications:** Unspecified urethral stricture **Impression**: • No leak. • Vesiculoureteral reflux on the right to the level of the renal calyces with a tube in the right renal collecting system.	
08/11/YYYY	Hospital/Provider Name	**Abdomen series and PA and lateral chest:** **Impression**: • No active disease seen in the chest. • Cardiomegaly. • Normal bowel gas pattern without evidence of free air or obstruction.	1346-1347
08/11/YYYY	Hospital/Provider Name	**Emergency room visit for abdominal pain, vomiting, and right flank pain:** **Clinical impression:** • Acute abdominal pain • Vomiting	1349-1356, 1357-1358, 1362-1366, 1359-1361
08/28/YYYY	Hospital/Provider Name	**Emergency room visit for headaches:** *Illegible notes* **Clinical impression:** Headaches Headache resolved with fluids, ___	1368-1373
11/06/YYYY	Hospital/Provider Name	**Office Visit for pain with urination:** **Clinical impression:** UTI	1376
11/09/YYYY	Hospital/Provider Name	**Office Visit for PPD reading:** **Assessment:** PPD negative.	1101
12/19/YYYY	Hospital/Provider Name	**Office Visit for right eye irritation and swelling:** **Assessment** Headache syndromes, likely cluster headache given H&P and relief with O2 therapy. Patient seen by Dr. XXXX **Plan**: Ibuprofen 600 mg Follow up in 5-7 days.	1102-1103
12/28/YYYY	Hospital/Provider Name	**Office Visit for right eye redness an ditching:** *Illegible notes* Right eye redness with pain and left hand rash and itching.	1374

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Impression: • Right eyelid ___ • Dermatitis left hand Continue Ibuprofen Erythromycin	
09/15/YYYY	Hospital/Provider Name	**Chest X-ray:** **Reason for exam:** Fever, cough.	1403-1406
09/16/YYYY	Hospital/Provider Name	**Lab reports**	1389-1402
09/16/YYYY	Hospital/Provider Name	**MRI of brain without contrast:** **Indication**: Dizziness and right-sided weakness. Nausea and vomiting. **Impression:** Normal	1407-1408
09/24/YYYY	Hospital/Provider Name	**Office Visit for right elbow, shoulder, and neck pain and possible syncope:** **History of present illness:** Feeling the same Pt seen there for right elbow, shoulder and neck pain and possible syncope—Abrupt onset 9/14 night. Patient claims X-rays and lab unremarkable - she has signed ROI in order that we can obtain these records She was given instruction to use OTC meds for pain and given Rx for Paxil and Xanax. **Assessment**: • Neck strain • Depression • Anxiety disorder NOS • Symptoms referable to a joint of the shoulder region right • Symptoms referable to a joint of the humerus/elbow - right **Plan**: • Obtain and evaluate previous medical records from ER • Return to the clinic if condition worsens or new symptoms arise • Continue current medication • Follow-up visit - soon for Physical Exam • Consultation with a mental health counselor • Consultation with an occupational therapist Paroxetine HCl 20 mg tabs	1099-1100, 1104-1105
10/22/YYYY	Hospital/Provider Name	**Office Visit for facial numbness:** *Illegible notes* **Impression:**	1375

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Hyperventilation Anxiety Depression Refills on Paxil and Xanax	
11/10/YYYY	Hospital/Provider Name	**Emergency room visit for right ankle injury:** **Chief complaint**: Soft tissue injury to right ankle. **Primary diagnosis:** Sprain/strain of the dorsum of the right foot. **MD summary:** Patient fell 12 steps and injured her right foot. It hurts to bear weight. **Prescription**: Ibuprofen 600 mg	1377-1379
03/24/YYYY	Hospital/Provider Name	**Office Visit for body numbness:** **Assessment**: Toxicity from psychotropic agents withdrawal from Paroxetine. Acute serotonin deficiency syndrome **Plan**: Anticipate full recovery over next week from withdrawal. Counseled on the 50% recurrence of major depression after d/c ing meds. Patient aware.	1106-1107
05/20/YYYY	Hospital/Provider Name	**Office Visit for right hand laceration:** The Chief Complaint is: C/o laceration on right hand like an hr. ago at home. **Assessment**: Open wound of the right little finger	1108-1112
11/14/YYYY	Hospital/Provider Name	**Emergency room visit for cough:** Asthma exacerbation.	1380-1388, 1403
11/16/YYYY	Hospital/Provider Name	**Office Visit for cough and chest pain:** Prescribed Prednisone and Tamiflu and Doxycycline.	1113-1114
04/15/YYYY	Hospital/Provider Name	**Office Visit for urinary frequency and dysuria:** *Illegible notes* Complains of urinary frequency and dysuria and ___. **Impression**: • UTI • Benign positional vertigo • Possible ureteral obstruction Meclizine 25mg Hearing screen	1409

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		RTC as needed	
07/08/YYYY	Hospital/Provider Name	**Office Visit for cuts on right foot:** Bactrim DS 800-160 mg Naproxen 375 mg	1115-1116
02/08/YYYY	Hospital/Provider Name	**Office Visit for physical exam:** Psychometric depression scale PHQ-9 Score: 11 Normal routine pelvic exam Left arm pain with movement. Pain scale: 8/10	1117-1122
02/25/YYYY	Hospital/Provider Name	**Follow-up Visit on cholesterol:** **Assessment:** • Hyperlipidemia • Obesity	1123-1125
03/05/YYYY	Hospital/Provider Name	**Emergency room visit for headaches:** C/o severe headache since yesterday at 22:00 Pt notes n/v, photophobia, dizziness, and otophobia today. Complains of a unilateral headache affecting the right side. This is a recurring problem, and patient has had previous similar episodes, but states has not been given dx of tension or migraine headaches. Did not take any meds at home for this. Headache localizes behind eyes. Headache is rated as moderately severe. This headache has progressively developed over a period of several days. Symptoms have remained stable. Complains of headache without obvious cause or trigger. No history of stiff neck, lateralizing weakness or altered mental status. No history of head injury or recent lumbar puncture. Denies scalp tenderness, jaw claudication or ENT symptoms. These symptoms are associated with photophobia. Has only had one or 2 episodes. Nondescript vomitus without blood. **Primary Diagnosis** • Headache • Nausea • Photophobia **Discharge prescriptions**: Motrin 600 mg **Discharge condition**: Stable.	494-511
12/20/YYYY	Hospital/Provider Name	**Office Visit for vomiting and dizziness:** **Assessment**:	1126-1129

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Gastroenteritis • Dehydration **Plan**: Labs, Zofran 4 mg	
03/31/YYYY	Hospital/Provider Name	**Office Visit for right arm numbness:** The Chief Complaint is: Right arm numbness that radiates up to neck. Neurological symptom sx (symptom) began 1 month ago without provocation: denies any trauma heavy lifting or exertion. Right handed: fingers felt like they were asleep and swollen: sx would come and go; pain began 3 days ago. Radiates from her band/fingers to arm in the past few days began to radiate to her right neck and head. **Cervical Spine:** **General/bilateral:** Spasm of the paracervical muscle. Spasm of the paracervical muscle on the right. Cervical spine ROM abnormal. Cervical spine pain was elicited by right-sided motion positive Spurling sign. **Assessment**: Neuropathy cervical: positive spurning sign: neurology referral ASAP, establish charity care today **Plan**: Neuropathy Medical Consult: Neurology Instructions: Progressively worsening pain and numbness weakness, from right head/neck to fingertips. sight handed no trauma neck pain, positive spurting sign **Lab**: CBC with Differential **Lab**: Sedimentation Rate (ESR) **Radiology/MRI**: MRI Neck **Medical Consult**: Electromyography EMG Cyclobenzaprine HCl 5 mg tabs, three times daily as needed, 30 days, 0 refills	1130-1132
04/03/YYYY	Hospital/Provider Name	**Emergency room visit for right arm numbness and facial numbness:** **Visit Reason**: Right arm numbness facial numbness **History of present illness:** Chief complaint is right-sided weakness, numbness, tingling and pain. The patient states she has been having similar signs and symptoms in the past, but over the last four days she started	293-307, 124-131, 310-328, 1412-1416

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		having some tingling in her right fingers, they became numb, now she does have some numbness all the way to the right lateral aspect of her neck. There is pain with any movement of her shoulder and elbows. Tingling in her left hand started the day as well. She states that at times she thinks even her right side of her face is tingling. She has had some questionable changes in vision. No headaches, no dizziness, no nausea or vomiting. She is in the emergency department with her daughter. The patient is Spanish-speaking only. Her daughter is helping with history and translation. The patient did see her family doctor, Dr. XXXX on March 31, YYYY for the same symptoms. At that point in time, it was thought to be muscular. The patient was given a prescription for Cyclobenzaprine, which did help her. **Musculoskeletal**: The patient has sensation to all extremities. The patient is able to flex and extend her right shoulder elbow, doing this, however, causes pain. She has what appears to be decreased strength in her right wrist, hand and shoulder. She found it very difficult to lift her right leg off the bed. **Emergency department course**: While in the emergency department, a stroke alert was called by the triage nurse due to her symptoms. An EKG was completed when she arrived and showing normal sinus rhythm at 75 beats per minute. This was due to the stroke alert being called. This is read as normal. INR is 1.1. Her CBC and BMP all within normal limits. We did do the CT of the head due to the stroke alert this shows no acute findings due to what certainly appears to be radiculopathy rather than a stroke. We did get a CT of her neck, non contrast. This shows some bilateral cervical lymph nodes which just for more numerous. Radiologist thought __ she followed up at some point in time, but it also shows a very mildly degenerative disc protrusion at C4-C5 and C5-C6. This was superimposed on a developmentally narrow spinal canal which results in mild encroachment on the thecal sac. I discussed the CT with the patient with a different daughter translating this time and the patient had no questions. She understood that following with her family doctor, Dr. XXXX was very appropriate. Discussions may be to have physical therapy and may be injections discussed and maybe oral medications discussed. I did provide the patient with naproxen while in the emergency department, a prescription for the same. She does have a cyclobenzaprine which I think will help at bedtime. We discussed using ice and heat. The patient once again was asked to see any questions, she had none. The patient then was given oral and written instructions and discharged from the emergency department. **Final diagnoses:** • Arm paresthesias, right. • Cervical disc disease.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Discharge Diagnosis(s): Arm paresthesia, right; Cervical disc disease **Prescriptions**: Naproxen 500 mg	
04/03/YYYY	Hospital/Provider Name	**CT of head without contrast:** **Reason for Exam** (CT Head or Brain w/o Contrast) Stroke. **Impression**: No CT evidence for acute infarct, mass, or intracranial hemorrhage.	308
04/03/YYYY	Hospital/Provider Name	**CT of cervical spine without contrast:** **Reason for Exam** (CT Spine Cervical w/o Contrast) Other (use special instructions) **Impression**: Bilateral cervical lymph nodes are normal sized but more numerous than expected. Considerations include reactive lymph nodes due to upper respiratory infection. Lymphoma or metastases are also considerations. Recommend follow-up clinically with further imaging as warranted such as a least a follow-up neck CT to assess resolution or progression. Very mild degenerative disc protrusions at C4-C5, C5-C6 superimposed on a developmentally narrow spinal canal results in mild encroachment on the thecal sac. Neural foramina are patent	308-309
04/08/YYYY	Hospital/Provider Name	**Follow-up Visit for right arm numbness:** Neurological symptoms had been referred to the ER due to worsening of sx of right arm numbness and pain radiating to her neck/head with blurred vision: patient had CT of neck and head revealing multiple lymph nodes, and: feeling better in terms of pain and numbness, tingling. Cyclobenzaprine helped with all sx but caused sedation; uses only at night. **Assessment**: Cervical radiculopathy **Plan**: **Tension headache** Ultram 50 mg tablets **Mononeuritis Nos** Cyclobenzaprine HCl 5 mg tabs, three times daily as needed, 30 days, 0 refills Tylenol with Codeine #3 300-30 MG TABS, as directed, 30 days, 0 refills, 1-2 p.o. every 6 hours as needed for severe pain Naprosyn 500 mg, twice daily as needed, 30 days, 1 refills	1133-1135

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Cervical radiculopathy Radiology/X-Ray: Chest X-Ray Instructions: cervical CT 04/03/14 showed numerous lymph nodes possible lymphoma	
04/09/YYYY	Hospital/Provider Name	**X-Ray of chest:** **History**: Brachial neuritis. **Impression**: No acute cardiopulmonary disease.	291-292, 1417
04/11/YYYY	Hospital/Provider Name	**Emergency room visit for chest pressure and upper extremity numbness:** **Visit Reason**: Chest pain **History of present illness:** 45 year old Spanish-speaking female presents to the ED complaining of chest pressure and upper extremity numbness. The patient was seen in the ED on 4/3 for evaluation of right arm numbness and tingling. These symptoms have not gone away, and she now presents with upper-left sided chest pressure and left arm numbness that began last night around 10:30 PM as she was laying down. The patient describes her arms as "heavy," and notes that her right arm is heavier than her left, but her left arm is more numb than her right. She also complains of bilateral facial numbness, right greater than left, and blurred vision. The patient describes her chest pain as a pressure, and notes that it does radiate into her back. The pain worsens when pressing on her chest and when moving her left arm. The patient has been able to walk today, although only slowly, and denies any speech impairment, itching, rash or skin changes, history of any medical conditions, tobacco use or EtOH use, HTN, hyperlipidemia, DM, or family history of CAD. She does not currently take any medication. The patient's PCP is Dr. XXXX from the 16th street clinic, who recommended via phone conversation with the patient that she come to the ED today. The patient presents with no cardiovascular risk factors. She has no further complaints at this time. **Musculoskeletal symptoms**: Back pain. Troponin-1: 0.00 ng/mL **Radiology results** **Interpretation:** No significant interval change and no non contrast CT evidence of acute intracranial injury or disease. **Impression and Plan** • Diagnosis	150-164, 107-120, 168-171, 174-176, 183-290

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Paresthesias. **Course**: Onset of paresthesias with pain 4-5 weeks ago. Right face and arm. Some fluctuations in symptomatology. Patient is claustrophobic and refuses MR scan. Exam is normal other than some sensory changes noted right arm, face and leg. Given the fluctuating course-history is not consistent with stroke. There is concern for demyelinating disease. Patient has no risk factors for stroke. Diagnosis is paresthesia uncertain etiology. Discussed with Dr. XXXX - covering hospitalist today. **Plan**: Patient may be discharged today. I discussed this with her. Next up and evaluation process is an open MR scan of brain with and without contrast. The patient may follow-up with me or another neurologist as per her primary care physician. **Discharge Diagnosis(s):** Chest pain; Paresthesias; Weakness **Plan** **Condition**: Stable, Guarded. **Disposition**: **Admit**: To Observation Telemetry Unit, Trivedi, Chinmaya B MD.	
04/11/YYYY	Hospital/Provider Name	**History and Physical note:** **Chief Complaint**: Right arm n/t/weakness r/o TIA/CVA; chest pain **History of present illness:** The patient was last known well at 10:30pm last PM, since then she started having head pressure and almost a "numbness" feeling to her right side of the head, and some weakness to extremities right>left, and tingling and numbness of bilateral arms. Patient describes some right sided facial numbness, but also does have some numbness to the left face as well. She is at times dizzy and light headed, and short of breath. She also complains of chest pressure/pain that is reproduces with palpation in ED. Patient apparently with some similar do few days ago with right arm n/t and w/u with CT of head and CT C-spine showing some DJD c spine and d/c home with dx cervical radiculopathy. **Location of symptoms**: Right face/arm n/t **Quality of symptoms**: Vague **Severity of symptoms**: Mild **Duration of symptoms**: Few days **Timing of symptoms**: Intermittent	141-146

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Exacerbating or relieving treatments or therapies: None so far **Additional co-morbidities/signs or symptoms**: cervical DJD noted on ED w/u with C-spine CT few days ago. Brought in for observation. **Assessment**: Patient brought in for observation to r/o CVA/TIA for right face/arm n/t. similar issues few days ago and d/c after CT C spine with some DJD and dx with cervical radiculopathy. Also with vague reproducible cp in ED. EKG no acute changes. C enzyme pending in ED. **Plan**: Right face/arm n/t (numbness/tingling). R/o (Rule out) CVA/TIA. Similar issues few days ago and d/c after CT c spine with some DJD and dx with cervical radiculopathy. ?etiology sx. check MRI Echo/Carotid in AM. Neuro/Leo consulted by ED prior to being brought in for observation. If w/u remains neg/ likely home in AM. ASA/Statin for now. Vague reproducible CP in ED. EKG no acute changes. C enzyme pending in ED. serial c enzymes. R/o acs although seems more musculoskeletal pain at this time. Monitor on tele. Check echo as ordered per CVA pathway. • Anxiety • Supportive care. • DJD/cervical spine Findings relatively mild. Therapy. Patient will need repeat CT c spine to f/u findings of cervical lymphadenopathy with pep in few weeks after d/c as per radiologist recommendation. For all other chronic medical conditions We'll provide supportive care and continue their home regiment. Patient can continue to follow up with their PCP after discharge for ongoing management. **DVT prophylaxis**: /EHR reviewed/ Lovenox **Disposition**: We'll have case management help with discharge planning Code Status: full code Anticipated date of discharge: Once further medically stabilized Observation	
04/11/YYYY	Hospital/Provider Name	**Consultation report:** **History of Present Illness:**	146-150

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		The patient presents with 04/12/YYYY. Dr. XXXX he had requested consultation for my opinion he regards to patient's complaints of right-sided paresthesia. Patient was admitted via emergency room. History obtained with a phone translator as patient is primarily Spanish speaking. Patient reports onset of right arm numbness approximately 4-5 weeks ago. Describes intermittent numbness. Along with the numbness she describes a sharp pain. The numbness is concentrated in the right arm but also may involve the right face. Right face and arm symptoms occur at the same time. She also reports pain in the back of the head as well as neck pain. Intermittent right leg numbness. This is not a prominent problem. There is no recent history of head or neck trauma. Patient also is some complaints of chest tightness which occurs in the dependent of her right arm numbness. Intermittent low back pain. She reports no change in bladder or bowel control. There is no visual change. No change in hearing or speech. She reports intermittent arm weakness. The pain became intense yesterday and the patient presented to the emergency room. She had been seen in the emergency room a few days prior with similar complaints. **Prescriptions** **Prescribed:** Naproxen 500 mg oral **Impression and Plan** • Diagnosis • Paresthesias. **Course**: Onset of paresthesias with pain 4-5 weeks ago. Right face and arm. Some fluctuations in symptomatology. Patient is claustrophobic and refuses MR scan. Exam is normal other than some sensory changes noted right arm, face and leg. Given the fluctuating course-history is not consistent with stroke. There is concern for demyelinating disease. Patient has no risk factors for stroke. Diagnosis is paresthesia uncertain etiology. Discussed with Dr. XXXX - covering hospitalist today. **Plan**: Patient may be discharged today. I discussed this with her. Next up and evaluation process is an open MR scan of brain with and without contrast. The patient may follow-up with me or another neurologist as per her primary care physician.	
04/11/YYYY	Hospital/Provider Name	**CT of brain without contrast:** **History**: Stroke alert. **Impression**: No significant interval change and no non contrast CT evidence of acute intracranial injury or disease.	172
04/11/YYYY	Hospital/Provider Name	**CT of the neck:** Bilateral cervical lymph nodes are normal sized but more numerous than expected. Considerations include reactive lymph nodes due to upper	135

