

THE STATE OF SOUTH CAROLINA
In The Supreme Court

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APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

S.C. Supreme Court

Avery B. Wilkerson, Appellate Panel Chairman, Commissioner

WCC File No.: 0818219
Ct. App. Case No.: 2011196087
Sup. Ct. Case No.: 2013001174

JOE OSMANSKI, EMPLOYEE,

PETITIONER,

V.

WATKINS & SHEPARD TRUCKING, INC.,
EMPLOYER, AND ZURICH NORTH AMERICAN
INSURANCE COMPANY, CARRIER,

RESPONDENTS,

APPENDIX
Volume 2 of 2

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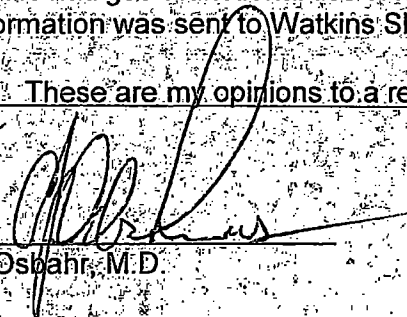
INDEX

IV. MEDICAL REPORTS	
Medical Records of Dr. Albert Osbahr dated 11/5/09	394
Questionnaire of Dr. Larry Chidgey dated 4/3/09	395
Medical Records of Dr. Larry Chidgey dated 1/12/09-5/14/09	397
Medical Records of Dr. Larry Chidgey dated 10/30/06	406
Employee History Form of Respondent dated 1/31/07-11/1/08	409
Correspondence from Respondent dated 1/30/07-11/24/08	410
Medical Records of Dr. Gerald Shealy dated 5/21/09-8/25/09	414
Operative Note of Dr. Gerald Shealy dated 7/8/09	421
Medical Records of Shands Hospital dated 1/12/09-2/23/09	423
Diagnostic report dated 11/2/08	432
Medical Records of Dr. John Fisher dated 10/22/08-11/13/08	433
Medical Records of Dr. James Bethea dated 12/23/08	435
Medical Records of Lexington Orthopaedics dated 11/6/08-12/15/08	437
Medical Records of Dr. Larry Chidgey dated 8/5/88-11/1/01	440
Questionnaire of Respondent dated 10/30/06	447
Medical Examination by Respondent dated 10/30/06	448
Medical Records of Dr. Larry Chidgey dated 1/10/01-3/22/02	449
Medical Records of Dr. John Fisher dated 10/22/08-11/13/08	452
Medical Records of Lexington Medical Center dated 11/2/08-11/4/08	453
Medical Records of Lexington Orthopaedics dated 11/6/08-11/20/08	463
Medical Records of Dr. Larry Chidgey dated 2/19/92-1/14/02	465
Medical Records of Shands Hospital dated 8/23/88-11/2/01	485
Medical Records of Dr. James C. McIntosh dated 11/5/08	504
Medical Records of Dr. John H. Fisher dated 10/22/08-11/13/08	505
Medical Records of Dr. Larry Chidgey dated 2/19/92-3/22/02	506
Medical Records of Shands Hospital dated 8/23/88-11/2/01	529
Medical Examination Report dated 10/30/06	548
Affirmative Action Program-undated	549
Guidelines of Respondent-undated	550
Life Care Services Job Analysis-undated	558
V. PROOF OF SERVICE	561

To whom it may concern:

I conducted a medical evaluation of Joseph Osmanski at the request of Watkins Shepard Trucking, LLC, on October 30, 2006. I noted on the evaluation form that there was an abnormality of Mr. Osmanski's left arm. My evaluation of his left arm revealed he was limited in supination to only 90 degrees, with 180 degrees being normal. His pronation was ok. He had good functional use of his left arm. Therefore I certified his ability to work. This information was sent to Watkins Shepard Trucking, LLC.

These are my opinions to a reasonable degree of medical certainty.


Al. Osbahr, M.D.