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		respiratory infection. Lymphoma or metastases are also considerations. Recommend follow up clinically with further imaging as warranted such as a least a follow up neck CT to assess resolution or progression Very mild degenerative disc protrusions at C4-C5, C5-C6 superimposed on a developmentally narrow spinal canal results in mild encroachment on the thecal sac. Neural foramina are patent	
04/11/YYYY	Hospital/Provider Name	**Ultrasound Carotid Duplex:** **Indications:** CVA **Impression**: • Right internal carotid stenosis of less than 50%. • Left internal carotid stenosis of 50 to 69% based on the flow velocities however no significant plaque is identified. If clinically indicated would consider MRA for further evaluation. • Vertebral flow is antegrade bilaterally.	173
04/11/YYYY	Hospital/Provider Name	Called by ER: patient-presented tonight 4/11/14 with chest pain and heaviness/weakness in right upper and lower limbs. Patient being admitted to the hospitalist service (PCP is M. Dunn) to evaluate for stroke. I discussed with ER doc her out patient record, significant anxiety and prior evaluations; he is aware and intends to proceed with admission.	1136
04/12/YYYY	Hospital/Provider Name	**Discharge Summary:** **Hospital Course** The patient presents with 04/12/YYYY. Dr. XXXX he had requested consultation for my opinion he regards to patient's complaints of right-sided paresthesia. Patient was admitted via emergency room. History obtained with a phone translator as patient is primarily Spanish speaking. Patient reports onset of right arm numbness approximately 4-5 weeks ago. Describes intermittent numbness. Along with the numbness she describes a sharp pain. The numbness is concentrated in the right arm but also may involve the right face. Right face and arm symptoms occur at the same time. She also reports pain in the back of the head as well as neck pain. Intermittent right leg numbness. This is not a prominent problem. There is no recent history of head or neck trauma. Patient also is some complaints of chest tightness which occurs in the dependent of her right arm numbness. Intermittent low back pain. She reports no change in bladder or bowel control. There is no visual change. No change in hearing or speech. She reports intermittent arm weakness. The pain became intense yesterday and the patient presented to the emergency room. She had been seen in the emergency room a few days prior with similar complaints. Medical history is negative for hypertension heart disease. No recent head or neck trauma. **Hospital course:**	134-141, 165-167, 657-992

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		Patient was admitted the day she presented to the hospital. Troponin was check X3 with 0.00 as a result x3. She underwent CT of the head, and carotid US. MRI was ordered but the patient was unable to complete due to claustrophobia. Her son was present and she agreed to have him interpret for us. She refused to take medication to try and get through the MRI and decided she wanted to order this as an outpatient in and open MRI. Per Dr. XXXX notes: Paresthesias. **Course**: Onset of paresthesias with pain 4-5 weeks ago. Right face and arm. Some fluctuations in symptomatology. Patient is claustrophobic and refuses MR scan. Exam is normal other than some sensory changes noted right arm, face and leg. Given the fluctuating course-history is not consistent with stroke. There is concern for demyelinating disease. Patient has no risk factors for stroke. Diagnosis is paresthesia uncertain etiology. Discussed with Dr. XXXX - covering hospitalist today. **Plan**: Patient may be discharged today. I discussed this with her. Next up and evaluation process is an open MR scan of brain with and without contrast. The patient may follow-up with me or another neurologist as per her primary care physician. I asked her to see her PCP and choose a location for the open MRI. She can follow up with Dr. XXXX or a neurologist of her choice after the MRI is complete. **Discharge Plan** Discharge Medications Naproxen 500 mg oral tablet: 1 tab(s) PO (oral) bid **Discharge Instructions** Activity Restrictions: Advance Activity as Tolerated. Driving Restrictions: No Driving Until You See Your Provider. Diet at Home: No Restrictions. Fluid Restrictions: No Restrictions. May Shower: Yes. Education and Follow-up Patient education: Med Surg Stroke Folder Spanish American Stroke Assoc (Custom). **Follow-up:** Gary J Leo Follow up after MRI done. She could also follow up with another Neurologist is recommended by PCP; Margaret M Dunn Patient should follow up in 5-7 days. Needs to be cleared by PCP for driving. Needs open MRI ordered for arm numbness.	
04/12/YYYY	Hospital/Provider Name	**Occupational Therapy initial evaluation:** **Subjective**: Patient reported no pain at rest. Reported 7/10 pain in posterior cervical region with movement. FACES Primary Pain Score: 8	177-179

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		Evaluation only Not recommending OT at this time, as patient performs ADL's independently ad safely.	
04/12/YYYY	Hospital/Provider Name	**Speech Therapy initial evaluation:** **SLP Additional Information**: Order received, chart reviewed. Spoke with RN. Patient no longer presenting with need for SLP. Evaluation only	179
04/12/YYYY	Hospital/Provider Name	**Physical Therapy Records** **Current Medical Course Rehab**: Patient went to ER secondary to feeling of pressure in head, and numbness and tingling along Right side of face and Right UE. Please refer to medical history for more details. **Assessment** Rehabilitation Potential: Good Justification for Skilled Care: No further in patient PT warranted **Plan** PT Plan Frequency: Evaluation only	179-182
04/13/YYYY	Hospital/Provider Name	**Emergency room visit for right arm numbness and dizziness:** Patient presents to the ED with c/o blurry vision and right sided paresthesias that began 2 hours PT A. Patient states she was evaluated yesterday at St Mary's for rig ht sided weakness and numbness and was scheduled for an MRI as part of her stroke work up. However, due to the patient's claustrophobia, an MRI was not performed. The patient has returned to the ED as her symptoms have returned. Patient now c/o heaviness, warmth, and tingling to her face and right arm, nausea, tinnitus in her right ear, and vertigo. Patient denies HA, balance issues, recent stress, any pain, vomiting, or any other associated symptoms. **Neurological**: Positive for numbness (to right side). Negative for headaches. Positive for heaviness, warmth and tingling to face and right arm **HENT**: Positive for tinnitus. **Gastrointestinal**: Positive for nausea. Patient is anxious with her eyes closed. Drift noted to pt's BUE and right leg. No facial droop or tongue deviation noted. Pt's plantar reflexes were down going.	517-527, 1033, 548, 551, 596

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		ED Course: Initial visit Discussed plan for a repeat head CT as the pt's symptoms have returned. Pt understands and agrees with the plan. 9:10 PM Spoke with the radiologist who reports the patient's head CT is normal. Because of the patient's vertigo with posterior cerebral symptoms we ordered a CT angiogram of the head and neck to rule out vertebral artery dissection or occlusion. 9:24 PM Per stroke RN, the pt passed the dysphagia test and was given an NIH score of 1 for right arm drift. Further history was obtained from the patient through the translator and her symptoms which began Friday evening never resolved. 2 hours prior to admission there was acute worsening of the symptoms. Actually she has had symptoms like this on and off for a month. 10:20 PM I spoke with Dr. XXXX regarding the patient's presentation and the Emergency Department work up that included negative head CT and CT angiogram. We further discussed and agreed that Dr. XXXX will consult The patient agrees with the plan and verbalized an understanding of it 10:24 PM Rechecked patient who states she is currently less dizzy. Patient c/o pain and heaviness when lifting her right arm. Patient states her symptoms began at 10 PM on Friday (2 days ago) and worsened 2 hours PTA but never completely resolved. On reexamination, the pt exhibits tenderness to her right trapezius, right upper and lower arm with no swelling. The patient had her eyes open and said vertigo was resolved. 11:17 PM I spoke with Dr. XXXX regarding the patient's presentation and the Emergency Department work up that included negative head CT and negative CT angiogram. We further discussed and collaboratively agreed that the pt will be admitted for further testing. 11:22 PM Rechecked patient who states her dizziness improved with the Meclizine. Patient continues to c/o numbness to her arm. Updated patient on her negative head CT and negative angiogram that did not show sign of CVA. Discussed my consult with Dr. XXXX and her recommendation for admission as she continues to exhibit right arm drift. Discussed that because the pt exhibits pain to her right arm, there may be a different etiology of the patient's symptoms than stroke. Discussed plan for admission for further testing. **Clinical Impression:** The primary encounter diagnosis was Right arm weakness. Diagnoses of Right arm pain and Vertigo were also pertinent to this visit.	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Patient to be admitted to Dr. XXXX in stable condition.	
04/13/YYYY	Hospital/Provider Name	**CT of head without contrast:** **History**: Vertigo. Right-sided paresthesias. **Findings**: The brain parenchymal volume s age-appropriate and the gray-white differentiation pattern is preserved. No evidence for intracranial hemorrhage or extra-axial fluid collection. No evidence of acute ischemia. The ventricular system is mid line, without evidence for hydrocephalus or intraventricular hemorrhage. The basal ganglia are unremarkable. Allowing for beam-hardening artifact, the posterior fossa structures are intact and the basal cisterns are patent. The paranasal sinuses and mastoid air cells demonstrate normal aeration and development. **Impression**: No acute intracranial findings.	638, 1426-1427
04/13/YYYY	Hospital/Provider Name	**CT angiogram of the head and neck:** **History**: Left arm pain. **Impression**: There is no evidence of dissection, aneurysm, or acute obstruction	641-642, 643-644, 1423-1425
04/14/YYYY	Hospital/Provider Name	**History and Physical note:** **Chief complaint:** • Numbness • Dizziness **History of present illness:** Patient with no pmhx (past medical history), who presents with c/o blurry vision and right sided paresthesias that began 2 hours ago. Patient states she was evaluated yesterday at St. Mary's for right sided weakness and numbness and was scheduled for an MRI as part of her stroke work up. However, due to the patient's claustrophobia, an MRI was not performed. The pt has returned to the ED as her symptoms have returned. Patient now c/o heaviness, warmth, and tingling to her face and right arm, nausea, tinnitus in her right ear, and vertigo. Patient denies HA, balance issues, recent stress, any pain, vomiting, or any other associated symptoms. **Review of systems:** **Neurological:** Positive for numbness (to right side). Negative for headaches. Positive for heaviness, warmth and tingling to face and right arm. Drift noted to patient's BUE and right leg. No facial droop or tongue deviation noted. Patient's plantar reflexes were down going.	531-536, 1418-1422

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		X-ray chest: Mild elevation of the right hemidiaphragm. **Assessment and Plan**: • Neuro: Given BIL Upper Extremity paresthesias with pain, most likely cervical radiculopathy. Will order MRI of C-spine, Neurology already consulted. Will give ASA for now. • DVT prophylaxis: Lovenox.	
04/14/YYYY	Hospital/Provider Name	**Consultation report:** **Chief Complaint**: Right-sided pain/numbness & dizziness Patient presented to the hospital with symptoms of Right sided pain/numbness and dizziness. Patient states that on and off for the last month she has had symptoms of Right sided pain and numbness, described as "heaviness." Since this last Friday, the symptoms have been persistent. She was seen Saturday, April 12th for these complaints but could not tolerate the MRI and was advised to seek further care if symptoms worsened. Patient also c/o neck pain for 2 weeks. She states that the numbness and pain occur simultaneously. Patient states today that symptoms persist. She denies any associated blurry vision, dysarthria, dysphagia, CP, weakness or difficulty ambulating. She does state, however, that "sometimes her RLE is weak and heavy." Initial NIHSS =1. The patient was not given tPA, as the last known well time was greater than 4.5 hours. The last known well time is unknown, but symptoms have been occurring over the last month. CT of the head and CTA head/neck were negative in the ED. Patient passed the dysphagia screen. ASA given in ED, patient does not take ASA regularly. **Impression and Plan:** Patient with essentially negative PMH, seen with Spanish interpretor who presented to the ED with complaints of neck pain and associated R sided pain and numbness. She has had these symptoms on and off for a month, but persisting now for several days. CTOH and CTA head/neck unremarkable. Stroke protocol initiated. Will get MRI brain and C-spine. ECHO ordered. ASA ordered per protocol. DVT prophylaxis secondary prevention. PT/OT/ST consulted. Provide patient and family with stroke education. Patient presents with a h/o waxing and waning numbness, heaviness of the Right UE for one month; worse x last two days, then presented to the ER. No recent trauma. No headache. There is cervicalgia, with numbness of diffuse RUE. No other focal numbness, tingling, or weakness. States Right UE is heavy, not weak. No vision or speech changes. No h/o similar changes **On exam:**	536-543, 646-652, 578-579, 552-557

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		Awake, alert, NAD. No dysarthria Pupils equal and reactive, EOMI. Face symmetrical, VFF. Intact pin V1-V3 B Strength diffusely mildly weak, no focal weakness Normal FNF Reflexes + 1 throughout, toes down going Dec pin diffuse Right UE, LUE, and Bilateral LE intact Diff dx includes cervical radiculopathy, vs. brachial plexopathy, cervical or cerebral demyelinative disease, or ischemic etiology. Will require sedation for MRI due to claustrophobia; will obtain MRI brain and C Spine with gad. Continue Aspirin for now, echo pending.	
04/15/YYYY	Hospital/Provider Name	**MRI of cervical spine without contrast:** **Clinical history**: Left-sided paresthesias. **Findings**: There is normal alignment and curvature of the cervical vertebra. The vertebral body heights are maintained. Bone marrow signal intensity is within normal limits. The intervertebral disc spaces are maintained. The cervical cord is normal in caliber and exhibits normal signal. The cerebellar tonsils are in normal position. C2-C3: No disc bulge or protrusion. No central canal stenosis is present. The neural foramina are patent bilaterally. C3-C4: No disc bulge or protrusion. No central canal stenosis is present. The neural foramina are patent bilaterally. C4-C5: No disc bulge or protrusion. No central canal stenosis is present. The neural foramina are patent bilaterally. C5-C6: There is a small central disc protrusion indenting the ventral thecal space without central canal stenosis. The neural foramen is patent bilaterally. C6-C7: No disc bulge or protrusion. No central canal stenosis is present. The neural foramina are patent bilaterally. C7-T1: No disc bulge or protrusion. No central canal stenosis is present. The neural foramina are patent bilaterally. **Impression**: • No central canal stenosis or neural foraminal narrowing. No cord lesion, cord signal abnormality, or mass. • Small central disc protrusion at C5-6 without central canal stenosis	655-656, 1432-1433

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		or neural foraminal narrowing.	
04/15/YYYY	Hospital/Provider Name	**Upper extremity venous Doppler study:** **Reason for exam**: Swelling and pain in left arm. **Impression**: No ultrasound evidence of deep venous thrombosis in the left upper extremity deep venous system.	1428-1429, 654
04/15/YYYY	Hospital/Provider Name	**MRI of brain without contrast:** **History**: Right-sided numbness and dizziness. **Findings**: There is no evidence of intracranial hemorrhage or abnormal extra axial fluid. The ventricular system is normal in size and configuration. Basal cisterns are patent. Major vascular flow voids are maintained. There are several punctate subcortical white matter T2 and FLAIR hyper intensities which are nonspecific. Visualized brain parenchyma demonstrates maintained gray-white matter differentiation. Limited evaluation of the visualized parts of the paranasal sinuses, mastoid air cells and bony calvarium is unremarkable. **Impression**: • No evidence of acute stroke, hemorrhage, or mass. • Minimal scattered T2 subcortical white matter hyper intensities which are nonspecific, but are likely related to small vessel ischemic change.	656, 1430-1431
04/15/YYYY	Hospital/Provider Name	**Echocardiogram report:** **Impression**: • Agitated saline was injected through a peripheral vein and did not show evidence of a shunt. • Normal LV size, systolic function and wall thickness, with no RWMAs. LV EF 60 %. • Grade II/IV diastolic dysfunction, moderately elevated filling pressures. • Normal right ventricular size and systolic function. • No hemodynamically significant cardiac valve abnormalities.	1031-1032
04/15/YYYY	Hospital/Provider Name	**Hospitalist notes:** Right facial and right sided numbness: ruled out acute stroke or cervical radiculopathy, MRI brain and cervical spine personally reviewed, the patient is being seen by neurology, will continue to monitor and use Meclizine as needed for dizziness. DVT prophylaxis: Lovenox and mechanical.	558-562, 596
04/16/YYYY	Hospital/Provider Name	**Inpatient behavioral health initial evaluation:** **Chief Complaint**: Concern for somatization	544-547

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		Informants: The patient, who is considered a good historian, as well the patient's medical record. **History of Present Illness**: Patient is a 45-year-old female who presented to the hospital with blurred vision and right-sided paresthesias. She has had a negative workup for stroke. The primary team consult in psychiatry secondary to concern for conversion disorder as there was no other medical explanation of her symptoms. Patient denies any stress or feelings of depression. Patient states that she would describe her mood as almost the best it could be. She states that she has no difficulty sleeping at night. She has no changes in her appetite. She denies any concerns of guilt or hopelessness. Patient had several family members there with her as well who all stated that she always seemed happy and had a smile on her face. They were not able to identify any stressors the patient may have. **Psychiatric Review of Symptoms:** Regarding symptoms of **depression**, the patient denies depressed mood, denies sleep difficulties, anhedonia, feelings of guilt, low energy, poor concentration, decreased/appetite, psychomotor slowing and suicidal ideation. When asked about symptoms of **generalized anxiety**, the patient denies increased worry and irritability. **Biopsychosocial Assessment:** Patient is seen today for possible conversion disorder secondary to negative neurologic workup. Patient does not exhibit/endorse symptoms of depression or stress but she is the primary caregiver for her children and states that she often wants things "perfect" for them. She recognizes not having any free time as she is always busy trying to do things in the home, as a single mom. She does not have much time to have hobbies. She doesn't interact with people her age, although she has 6 sisters around the neighborhood **DSM IV Diagnoses:** • Axis I –R/o conversion disorder • Axis II- • Axis III - right sided paresthesias • Axis IV -primary caregiver for her children, father of children lives in Mexico **Plan**: • Patient's symptoms are currently resolving but would fit with a typical conversion disorder pattern as she seems indifferent to her symptoms. • Conversion disorder, is a diagnosis of exclusion. She is assessed by neurology, has und extensive workup that failed to identify any	

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		etiology that can explain her symptoms, which are now resolving. • It is not necessary for her to have a known stressor or to be depressed in order to manifest these physical symptoms. Discussed with patient that she would likely benefit from outpatient mental health services which are available at the 16th street clinic (where she is already established). A number for the patient to call was provided in the patient's discharge instructions. • I do not see a need to start a new medication she'll benefit from ongoing psychotherapy at 16 to clinic where there are Spanish-speaking providers. The patient processed the psychosocial stressors in therapy and showed awareness of discussed coping strategies.	
04/16/YYYY	Hospital/Provider Name	**Progress Notes:** **Subjective**: Patient seen with use of Spanish interpretor. "Feels better today." Complains of some neck tightness. Discussed diagnostic results, patient agrees with plan to de home. No new neuro complaints, denies weakness, paresthesias or dizziness. Discussed with patient's daughter, the mood/affect of the patient. Patient has not had any increased stress recently and is normally a "happy" person. **Impression and Plan:** Patient with essentially negative PMH, seen with Spanish interpretor who presented to the ED with complaints of neck pain and associated R sided pain and numbness. She has had these symptoms on and off for a month, but persisting now for several days. CTOH and CTA head/neck unremarkable. MRI brain and C-spine unremarkable. Echo unremarkable. ASA ordered per protocol for now. No obvious cerebrovascular diagnosis. Discussed with attending obtaining psych consult. Ok to discharge to home from neuro prospective. Recommend Flexeril prn for musculoskeletal pain. 45 y/o woman with Right UE heaviness. Exam through interpreter. States sx have improved; no new symptoms. On exam, strength equal and intact throughout. Normal reflexes + 1 throughout, toes down going. Intact pin B UE and LE. MRI brain and C spine without acute pathology. Echo normal Likely musculoskeletal pain with tenderness to palpation in the right shoulder. Apprec site input given flat affect. Stable for Discharge.	562-568
04/14/YYYY-04/16/YYYY	Hospital/Provider Name	**Speech Therapy Records** **Treatment dates:** 04/14/YYYY, 04/16/YYYY **Recommendations:**	548-549, 572-575, 591-595