11/6/09
Date

**George
Sink, P.A.****INJURY LAWYERS****www.sinklawn.com**240 Stoneridge Drive
Suite 402
Columbia, SC 29210
FAX: 803-929-1811
803-929-1920Paula Howker Amick
E-mail: pamick@sinklawn.com

April 3, 2009

VIA FACSIMILE AND FIRST CLASS MAIL 352-273-7293

238962.20

Dr. Larry K. Chidgey
University of Florida Physicians
3450 Hull Road
P.O. Box 112727
Gainesville, FL 32611RE: Joseph A. Osmanski vs. Watkins Shepard Trucking/Zurich American Insurance
Company
WCC File Number : 0818219
Date of Incident : 11/1/2008
Our File Number : 238962.20

Dear Dr. Chidgey:

As discussed with your office, we represent Mr. Osmanski in his claim arising from a work-related injury on or about November 1, 2008. We appreciate you kindly agreeing to respond to the following for purposes of presenting our client's claim at an upcoming hearing before the South Carolina Workers' Compensation Commission:

1. I previously treated Mr. Osmanski for a left elbow joint replacement, pursuant to a previous injury which occurred over ten years ago.

Yes ☒ No ☐

2. After his release, and pursuant to my recommendations, Mr. Osmanski gradually returned to activities, as *tolerated*, including employment which required him to use and lift with his left arm.

Yes ☒ No ☐

3. Based upon Mr. Osmanski's history and prior records, he had been functioning well and was able to perform all the tasks required of him in his new position as a driver, including duties which required him to load and unload freight.

Yes ☒ No ☐

4. Based upon his history and medical records, but for the unusual event of the heavy weight falling unexpectedly on to his left arm, damaging the joint replacement itself, Mr. Osmanski would have undoubtedly been able to continue his work activities for the employer, as he had for the two years prior to this work-related injury on or about November 1, 2008.

Yes ☒ No ☐

Dr. Larry K. Chidgey
April 3, 2009
Page 2 of 2

1. Mr. Osmanski is in need of additional medical treatment to include

new total elbow replacement

The above responses represent my opinions to a reasonable degree of medical certainty.

4/14/09
Date

Dr. Larry K. Chidgey

Thank you for your assistance in this matter.

Sincerely,

Christina Logan for
Paula Howker Amick
Attorney at Law

Vcl
Enclosure

cc: Joseph Osmanski

UNIVERSITY OF
FLORIDA
PHYSICIANS

UF Orthopedics and Sports Medicine Institute 396
3450 Hun Road, P.O. Box 112733
Gainesville, FL 32611-2733
Clinic: (352) 273-7001 • Fax (352) 273-7295

Work Limitations/Release

Faxed To: _____ Date Faxed 5-14-09
Faxed By: Margie Adjuster's Name 803 894-7661 Fax #
Attending Physician: Chidgey Dell Sahajpal Wright
PATIENT'S NAME: Osmanchi Joseph MARN # 675885 DATE OF SERVICE: 5-14-09

DIAGNOSIS: _____
The above employee was examined and has been classified as follows as of this examination date:

- ☒ Temporarily not recommended for employment.
Estimated date of return to work _____
☐ Employable (full duty) with no restrictions.
May return to work on _____
☐ Employable (light duty) with limitations as follows: _____
☐ May return to work on _____
☒ No use of left hand.

Copies to: Employee and Employer
Employee's date of next appointment: _____

RESTRICTIONS FOR RIGHT / LEFT HAND

- ☐ Can use involved hand as minimal helping hand.
☐ Must wear splint / cannot get hand wet or dirty.
☐ No heavy lifting with hand. Limited to _____ pounds.
☐ No high resistance pinching, pulling, pushing, gripping or twisting activities with hand.
☐ No vibratory tools.
☐ Restrictions for _____ days / weeks / months.
☐ Specific restrictions: _____
☐ No overhead reaching.

ORTH-44-08C



UNIVERSITY OF FLORIDA

OSMANSKI, JOSEPH ARTHUR
STH # 00675885

UF Orthopaedics and Sports Medicine Institute
UF Orthopaedic Clinic

3450 Hull Road
P.O. Box 112733
Gainesville, FL 32611-2733
Clinic (352) 273-7001
Fax (352) 273-7295

SHANDS at UF CLINIC

04/01/2009

DIAGNOSIS: His left history of left total elbow arthroplasty.

Mr. Osmanski returns to clinic today. When he was last seen it was for concern for infection, we obtained lab values. His lab values were within normal limits. However, the patient continues to have an increased amount of pain. He is unable to actively flex his left arm secondary to pain and weakness. The patient does have passive flexion but there is no active flexion noted. On radiographic examination there is radiolucency around the humeral stem.

ASSESSMENT: Loose prosthesis.

PLAN: Our plan will be to take the patient for a revision left total elbow arthroplasty. In addition, we would explore the anterior aspect to exam if he has had any ligamentous disruption of his elbow flexors. There is concern for this since the patient has no active flexion and does have passive flexion. We will see the patient back when we can schedule this.