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		Continue general solids / thin liquids (straws ok) Meds whole **Assessment**: Patient was seen on ASLMC 6KLM for clinical swallow evaluation. Spanish interpreter was present. Patient was alert, and tolerated all consistencies trialed in limited amounts WFL. Continued skilled speech therapy is required for on-going diet tolerance verification, and patient/ family education. **Admitting complaint:** • Vertigo • Right arm pain • Right arm weakness **Plan**: Swallow: Verify tolerance of general / thin. **As of 04/16/YYYY:** Patient was seen on 6klm for swallow treatment and communication and cognition evaluation. Pt seen for swallow assessment of diet tolerance, patient eating a whole apple and drinking thin water from a straw when writer arrived. No overt SS (Signs and Symptoms) of aspiration/penetration noted, Patient and RN also deny any concerns for Patient's swallowing. Communication/cognitive evaluation completed using informal and standardized tools (MOCA in Spanish). Patient scored 27/30 on the MOCA, normal is more than 26/30. Patient missed 3 points for delayed recall (remembering 2/5 random words after 5 min delay with multiple staff and family interruptions). Patient's speech was clear and appropriate, Patient answered questions adequately and demonstrated a good sense of humor throughout session. Patient demonstrates com/cog and swallowing function which is WFL, no further skilled speech therapy warranted at this time. **Reviewer's comments: The interim therapy records are summarized with significant events.*	
04/14/YYYY-04/16/YYYY	Hospital/Provider Name	**Physical Therapy Records** **Treatment dates:** 04/14/YYYY, 04/15/YYYY, 04/16/YYYY **Admitting complaint:** • Vertigo • Right arm pain • Right arm weakness	550, 569-572, 580-582, 585-588

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Precautions Comments: Mild unsteadiness, recommend hands-on assist. **Assessment**: PT Initial Evaluation completed (with assist of Spanish Interpreter) for this pleasant 45 y/o female who is admitted with Right facial and arm weakness, numbness, heaviness in her head, dizziness. Patient is now presenting below baseline with the following impairments of the above symptoms and requiring close supervision to min A for mobility. Of note, patient is usually very independent with mobility until recently. Additional time setting up interpreter for future therapy sessions. Time spent educating the patient re: the role of PT, informing the RN re: patient's current mobility status and posting the multi-colored mobility sheet in the patient's room. Patient will benefit from continued skilled PT to address the above impairments and maximize mobility independence, reducing burden of care prior to d/c. **Plan**: Continue skilled PT, including the following Treatment/Interventions: Functional transfer training; Equipment eval/education; Bed mobility; Gait training; Endurance training; Stairs retraining. **As of 04/16/YYYY:** **Assessment**: Patient progressing well toward goals- currently pt has net inpatient goals and is independent with Functional Mobility w/o Assistive device. Pt also assessed for vestibular component to C/o dizziness- pt did have positive Hall pike Dix on L and was treated with Epley maneuver- patient would benefit from Further vestibular rehab as an OP - referral Made to OP Coordinator. Will D/C acute PT services. **Plan**: Continue skilled PT, including the following Treatment/Interventions: Functional transfer training; Endurance training; Bed mobility; Gait training. **Frequency Comments**: Discharge PT. **Reviewer's comments: The interim therapy records are summarized with significant events.*	
04/14/YYYY-04/16/YYYY	Hospital/Provider Name	**Occupational Therapy Records** **Treatment dates:** 04/14/YYYY, 04/15/YYYY, 04/16/YYYY **Admitting complaint:** • Vertigo • Right arm pain • Right arm weakness	575-577, 582-585, 568, 588-591

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Precautions Comments: Mild unsteadiness, recommend hands-on assist. **Assessment**: Pt is seen for initial OT evaluation; interpreter used for session. Pt appears to be slightly below baseline measured by needing minimal assist with functional ambulation, transfers, and ADL tasks. Patient complains of numbness and tingling in Right side of face, and Right UE. No significant RUE weakness noted and pt able to perform bilateral functional tasks. Patient would continue to benefit from further skilled OT to progress in goals and assist in restoring functional independence. **Plan**: Continue skilled OT, including the following Treatment Interventions: ADL retraining; Functional transfer training; Compensatory technique education. **As of 04/16/YYYY:** Patient reports feeling she can care for self at home. Patient reports left hand and UE continues to be numb however able to functionally use for feeding self, item retrieval. No c/o pain. Interpreter present. Patient reports right hand and UE continues to be numb. Patient sitting at edge of bed with daughter present end of session. **Recommendations for Discharge**: OT: Home therapy. **Reviewer's comments: The interim therapy records are summarized with significant events.*	
04/16/YYYY	Hospital/Provider Name	**Discharge Summary for right facial numbness:** **Admit date: 04/13/YYYY** **Discharge date: 04/16/YYYY** **Right facial and right sided numbness**: Ruled out acute stroke or cervical radiculopathy, MRI brain and cervical spine personally reviewed, the patient was followed by neurology and was evaluated by psychiatry and it was concluded that she has atypical conversion disorder. She will be discharged on Meclizine as needed for dizziness. **Consults**: Neurology, psychiatry **Diagnosis**: Conversion disorder **Patient Instructions:** Activity: activity as tolerated	1434-1447, 597-637, 639-640645, 653, 528-530

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Diet: cardiac diet **Wound C**are: none needed **Follow-up** with Sixteenth Street Community Center in 1-2 weeks. **Disposition**: Home	
04/16/YYYY	Hospital/Provider Name	**Discussion:** Discussed patient with Dr. XXXX who is caring for her at SLMC: Patient has had a w/u for stroke after presenting with right sided weakness, vertigo, face and upper and lower extremities, but with PT strength appeared normal. She had a CT angiogram. MRI of her neck. Echo; all normal. She presented with a flat affect. And psych was consulted. Their dx is atypical conversion disorder. D/C on Meclizine. Will f/u upon d/c	1137
04/22/YYYY	Hospital/Provider Name	**Follow up visit for ER:** F/U after hospitalization Presented to ER with chest pain, headache, neck, right shoulder and arm pain. Right arm had tingling sensation without motor deficit. Was transferred from St. Mary' to St. XXXX, and had several scans performed. Diagnosed with muscle spasms in the neck and chronic headaches. Advised to continue NSAIDs: has been taking Naproxen 500mg two tablets bid x 1 week. Has had burning epigastrically x 1 week **Assessment** • Chronic Daily Headache • Cervicalgia **Plan** **Anxiety** Medical Consult; Behavioral Health **Mononeuritis Nos** Naprosyn 500 mg **Cervicalgia** Therapy/Physical Therapy: PT Neck Instructions: Internal PT/OT Referrals Follow-up visit 1 month with PCP.	1138-1140
05/08/YYYY	Hospital/Provider Name	**Initial Physical Therapy evaluation for cervicalgia and headaches:** **Subjective**: I am having a lot of neck pain and really bad headaches at home. The pain is worse when I am tired. I feel like I can't care for my kids at times because the pain is so bad.	1141-1143, 1448

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain level: 8/10 Patient rated at 8/10 neck pain with headaches up back of neck to top of head. **Objective/Treatment:** Strength: 4-/5 at bilateral shoulders and 4/5 in distal UEs. 2-/5 Abdominals, 2+/5 thoracic/lumbar paraspinals, 2/5 cervical paraspinals. Active Range of Motion: Lumbar AROM: 0-20 degrees rotation, 30% of normal FBI WNL BB, and 20% of normal Bilateral SB. with PROM equal to AROM for all motions Cervical AROM: 0-25 degrees rotation, 70% of normal FB/BB, and 20% of normal Bilateral SB. with PROM equal to AROM for all motions with increased pain at all end ranges. Bilateral Shoulder AROM: 0-160 flex/0-140 degrees ABD, 0-30 IR, 0-20 degrees ER, 0-20 degrees ext Bilateral Shoulder PROM: 0-175 flex/0-170 degrees ABD, 0-50 IR, 0-40 degrees ER, 0-25 degrees ext **Posture**: Severe forward head and shoulders noted with excessive upper thoracic kyphosis and lumbar spine lordosis. No scoliosis. **Palpation**: Moderate spasm are noted in bilateral C3-T6 paraspinals with severe tightness also noted in bilateral upper traps, SCM, levator scapulae, pectoralis major/minor, and scalene muscle groups. **Sensation**: Normal to all modalities **Special Tests/Observations**: - compression test of cervical spine. Patient got slightly dizzy when extending and rotating her head rapidly in the clinic. **Treatment**: • E-stimulation manual therapy • Neuromuscular re-education Once a week for 12 weeks **Treatment plan:** • Therapeutic Exercise • Neuromuscular Re-Education • Modalities: Iontophoresis/Electrical Stimulation/ MHP/Ultrasound • Manual Therapy • Therapeutic Activities • Neuromuscular Re-Education • Mechanical Traction- if needed	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Activities of Daily Living/Self-Care • Gait Training	
05/12/YYYY	Hospital/Provider Name	**Follow-up Visit for right arm numbness:** **Pain intensity**: 7/10 Neurological symptoms sx much improved; uses the muscle relaxant at night every night to help relax her neck/shoulders. PT helps a lot; no more numbness or tingling right upper and lower extremities, pain resolved except for in right neck Psychological symptoms admitted 04/14/YYYY-04/16/YYYY with right sided pain and paresthesias. Patient underwent studies including MRI of brain and c-spine. Psychiatric consultation; pt diagnosed with conversion d/o (disorder). Patient states that she is now feeling well; denies depression, pain, fatigue, dizziness, impaired memory or concentration. She states she is doing well at home with family. **Assessment**: Cervicalgia possible conversion disorder. Pt's recent sx have nearly completely resolved. **Plan** Mononeuritis Nos EC-Naprosyn 500 MG TBEC, twice daily as needed. Return to the clinic if condition worsens or new symptoms arise Follow-up visit 2 months	1144-1146
05/23/YYYY	Hospital/Provider Name	**Follow-up Visit for neck pain, headache, and body aches:** **Chief complaint**: Neck pain, headaches, and body pain since last night. **Pain level**: 8/10 **Assessment**: • Nausea with vomiting • Headache syndromes • Cervicalgia • Symptoms referable to multiple joints • Administered Ketorolac Tromethamine 30 MG/ML • patient • Administered Ondansetron ODT 4 mg tabs **Plan**: • Medication list reviewed and Updated by Provider	1154-1157

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Return to the clinic if condition worsens or new symptoms arise • No vaccines needed today • Clinical summary provided to patient • 60mg Toradol • Zofran 8mg ODT	
06/09/YYYY	Hospital/Provider Name	**Office Visit for toothache:** **The Chief Complaint is**: Follow up and c/o toothache x 1 week. **Pain scale:** 10/10 Psychological symptoms mild headache Citalopram 20 mg 1/2 daily and melatonin. Dental pain in left lower last molar: sensitivity to hot and cold. **Assessment**: • Pain tooth ache • Anxiety • Conversion disorder **Cervicalgia** EC-Naprosyn 500 mg	1167-1169
06/22/YYYY	Hospital/Provider Name	**Emergency room visit for headaches:** Patient to ED via triage. Patient c/o HA and vomiting since this morning. Took ibuprofen 600mg w/ no relief. Took Zofran for nausea w/ no relief. Denies photosensitivity, denies vision changes. 6:07 PM: Patient presents to ED c/o right-sided HA that began when she woke up this AM. The patient took 600mg Ibuprofen 1.5 hours PTA, but vomited it back up, and it did not provide any relief. The pt had h/o recurrent HA previously, and this HA feels similar. Patient also c/o nausea, vomiting x6 episodes, weakness, and denies fevers, chills, GP, back pain, depression, or any other associated sx. The patient has h/o hysterectomy. There are no other alleviating or modifying factors at this time. Patient was admitted 4/YYYY for right-sided numbness. She was found to have atypical conversion disorder. Pt had received a head/neck CT angio, head CT, brain MRI, and all were WNL. **Gastrointestinal**: Positive for nausea and vomiting **Neurological**: Positive for weakness and headaches. **Musculoskeletal**: Normal range of motion. **Lymphadenopathy**: She has no cervical adenopathy. **Neurological**: She is alert and oriented to person, place, and time. No	993-1000, 1001-1030

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		cranial nerve deficit or sensory deficit. She exhibits normal muscle tone. She displays a negative Romberg sign. Coordination normal. No finger to nose dysmetria. Normal sensation throughout all extremities. Normal strength throughout all extremities. No facial droop. **ED Course** 7:13 PM: I rechecked the pt She rates her pain as a 7/10, and reports it is relieving. Patient's daughter states that the patient has Zofran, but it did not relieve the nausea. Patient is smiling, and was encouraged to f/u with PCP. Return to ED warnings given if sx develop or worsen. I d/w patient plan for d/c. Patient agrees with plan, and all questions were addressed and answered. **MDM** **Clinical Impression** The encounter diagnosis was HA (headache). **Follow-up**: Margaret M Dunn, MD Schedule an appointment as soon as possible for a visit. Patient is discharged in stable condition.	
05/14/YYYY-07/15/YYYY	Hospital/Provider Name	**Summary of interim Physical Therapy visits for cervicalgia and headaches:** **Treatment dates:** 05/20/YYYY, 05/22/YYYY, 05/27/YYYY, 05/29/YYYY, 06/03/YYYY, 06/05/YYYY, 06/10/YYYY, 06/24/YYYY, 06/26/YYYY, 07/01/YYYY, 07/15/YYYY Pain level: 6-10/10 **Treatment rendered:** • Ultrasound • Electrical stimulation • Neuromuscular re-education • Therapeutic exercises • Therapeutic activities • Manual therapy As of 07/15/YYYY: Patient reports severe pain today. Pain is constant in RUE and patient also report tingling in R UE and LE. Pain has been increased for about 1 week. Patient tolerated therapy well today. Patient had decreased sx after treatment. Patient continues to have signs of nerve or cord impingement at	1147-1148, 1149-1151, 1152-1153, 1160-1161, 1162-1164, 1158-1159, 1165-1166, 1170-1171, 1172-1173, 1174-1175, 1176-1178, 1179-1181

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		C 5- 7. Patient has had 13 PT sessions with about 40% improvement. Further diagnostics may be indicated. **Reviewer's comments: The interim visits are summarized with significant events.*	
07/17/YYYY	Hospital/Provider Name	**Follow-up Visit from physical therapy:** Neurological symptoms she is taking Citalopram and anxiety seems to be about the same; good and bad days of anxiety. Does not believe that her vertigo is due to medication. Sharp pain in arm and leg on the right side. She notes vertigo that lasts seconds and recurs frequently throughout the day. She has nausea and takes nausea pills for this and they help. Zofran. Takes Zofran almost all days. Rx from the hospital. She has been taking it for about l week regularly due to nausea. Right arm asleep and face and leg all feel asleep. The same sx as before. More vertigo than before Per daughter; patient is feeling dizzy with house work; cannot do: needs to sit down. She never asked for help before. She now needs her children to help her. Pain and dizziness. She lives with her children. **Pain intensity**: 8/10 **Assessment** • Anxiety • Vertigo • Conversion disorder discussed at length the results of her H&P, labs and studies as well as neuro and psych consults and that no physical abnormality was found. Yet validated that she is experiencing her present sx. Discussed the anxiety and depression that she is suffering from and the importance of continues counseling. Daughter, Julia, has been researching conversion disorder and is supportive. **Plan** • Anxiety Citalopram Hydrobromide 40 mg tabs, take one daily, 30 days, 3 refills, note increased dose • Continue current medication • Clinical summary provided to patient • Follow-up visit 1 month for conversion disorder	1182-1184
10/25/YYYY	Hospital/Provider Name	**Emergency room visit for facial numbness:** **Summary:** Patient presented to ED with headache and possible stroke. Immediate comprehensive evaluation and involvement of the stroke team was accomplished. Headache unilateral on right and patient had mild right facial	449-474, 475-490

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		droop and minimal/mild weakness. NIH score 2. Presented 6 hours post sx onset. CT and CTA both negative. No evidence of CVA, thrombus, aneurysm, tumor. I spoke with Dr. XXXX about scan. Dr. XXXX was neurology consult. This is likely complex migraine and patient feels much better with sx resolution here and is able to be discharged home. **Assessment**: Complicated migraine. **Prescriptions**: Naproxen Oral Tablet 250 Promethazine HCL (Promethazine) Oral Tablet 25 mg	
11/04/YYYY	Hospital/Provider Name	**Urgent walk in visit for numbness of face and arm on right side:** **The Chief Complaint is**: Patient c/o numbness on Right side of face and arm, SLH ER visit on Saturday. Pain = 10/10 Intensity Went to SLH over the weekend for HA and Left arm/leg pain According to patient-CT and an EKG-all was normal Was written Naprosyn-not alleviating pain Right facial pain resolved No c/o chest pain C/o Right arm and lumbar pain Denies injury Works at home Right shoulder pain with radiation distally LBP chronic Pain Post Toradol injection = 7 /10 Intensity **Assessment** • Obesity • Lumbago • Chronic pain • Pain in upper arm **Plan** **Lumbago** • Cyclobenzaprine HCl 10 mg tabs, take 1 at bedtime, 10 days, 0 refills, Medication list reviewed and Updated by Provider • Go to the emergency room if condition worsens • Maintain a healthy diet & exercise • Weight management • No vaccines needed today • Toradol 60mg • Home range of motion exercises for the lower back	1185-1187

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Clinical summary provided to patient	
12/31/YYYY	Hospital/Provider Name	**Emergency room visit for headaches:** History comes from patient. The onset of the presenting problem started 1 day(s) ago. Have reviewed and agree with RN note. Able to get a good history. Language interpreter used. Language barrier exists during history. Complains of headache without obvious cause or trigger. Patient gets occasional headaches. Has had a prior evaluation of headaches. Presents with recurrence of an uncomplicated migraine headache. Has had previous similar headaches and this is usual presentation of headache. Patient has been previously diagnosed with migraine and has been treated appropriately. Complains of a unilateral headache affecting the right side. This is a recurring problem, and patient has had previous similar episodes. Headache seems to be localized to the frontal area. Headache localizes behind eyes. These headache symptoms are quite severe. This headache developed gradually over a period of several hours. Symptoms have remained stable. No positional component. Has migraine headaches. No history of stiff neck, lateralizing weakness or altered mental status. No history of head injury or recent lumbar puncture. Denies scalp tenderness, jaw claudication or ENT symptoms. These symptoms are associated with photophobia. Patient has had 3 or 4 episodes but in between has been holding down fluids fairly well. No ill contacts with similar GI symptoms. No fever, chills, or sweats. Nonsmoker. No history of significant hypertension, diabetes, or atrial fibrillation. No known underlying CNS pathology. **Discharge Prescriptions** • Zofran ODT oral tablet. disintegrating 4 mg • Ibuprofen oral tablet 800 mg **Discharge Summary** **Chief Complaint**: Headache. **Primary Diagnosis**: Migraine; Photophobia; Vomiting. **Disposition Notes**: Condition at disposition - good; Decision to discharge the patient; Arrange for a follow up appointment with patient's own Primary Care Provider in 3-5 days or immediately if your symptoms get worse; Disposition status is discharge: Patient removed from tracking board and discharged from the department by Laura Redenbaugh RN. Discharge Prescriptions: Zofran ODT oral 4 mg tablet disintegrating 1 tablet(s) by mouth every 8 hours, Ibuprofen oral 800 mg tablet 1 tablet(s) by mouth three times a day	429-445
03/12/YYYY	Hospital/Provider Name	**Follow-up Visit for right hand and arm pain:** **The Chief Complaint is:** F/u right hand and arm pain.	1188-1190

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain = 10/10 Intensity Neurological symptoms right hand 3rd and 4th digits painful and tingling pain in right hand as well especially at night. Pain is constant but some days it' worse. She stares that she has this same pain for the last year and well as pain in the right neck. The pain is difficult to describe: burning. She is not using any medication for pain. In the past nothing helped. She was on a med for anxiety but caused headache. Rx Cyclobenzaprine, but caused sedation Psychological symptoms Her anxiety is a little better with Citalopram; sleeping better, but due to her hand. If only her hand were better, life would be much better. **Assessment**: • Anxiety could not tolerate Citalopram: Will instead try Effexor • Neuropathy • Conversion disorder encouraged further counseling **Plan** **Anxiety** Effexor XR 37.5 mg CP24, take one daily, 90 days, 1 refills **Brachial Neuritis Nos** Voltaren 1 % gel, apply to affected area twice daily • Medication list reviewed and Updated by Provider • Return to the clinic if condition worsens or new symptoms arise • Continue current medication • Clinical summary provided to patient • Follow-up visit if change from Citalopram to Effexor in about 2 weeks	
03/26/YYYY	Hospital/Provider Name	**Follow-up Visit for medications:** Neurological symptoms hand sx have resolved with Effexor. She is feeling much better and is more hopeful. Sleeping better, less anxious. Voltaren for hand pain: she was using 4x/day before and now only at night. Psychological symptoms started on Effexor 3/12/15: no problem with hand now: sleeping better. **Assessment**: • Anxiety • Neuropathy • Conversion disorder encouraged further counseling **Brachial Neuritis Nos**	1191-1193

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Voltaren 1 % gel, apply to affected area twice daily • Return to the clinic if condition worsens or new symptoms arise • Continue current medication • Clinical summary provided to patient	
06/11/YYYY	Hospital/Provider Name	**Follow-up Visit for headaches:** **Headaches** for one day**:** Pain intensity: 10/10 +nausea +photosensitivity No improvement with Ibuprofen **Assessment**: Migraine headaches Administered Ketorolac Tromethamine 60 mg/2ml Administered Ondansetron 4 mg **Plan**: • Migraine headache • Naprosyn 500 mg tabs • Toradol 60mg • Ondansetron 8mg • Clinical summary provided to patient • Patient states improvement on pain prior to being exited states 8/10 on pain	1194-1197
06/28/YYYY	Hospital/Provider Name	**Emergency room visit for migraine:** Although this is typical of the patient's usual migraine headaches, these symptoms are somewhat more severe than usual. **Primary Diagnosis** • Migraine • Photophobia • Headache **Discharge prescriptions:** Zofran ODT 4 mg	408-425, 1449-1453
06/29/YYYY	Hospital/Provider Name	**Follow-up Visit for headaches:** Migraine headache discussed medication use at length and keeping a headache diary to review on f/u. **Plan**: • Sumatriptan Succinate 50 mg tabs • Reglan 10 mg	1198-1200
Motor Vehicle Collision on MM/DD/YYYY			

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
04/15/YYYY	Hospital/Provider Name	**EMS report for motor vehicle collision:** **Location:** XXXX, Milwaukee, WI 53215 **Nature of call**: Motor vehicle crash **Call Taken by**: XXXX fire dept **Destination**: St XXXX Medical Center **Received**: 14:20 **Dispatch**: 14:21 **En route**: 14:21 **At scene**: 14:27 **At patient**: 14:28 **Transport**: 14:40 **At destination:** 14:46 **Transport Explanation:** Lower back and neck pain **Chief complaint**: Back Pain **Assessment**: Breathing Normal Respirations Circulation Pulses - Radial - Normal (2+) Mental Status Normal (A & O x 4) Level of Consciousness A&Ox4 Central Nervous System: Neuro Intact **Primary Impression:** Unspecified Condition Lower back and neck pain **Trauma description:** MVA Damage Rear - Minor MVA- Speed - Initial Speed < 20 MPH MVA Protective Devices - Lap & Shoulder Belt MVA - Position in Vehicle – Driver **C-collar type**: Adjustable, adult; selective Cervical spine **Meets Nexus criteria**: Yes	89-93

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Narrative: Bell 406 dispatched motor vehicle collision and responded with lights and sirens for 47 y/o female patient. Found patient sitting in driver's seat of personal vehicle under care of MFD E-7 and MPD 626. Patient presented a/ox4. Language barrier present since patient is Spanish speaking only. Patient had a chief complaint of pain in neck and across lower back after a motor vehicle: collision. Patient was driver of vehicle; patient was rear ended by another vehicle traveling about 15 mph; minor damage to patient's car. Patient was seat belted. No air bag deployment. No spidering of windshield. Patient stated no loss of consciousness, no head pain, no difficulty breathing, nor any nausea/vomiting. C-collar was placed on patient. Patient was positioned supine head elevated and secured 5x on EMS cot. Patient assessment, vitals, and blood sugar 140 mg/dl obtained on ambulance. No obvious deformities noted on patient. Patient was monitored and reassessed throughout transport. Patient was transported in to St. XXXX emergency via cot and transferred to bed 15 all without incident. Patient care/report given to facility staff. All necessary signatures obtained; patient unable to sign HIPPA signature since patient was Spanish speaking only.	
04/15/YYYY	Hospital/Provider Name	**Triage visit for motor vehicle collision:** Patient arrives by ambulance in hard c-collar, patient was the driver in a vehicle and was rear ended at 15 mph. No air bags deployed and patient denies LOC. Patient reports wearing a seatbelt. Patient has history of asthma. **Triage Plan - Patient Acuity**: 3 **Vitals** - Temp: 98.2 °F (36.8 °C); Heart Rate: 108; Respiratory rate: 20; Blood pressure: 138/74 mmHg; Spo2: 99 % **Pain Scales - Pain Assessment:** Pain scale: 10 Pain Type: Acute pain Location: Neck; Acute Pain Descriptor(s): Posterior Acute Pain Quality: Sharp Acute Pain Aggravating Factors: Movement; Touch Multiple Acute Pain Sites: Yes Acute Pain Location: Head Acute Pain Descriptor: Middle; Lower Acute Pain Quality: Sharp Aggravating Factors: Activity: Movement	2-10

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Splinting - Type of Splint: C-collar removed by provider; Splint Location: (Neck); CMS Intact After the Splint: Yes **Orders**: • X-ray lumbar spine 2 or 3 views • X-ray thoracic spine 3 views • CT head brain • CT cervical spine • Morphine injection 4 mg **Diagnosis**: • Strain of muscle, fascia and tendon at neck level, initial encounter • Pain in thoracic spine • Low back pain **Medication Given:** Ketorolac injection 30 mg - Dose: 30 mg; Route: Intramuscular; Site **Discharge Orders Placed:** Naproxen (Naprosyn) 500 mg tablet; Hydrocodone-acetaminophen (Norco) 5-325 mg per tablet	
04/15/YYYY	Hospital/Provider Name	**Emergency room visit for motor vehicle collision:** **Chief Complaint**: Neck Pain Patient presents to ED with C-Collar in place via EMS s/p MVC that occurred PTA (Prior to Arrival). The patient was a restrained driver of a vehicle that was rear ended while stopped at a red light. There was no air bag deployment. Patient now complains of neck pain, back pain, HA (headache) and numbness in her left face. She does not remember if she hit her head during the collision. Patient denies LOC, visual changes, nausea, vomiting, abdominal pain, CP, or SOB. She does not take any anticoagulants. The patient verbalizes no further complaints or modifying factors at this time. **Review of Systems:** **Constitutional**: Negative for fever, chills and unexpected weight change. **HENT**: Negative for congestion, rhinorrhea and sore throat. **Eyes**: Negative for pain and visual disturbance. **Respiratory**: Negative for cough, chest tightness and shortness of breath. **Cardiovascular**: Negative for chest pain and leg swelling. **Gastrointestinal**: Negative for nausea, vomiting, abdominal pain, diarrhea and constipation. **Endocrine**: Negative for polydipsia. **Genitourinary**: Negative for urgency, frequency and difficulty urinating. **Musculoskeletal**: Positive for back pain and neck pain. Negative for	10-54

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		myalgias and arthralgias. **Skin**: Negative for color change, pallor and rash. **Neurological**: Positive for numbness (left face) and headaches. Negative for dizziness, weakness and light-headedness. -LOC **Physical Exam** **Constitutional:** She appears well-developed and well-nourished. No distress. **HENT**: **Head**: Normocephalic and atraumatic. Head is without abrasion and without contusion. **Right Ear:** External ear normal. **Left Ear:** External ear normal. **Mouth/Throat**: Oropharynx is clear and moist. No oropharyngeal exudate. **Eyes**: EOM are normal. Pupils are equal, round, and reactive to light. No scleral icterus. **Neck**: Neck supple. No tracheal deviation present. **Cardiovascular**: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. **Pulses**: Radial pulses are 2+ on the right side, and 2+ on the left side. **Pulmonary/Chest**: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales. **Abdominal**: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is no tenderness. **Musculoskeletal**: Normal range of motion. **Cervical back**: She exhibits tenderness (posterior). **Lymphadenopathy**: She has no cervical adenopathy. **Neurological**: She is alert. She has normal strength and normal reflexes. Decreased sensation on the left aspect of her face. No other cranial nerve deficits. **Skin**: Skin is warm and dry. She is not diaphoretic. No erythema. No pallor. **Psychiatric**: She has a normal mood and affect. Nursing note and vitals reviewed. *Radiology reports are reviewed in individual rows below.* **ED medication orders**: Ketorolac injection 30mg **ED Course:** 3:17 PM Initial Plan: I performed the initial assessment and evaluation of the patient: The plan is to treat with pain medication, as well as evaluate with XR and CT. The patient agrees with the plan and will be re-assessed shortly. 5:16 PM: I reviewed patient's CT results and removed patient's c-collar	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		7:36 PM: I rechecked the patient and informed her that the imaging looked good. I informed her that she may have a small bulging disk in her neck that can cause some pain. I discussed with her that she will likely have some bad muscle strains from the accident and may even be more sore tomorrow. Over the next week or so, her pain should improve. I will provide her with an Rx for pain medication. Patient was advised to follow up with her PCP in one week. The patient is aware to return to the ED in case of worsening of sx or development of new sx, bladder/bowel incontinence or saddle paresthesias. The pt verbalizes understanding and agrees with the discharge plan. All questions and concerns were addressed at this time. **Clinical Impression:** The primary encounter diagnosis was MVC (motor vehicle collision). Diagnoses of Neck muscle strain, initial encounter and Back pain of thoracolumbar region were also pertinent to this visit. **Follow-up**: Mustafa Farooque, MD. In 1 week **For follow up for this visit:** AHCM St XXXX Emergency Services For any new or worsening symptoms The patient was provided with a recommendation to follow up with a primary care provider and obtain reassessment of his/her blood pressure within three months. **Start taking these medications:** • Naprosyn 500 mg • Norco 5-325 mg **Discharge medication list:** • Metoclopramide (Reglan) 5 mg tablet • Butalbital-acetaminophen-caffeine (Fioricet/Codeine) 50-325-40-30 mg per capsule • Naproxen (Naprosyn) 500 mg tablet Patient is discharged in stable condition.	
04/15/YYYY	Hospital/Provider Name	**CT of head without contrast:** **History**: Motor vehicle collision with left-sided facial paresthesias. **Impression**: Unremarkable unenhanced CT of the head.	18
04/15/YYYY	Hospital/Provider Name	**CT of cervical spine without contrast:** **History**: Motor vehicle accident, rear-ended. **Impression**:	18-19

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• No cervical fracture or subluxation. • Probable disc bulge C5-6, may be slightly increased from prior MRI April YYYY however evaluation by CT technique is limited.	
04/15/YYYY	Hospital/Provider Name	**X-ray of thoracic spine and lumbar spine including Swimmers:** **History**: MVC, low back pain. **Impression**: **Thoracic spine**: Subtle S-shaped scoliosis. This could be positional or related to spasm. Vertebral body height is maintained. Cervicothoracic junction is difficult to adequately visualize on plain film. However, cervicothoracic junction was evaluated on cervical spine CT performed today. **Lumbar spine**: There appear to be 5 non rib-bearing lumbar type vertebral bodies. Alignment is maintained. Disc height and vertebral body height is maintained. Minimal facet arthropathy is noted.	20
04/21/YYYY	Hospital/Provider Name	**Urgent walk in visit for neck pain, back pain, and left knee pain:** **Active Problems** • Anxiety • Compartment Syndrome • Conversion Disorder • Hyperlipidemia • Neuropathy • Obesity • Stillbirth • Total Abdominal Hysterectomy • Tubal Ligation Status • Vertigo **Chief Complaint** C/o back pain and neck pain after a car accident on April 15, YYYY. **History Of Present Illness** Patient was driver and was rear ended. Patient did have seat belt. Since then has been having neck pain. Neck pain occasionally radiates to right arm but not often. No numbness or tingling in the upper or lower extremities. Nausea and intermittent vomiting which she feels like it is getting worse. Intermittently feeling dizzy (spinning) especially when bending forward. No fever. Having constant headache - severe at times but more mild at other times Patient went to SLMC and had imaging performed on neck. Taking Vicodin and Cyclobenzaprine. Still not helping. Scheduled to start PT 5/2/16. Pain = 10/10 Intensity	1035-1038

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		• Menopause has occurred • Left knee joint pain for 6 days which is worsening. Bone pain in the right knee - patient is unsure if she hit her knee during the MVA • Vertigo • No request for consultation by specialist since last visit • No recent hospitalization since last visit • No previous emergency room visit since last visit **Current medication:** • Hydrocodone-Acetaminophen 5-325 MG Tablet 1-2 tabs every 4 hours as needed for pain, 30 days, 0 refills • Naproxen 500 mg Tablet take 1 twice a day with meals, 15 days, 0 refills • Reglan 10 mg Tablet as directed • Voltaren 1 % Gel (jelly) Apply to Affected Area Twice Daily: Do not take NSAIDs such as Naprosyn while on it., 30 days, 6 refills **Physical findings:** Tenderness of the posterior neck through C7 Maneuvers: Neck pain was elicited by motion - limited range of motion due to pain-limited especially vertical movement. **Musculoskeletal System:** **Shoulder:** **General/bilateral**: Tenderness on palpation of both trapezius muscles. Tenderness on palpation of both upper trapezius muscles. Tenderness on palpation of both middle trapezius muscles. Tenderness on palpation of both lower trapezius muscles. **Knee**: **Left Knee**: Pain was elicited by motion. Tenderness was observed on ambulation. **Neurological**: **Cranial Nerves**: II-XII normal. **Motor**: Strength was normal. **Assessment**: • Arthralgia of the left knee/patella/tibia/fibula [Pain in left knee] • Trapezius muscle strain [Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, unspecified arm, initial encounter] • Vertigo [Benign paroxysmal vertigo, unspecified ear] • Cervicalgia [Cervicalgia] • Administered Ondansetron 4 mg	

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		Plan: **Benign paroxysmal vertigo, unspecified ear** Meclizine HCl 25 mg tabs, three times a day, 14 days, 0 refills Ondansetron 4 mg TBDP, three times a day PRN nausea, 7 days, 0 refills **Pain in left knee** Radiology/X-Ray: Knee X-Ray • Return to the clinic if condition worsens or new symptoms arise • Follow-up visit with PCP • Zofran 4mg SL x 1 dose- patient feels improved at discharge. • Will review radiology records from SLMC. • Patient to start PT May 2nd. • If headache worsens, recommend going to ER for further work up.	
05/02/YYYY	Hospital/Provider Name	**Office Visit for cervical, thoracic, and lumbar pain along with headaches:** The patient complains of headaches, dizziness, neck pain, radiating into the right upper extremity with numbness and weakness, thoracic and lower back pain, radiating into the right hip and left knee pain. The patient states that on 4/15/16, as she was driving her vehicle, she was approaching an intersection. While there was a red light and she went almost into a complete stop, the vehicle behind her rear ended her vehicle. The impact was quite severe. The trunk of her vehicle was pushed in. The patient recalls being thrown backwards and then forward. She -states that she developed immediate neck pain and headache. She was taken by ambulance to St. XXXX Hospital, where she was examined. X-rays were done and she is not quite sure if a CT or an MRI of the cervical spine was done as well. She was sent home on medications and follow up with her primary care physician, where she got a prescription for Antivert, Percocet as well as Vicodin and Naproxen. She states that her symptoms have persisted. The headaches are described as starting in the posterior aspect of her head and radiating forward. The neck pain radiates into both upper shoulders and throughout the right upper extremity, all the way down to her fingers with numbness and sensation of weakness in the right upper extremity. There is also complaint of a swelling sensation in the right upper extremity. There is pain in between the shoulder blades as well as lower back pain, radiating into the right hip. She is not sure if she struck her hip or left knee with anything in the vehicle. The left knee pain is also quite substantial. She described as difficult walking due to the pain in the left knee. On physical exam, the patient is alert and oriented in time, place and person. She came, accompanied by her daughter. She appears uncomfortable due to pain. She ambulates with an antalgic gait favoring the left lower extremity. She is unable to ambulate on heels or toes even with	384-386, 1072-1074

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		assistance of one due to complaint of increasing pain in the left knee. Deep tendon reflexes are symmetric for biceps and brachioradialis and knee and ankle jerks bilaterally, for the left triceps is 2+ and for the right triceps is trace. The muscle power is 5/5 for grip, wrist flexion and extension, elbow flexion and shoulder flexion and is 5/5 for the left elbow extension and 4/5 for the right elbow extension. Ankle dorsiflexion is 5/5 bilaterally. Straight leg raising in the sitting position is negative bilaterally. Patrick's is negative bilaterally. There is tenderness to deep palpation with spasm in the cervical paraspinal muscles bilaterally extending into both upper trapezius. There is tenderness to deep palpation in the mid-thoracic paraspinal muscles bilaterally with evidence of trigger points in both rhomboids. There is tenderness to deep palpation with spasm in the lumbosacral paraspinal muscles bilaterally, right more so than left with exquisite tenderness to palpation over the right greater trochanteric bursa. Examination of the left knee reveals mild knee joint effusion with no increase in the local temperature. There is no knee instability. McMurray is positive. There is tenderness to palpation over the patella and when compressing the patella. **Impressions**: • Cervical sprain with radiculitis, most likely involving the right C7 nerve root. • Thoracic sprain with residual trigger points in both rhomboid muscles. • Lumbosacral sprain. • Right hip sprain with symptoms consistent with a right greater trochanteric bursitis. • Left knee sprain, rule out underlying derangement. • Cervicogenic headaches. • Dizziness. The conditions were discussed with the patient. I will request the records from the emergency room. The patient is currently taking medications in the form of Hydrocodone and Naproxen as well as Antivert for the dizziness. Regarding the pain control, she is still quite symptomatic. She was agreeable to consider the possibility of a course of physical therapy and will start a course of physical therapy consisting of different modalities, manual therapy and progressive therapeutic exercises. I will request the records from the emergency room before considering further x-rays. The patient will be rechecked in three weeks, sooner if needed.	
05/05/YYYY	Hospital/Provider Name	**Emergency room visit for left knee pain:** **Triage notes:** Patient to triage with c/o left knee pain since a car accident on 4/15/YYYY. Patient was evaluated at that time but was not having knee pain then. Patient reports she starts physical therapy for the knee tomorrow. Daughter is interpreting at patient's request. Patient reports taking 800mg Ibuprofen 1 hour ago.	55-88

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		Pain scale: 8 **Type**: Acute **Aggravating factors**: Ambulation Splint applied **Vital signs**: **Temperature**: 98.5 F **Heart rate**: 77 **Respiratory rate**: 18 **Blood pressure**: 123/65 mmHg **SpO2**: 97% **12:13 AM**: Patient presents to ED c/o bilateral knee pain, left worse than right that has been worsening s/p MVC on 04/15/YYYY. Per the daughter: She was the belted driver in a vehicle that was rear-ended while stopped at a stoplight. She was initially evaluated, but did not have knee pain at that time. She then awoke the next morning with myalgias. And the knee pain developed shortly after. It has not improved since that time, the left knee has locked on her twice, and there is the sensation that her kneecaps are moving. She is having difficulty sitting, laying, or standing for too long at a time. The pain is exacerbated by movement and weight bearing. She cannot recall if she hit the knees on the dashboard during the accident. She has seen her PCP for the pain, and they referred her to physical therapy with Pain Management which is scheduled to start tomorrow. She has not had imaging of her knees previously. She voices no other sx (symptoms) or concerns at this time. **Review of Systems** **Constitutional:** Negative for fever, chills and appetite change. **HENT**: Negative for congestion and sore throat. **Eyes**: Negative for redness. **Respiratory**: Negative for cough and shortness of breath. **Cardiovascular**: Negative for chest pain, palpitations and leg swelling. **Gastrointestinal**: Negative for nausea, vomiting, abdominal pain, diarrhea, constipation and blood in stool. **Genitourinary**: Negative for dysuria, urgency, frequency, hematuria and flank pain. **Musculoskeletal**: Negative for back pain. + Bilateral knee pain, left worse than right, unable to remain sitting, standing, or laying for extended periods of time **Skin**: Negative for rash. **Neurological**: Negative for weakness and headaches. **Hematological**: Negative for adenopathy. **Psychiatric/Behavioral**: Negative for confusion. The patient is not nervous/anxious.	