I saw and evaluated this patient. I discussed the patient with the resident and agree with the findings and plan as documented in the above note.

Electronically Reviewed and Signed by
Larry K. Chidgey, M.D. 04/13/2009 21:32
Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: John D. McCormick, MD
/MDQ 04/01/2009:04/01/2009 4:16 P
UDN: 4156068 Job ID# 004335729

cc:

*



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FLORIDA

OSMANSKI, JOSEPH ARTHUR
STH # 00675885

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Fax (352) 273-7295

SHANDS at UF CLINIC
02/23/2009

The patient returns for followup of his elbow. He is not making any progress and the pain is substantial. I think we need to check some lab work and make sure there is nothing going on with that. We will see him back after the infection studies are complete. We may then need to move forward with a revision.

Electronically Reviewed and Signed by
Larry K. Chidgey, M.D. 03/02/2009 08:46
Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.
LKC/MDQ: 02/23/2009-02/23/2009 9:23 A
UDN: 4103264 Job ID# 004278127

cc:

*



UNIVERSITY OF FLORIDA

OSMANSKI, JOSEPH ARTHUR
STH # 00675885

UF Orthopaedics and Sports Medicine Institute
UF Orthopaedic Clinic

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SHANDS at UF CLINIC

01/12/2009

The patient returns having had an injury to his left elbow. He has an implant that is in and he right now is having a lot of pain in the elbow. X-rays are unclear as to whether or not he has disrupted the implant. I would like to just have things settle down for the next few weeks in a brace and repeat x-rays in about four weeks of the left elbow. He may have even cracked through the humerus. On some of the views it looks like that may be the case.

Electronically Reviewed and Signed by
Larry K. Chidgey, M.D. 01/22/2009 09:15
Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.
LKC/MDQ 01/12/2009 01/12/2009 11:53 A
UDN: 4045561 Job ID# 004215757

cc:

UNIVERSITY OF FLORIDA PHYSICIANS

UF Orthopaedics and Sports Medicine Institute
UF Orthopaedic Clinic

NAME: Joseph Osman

Date 1/12/01

MRN 675685

Date of Injury: 12/1/05

Are you a Student ☐ Yes ☒ No Attending What School?

Daytime Phone: 783-687-0866

Email Address: ozzieplus@aol.com

General: ☒ Male ☐ Female Date of Birth

Age: 44

Race: ☐ Caucasian ☐ African-American

☐ Hispanic

☐ Asian

☐ Other

HEALTH HISTORY OF PATIENT

☒ No change from prior visit

	Yes	No
Alcoholism	☐	☒
Anemia	☐	☒
Arthritis	☐	☒
Asthma	☐	☒
Birth Defects	☐	☒
Bleeding Disorders	☐	☒
Cancer	☐	☒
Diabetes	☐	☒
Depression/Mental Problems	☐	☒
Glaucoma	☐	☒
Gout	☐	☒
Heart Disease	☐	☒
High Blood Pressure	☐	☒
Kidney Disease	☐	☒
Liver Disorder	☐	☒
Breathing/Lung Problems	☐	☒
Osteoporosis	☐	☒
(Low bone density)	☐	☒
Phlebitis/Blood Clots in	☐	☒
Legs or Lungs	☐	☒
Seizures/Epilepsy	☐	☒
Sickle Cell Anemia	☐	☒
Stroke	☐	☒
Thyroid Problem	☐	☒
Tuberculosis	☐	☒
Ulcers	☐	☒
Other Illnesses	☐	☒

Explain all Yes answers

PREVIOUS SURGERIES

☐ Appendix	☐ Breast
☐ Colon	☐ Gall Bladder
☐ Heart	☐ Hernia (repair)
☐ Kidney	☐ Ovaries
☐ Prostate	☐ Small Intestine
☐ Stomach	☐ Thyroid
☐ Tonsils	☐ Uterus
☐ Extremity:	
☒ No Surgery since last visit	
Other Surgeries:	

FAMILY HISTORY

☒ No change from prior visit

	Yes	No
Blood clots in legs or lungs	☐	☒
Heart Disease	☐	☒
High Blood Pressure	☐	☒
Diabetes	☐	☒
Arthritis	☐	☒
Kidney Disease	☐	☒
Cancer	☐	☒
Bleeding Disorders	☐	☒
Osteoporosis (low bone density)	☐	☒
Complications from Anesthesia	☐	☒

Explain all Yes answers:

Age/Cause of death of parents, brothers or sisters (only if younger than age 45 at time of death):

SOCIAL HISTORY

Most Recent Occupation

Are you currently employed? ☒ Yes ☐ No

What type of work? TRUCK DRIVER

☒ Married ☐ Single ☐ Widowed

Number of Children Living 9

Number of Pregnancies

Presently Living Alone? ☐ Yes ☒ No

☐ Non-Smoker ☒ Smoke

Quit (when?) _____
Smoke(d) 1 packs per day for _____ years.