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		Physical Exam **Constitutional**: She is oriented to person, place, and time. She appears well-developed and well-nourished. **HENT**: Head: Normocephalic and atraumatic. Eyes: Conjunctivae are normal. **Neck**: Normal range of motion. Neck supple. **Cardiovascular**: DP and PT pulses are intact and equal bilaterally. **Pulmonary/Chest**: Effort normal. **Musculoskeletal**: Normal range of motion. **Right knee**: She exhibits no swelling, no ecchymosis and no deformity. Tenderness found. Patellar tendon tenderness noted. **Left knee**: She exhibits effusion (Small). She exhibits no swelling, no ecchymosis and no deformity. Tenderness found. Patellar tendon tenderness noted. **Right ankle**: Normal. **Left ankle**: Normal. **Right foot:** Normal. **Left foot**: Normal. There is tenderness along the right patellar tendon and over the right patella. There is grinding and pain with ROM of the right knee. There is no varus or valgus laxity appreciated. There is tenderness over the left patellar tendon, soft tissue, and joint line. There is no abnormal patellar movement, but there is some grinding with ROM. There is no varus or valgus laxity. **Neurological**: She is alert and oriented to person, place, and time. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6. Sensation is intact throughout the BLE. **Skin**: Skin is warm and dry. **Psychiatric**: She has a normal mood and affect. Her behavior is normal. Nursing note and vitals reviewed. **ED Course** **12:12 AM**: I reviewed the patient's medications, allergies, and past medical and surgical history in Epic. Noted that the patient was seen on 04/15/YYYY s/p MVC. She was the restrained driver of a vehicle that was rear-ended while at a stoplight. She was evaluated for neck and back pain. She had a negative head CT, T-spine x-rays, and L-spine x-rays. A CT of her C-spine revealed no fracture, but there was a disc bulge at C5-6 which was previously noted on an MRI from 04/YYYY. She was prescribed Norco and Naproxen. **12:23 AM**: I reviewed the patient's records in the Wisconsin Prescription Drug Monitoring Program Database. **12:28 AM**: After initial examination, the patient presents with bilateral knee	

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		pain, left worse than right, s/p MVC on 04/15/YYYY. Plan discussed for bilateral knee x-rays. I will order Tramadol to help improve symptoms. They understand and agree to the plan. All questions have been addressed. **1:28 AM**: I rechecked the patient. She is resting comfortably. I discussed with the patient and her daughter that the x-rays were unremarkable and did not reveal any acute fractures or dislocations. I advised that no further ED workup is required at this time. I will send her with a left knee immobilizer, and advised that she should keep her physical therapy appointment. I will prescribe her some pain medication as well. They were given ED warnings, instructions for the plan, and follow up information. They understand and agree with the plan of care. Any questions have been answered. **Medications administered:** Tramadol 50 mg tablet. **Home medications:** • Tramadol 50mg • Naproxen 500mg • Norco 5-325 mg • Reglan 5 mg • Fioricet/Codeine 50-325mg **MDM** The patient was provided with a recommendation to follow up with a primary care provider and obtain reassessment of their blood pressure within three months Name of equipment: Left knee immobilizer Length of Need: Until follow-up **Clinical Impression** The primary encounter diagnosis was left knee pain. A diagnosis of right knee pain was also pertinent to this visit. **Follow-up:** • Dennis J Andersen, MD Call to schedule follow up with orthopedic doctor. • Wear immobilizer. • Ice on and off. • Ultram and Ibuprofen for pain. Return if new symptoms. • Margaret M Dunn, MD Call and continue to follow up with your primary care doctor as well. **Discharge Medication List** Start taking these medications: Tramadol 50 mg	

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		Patient is discharged in stable condition.	
05/05/YYYY	Hospital/Provider Name	**X-ray of left knee:** **History:** Pain after MVC **Impression**: No acute fracture or dislocation.	66-67
05/05/YYYY	Hospital/Provider Name	**X-ray of right knee:** **History**: Right knee pain, MVC few weeks ago **Impression**: No acute fracture or dislocation.	67
05/09/YYYY	Hospital/Provider Name	**Initial Physical Therapy evaluation:** **Diagnosis**: Cervical, thoracic, lumbosacral, right shoulder and right hip **History**: The patient is a 48-year-old female, who reports neck (radiating into the right upper extremity), middle back, low back radiating into the right hip/gluteal region s/p MV A 4/15/16. Patient also remarks that she is having headaches. Patient reports her left knee is also painful. Patient reports prior to MVA she did not have these symptoms. Patient reports a numbness and weakness sensation into her right shoulder/ arm. Patient reports increased symptoms with turning her head, sleeping, lifting or carrying objects, prolonged sitting /standing /walking, ascending/ descending stairs. Patient reports decreased symptoms with brief periods of rest and changing positions frequently. PMH is unremarkable. Patient is right hand dominant. **Clinical examination:** **Posture**: Upright. **Gait**: Patient ambulates with decreased cadence, stride length, independently. **Active range of motion**: Cervical rotation 0-51, lateral flexion 0-11, bilaterally. Lumbar forward flexion fingertips 18" from floor, lumbar lateral flexion to mid thigh. Right hip external rotation 0-25°, internal rotation 0-18°. **Strength**: Bilateral upper and lower extremities 5-/5 except right triceps, gluteals, hamstrings 4+/5. **Palpation**: Increased tone and tenderness to the bilateral cervical paraspinals, levator scapulae, rhomboids, scalenes, and suboccipitals, lumbar paraspinals, and gluteals, right > left. **Special Tests**: 90/90 hamstring test left +38 degrees of extension, right + 45 degrees of extension. **Problem List:** • Decreased tolerance for activities of daily living. • Decreased cervical, lumbar, hip active range of motion. • Decreased right upper and lower extremity strength.	405-406

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		• Abnormal posture. • Abnormal gait. • Decreased flexibility. • Abnormal tone. **Plan**: The patient will participate in skilled physical therapy including, modalities, manual therapy and therapeutic exercise two times per week as tolerated. The patient will follow up with physician in approximately three weeks. The patient has been educated on plan of care and is agreement to participate in skilled physical therapy.	
05/19/YYYY	Hospital/Provider Name	**Office Visit for physical examination:** **Active Problems**: • Anxiety - Has difficulty going to stores or places with a lot of people Will f/u with Behavioral Health • Compartment Syndrome - left hand, requiring a fasciotomy Froedtert YYYY • Conversion Disorder - admitted to SLMC with multiple somatic complaints and many negative imaging studies done to evaluate right sided pain/numbness: psychiatric eval considered conversion d/o • Hyperlipidemia • Neuropathy • Vertigo **Chief complaint**: The Chief Complaint is: Physical exam. **History of present illness** Ran out of Effexor which was helping for anxiety. She tried to get a refill but was told she needed a physical. She is not taking anything for pain from MVA 4/16. Able to sleep well; unable to tolerate Hydrocodone. • Pain in back shoulders and left knee: Worst with laying in bed and left knee with walking. • Pain= 8/10 Intensity • Request consultation by specialist since last visit=Sees PT Mon, Wed, Fri q (every) week • A previous emergency room visit since last visit-St. XXXX 4/YYYY • Ran out of medication and has been noncompliant with medication **Current medication:** Naproxen 500 mg Tablet take l twice a day with meals, 15 days, 0 refills **Review of systems** **Musculoskeletal**: Musculoskeletal symptoms low back pain=Due to MVA	1039-1044

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		4/15/16 and arthralgias neck and Left knee - Due to MVA 4/15/16. No localized soft tissue swelling in a lower extremity. **Neurological**: Dizziness. No fainting, no convulsions, no paralysis, and no numbness. **Psychological**: Anxiety. No depression, no sleep disturbances, and not thinking about suicide. Feeling weak. **Physical exam:** **Teeth**: Dental abnormalities right lower wisdom tooth tender. **Musculoskeletal System:** **Cervical Spine**: Cervical spine showed no abnormalities. **Assessment** • Anxiety [Anxiety disorder, unspecified] • Normal routine history and physical [Encounter for general adult medical examination with abnormal findings] • Hyperlipidemia [Mixed hyperlipidemia] • Obesity [Other obesity due to excess calories] **Therapy** Transition in care, clinical summary provided. **Plan** • Anxiety disorder, unspecified Effexor XR 37.5 MG • Sprain of ligaments of lumbar spine, initial encounter Naproxen 500 MG TABS • Strain unspecified muscle/fascia/tendon at shoulder/up arm, unspecified arm, initial Cyclobenzaprine HCl 5 mg tabs Medication list reviewed and Updated by Provider Return to the clinic if condition worsens or new symptoms arise Follow-up visit pain Clinical summary provided to patient Referral to dentist dental associates **Practice management** Standardized depression screening: negative for symptoms per MA screening- During the past month, has not often been bothered by feeling down, depressed or hopeless and negative for symptoms per MA screening: During the past month has not often been bothered by little interest or pleasure in doing things.	
05/31/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain along with headaches:** Since first seen, the patient has been attending physical therapy. She states	383, 1071

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		that this has been of help, though still notices pain in the neck, radiating into the right upper extremity as well as lower back pain, radiating into the right hip and left knee pain and pain in the thoracic region. The patient has been taking Antivert and this has helped with her dizziness. She continues with headaches. On physical exam, there is tenderness to deep palpation with spasm in the cervical paraspinal muscles bilaterally extending into both upper trapezius. She also continues with tenderness to deep palpation in the mid-thoracic paraspinal muscles bilaterally with trigger points in both rhomboid muscles. There is tenderness to deep palpation with spasm in the lumbar paraspinal muscles bilaterally, right more so than left with exquisite tenderness over the right greater trochanteric bursa. Examination of the left knee reveals a mild knee joint effusion with no increase in the local temperature. **Impressions**: • Cervical sprain with radiculopathy, most likely involving the right C7 nerve root. • Thoracic sprain with residual trigger points in both rhomboid muscles. • Lumbosacral sprain. • Right hip sprain, symptoms consistent with a right greater trochanteric bursitis. • Left knee sprain, rule out underlying derangement. • Cervicogenic headaches. • Dizziness. There has been some improvement since initially seen, though the patient is still quite symptomatic. She is noticing some improvement with physical therapy and was advised to continue attending physical therapy. She will continue working on her home exercise program and will be rechecked in three weeks. To be noted, I will request once again the notes from the emergency room.	
06/21/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain along with headaches:** Since her last visit, the patient continued with physical therapy. She states that the symptoms have persisted. She still notices neck pain radiating into the right upper extremity as well as lower back radiating into the right hip. She states that the lower back is quite severe. There is pain also in the left knee and thoracic region. She continues with headaches. The dizziness has decreased. On physical exam, she continues with tenderness to deep palpation with spasm in the cervical paraspinal muscles bilaterally extending into both upper trapezius. There is still tenderness to deep palpation in the mid-thoracic paraspinal muscles bilaterally, right more so than left with trigger	381-382, 1069-1070

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		point in the right rhomboid muscle. There is tenderness to deep palpation with spasm in the right lower lumbar paraspinal muscles with evidence of trigger point in the right lower quadratus lumbaris as well as a trigger point in the right gluteus medius. There is still tenderness to palpation over the right greater trochanteric bursa. Examination of the left knee reveals a mild knee joint effusion with no increase in the local temperature. **Impressions**: • Cervical sprain with radiculopathy, most likely involving the right C7 nerve root. • Thoracic sprain with residual trigger points, more so affecting the right rhomboid muscle. • Lumbosacral sprain, still quite symptomatic. She states that the pain in the lower back is interfering with her daily activities at home. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis. • Left knee sprain rule out derangement. • Cervicogenic headaches. • Dizziness, improved. The condition was discussed with the patient. As noted, the main complaint at this time is the lower back symptoms. We discussed the possibility of a trigger point injection and she was agreeable with this alternative. The patient will continue with physical therapy. She was given a prescription for Tramadol 50 mg, as Naproxen has not been helping much. **Addendum**: **Procedure**: The patient was given trigger point injections with a total of Kenalog 40 mg, Lidocaine 1 % without epinephrine and Marcaine 0.5% within the right lower quadratus lumbaris and right gluteus medius. The patient tolerated the procedure well. The patient will be rechecked in two weeks. To be noted I will request the records from the emergency room one more time as they have not arrived yet.	
07/08/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain along with headaches:** During her last visit, the patient received trigger point injections within the right lower quadratus lumbaris and right gluteus medius. She states that it has been of help, though there is still substantial pain in the lower back. She still notices pain radiating to the right upper extremity and states that the left knee pain has persisted. I had an opportunity to review all the records from St. XXXX Hospital. It was noted in YYYY, she underwent an MRI of the cervical spine that showed a slight bulge at C5-6. By further talking to the patient, she states that at that time, she had an episode of numbness of the right side of her body and an MRI of the cervical spine was done. She states that within the next 2-3 weeks, those symptoms resolved. It was also noted that the CT scan done after the car accident on 04/15/16, showed that there	379-380, 1067-1068

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		was "slight increase" of the disc bulge at C5-6. The patient has continued to complain of pain in the cervical area radiating to the right upper extremity. The lower back pain continues radiating to the right hip. She states that the left knee is still giving her problems. There are headaches that are present in the posterior aspect of the head. By further looking in the records, she was in the emergency room after the accident for an episode of headache. The patient acknowledges that approximately 10 years ago, she suffered from migraine headaches, though they stopped. She states that the headaches at this time are different than the migraines and they stay in the posterior aspect of her head. On physical exam, the patient continues with tenderness to deep palpation with spasm in the cervical paraspinal muscles bilaterally extending to both upper trapezius. She continues with tenderness over the mid-thoracic paraspinal muscles, right more so that left with trigger point in the right rhomboid muscle as well as tenderness to deep palpation with spasm in the right lower lumbar paraspinal muscles. Examination of the left knee reveals mild knee joint effusion with no increase in the local temperature. **Impressions**: • Cervical sprain with radiculitis, involving C7 nerve root. I advised the patient to undergo an MRI of the cervical spine, as the symptoms have persisted with radiculopathy. • Thoracic sprain with residual trigger points, more so affecting the right rhomboid muscle. • Lumbosacral sprain, some improvement after the trigger point injection, though still symptomatic. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis. • Left knee sprain rule out derangement. I will refer the patient for an MRI of the left knee. • Cervicogenic headaches. • Dizziness, controlled with medications. The patient will continue with physical therapy. I will recheck the patient after the workup is completed.	
07/15/YYYY	Hospital/Provider Name	**Follow up visit for left knee pain:** Patient came in today without an appointment. She states yesterday as she was walking, suddenly there was a severe pain in the left knee and her left knee gave out on her. She went down, landed on her buttock, and states she tried to break the fall with her arms. Maria has also been noticing some pain in the left chest wall area, but did not strike the left chest wall. She has an appointment to have an MRI of the left knee this coming Wednesday. On physical exam, the left knee reveals a mild knee joint effusion with no increase in the local temperature. There is tenderness to palpation in	378

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		posterolateral aspect of the left chest wall. **Impressions and Comments:** Unhappily the patient continued with left knee pain. She is going to go for an MRI this coming Wednesday to rule out derangement. As she fell, she sprained the left chest wall area. The patient will continue with physical therapy, will go through the MRI of the left knee, and will be rechecked after the MRI is completed.	
08/01/YYYY	Hospital/Provider Name	**Follow up visit for left knee pain and cervical pain:** Since her last visit, the patient states that the left knee and cervical pains have persisted. She does have scheduled MRI on 8/8/16 for the cervical spine and left knee. Regarding the lower back, it has improved after the trigger point injection as well as physical therapy. There is still right hip pain, though this is also improving with physical therapy. There is still also pain in the thoracic area, though overall this has continued to improve. On physical exam, she continues with tenderness to deep palpation with spasm in the cervical paraspinal muscles bilaterally extending into both upper trapezius. There is a trigger point in the right rhomboid muscle. There is tenderness to deep palpation in the right lower lumbar paraspinal muscles, though the spasm has decreased substantially. There is still tenderness to deep palpation over the right greater trochanteric bursa. **Impressions**: • Cervical sprain with radiculopathy involving the C7 nerve root. • The patient is still symptomatic. We will wait to see the results of the MRI of the cervical spine. • Thoracic sprain with a residual trigger point affecting the right rhomboid muscle. • Lumbosacral sprain, continues to improve. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis, still present. • Left knee sprain, rule out derangement. The patient does have an MRI scheduled on 8/8/16. • Cervicogenic headaches. • Dizziness, well controlled with medications. The patient will continue with physical therapy and will be rechecked after the MRI is completed.	376-377, 1066
08/08/YYYY	Hospital/Provider Name	**MRI of left knee:** **Clinical Information**: Knee pain. **Findings**: **Menisci**:	94-95, 374-375, 1064-1065

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		Medial meniscus: Horizontal tear of the posterior horn and horn body junction with extension to the inferior articular surface. Small radial tear component (series 5, image 12) No meniscal extrusion. No para meniscal cyst. Lateral meniscus: Normal. **Ligaments**: Cruciate ligaments: Intact. Medial collateral ligament: Superficial and deep components intact. No periligamentous edema. Lateral collateral ligament: Intact. Posterolateral corner structures: Intact. Posteromedial corner structures: Intact. **Extensor Mechanism**: The distal quadriceps and patellar tendons are intact. The patella is normally positioned within the femoral groove. There is no retinacular disruption. **Fluid**: Joint effusion: No joint effusion. Baker cyst/ganglion cyst: No Baker or ganglion cysts. **Osseous/articular structures**: **Bones**: No fracture, stress reaction, or osseous lesion is seen. **Patellofemoral compartment**: Full-thickness fissuring at the median ridge with subjacent edema and cystic change. **Medial compartment**: 3 x 5 mm full-thickness cartilage defect in the medial tibial plateau. Moderate subjacent marrow edema. **Lateral compartment**: No hyaline cartilage disease. **Intra-articular fragments**: None. **Other**: None. **Impression**: • Horizontal tear of the posterior horn and horn body junction of the medial meniscus extending to the inferior articular surface with small radial component near the posterior horn root attachment. No	

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		meniscal extrusion. • No cruciate or collateral ligament tears. • Patellofemoral compartment and medial compartment cartilage damage described in detail above.	
08/08/YYYY	Hospital/Provider Name	**MRI of cervical spine without contrast:** **Clinical information:** MVA 04/15/YYYY. Neck pain going into the right shoulder. **Findings**: Visualized posterior fossa structures and the brainstem are unremarkable. The craniocervical junction is unremarkable. The spinal cord is normal in outline and shows no expansion or volume loss. There is no abnormal cord signal. There is mild developmental narrowing of the cervical spinal canal. Cervical vertebral bodies are normal in height and show no evidence for marrow infiltrative disease. Multilevel degenerative disc disease is seen with multilevel loss of normal T2 signal. A level-wise analysis is as follows: **C1-C2**: There is no spinal canal narrowing. **C2-C3**: This level was not imaged in the axial plane. Available sagittal images however do not show significant disc bulge or spinal canal/neural foraminal narrowing. **C3-C4**: There is a small central disc herniation, without cord contact. The spinal canal is patent. The neural foramina are patent bilaterally. **C4-C5**: Mild disc bulge is seen. There is mild developmental narrowing of the spinal canal. The neural foramina are patent bilaterally. **C5-C6**: Disc bulge is seen with a central disc herniation which contacts and mildly deforms the ventral cord surface. There is moderate narrowing of the spinal canal with decreased CSF on the anterior and posterior aspects of the spinal cord. No abnormal cord signal is however seen. There is mild uncovertebral hypertrophy. The neural foramina are patent bilaterally. **C6-C7**: There is mild disc bulge. Mild spinal canal narrowing is seen. The cord shows normal outline. Mild right-sided neural foraminal narrowing is seen. **C7-T1**: There is no spinal canal/neural foraminal narrowing. **Impression**: • Mild developmental narrowing of the cervical spinal canal.	96-97, 371-373, 1061-1063

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		Degenerative disc disease at C5-C6 contributes to overall moderate spinal canal narrowing, especially in the anteroposterior dimension. No abnormal cord signal. • Mild degenerative disc disease elsewhere. • Mild right C6-C7 neural foraminal narrowing. The neural foramina at other levels are patent.	
08/22/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain:** Since her last visit, the patient underwent an MRI of the right knee that did show evidence of horizontal tear of a posterior horn of the medial meniscus extending into the articular surface. The patient states that the left knee is giving her substantial pain. She also continues complaining of right-sided neck pain. There is still pain that radiates in between the shoulder blades on the right. The MRI of the cervical spine did show mild right C6- 7 neural foraminal narrowing. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root. • The MRI did show some mild right C6- 7 neural foramina and at C5-6 it did show a central disc herniation with moderate narrowing of the spinal canal. The symptoms continued to be present. I will refer the patient to Dr. XXXX for possible injections. • Thoracic sprain with residual trigger points affecting the right rhomboid, improving. • Lumbosacral sprain, continue to improve. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis, still present. • Left knee pain with evidence of meniscus tear. • The patient was agreeable to consider the possibility of an injection. She will be scheduled for fluoroscopy-guided left knee intraarticular injection. • Cervicogenic headaches, some improvement. • Dizziness, well controlled with medications. The patient will continue with physical therapy.	370, 1060
09/02/YYYY	Hospital/Provider Name	**Office visit for neck pain, back pain, and left knee pain:** Patient is a pleasant 48- year-old female, who on 4/15/16 was involved in a motor vehicle accident. She was rear- ended. She had a severe rear-end motor vehicle accident. The airbag did not go off. She had uncertain loss of consciousness and uncertain head trauma. She had immediate posterior headache, neck pain, back pain and left knee pain with right upper extremity numbness and tingling. The current pain is 10/10 in severity in the right neck and posterior shoulder radiating to digits 3 and 4 on the right with electrical sensation.	367-369, 1057-1059

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		Otherwise, the pain is stabbing and burning. She also has significant back pain and right lower extremity radicular pain as well as continued left knee pain. She denies any changes in bowel, bladder or balance. She has been going to physical therapy, which is moderately helpful. She has been taking Naproxen and Tylenol and they have not been helpful. Tramadol 2-3 times per day has been moderately helpful. She did have a left knee joint injection and trigger point injection with Dr. XXXX in the past. 8/8/16: Cervical MRI showed C5-6 central herniation with mild degenerative disc disease at C3- 7 and mild right C6- 7 stenosis. 4/15/16: Thoracic x-ray showed subtle scoliosis. Lumbar x-ray showed mild degenerative changes. CT of the cervical spine showed probable C5-6 disc bulge. **Review of Systems** Constitutional: No fevers or chills Eyes: No double vision Ear Nose & Throat: No dizziness Cardiovascular: No swelling in feet Respiratory: No shortness of breath Gastrointestinal: Positive difficulty controlling bowels. Genitourinary: Positive difficulty controlling bladder Musculoskeletal: No joint swelling Skin: No rashes Nervous system: No numbness/tingling in hands or feet Psychiatric: No depression. No problems sleeping **Physical Examination** **Neurologic**: She is able to heel walk, toe walk and tandem walk. In bilateral upper extremities strength is pain inhibited, but at least -5/5. Sensation to light touch is intact with exception of the right digits 3 and 4. Deep tendon reflexes are 1 + in bilateral upper extremities. **Musculoskeletal**: Gait is hesitant and antalgic, but stable. Cervical range of motion is mildly restricted in all planes with similar pain at end-range. Spurling's maneuvers in both directions cause right-sided neck pain. She is diffusely tender over the right cervical paraspinals, upper trapezius and levator scapulae and nontender over the left. **Assessment and Plan** In summary, this is a 48-year-old female with a history of depression with severe sub acute neck pain with a radicular component, back pain with radicular component and left knee pain. • I agree with Dr. XXXX that this most likely represents right C7 radiculopathy, probably secondary to foraminal stenosis along with a stinger injury secondary to whiplash from the motor vehicle	

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		accident. It is possible that there is also a secondary versus less likely primary cervical facet syndrome. • As the patient has failed conservative measures including physical therapy and NSAIDs, for both diagnostic and therapeutic reasons, a cervical interlaminar epidural will be performed. The patient is informed on the benefits, alternatives and risks of the procedure including bleeding, infection or increased pain and permanent nerve damage and she agreed to go ahead. • I have also written her for the Tramadol t.i.d.	
09/16/YYYY	Hospital/Provider Name	**Procedure Report:** **Preoperative Diagnosis**: Cervical radiculopathy. **Postoperative Diagnosis:** Cervical radiculopathy. **Operative Procedure:** T1-T2 interlaminar epidural **Surgeon**: Dr. XXXX, MD. **Procedure**: The patient remained awake throughout the procedure in order to interact and give feedback. The x-ray technician was supervised and instructed to operate the fluoroscopy machine. The patient was placed in the prone position on the treatment table with a pillow under the upper thorax to reduce the natural cervical lordosis. Skin over and surrounding the treatment area was cleansed with Chloraprep. The area was covered with sterile drapes leaving a small window opening for needle placement. Fluoroscopy was used to identify the bony landmarks of the interlaminar space and the planned needle approach. The skin, subcutaneous tissue, and muscle within the planned approach were anesthetized with 1 % Lidocaine. With intermittent fluoroscopy, a 20 gauge 3 W' Touhy needle was gently guided into the Tl-2 interlaminar space. The needle was advanced using the loss of resistance technique to find the epidural space. Multiple fluoroscopic views were used to ensure proper needle placement. Approximately 1 cc of isovue 200 (nonionic contrast agent) was injected under live fluoroscopy. Correct needle placement was confirmed by production of an appropriate epidurogram and radiculogram without concurrent vascular dye pattern. Aspiration with the syringe resulted in no blood return. A test does of approximately 0.5 cc 1 % Lidocaine was injected, there were no sequelae after 1-2 minutes. Finally, the treatment solution consisting of 1 cc test dose of 1 % Lidocaine with no sequelae, which is followed by 1 cc of Depomedrol 80 mg/mL and 1 cc of 1	364-366

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		% Lidocaine was injected. All injected medications were preservative free. Sterile technique was used throughout the procedure. **Additional details**: Originally planned to use the C7-Tl interlaminar space, however, due to multiple osteophytes on the lamina, the entry was difficult, thus we elected to go through the lower which went smoothly. Also of note, the patient had excellent pain relief immediately after the procedure. **Complications**: None. The patient tolerated the procedure well. **Discussion**: The patient was discharged in stable condition with instructions to ice the injection site as needed for 15 to 20 minutes as frequently as twice per hour for the next two days, to avoid aggressive activities for two to three days, and to resume usual medications. Also, the patient was instructed to seek immediate medical attention for shortness of breath, chest pain, fevers, chills, increased pain, weakness, sensory or motor changes, or changes in bowel or bladder function. A follow-up appointment was scheduled.	
09/19/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain:** During her last visit with me, the patient underwent a fluoroscopy-guided left knee intraarticular steroid injection. She states that she only got a few days of relief regarding the left knee and the symptoms persisted. She continues with cervical pain with radiculopathy and was seen by Dr. XXXX on Friday for an epidural steroid injection. She will follow up with Dr. XXXX regarding this condition. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root, will continue with Dr. XXXX. • Thoracic sprain with residual trigger points affecting the right rhomboid, overall improved. • Lumbosacral sprain, overall improved. • Right hip sprain with symptoms consistent with a right greater trochanteric bursitis, still symptomatic. • Left knee pain with evidence of a meniscal tear. • The patient did not have a significant response to intraarticular steroid injection. We will get orthopedic surgeon evaluation. • Cervicogenic headaches, some improvement. • Dizziness, well controlled with medications. The patient will continue with physical therapy. She will be rechecked three weeks.	363
10/03/YYYY	Hospital/Provider	**Office Visit for evaluation of left knee injury:**	1460-1470,

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	Name	Patient was involved in a motor vehicle accident on 4/15/YYYY. She was the restrained driver. She was hit from behind by a truck. She believes that her left knee struck the door and possibly twisted as the foot was planted, however, she had what sounds like brief loss of consciousness or at least disorientation. Her daughter is present and said immediately after the accident she was not responding to her questions and then kind of snapped out of it. She was seen at St. XXXX Hospital. X-rays were taken there, which I reviewed today. They are non-weight bearing x-rays and they are negative. She has subsequently been treated with Dr. XXXX. She had a cortisone injection in her knee about three months ago. She said that this gave her relief for about three days. She was subsequently referred for an MRI scan of her knee, which was performed at CDI on 8/8. I reviewed the images and the report today. It is notable for horizontal tears, posterior horn and horn body junction of the medial meniscus with a radial component as well and no meniscal extrusion. Lateral meniscus is normal. Chondral fissuring and adjacent cystic change at the patellofemoral compartment and a full thickness cartilage defect in the medial tibial plateau is noted. She has been doing some therapy exercises as well. She is still having pain in the knee. It is primarily medially and deep in the knee. It is not locking, catching or giving way. She has not tried a brace. On exam today, she is accompanied by her daughter. She is walking with an antalgic limp on her left side. **Review of Systems:** **Musculoskeletal**: No new muscle, tendon, bone, or ligament aches pains deformity or abnormalities are noted. **Physical Exam:** Focused left lower extremity examination reveals normal appearing skin about the knee. Non-irritable passive motion about the hip and ankle. The knee has a small effusion. Tenderness at the medial joint line is present. Range of motion is 0 to 130 degrees. Good strength with knee flexion/extension. No lateral sided tenderness. Stable to varus and valgus stress. Stable to anterior and posterior stress. Calf is non-tender. Motor, sensory and circulatory exam of the foot and ankle is normal. **Assessment**: Motor vehicle accident resulting in a left knee medial meniscus tear and aggravation of chondromalacia of the knee. **Plan**: Options were discussed today, including continuing conservative treatment with therapy exercises, possibly repeating cortisone and trying a knee brace.	1051-1053, 1054-1056

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		However, I do think sufficient effort has been given towards conservative treatment to this point and her symptoms do correlate to her meniscus tear, therefore, I think that she would be a good candidate for arthroscopic partial medial meniscectomy. We discussed the procedure today, as well as it common risks, benefits and expectations regarding postoperative course and recovery. She is going to think about it. If she wants to schedule surgery, she has my scheduler's contact information and I would happily do that for her at her convenience.	
05/09/YYYY-10/06/YYYY	Hospital/Provider Name	**Summary of interim Physical Therapy visits:** *Illegible notes* **Treatment dates:** 05/09/YYYY, 05/12/YYYY, 05/16/YYYY, 05/18/YYYY, 05/23/YYYY, 05/24/YYYY, 05/27/YYYY, 05/31/YYYY, 06/07/YYYY, 06/09/YYYY, 06/13/YYYY, 06/17/YYYY, 06/21/YYYY, 06/27/YYYY, 07/01/YYYY, 07/08/YYYY, 07/12/YYYY, 07/16/YYYY, 07/26/YYYY, 08/19/YYYY, 08/22/YYYY, 09/12/YYYY, 09/27/YYYY, 09/29/YYYY, 10/04/YYYY, 10/06/YYYY **Complaints**: Neck and back pain. **Treatment rendered:** • Therapeutic exercises • Manual therapy • Soft tissue mobilization • Electrical stimulation • Hot/cold pack Continue goals. **Reviewer's comments: The interim visits are summarized with significant events*	396-404
10/11/YYYY	Hospital/Provider Name	**Correspondence letter:** **Dear Margaret M Dunn, MD:** Our mutual patient is scheduled for Left Knee Arthroscopy Partial Medial Meniscectomy on October 26, YYYY under General anesthesia. The patient has indicated that she will be scheduling a preoperative History and Physical with you. She is scheduled to have the procedure at Lake Country Surgery Center. The required lab work for a patient of her age is listed on the enclosed form. The lab work can be done in your office and results faxed to the facility, as well as to our office or the patient can go to a lab facility of their choosing. Information on your upcoming surgery **Place of surgery**: Lake Country Surgery Center	1510-1519

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Date/time of surgery: October 26,YYYY at 11:30 am **Time of arrival** 10:00 am **Place of arrival** Admitting Department **Surgical procedure**: Left Knee Arthroscopy Partial Medial Meniscectomy	
10/12/YYYY	Hospital/Provider Name	**Office Visit for pre-operative left knee arthroscopy:** **Chief complaint** Patient here for pre-op for left knee arthroscopy partial medial meniscectomy by Dr Jonathan Printz. **History of present illness** Pain = 10/10 Intensity **Review of systems** **Head**: Headache right side. She has had the pain on the right side of head since she was in the car accident that also injured her left knee for which she is having surgery. No sinus pain. **Musculoskeletal**: No arthralgias and no localized soft tissue swelling in a lower extremity. **Neurological**: Dizziness. No fainting, no convulsions, no paralysis, and no numbness. **Assessment** • Visit for: preoperative exam [Encounter for other pre-procedural examination] Left knee arthroscopy partial medial meniscectomy, Dr. XXXX orthopedic • Internal derangement of left knee [Unspecified internal derangement of left knee] • Muscle spasm [Other muscle spasm] right side of head and neck are in pain after MVA. Trial of muscle relaxer **Plan** **Mixed hyperlipidemia** Labs **Other muscle spasm** Tizanidine HCl 4 mg tabs, take as needed q (every) 8 hours pm for neck pains and headache and back pains, causes drowsiness, do not take if driving or working., 30 days, 2 refills **Encounter for other pre-procedural examination** Lab: CBC with Differential Lab: BMP (Basic Metabolic Panel)	1045-1050, 1086-1091

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		Rx muscle relaxer for right head and neck pain since accident. Recheck BP before she leaves. She is having surgery on 10/26/16 She normally easily tolerates > 4 METs of activity however now is limited due to pain from lower back and knee. **Practice management** Standardized depression screening: negative for symptoms per MA screening: During the past month has not often been bothered by little interest or pleasure in doing things and negative for symptoms per MA screening. During the past month, has not often been bothered by feeling down, depressed or hopeless.	
10/17/YYYY	Hospital/Provider Name	**Office Visit for right hip, left knee, cervical, thoracic, and lumbar pain:** Since her last visit the patient was evaluated by Dr. XXXX who recommended arthroscopic surgery of the left knee she has been scheduled for the surgeon on the 10/26/16. Regarding the cervical symptoms, she continues to notice radiation of the pain into the right upper extremity. Regarding the right hip pain it continued to be symptomatic. She states that physical therapy gives her temporary improvement, though the symptoms come back. On physical exam she continues with tenderness to deep palpation over the right greater trochanteric bursa. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root. We will follow up with Dr. XXXX regarding this condition. • Thoracic sprain with residual trigger point affecting the right rhomboid, at present, doing well. • Lumbosacral sprain, overall doing well. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis, still symptomatic. She has not responded well to conservative treatment regarding this condition. We discussed the possibility of an intraarticular steroid injection and she was agreeable with this alternative. The patient will be scheduled for a fluoroscopy-guided right hip intraarticular steroid injection with local anesthetics. This would also help diagnostically as well as therapeutically. • Left knee meniscus tear; will follow up with Dr. XXXX for surgery, she has failed conservative treatment. • Cervicogenic headaches; overall improved. • Dizziness; well controlled with medications. She has continued taking the medications. The patient will stop physical therapy.	361-362
10/26/YYYY	Hospital/Provider	**Operative Report:**	339-340,

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	**Preoperative diagnosis**: Left knee current, complex medial meniscus tear. **Postoperative diagnosis**: Left knee current, complex medial meniscus tear. **Procedure performed**: Left knee arthroscopic partial medial meniscectomy. **Anesthesia**: General. **Complications**: None apparent. **Brief history**: This patient is a pleasant individual who recently presented to the outpatient orthopaedic surgery clinic with a knee injury following a motor vehicle accident. The history, physical exam and MRI findings support the above diagnosis. The rationale for, as well as common risks, benefits to surgical intervention, were reviewed and informed consent has been given for the above procedure. **Description of procedure**: The patient was identified in the holding area. The knee was marked with indelible marker. The patient was then brought to the operating room. A timeout was performed and IV antibiotics were administered before starting the procedure. After administration of general anesthesia without incident, the patient was positioned supine and a non-sterile, high thigh tourniquet was applied. The thigh was placed in a thigh holder. The non-operative lower extremity was placed in a well-leg holder. Operative lower extremity was then widely prepped and draped in the usual sterile fashion. The limb was exsanguinated with an Ace bandage. The tourniquet was inflated to 300 mmHg. A standard anterolateral arthroscopy portal was established. Following this, an anteromedial portal was established under direct spinal needle visualization. Diagnostic arthroscopy of the medial compartment revealed well-preserved chondral surfaces on the majority of the medial femoral condyle. Partial thickness cartilage loss along the most medial margin was noted along the weight bearing surface. Areas of grade 2 and small areas of full-thickness cartilage loss were present at the medial tibial plateau. A small, radial tear involving the posterior horn was noted. It was resected back to a smooth margin using a combination of arthroscopic biters and an arthroscopic shaver. The MRI did demonstrate a horizontal tear of the medial meniscus, though I do not appreciate one. Examination of the notch revealed a normal ACL and PCL. In the lateral compartment, the articular surfaces were well preserved and the lateral meniscus and popliteus were normal. In the patellofemoral joint, there were well preserved chondral surfaces on the patella and trochlea. The suprapatellar pouch and gutters were free of loose bodies. The knee was then drained. The arthroscope was withdrawn. The portal incisions were closed with 3-0 nylon suture. The incisional areas and fat pad were well infiltrated with local anesthetic. Sterile gauze dressings were applied over	330-338, 341-345, 1520-1537