☐ Beer/Wine _____ drinks per week

☐ Shots of liquor _____ shots per week

☐ Other drug use

REVIEW OF SYSTEMS

Have you recently or do you now have:

	Yes	No
☒ No to all	☐	☐
Anxiety	☐	☐
Recent vision change	☐	☐
Recent loss of hearing	☐	☐
Difficulty swallowing	☐	☐
Unplanned weight loss	☐	☐
Toothache/Bleeding Gums	☐	☐
Nausea or Vomiting	☐	☐
Shortness of breath	☐	☐
Fever	☐	☐
Chest pain	☐	☐
Heart Problems	☐	☐
Bowel or Bladder problems	☐	☐
Leakage of bowel or bladder	☐	☐
Numbness or tingling	☐	☐
Weakness	☐	☐
Bleeding problems	☐	☐
Frequent Headaches	☐	☐
Insomnia	☐	☐

Sleep is limited by:

Explain all Yes answers:

Women:

Irregular periods	☐	☐
Frequent spotting	☐	☐
Are you Pregnant?	☐	☐
Are you Nursing?	☐	☐

For Office Use Only

Vitals

Ht. _____ Wt. _____

Resp. _____ Pulse _____

BP _____ Temp _____

Physician Signature

Date

ORTH-10-072

Patient Name: _____ Soc. Sec. #: _____ DIA: _____ Visit/Review Date: _____

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical findings. *Functional limitations and restrictions do not necessarily equate to an automatic limitation or restriction in function.*

- ☐ 21. No functional limitations identified or restrictions prescribed as of the following date: _____
- ☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____ *Use additional sheet if needed.*
- ☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part: _____ *Use additional sheet if needed.*

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist > overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐ Other			

NO USE (L) (R) (B) (H) (F) (A) (C) (D) (E) (G) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)

COMMENTS:
Other choices: Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. Specify those functional limitations and restrictions, in item 23, which are permanent if MMI / PIR have been assigned in item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: _____ ☐ b) NO ☐ c) Anticipated MMI date: _____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) Yes ☐ f) No
 Comments: _____

25. % Permanent Impairment Rating (body as a whole) _____ Body part/system: _____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):

- ☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?

- ☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: _____

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Physician Group: _____ Date: 1/12/09
 Physician Signature: _____ Physician DOH License #: _____
 Physician Name: Dr. C. Chidez (print name) Physician Specialty: Orthopedics

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ Provider DOH License #: _____
 Provider Name: _____ (print name) Date: _____

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date: 1/12/09	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name: Osmanski, Joseph	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name:	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:

☒ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.

☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date

If YES or UNDETERMINED, explain:

12. Diagnosis(es):

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.

a) Is there a pre-existing condition contributing to the current medical disorder?

☐ a) NO ☐ a) YES ☐ a) UNDETERMINED as of this date

b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?

☐ b) NO ☐ b) exacerbation ☐ b) aggravation ☐ b) UNDETERMINED as of this date

c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?

☐ c) NO ☐ c) YES

d) Given your responses to the items above, is the injury/illness in question the major contributing cause for:

☐ d) NO ☐ d) YES the reported medical condition?
☐ d) NO ☐ d) YES the treatment recommended (management/treatment plan)?
☐ d) NO ☐ d) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III - Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV.

☐ 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV.

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.

~~THIS IS PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICE~~

☐ a) Consultation with or referral to a specialist. Identify principal physician:

Identify specialty & provide rationale:

☐ a) CONSULT ONLY ☐ a) REFERRAL & CO-MANAGE ☐ a) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify)

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:

☐ c) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.