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		Xeroform. It was secured with Webril and a gentle compressive Ace wrap. Tourniquet was deflated, and a hinged knee brace limiting flexion beyond 90 degrees was applied. The patient was awakened from anesthesia and transferred to a stretcher and taken to recovery in stable condition. There were no apparent complications. The patient will be discharged home and follow-up with me in one week for suture removal.	
11/03/YYYY	Hospital/Provider Name	**Post-operative follow up visit for left knee:** **Chief Complaint**: Postop check left knee. This patient returns for scheduled follow-up status post arthroscopic partial left medial meniscectomy. She is doing okay. She is still having some soreness in the knee. She is ambulating with crutches. Denies calf pain. **Physical Exam:** Her medial and lateral portal incisions are healing nicely with no signs of infection. The calf is non-tender. The knee has a small effusion. Mild tenderness around the medial knee is present. Motor, sensory and circulatory exam of the foot and ankle is normal. **Diagnostic Test:** I reviewed her arthroscopic photos and surgical findings with her today. **Assessment**: Left knee medial meniscus tear resultant from a motor vehicle accident on 4/15/YYYY. Date of surgery was 10/26/YYYY. She is doing as expected. **Plan**: We will begin physical therapy. She will continue Naproxen for pain control and return to me in four weeks for clinical check.	1546, 1538-1545, 1547-1557
11/10/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee surgery:** Since last seen, the patient underwent arthroscopic surgery of the left knee done by Dr. XXXX on 10/26/16. She states that she had to spend more time in bed initially and that increased her right hip pain. She states that overall from the initial pain after the surgery, the left knee feels much better. Regarding the hip, she does notice pain in the right hip. The pain in the cervical area is still present. On physical exam, there is tenderness to deep palpation over the right greater trochanteric bursa. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root, will continue to follow up with Dr. XXXX. • Thoracic strain with residual trigger point in the right rhomboid,	360

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		overall doing well. • Lumbosacral sprain, overall doing well. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis, still symptomatic. The patient had surgery recently regarding the left knee. We will wait 2-3 more weeks before considering the possibility of a right hip injection. • Left knee meniscus tear, status post arthroscopic surgery of the left knee on 10/26/16. • Cervicogenic headaches, much improved. • Dizziness, resolved. The patient will be rechecked in three weeks.	
11/21/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee surgery:** **chief complaint** **The Chief Complaint is**: F/u from knee surgery. **History of present illness** XXXX is a 48 year old female. Pain neck, lower back = 8/10 Intensity Request consultation by specialist since last visit Surgery went smoothly; PT progressing. No pain, swelling. Improved mobility. **Current medication** Diclofenac Sodium 3 % Gel (jelly) Apply 2-4 grams to area of pain 3x/day, 30 days, I refills Effexor XR 75 mg capsule, extended-release 24 hour CP24, take one daily, 30 days, 6 refills **Physical exam:** **Musculoskeletal System:** **Knee**: General/bilateral: Knees showed abnormalities incisions well-healed. **Assessment** • Anxiety [Anxiety disorder, unspecified] • Obesity [Other obesity due to excess calories] • Internal derangement of left knee [Unspecified internal derangement of left knee] left knee arthroscopy with meniscectomy 10/26/16: feeling better **Plan** **Cervicalgia** Diclofenac Sodium 3 % gel, Apply 2-4 grams to area of pain 3x/day, 30 days, 1 refills • Medication list reviewed and Updated by Provider	1083-1085

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		• Return to the clinic if condition worsens or new symptoms arise • Continue current medication • Follow-up visit 2 months for anxiety	
11/29/YYYY	Hospital/Provider Name	**Initial Physical Therapy evaluation for left knee medial meniscectomy:** **History**: The patient is a 48-year-old female, who presents today with left knee pain s/p medial meniscectomy. She reports left knee pain started after a MVA on 4/15/16. She had previously been seen at our office from physical therapy from 5/9/16 to 10/6/16. Today she reports 6/10 knee pain and numbness/tingling at the end of the day. She reports difficulty with stairs (10 step entry to home). Her daughter has been assisting her with cooking, cleaning, and laundry. Her daughter has also been doing her grocery shopping for her. Standing tolerance is 15 minutes. She is also having difficulty sleeping through the night and getting in/out bed without help from upper extremities. She uses her cane for community ambulation and in her home. **Clinical Examination:** **Observation**: Surgical sites healing well no drainage noted; increased swelling noted over the medial aspect of left knee and posterior lateral left knee. Gait: pt presents today ambulating with cane, decreased step and stride length left, decreased weight bearing left, decreased left knee flexion and terminal knee extension AROM Knee flexion left 91 *, right 128, left extension -2, right 0 PROM Knee flexion left 91, extension -1 (* denotes pain with movement) **Strength**: Hip flexion: right 4+ left 4 knee flexion: right. 4 left 4".' **Knee extension**: Right 5 left 3+ **Circumference**: Joint line left 36cm, right 34.5cm **Patellar mobility**: Decreased medial and inferior/superior glides Palpation: increased tightness/tenderness left bicep femoris, left vastus lateralis, and left IT band. **Problem List:** • Decreased left knee AROM • Decreased left leg strength • Increased pain with ADL's.	392-393

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Decreased independence with ADL's • Decreased independence with walking • Decreased walking and standing tolerance **Plan of Care**: Patient will be seen for skilled physical therapy 2-3x/week for 8-12 weeks. Treatments will consist of modalities, manual therapy, neuromuscular, re-education, therapeutic exercise, functional training and patient education. We will provide the ordering provider with a progress report prior to follow-up appointment in approximately four weeks. PT plan of care has been discussed with the patient who agrees to comply.	
12/01/YYYY	Hospital/Provider Name	**Post-operative check up visit for left knee:** **Chief Complaint**: Post op check left knee. This patient returns for scheduled follow-up status post arthroscopic partial left medial meniscectomy. She is doing well, making nice progress through PT. She has occasional soreness in the knee. Denies calf pain. **Physical Exam:** Her medial and lateral portal incisions are healing nicely with no signs of infection. The calf is non-tender. The knee has no small effusion. Mild tenderness around the medial knee is present. Motor, sensory and circulatory exam of the foot and ankle is normal. **Assessment**: Left knee medial meniscus tear resultant from a motor vehicle accident on 4/15/YYYY, s/p arthroscopic intervention on 10/26/YYYY. She is doing as expected. **Plan**: She will continue physical therapy. She was given a refill of Norco for pain control with PT. She will follow up in one month.	1558-1572
12/02/YYYY	Hospital/Provider Name	**Telephone note:** Patient would like her Celebrex to be filled at the 16th Street Clinic not the Walgreens on 25th and Lincoln as originally noted in chart. Walgreens was called and agreed to forward prescription to 16th Street Clinic per patient's request.	1573-1578
12/21/YYYY	Hospital/Provider Name	**Follow-up Visit for right hip pain:** Since her last visit, the patient has continued to notice neck pain, radiating to the right upper shoulder as well as right hip pain. She has been going for physical therapy regarding her left knee post surgical therapy. The main complaint is the right hip pain that has continued to be present.	358

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		On physical exam, the patient continued with tenderness to deep palpation over the right greater trochanteric bursa. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root. The patient will continue following up with Dr. XXXX. • Thoracic sprain with residual trigger point in the right rhomboid, doing well. • Lumbosacral sprain, overall doing well. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis, still symptomatic. The possibility of an injection was discussed with the patient and she was agreeable with this alternative. A separate report will be dictated for fluoroscopy-guided right hip intraarticular Kenalog injection with local anesthetics. This is to be noted that immediately after the injection, she noted complete relief of her symptoms. • Left knee meniscus tear status post arthroscopic surgery of the left knee on 10/26/16. Will go through physical therapy. • Cervicogenic headaches, overall much improved. • Dizziness, resolved. The patient will be rechecked in two weeks	
12/21/YYYY	Hospital/Provider Name	**Procedure report:** Fluoroscopy guided right hip injection with local anesthetics and steroid under fluoroscopy positioning with a C-arm. Documentation with contrast material and X-rays. **Indication**: Right hip pain with underlying osteoarthritis. **Description of the procedure:** The procedure and potential complications were explained to the patient and voluntary informed consent was obtained. The patient was positioned on their left side and the skin was prepped in the usual fashion. After locating the entrance point with a radiopaque marker, the site to approach from the surface skin was marked with an indelible pen. The skin was prepped and draped in a sterile fashion. Subcutaneous lidocaine was instilled into the superficial soft tissue. With the use of fluoroscopy guidance, a 22 gauge spinal needle was inserted and advanced into the right hip, under direct fluoroscopic visualization. After confirmation of the intraarticular positioning of the needle tip with injection of Isovue M 200, Kenalog 40 mg and Bupivacaine 0.25, 3 cc was instilled into the right hip joint. The needle was removed and the patient was repositioned. No complications were observed during the procedure or immediately after the procedure. The complete procedure was well tolerated. The patient was then moved to the recovery area. After the patient remained stable for half an hour, the patient was discharged home with instructions.	359

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01/04/YYYY	Hospital/Provider Name	**Follow-up Visit for right hip pain:** During her last visit, the patient received a right hip intraarticular steroid injection with local anesthetics. She states that she got excellent relief for a few days and now the symptoms are back. She continues to complain of right hip pain. Regarding the left knee, she continues to notice improvement with physical therapy. Regarding the cervical spine, it continues to be symptomatic. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root. • The patient will continue following up with Dr. XXXX. • Thoracic sprain with residual trigger point in the right rhomboid, doing well. • Lumbosacral sprain, doing well. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis. • The patient had excellent temporary relief with the intraarticular steroid injection with local anesthetics though unhappily, the symptoms have returned. I will refer the patient for an MRI of the right hip. • Left knee meniscus tear status post arthroscopic surgery of the left knee on 10/26/16. The patient is improving with physical therapy. • Cervicogenic headaches, much improved. • Dizziness, resolved. The patient will be rechecked after the MRI is completed.	354
11/29/YYYY-01/11/YYYY	Hospital/Provider Name	**Summary of interim Physical Therapy visits for left knee medial meniscectomy:** **Diagnosis**: Left knee medial meniscectomy **Treatment dates:** 11/29/YYYY, 11/30/YYYY, 12/07/YYYY, 12/27/YYYY, 01/03/YYYY, 01/10/YYYY, 01/11/YYYY **As of 01/10/YYYY:** **Current Functional Status**: Patient reports independence with cooking, cleaning, laundry, and grocery shopping. She is still having some difficulty with stairs. She is able to negotiate them independently; however increased repetitions causes increased pain. She is able to ambulate in the community and at home without cane. She also no longer requires the use of her upper extremities for bed mobility and transfers. Standing tolerance has improved to greater than 15 minutes. She was performing half squats as part of her home exercise program but they caused increased symptoms so we have put them on hold for now. She reports compliance with home exercise program. **Clinical Examination:**	387-391

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Observation: Surgical sites healing well no drainage noted; increased swelling noted over the medial aspect of left knee and posterior lateral left knee. (decreased swelling noted) **Gait**: Patient presents today ambulating with cane, decreased step and stride length left, decreased weight bearing left, decreased left knee flexion and terminal knee extension (pt is now ambulating without AD (assistive device) she demonstrates improved step and stride length along with increased left knee flexion and terminal knee extension). AROM Knee flexion left 91 * (increased to 126) right 128, left extension -2 (increased to 0), right 0 PROM Knee flexion left 91 (increased to 130), extension -1 (* denotes pain with movement) **Strength**: Hip flexion: right 4+ (increased to 5) left 4 (increased to 4+) **Knee flexion**: right 4 (increased to 5) left 4- (increased to 4 +) **Knee extension**: right 5 left 3+ (increased to 4+) **Circumference**: joint line left 36cm (decreased to 35.5cm), right 34.5cm **Single leg balance**: right 6 seconds, left 3 seconds **Patellar mobility**: Decreased medial and inferior/superior glides(improved mobility noted) **Palpation**: Increased tightness/tenderness left bicep femoris, left vastus lateralis, and left IT band. (decreased tightness/tenderness noted through knee, quad, and hamstring/IT band, still some tightness noted lateral gastroc) **Problem List**: • Decreased left leg strength • Increased pain with stairs • Decreased walking and standing tolerance • Decreased balance **Plan of Care**: Patient would benefit from continued skilled physical therapy to address remaining deficits above. **As of 01/11/YYYY:** Patient reports decreased knee pain. Received electrical stimulation, hot/cold pack application, home exercises, and manual therapy. **Reviewer's comments: The interim visit are summarized with significant events.*	
01/12/YYYY	Hospital/Provider	**Post-operative check up visit for left knee:**	1581-1593

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Name	**Chief Complaint:** Postop check left knee. This patient returns for scheduled follow-up status post arthroscopic partial left knee medial meniscectomy. She is doing well. Completed formal PT. She has occasional soreness in the knee. Denies calf pain. **Physical Exam:** Her medial and lateral portal incisions are healing nicely with no signs of infection. The calf is non-tender. The knee has no effusion. Mild tenderness around the medial knee is present. Motor, sensory and circulatory exam of the foot and ankle is normal. **Assessment:** Left knee medial meniscus tear resultant from a motor vehicle accident on 04/15/YYYY, s/p arthroscopic intervention on 10/26/YYYY. She is doing as well. **Plan**: She will discontinue physical therapy and focus on HEP as needed. She was given a refill of Celebrex for pain. She will follow up on an as needed basis.	
01/18/YYYY	Hospital/Provider Name	**MRI of lumbar spine without contrast:** **Examination**: MRI lumbar spine without contrast. **Clinical information**: 48-year-old female with right lumbar pain. **Findings**: **Alignment**: There is mild dextroscoliosis with no significant vertebral subluxation. **Developmental spinal canal narrowing**: There is no developmental spinal canal narrowing. **Discs**: The discs are well preserved in height and signal apart from mild loss of disc height and T2 hyperintensity from within the L5-S1 disc. **Vertebrae**: Vertebrae are maintained in height and marrow signal. **Distal cord**: The distal cord has normal signal. The conus terminates at upper L2. There is distortion of the roots of the cauda equina at the L4 level with suggestion of adhesions or possibly an arachnoid cyst within the right side of the thecal sac that marginates the nerve roots medially. Mild distortion of the nerve roots is also noted at the L4-L5 and upper L5 level where the nerve roots appear marginated anteriorly. **Level-wise findings are as follows:** Imaged lower thoracic levels: There is no significant spinal canal or foraminal stenosis. A shallow left paracentral disc herniation at the T12-L1 level does not contact the cord.	98-100, 355-357

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		L1-L2: There is no significant spinal canal or foraminal stenosis. **L2-L3**: There is no significant spinal canal or foraminal stenosis. There is minimal disc bulging. **L3-L4**: There is no significant spinal canal or foraminal stenosis. There is minimal disc bulging and mild facet arthropathy. **L4-L5:** There is a shallow disc bulge and mild facet and ligamentum flavum hypertrophy that minimally narrows the neural foramina. No significant canal stenosis is seen. **L5-S1**: There is a central disc herniation that barely indents the ventral aspect of the thecal sac with no nerve root impingement. There is mild facet arthropathy with minimal .narrowing of the neural foramina. Imaged sacroiliac joints: The SI joints are barely visualized on this scan. Imaged abdomen, pelvis, and retro peritoneum: No abdominal, pelvic, or retroperitoneal abnormalities are detected on limited imaging. **Impression**: • Modest degenerative changes in the lower lumbar spine with no nerve root impingement. Facet arthropathy is most pronounced at L4-L5. Degenerative disc disease is most pronounced at L5-S1. No significant canal or foraminal stenosis. • Distortion of the roots of the cauda equina at the L4 and upper L5 levels with the nerve roots marginated medially at L4 and anteriorly at the upper L5 level. This may be due to adhesions/arachnoiditis. There may be a small arachnoid cyst at the L4 level. A contrast enhanced scan would further clarify.	
02/15/YYYY	Hospital/Provider Name	**MR of right hip:** **Clinical Information**: Right hip pain and discomfort. History of motor vehicle accident in YYYY. **Findings**: Osseous structures: No fracture, stress reaction, Avascular necrosis, or focal osseous lesion is seen. There is a sclerotic focus within the right femoral neck which was appreciated on the prior CT scan of YYYY and is consistent with a bone island. **Articular cartilage/labrum:** Articular Cartilage: There is no joint space narrowing or cartilage disease. Labrum: No labral tear or paralabral cyst is identified. **Joint/bursal effusion:** **Joint Effusion**: There is no joint effusion. **Intra-articular fragments**: None. **Bursal effusion**: There is mild T2 hyperintensity overlying the greater trochanter which may represent mild inflammatory change. There is no discrete bursal effusion.	101-102, 352-353

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Muscles and tendons: **Abductor tendons**: The gluteus medius and gluteus minimus tendinous insertions are intact. **Hamstring Origins**: The hamstring origins are intact. **Other**: The remainder of the muscles and tendons surrounding the hip are intact. **Impression**: • No fracture, dislocation, or evidence of AVN. • No discrete labral tear or abnormality is evident. • No full-thickness chondromalacia is identified. • Focal T2 hyperintensity adjacent to the greater trochanter which may represent mild inflammatory changes in the region of the lateral hip. There is no bursal effusion. • No joint effusion.	
02/20/YYYY	Hospital/Provider Name	**Follow-up Visit for right hip pain:** Since her last visit, the patient underwent an MRI of the right hip that showed mild inflammatory changes in the region of the greater trochanteric bursa. The patient has continued to complain of pain in the right hip. Regarding the left hip, it is substantially better. On physical exam, there is tenderness to deep palpation over the right greater trochanteric bursa. **Impressions**: • Cervical pain with radiculopathy involving the C7 nerve root. The patient will continue following up with Dr. XXXX. • Thoracic sprain, doing well. • Lumbosacral sprain, doing well. • Right hip sprain with symptoms consistent with right greater trochanteric bursitis. We discussed the results of the MRI and she was agreeable to consider the possibility of a right greater trochanteric bursa injection. The patient will be scheduled for fluoroscopy guided right greater trochanteric bursa. • Left knee meniscus tear status post arthroscopic surgery of the left knee on 10/26/16, much improved. • Cervicogenic headaches, much improved though occasional headache • Dizziness, resolved.	351
02/22/YYYY	Hospital/Provider Name	**Procedure Report:** Fluoroscopy guided right hip injection with local anesthetics and steroid under fluoroscopy positioning with a C-arm. Documentation with contrast	350

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		material and x-rays. **Indication**: right hip pain with underlying osteoarthritis. **Description of the procedure:** The procedure and potential complications were explained to the patient and voluntary informed consent was obtained. The patient was positioned on their left side and the skin was prepped in the-usual-fashion. After locating the entrance point with· a radiopaque marker; the site to approach from the surface skin was marked with an indelible pen. The skin was prepped and draped in a sterile fashion. Subcutaneous Lidocaine 1 % was instilled into the superficial soft tissue. With the use of fluoroscopy guidance, a 22 gauge 3 1/2" spinal needle was inserted and advanced into the right hip, under direct fluoroscopic visualization. After confirmation of the intraarticular positioning of the needle tip with injection of Isovue M 200, Kenalog 40.mg and bupivacaine 0.25%, 3 cc was instilled into the right hip joint. The needle was removed and the patient was repositioned. No complications were observed during. The procedure or immediately after the procedure. The complete procedure was well tolerated. The patient was then moved to the recovery area. After the patient remained stable for half an hour, the patient was discharged home with instructions.	
03/18/YYYY	Hospital/Provider Name	**Discharge Summary for small bowel obstruction:** **Admission Date**: 3/15/YYYY **Discharge Date:** 3/18/YYYY **Reason for Admission**: Abdominal distention **Admission Diagnosis;** • Epigastric pain • Small bowel obstruction **Discharge Diagnosis:** Small bowel obstruction **Reviewer's comments: The hospitalization records from 03/15/YYYY to 03/18/YYYY are unavailable for review. This visit is unrelated and hence we have not elaborated.*	1094-1096
03/27/YYYY	Hospital/Provider Name	**Follow-up Visit for right hip pain, left knee pain, and neck pain:** During her last visit, the patient underwent a right greater trochanteric bursa injection. The patient states that injection has been of tremendous help. At the present, very seldom, she notices some discomfort in the right hip area. Regarding the cervical pain, at present, she is essentially asymptomatic. The headaches also have resolved. She though states that there is still pain in the left knee and some days are better and some days are worse.	348-349

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		On physical exam, the patient ambulates with a physiological gait. The range of motion of cervical spine and trunk is within normal limits. Examination of the left knee reveals mild knee joint effusion with slight increase in the local temperature. There is no further tenderness to deep palpation over the greater trochanteric bursa. There is no tenderness to deep palpation in the cervical paraspinal muscles or the lumbar paraspinal muscles or the thoracic paraspinal muscles. **Impressions**: • Cervical sprain with radiculopathy involving the C7 nerve root. The patient had an excellent response to the epidural steroid injection. • Thoracic sprain, resolved. • Lumbosacral sprain , resolved • Right hip sprain resulting in a right greater trochanteric bursitis. The patient had an excellent response to the right greater trochanteric bursa injection. • Left knee meniscus tear status post arthroscopic surgery of the left knee on 10/26/16, starting to notice some pain coming back. The patient was advised to see how the symptoms evolve over the next few weeks. • Cervicogenic headaches, resolved. • Dizziness, resolved. To a reasonable degree of medical certainty, the patient suffered as a result of the car accident of 4/15/16, injuries as noted above. She was treated with physical therapy as well as intraarticular injections as well as cervical epidural injection. She recovered from all symptoms except for the left knee where she still is noticing off and on pain. This is a permanent condition. She was advised that if the symptoms deteriorate, she will contact my office and will consider a follow-up intraarticular steroid injection. She was also advised that if the symptoms get worse, she will need to follow up with the orthopedic surgeon for further recommendations. The patient will contact my office as needed.	
04/06/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** Patient is here today for follow-up and reevaluation of left knee. Patient was last seen in January YYYY where she was recovering nicely from left knee arthroscopy and partial meniscectomy. She notes recently the knee started hurting again without injury or trauma. She states pain is both medial and lateral. She complains of giving way sensation. She denies swelling. **ROS**: **Constitutional**: No nausea fever vomiting chills or diarrhea. No unexpected weight changes. **Musculoskeletal**: No new muscle joint ligament or bone aches, pains, limitations or abnormalities	1594-1609

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		General: she is well dressed and well-nourished and in no acute distress. Her affect is appropriate. She is cooperative with the exam today. She is alert and oriented x3. She walks with normal gait pattern and stands with a normal posture. **Musculoskeletal**: Full extension to 120 degrees of flexion. There is no effusion. There is tenderness along the medial and lateral joint line. There is tenderness about the patellofemoral joint. There is no crepitus with range of motion. The knee is otherwise stable. **Integument**: Intact. Portals are healed. **Neurovascular**: Calf is supple and nontender. Sensation is intact to light touch. Distal motor is intact. **Data**: 3 views of the left knee obtained today reveal well-preserved joint spaces. There is a small opacity noted in the anterior knee of uncertain significance, bony in appearance. Nothing acute. **Impression**: • Pain • Left knee pain • S/P medial meniscectomy of left knee **Plan**: Treatment options are discussed with the patient. An MRI scan for reevaluation is recommended. This is ordered today. She is in agreement with this. She will follow up after same. Further treatment options to be discussed at that time.	
04/11/YYYY	Hospital/Provider Name	**MRI of left knee:** **History**: Left knee pain, motor vehicle accident April YYYY. Patient has had knee surgery in October of YYYY. Pain medial and laterally with swelling. The knee locks up and gives out. **Findings**: Bone marrow signal: There is noted some stress edema involving the medial tibial plateau with areas of sclerosis and subcortical cyst formation. Image 10 series 6, image 10 series 5. There is subcortical cyst formation/stress edema involving the patella centrally Image 9 series 2. **Joint fluid**: There is a physiologic amount of joint fluid. **Articular cartilages:** Medial compartment cartilage shows areas of cartilage loss up to 50%. Lateral joint compartment cartilage shows mild areas of cartilage loss less	1610-1612, 1613-1625

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		than 50% Patellofemoral compartment shows mild areas of cartilage loss less than 50%. **Quadriceps and patellar tendons**: Intact **Cruciate ligaments**: Intact. **Collateral ligaments**: Intact. **Menisci**: The posterior ham of the medial meniscus apex is blunted, reference image 15 series 4. There is abnormal linear signal in the posterior horn image 16 series 4 which extends to the intra-articular surface. Findings are compatible either with meniscal tear or post-meniscectomy change. Clinical correlation is suggested. Lateral meniscus is intact. **Impression**: • Abnormal posterior horn medial meniscus consistent with meniscal tear versus post-meniscectomy change. • There is noted some stress edema and sclerosis involving the medial tibial plateau.	
04/20/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** Patient is here today for follow-up and reevaluation of left knee. Patient was last seen in January YYYY where she was recovering nicely from left knee arthroscopy and partial meniscectomy. She notes recently the knee started hurting again without injury or trauma. She states pain is primarily medial in nature. She complains of giving way sensation. She denies swelling. She recently completed an MRI scan. **Physical exam:** **Musculoskeletal:** Full extension to 120 degrees of flexion. There is no effusion. There is tenderness along the medial and lateral joint line. There is tenderness about the patella femoral joint. There is no crepitus with range of motion. The knee is otherwise stable. **Data**: MRI of the left knee demonstrates some stress edema involving the medial tibial plateau with areas of sclerosis and subcortical cyst formation. Also noted are findings compatible with post meniscectomy change. **Impression**: Left knee pain from bone marrow edema at the medial tibial plateau with subcortical cyst formation **Plan**: Treatment options are discussed with the patient. Ultimately she really	1626-1647

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		needs to unload force at that knee. She will try to remain non-weight bearing with crutches for 2 months. She was given a genutrain knee sleeve which provided some relief. All questions are answered. Follow-up in 2-3 months.	
04/26/YYYY	Hospital/Provider Name	**Correspondence report:** This report summarizes the care I have provided for Ms. XXXX related to a left knee injury sustained in an automobile accident on April 15, YYYY. The opinions in this report are made to a reasonable degree of medical and orthopedic surgical probability. As you know, Ms. XXXX is a pleasant 48-year-old woman who was a restrained driver when she was hit from behind by another motor vehicle on April 15, YYYY. In the accident, her left knee struck the car door. In addition, her knee twisted to some extent because her foot was planted against the floor. She noted immediate left knee pain following the accident. She reported no history of injury or problems to the left knee prior to the accident. I first evaluated Ms. XXXX injury on October 3, YYYY. Prior to seeing me, she had had treatment with Dr. XXXX, who had given her a cortisone injection, which provided her temporary relief. She has also undergone other conservative treatment including oral anti-inflammatory medications and therapy exercises prior to seeing me. An MRI scan of the left knee was performed at CDI On August 8, YYYY was notable for tearing of the medial meniscus, as well as chondromalacia in the patellofemoral compartment and medial compartment of the knee. Swelling in the tibia bone adjacent to the left knee was noted on the initial MRI scan. Based on her continued symptoms, despite conservative treatment, my recommendation was left knee arthroscopy with partial medial meniscectomy. I performed this surgery on October 26, YYYY. Surgery was uncomplicated. Her postoperative course was routine. She was referred for physical therapy. She was having improvement at her office visit on January 12, YYYY. However, she returned with complaints of increasing pain in the knee recently on April 6, YYYY. I ordered a new MRI scan which was performed April 11, YYYY. This study has shown interval increased swelling in her proximal tibia bone consistent with a stress reaction or mild stress fracture. This appears worse than it did on the previous MRI scan. My recommendation has been to protect her knee by implementing a non-weight bearing restriction for 8 weeks. She is scheduled to see me back for clinical follow-up in June YYYY. In my opinion, patient's left medial meniscus tear was a direct result of the motor vehicle accident on April 15, YYYY. In addition, the accident has caused aggravation of pre-existing chondromalacia in her knee. My basis	1657-1659, 1648-1656, 1660-1666

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		for this opinion is she did not have any symptoms or problems with the left knee prior to the accident. The accident was more likely than not a substantial factor in causing an aggravation of these conditions. Her treatment is ongoing, therefore I am unable to opine as to whether these conditions will be permanent. I am concerned that the swelling in her bone is a sign of progression of her chondromalacia in her knee and worsening degenerative and arthritic change. This may progress to a permanent condition, but I am unable to determine that until I see her back to check her clinical progress. Presently, these injuries continue to affect her quality of life and her occupation. Due to her weight bearing restriction it limits her ability to enjoy her current occupation as she is on a weight bearing restriction with a walker. I anticipate we will discontinue the weight bearing restriction when I see her back in June, but I am unable to determine if she will have any permanent limitations or restrictions at this time. She does require continued care for her left knee at this time. Anticipate she will need additional physical therapy after the current weight bearing restrictions are lifted. Again, I am concerned she is having a progression of knee arthritis. Further treatments may include cortisone injections, hyaluronic acid injections, bracing, and possibly a total knee arthroplasty. The opinions in this report are made to a reasonable degree of medical and orthopedic surgical probability today.	
05/02/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain and anxiety:** **Chief complaint**: Follow up from St. XXXX and form. **History of present illness:** Pain = 8/10 Intensity left knee Request consultation by specialist since last visit surgeon for left knee Left knee stress fracture and cyst: worse than before surgery 10/27/16. Crutches x 2 months and recheck with Dr. XXXX. Having a lot of pain; making her feel more depressed due to inactivity. **Current medication** • Effexor XR 75 mg capsule, extended-release 24 hour, take one daily, 30 days, 6 refills • Meloxicam 15mg oral tablet take 1 by mouth every day. Take I tablet by mouth every day with food. **Physical exam:** **Left knee**: Tenderness to palpation. **Assessment**	1080-1082

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• Anxiety (Anxiety disorder, unspecified) • Closed stress fracture of left tibia (Stress fracture, left tibia, subsequent encounter for fracture with routine healing) **Plan**: • Anxiety disorder, unspecified • Medical Consult; Behavioral Health • Medication list reviewed: no changes needed/reported by patient • Obtain and evaluate previous medical records ortho: Dr. XXXX. • Follow-up visit 6/28 with ortho and couple weeks later with me	
06/29/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** **Chief Complaint:** Left knee pain. Patient injured her left knee in a motor vehicle accident in April YYYY resulting in a left knee medial meniscus tear and aggravation of arthritis. She underwent arthroscopic partial meniscectomy October 26, YYYY. She's had continued complaints of medial and lateral sided knee pain. Follow-up MRI scan after surgery demonstrated edema in her medial, proximal tibial plateau. In addition, moderate chondromalacia in the medial and lateral compartments were noted. I have placed her on crutches for the last several weeks to try to settle this down. She has not had any improvement in her symptoms. She continues to have swelling and pain in the knee. **Physical Exam**: Left knee has a small effusion. Tenderness is present at both the medial and lateral femoral condyle areas, worse medially. Range of motion 0-125". Strength maintained with resisted knee flexion and extension. The knee is ligamentously stable. Alignment is neutral. The calf is nontender. Sensation and circulation is normal about the foot and ankle. **Diagnostic Testing**: None today **Assessment**: Motor vehicle accident resulting in a left knee medial meniscus tear and aggravation of left knee primary, localized osteoarthritis. **Plan**: At this recommend we try an offloading brace. She was measured for him today, and this will be ordered and fit when it comes in. I offered a repeat a cortisone injection but she declined. Lubricant injections may be an option as well. If she has continued symptoms, she may be a candidate for total knee replacement. I will see her back in 4 weeks for clinical check.	1667-1684
07/17/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** **Chief Complaint:** Left knee pain. Patient injured her left knee in a motor vehicle accident in April YYYY resulting in a left knee medial meniscus tear and aggravation of arthritis. She underwent arthroscopic partial meniscectomy October 26, YYYY.	1685-1700

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		She's had continued complaints of medial and lateral sided knee pain. Follow-up MRI scan after surgery demonstrated edema in her medial, proximal tibial plateau In addition, moderate chondromalacia in the medial and lateral compartments were noted. I have placed her on crutches for the last several weeks to try to settle this down. She has not had any improvement in her symptoms. She continues to have swelling and pain in the knee. We have ordered a customize unloader brace for her. She comes in for fitting of that today. She is still using crutches due to the pain. She continues to have swelling in the knee. **Physical Exam:** Left knee has a small effusion. Tenderness is present at both the medial and lateral femoral condyle areas, worse medially. Range of motion 0-125'. Strength maintained with resisted knee flexion and extension. The knee is ligamentously stable. Alignment is neutral. The calf is nontender. Sensation and circulation is normal about the foot and ankle. **Diagnostic Testing**: None today. **Assessment**: Motor vehicle accident resulting in a left knee medial meniscus tear and aggravation of left knee primary, localized osteoarthritis. **Plan**: She was fitted for the unloader brace today. She is instructed how to don and doff the brace. I offered a repeat a cortisone injection but she declined. Lubricant injections may be an option as well. Meloxicam refill provided today. She has continued symptoms, she may be a candidate for total knee replacement. I will see her back in 4 weeks for clinical check.	
08/14/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** **Chief Complaint:** Left knee pain. Patient injured her left knee in a motor vehicle accident in April YYYY resulting in a left knee medial meniscus tear and aggravation of arthritis. For brief review of her history, she underwent arthroscopic partial meniscectomy October 26, YYYY. She's had continued complaints of medial and lateral sided knee pain. Follow-up MRI scan after surgery demonstrated edema in her medial, proximal tibial plateau. In addition, moderate chondromalacia in the medial and lateral compartments were noted. At last visit we fitted her for an unloader brace. She is feeling better. She does still have medial sided knee pain. She is ambulating with a cane. **Physical Exam**: She ambulates with a slight limp using her cane. Her unloader brace is fitting appropriately today. Left knee has a small effusion. Tenderness is present at both the medial and lateral femoral condyle areas, worse medially. Range of motion 0-125°. Strength maintained with resisted knee flexion and extension. The knee is ligamentously stable. Alignment is	1092-1093, 1701-1714

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		neutral. The calf is nontender. Sensation and circulation is normal about the foot and ankle. **Diagnostic Testing**: None today. **Assessment**: Motor vehicle accident resulting in a left knee medial meniscus tear and aggravation of left knee primary, localized osteoarthritis. **Plan**: She will continue using the unloader brace. We discussed repeating a cortisone injection versus trying lubricant injections. She will continue meloxicam as needed. If she has continued symptoms, she may be a candidate for total knee replacement. I will see her back in 2 months for clinical check.	
09/14/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain and anxiety:** **Chief complaint:** Follow up. **History of present illness:** Pain = 5/10 Intensity left knee A previous emergency room visit since last visit 09/03/17 St. XXXX Left knee pain persists after arthroscopic surgery, PT, brace: surgeon discussed joint replacement. She had 6 weeks PT and pain better with therapy: once it stopped pain recurred. She wanted to discuss the option of surgery. Brace doesn't seem to fit correctly: falls off: tender to touch. **Physical exam:** **Musculoskeletal System:** **Knee:** General/bilateral: Knees showed abnormalities left: mild palpation caused pain beyond expectation for light touch. Pain was elicited by motion of the knee. Appearance of the knees was normal. Left Knee: Examined. **Assessment**: • Anxiety [Anxiety disorder, unspecified] • Obesity [Other obesity due to excess calories] • Derangement of medial meniscus of left knee due to old tear/injury (Derangement of other medial meniscus due to old tear or injury, left knee) **Therapy**: Transition in care, clinical summary provided. **Plan**: Other specified anxiety disorders	1076-1079

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Effexor XR 75 mg CP24, take one capsule by mouth every day, 30 days, 0 refills Derangement of medial meniscus due to old tear/injection, left knee **Therapy/Physical Therapy:** PT Knee **Instructions**: Internal PT/OT Referrals: Patient has an h/o chronic pain disorder. Her ortho states he has tried all options and suggests perhaps she needs a knee replacement. I urged her to lose wt if possible, and pursue therapy. Referring to nutrition Diclofenac Sodium 75 mg TBEC, take 1 by mouth 2 times daily prn pain: not to be used daily: alternate with Tylenol if using more regularly, 30 days, 1 refills Medication list reviewed: no changes needed/reported by patient Return to the clinic if condition worsens or new symptoms arise Continue current medication Follow-up visit **Practice management**: Standardized depression screening: negative for symptoms per MA screening- During the past month, has not often been bothered by feeling down, depressed or hopeless and negative for symptoms per MA screening: During the past month has not often been bothered by little interest or pleasure in doing things.	
10/16/YYYY	Hospital/Provider Name	**Follow-up Visit for left knee pain:** **Chief Complaint:** Left knee pain. Patient injured her left knee in a motor vehicle accident in April YYYY resulting in a left knee medial meniscus tear and aggravation of arthritis. For brief review of her history, she underwent arthroscopic partial meniscectomy October 26, YYYY. She's had continued complaints of medial and lateral sided knee pain. Follow-up MRI scan after surgery demonstrated edema in her medial, proximal tibial plateau. In addition, moderate chondromalacia in the medial and lateral compartments were noted. She has been using an un-loader brace occasionally. She is actually feeling better since I saw her last. She continues to take oral Diclofenac house prescribed by her PCP. She is no longer having knee pain. She is no longer using a cane. **Physical Exam:** She ambulates without a limp. Left knee has a trace effusion. No tenderness at the medial note lateral joint lines. Range of motion 0-130°. Strength maintained with resisted knee flexion and extension. The knee is ligamentously stable. Alignment is neutral. The calf is non tender. Sensation and circulation is normal about the foot and ankle.	1715-1728

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Diagnostic Testing: None today. **Assessment**: Motor vehicle accident resulting in a left knee medial meniscus tear and aggravation of left knee primary, localized osteoarthritis. **Plan**: She is clinically improved at this point. I think she would benefit from continued Diclofenac as needed. She may use the unloader brace as needed. Follow-up with me as needed.	

Other records:

Duplicate records, orders, fax sheets, legal documents, consents, patient's information, face sheet

PDF Ref: 1, 103-106, 121-123, 132-133, 329, 346-347, 394-395, 407, 426-428, 446-448, 491-493, 512-516, 1034, 1075, 1097, 1201-1231, 1324, 1348, 1367, 1454-1459, 1579-1580, 1471-1504, 1505-1509

***Reviewer's Comments:** All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*