☐ c) Physical Reconditioning (Level II Patient Classification)

☐ c) Interdisciplinary Rehabilitation Program (Level III Patient Classification)

Specific instruction(s):

☐ d) Pharmaceutical(s) (specify):

☐ e) DME or Medical Supplies:

☐ f) Surgical Intervention - specify procedure(s):

☐ f) In-Office:

☐ f) Surgical Facility:

☐ f) Injectable(s) (e.g. pain management):

☐ g) Attendant Care:

fax 706-465-086

Current problem

Reason for Today's Visit: elbow pain

Is visit due to Injury or Accident? ☒ Yes ☐ No

Injury date: 1/1/08 Surgery Date: 1/1/08

Referring physician: _____

How did it happen? Arthritic

What treatment or tests have you had for this current problem?

☐ Chiropractic treatment: # of visits: _____

☒ Xrays ☐ MRI ☐ CT scan ☐ EMG

☐ Other diagnostic tests: _____

☐ Surgery

☐ Injection

☒ Splinting/Bracing

☐ Massage Therapy: # of visits: _____

☐ Physical Therapy

☐ Occupational Therapy

What activities make your pain worse? Morning

What activities make your pain better? Keep it in sleep

How far can you walk? _____

What stops you? _____

When are your problems most severe?

☐ Morning

☐ Afternoon

☐ Evening

☒ Consistent all day

What is your normal sleeping position?

☐ Stomach

☒ Side/lying

☐ Back

Have you had this problem before?

☐ Yes

☒ No

If yes, then when _____

Previous treatment?

☐ Yes

☐ No

If yes, then what _____

Exercise prior to this problem:

Regularly?

☒ Yes

☐ No

What/how often? _____

Are your complaints affecting your ability to exercise or generally be active?

☒ Yes

☐ No

Additional questions:

☐ Yes ☒ No Do you frequently feel pain in your chest or heart?

☐ Yes ☒ No Do you know of any other reason why you should not do physical activity?

Your current pain:

Indicate on the diagram below the location and nature of your current pain according to the following symbols:
Do not indicate areas of pain which are not related to your present problem:

Pain location/quality: (indicate on diagram)

x x x Dull/aching pain ^ ^ ^ Sharp pain

+ + + Pins and Needles = = = Numbness

Pain Rating: On a scale of zero to ten

0 (zero) being no pain

10 (ten) being the worst pain imaginable

How would you rate the intensity of your pain?

Now 0 1 2 3 4 5 6 7 8 9 10

Worst Day 0 1 2 3 4 5 6 7 8 9 10

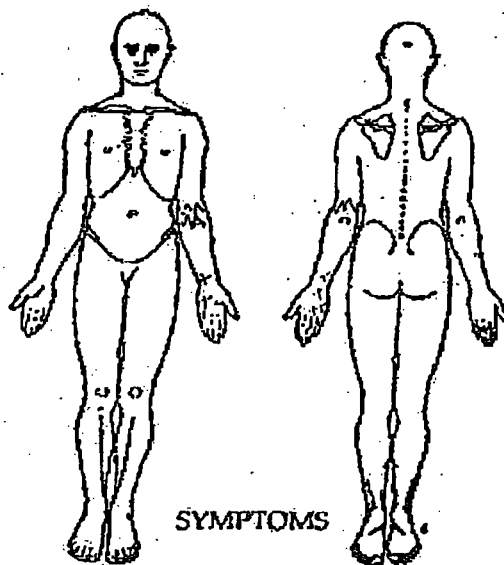
Best Day 0 1 2 3 4 5 6 7 8 9 10

How stressful is the pain you are feeling?

Now 0 1 2 3 4 5 6 7 8 9 10

Worst Day 0 1 2 3 4 5 6 7 8 9 10

Best Day 0 1 2 3 4 5 6 7 8 9 10



Since this problem began is the problem:

☐ Increasing

☐ Decreasing

☒ Unchanged

Your goals for treatment are: _____

UNIVERSITY OF FLORIDA PHYSICIANS
Department of Orthopaedics and Rehabilitation

UF&Shands Orthopaedics and Sports Medicine Institute
Shands Hand and Upper Extremity Clinic
3450 Hull Road Gainesville, FL 32607

UF Physicians: (352) 273-7001
Shands Rehab: (352) 273-7005
Rehab Fax: (352) 273-7327

Referral Information

Date

Patient's Name

MRN

Referring Physician

Diagnosis

Code

Comments/Precautions

Date of Surgery

Surgical Procedure

Frequency

Duration

If not stated, therapist will determine Frequency/Duration of Tx

OT and/or PT

Evaluate & Treat

Nerve Function/Sensation
R.O.M.
Strength
Manual Muscle Test
Functional Capacity Evaluation
Shoulder Pre-Op
Shoulder Eval: Specify
Other

Exercise

R.O.M.
Active
Active-Assisted
Passive
Resisted/Strengthening
A.D.L.
Myofascial Release
Other

Modalities

Hot/Cold
TENS
FES
Jobst Pump
CPM (specify)
Iontophoresis
Fluidotherapy
Paraffin
Other

Splinting

Static
Dynamic
Static Progressive
Serial Casting
Custom Ordered Dynamic
Other

Edema/Scar Management

Spenco Gel
Otoform
Silastic Gel
Massage/Release
Isotoner Glove
Coban
Other

My signature certifies this treatment is medically necessary based on the patient's treatment plan for the diagnosis/condition stated above.

Signature

Date

Physician License Number/UPRN

SMAN,SKI Joseph Arthur 9/24/14 192 ☐ F ☐ Follow Up 10/30/14

City, State, Zip Code Pelton SC 29103 Work Tel: (803) 341-1630 Driver License No: 100520508 License Class: ☒ A ☐ B ☐ C ☐ D ☐ Other SC

Home Tel: (803) 874-7111

HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver.

Any illness or injury in last 5 years?
 Head/Brain Injuries, disorders or illnesses
 Seizures, epilepsy
☐ Medication
 Eye disorders or impaired vision (except corrective lenses)
 Ear disorders, loss of hearing or balance
 Heart disease or heart attack (other cardiovascular condition)
☐ Hypertension
 Heart surgery (bypass, catheterization, angioplasty, pacemaker)
 High blood pressure ☐ Radiation
 Muscular disease
 Shortness of breath

YES NO
☐ 1. Lung disease, emphysema, asthma, chronic bronchitis
☐ 2. Kidney disease, dialysis
☐ 3. Liver disease
☐ 4. Digestive problems
☐ 5. Diabetes or elevated blood sugar controlled by:
☐ a. diet
☐ b. pills
☐ c. insulin
☐ 6. Nervous or psychiatric disorders, e.g., severe depression
☐ 7. Medication
☐ 8. Loss of, or altered consciousness

YES NO
☐ 9. Fainting, dizziness
☐ 10. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loss of energy
☐ 11. Stroke or paralysis
☐ 12. Missing or impaired hand, arm, foot, leg, finger, toe
☐ 13. Spinal injury or disease
☐ 14. Chronic low back pain
☐ 15. Regular, frequent alcohol use
☐ 16. Narcotic or habit forming drug use

YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

and the above information is complete and true, I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Signature: Joseph A. Osman Date: 10/30/14
 Driver's Signature Date

Examiners Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, over-the-counter medications, while driving. This discussion must be documented below.)

Smoker

VISION (Medical Examiner completes Section 3 through 7) Name: Last Osman First Joseph Middle Arthur

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye.
 The use of corrective lenses should be noted on the Medical Examiner's Certificate.
NOTES: When other than the Snellen chart is used, give test results in Snellen comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears glasses, or lenses to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obtained. Monocular drivers are not qualified.
 If readings must be provided:

Y	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
YE	20/20	20/20	Right Eye: 65°
E	20/20	20/20	Left Eye: 75°
YE	20/20	20/20	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing:
☐ Corrective Lenses
 Monocular Vision: ☐ Yes ☒ No

next line only if vision testing is done by an Ophthalmologist or Optometrist

Examination Name of Ophthalmologist or Optometrist (Print) Tel No. License No./State of Issue Signature

HEARING Standard: a) Must first perceive forced whispered voice at 5 ft., with or without hearing aid, or b) average hearing loss in better ear = 40dB
☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

NOTES: To convert audiometric test results from ISO to ANSI: -14 dB from ISO for 500 Hz; -10 dB for 1,000 Hz; -6.5 dB for 2,000 Hz. To average, add the midrange for 3 frequencies tested and divide by 3. All readings must be recorded.

Distance from individual at which whispered voice can first be heard	Right Ear	Left Ear	b) If audiometer is used, record hearing loss in decibels (see to ANSI Z24.5-1991)	Right Ear	Left Ear
	500 Hz: 00, 1000 Hz: 05, Average: 16.5	500 Hz: 20, 1000 Hz: 20, Average: 18.5			

BLOOD PRESSURE/PULSE RATE Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Systolic	Diastolic	Reading	Category	Expiration Date	Recertification
138	88	140-159/90-99	Stage 1	1 year	1 year if <140/90. One-time certificate for 3 months if 141-159/91-99.
		160-179/100-109	Stage 2	One-time certificate for 3 months	1 year from date of exam if <140/90
		>180/110	Stage 3	6 months from date of exam if <140/90	6 months if <140/90

LABORATORY AND OTHER TEST FINDINGS Numerical readings must be recorded.

is required. Protein, blood or sugar in the urine may be an indication for further testing to any underlying medical problem, noting (Describe and record)

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
	1.020	Trace	High	High

PHYSICAL EXAMINATION Height: 5'11" (in) Weight: 300 (lbs) Name: Last Osman First Joseph Middle Arthur

ence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible if the condition, if neglected, could result in more serious illness that might affect driving.
 18 If there are any abnormalities, check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been documented by a physician to the Medical Examiner for guidance.

SYSTEM	CHECK FOR:	YES	NO	SYSTEM	CHECK FOR:	YES	NO
Appearance of Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse	☒	☐	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, distended abdomen and muscle wastage	☐	☒
	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle tenderness, extraocular movement, nystagmus, anisocoria, and other abnormality, cornea, conjunctiva, sclera, lacrimal gland, and tear duct	☒	☐	8. Vascular system	Abnormal pulse and amplitude, carotid or aortic bruits, varicose veins, hemorrhoids	☐	☒
	Scarring of tympanic membrane, occlusion of external canal, perforated eardrum	☒	☐	9. Genito-urinary system		☐	☒
		☒	☐	10. Extremities/Limb	Loss or impairment of leg, foot, toe, arm, hand, finger, perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypostasis, incontinence, grasp and prehension	☐	☒

MEDICAL EXAMINATION REPORT FOR COMMERCIAL DRIVER FITNESS DETERMINATION

Wm. **Shepherd Truck** 840879

1. DRIVER'S INFORMATION Driver completes this section.

Driver's Name (Last, First, Middle) OSMANSKI Joseph Arthur Social Security No. 011111 Birthdate 1/2 Age 42 Sex ☒ M ☐ F ☐ New certification ☐ Recertification ☐ Follow Up ☐ Date of Exam 10/30/06

Address 1576140 Kt City, State, Zip Code Pelham, SC 29123 Work Tel: (803) 341-1530 Home Tel: (803) 874-7111 Driver License No. 100560508 License Class ☒ A ☐ B ☐ C ☐ D ☐ Other SC State of Iss. SC

2. HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver.

YES	NO	YES	NO	YES	NO
☒	☐	☒	☐	☒	☐
Any illness or injury in last 5 years?		Lung disease, emphysema, asthma, chronic bronchitis		Fainting, dizziness	
☒		☒		☒	
Head/Brain injuries, disorders or illnesses		Kidney disease, dialysis		Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	
☒		☒		☒	
Seizures, epilepsy		Liver disease		Stroke or paralysis	
☐		☒		☒	
Medication		Digestive problems		Numbness or impaired hand, arm, foot, leg, finger, toe	
☐		☒		☐	
Eye disorders or impaired vision (except corrective lenses)		Diabetes or elevated blood sugar controlled by:		Spinal injury or disease	
☒		diet		☐	
☐		insulin		Chronic low back pain	
Ear disorders, loss of hearing or balance		☒		☒	
☒		Nervous or psychiatric disorder, e.g., severe depression		Regular, frequent alcohol use	
☐		Medication		☒	
Heart disease or heart attack, other cardiovascular condition		☒		Narcotic or habit forming drug use	
☐		Loss of, or altered consciousness		☐	
Medication					
☒					
Heart surgery (valve replacement/bypass, angioplasty, pacemaker)					
☐					
High blood pressure					
☐					
Medication					
☐					
Shortness of breath					
☐					

For any YES answer, indicate onset date, diagnosis, treating physician's name with address, and any current limitation. List all medications (including over-the-counter medications) used regularly or as needed.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature Joseph A. Osmanski Date 10/30/06

Medical Examiner Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

Smoker

TESTING (Medical Examiner completes Section 3 through 7) Name: Last Osmanski First Joseph Middle Arthur

3. VISION Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio: 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/20	20/20	Right Eye 85
Left Eye	20/20	20/20	Left Eye 85
Both Eyes	20/20	20/20	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing:

☐ Corrective Lenses

Monocular Vision: ☐ Yes ☒ No

Complete next line only if vision testing is done by an Ophthalmologist or Optometrist

Date of Examination 10/30/06 Name of Ophthalmologist or Optometrist (print) Dr. [Signature] Tel No. [Blank] License No./State of Issue [Blank] Signature [Signature]

4. HEARING Standard: a) Must first perceive forced whispered voice ≥ 5 ft. with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB.

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded:		Right Ear		Left Ear	
a) Record distance from individual at which forced whispered voice can first be heard.	Feet	Feet	Feet	Feet	Feet

b) If audiometer is used, record hearing loss in decibels (acc. to ANSI Z24.5-1951)

5. BLOOD PRESSURE / PULSE RATE		Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.	
Blood Pressure	Systolic	Diastolic	Category
	138	88	Stage 1

Driver qualified if $\leq 140/90$.

Pulse Rate: ☒ Regular ☐ Irregular

Record Pulse Rate 60

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if $\leq 140/90$. One-time certificate for 3 months 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months	1 year from date of exam if $\leq 140/90$
$\geq 180/110$	Stage 3	6 months from date of exam if $\leq 140/90$	6 months if $\leq 140/90$

6. LABORATORY AND OTHER TEST FINDINGS Numerical readings must be recorded.

[illegible]

Employee History

19289

JOSEPH A OSMANSKI

Register #	Loss Date	Lost Days	Restricted Days	Category	Descriptions
142108	11/1/2008	0	0	Injury	Loss Desc: ZURICH MEDICAL ONLY - States breaking down freight Lazy Boy Chairs and reached for chair and it came down and he hyperextended his left elbow. Saw ER and will f/u with Ortho today 11/3/08
		Pending		Injury Desc:	ZURICH MEDICAL - States hyperextended left elbow. F/u with Orthopedic 11/3/08 regarding status.
0701AX08	7/1/2008			Report Only	Loss Desc: 10/31/06 Exp Conway, SC left turn - Driver states he caught a parked vehicle with his tailswing making a left turn into parking lot damaging mirror, and scraping/denting door and front qtr. Panel
		Preventable		Injury Desc:	
		\$5,185.44			
0131X07	1/31/2007			Report Only	Loss Desc: Driver states that he was turning right and hit a parked vehicle Loris, SC (P) \$135.30
		Preventable		Injury Desc:	
		\$135.30			



TRUCKING, INC.

November 24, 2008

CORPORATE OFFICE

N6400 Hwy 10 West

P.O. Box 5328

Missoula, MT 59806

Direct (406) 532-6461

Toll free (800) 548-8895 x 461

Direct fax (406) 532-6561

E-Mail glorya@wksh.com

Mr. Joseph Osmanski

Pelion, SC 29123

RE: FMLA Leave Certification

Dear Mr. Osmanski:

It is my understanding that you have been off work since November 1, 2008 as a result of a work related injury. Since Watkins and Shepard runs FMLA leave concurrently with work related injury leaves of absence, I thought it would be a good idea to provide you with the following information in writing.

The Family Medical Leave Act is one of many federal regulation guidelines we must follow. Under this Act an eligible employee may be entitled to a maximum of 12 weeks of unpaid leave in any consecutive rolling twelve months period due to FMLA-qualified reasons beginning with the date a qualifying leave is actually taken by the employee.

You are considered an eligible employee because you have been employed by Watkins and Shepard Trucking, Inc. for at least 12 consecutive months and may be deemed to be qualified for the leave because of a serious health condition that leaves you unable to perform the functions of your driving position. Your FMLA leave began November 1, 2008. The leave will be satisfied on January 24, 2009, if you are unable to return to work prior to that date.

Entitlements under a qualified FMLA leave include:

- Maintenance of active group health care plan participation. You may pay the monthly premium during the 12 weeks approved leave by sending a certified check or money order at the first of each month made payable to Watkins and Shepard Trucking in the amount of \$867.08 (\$455.68 for the health coverage; \$26.80 for the life coverage; and \$384.60 for the Flex Spending Account) or you can wait until you return to work and have the outstanding premiums deducted from your payroll in set increments for a short period of time until you are caught up.
- Rights to job and benefit restoration to the same or equivalent position upon returning from FMLA leave prior to the leave being satisfied.
- Protection from adverse action resulting from taking leave.

Page 2 – Joseph Osmanski

FMLA leave at Watkins and Shepard Trucking runs concurrently with other types of leave such as a workers compensation leave of absence.

While on FMLA leave you will not accrue personal leave (vacation) or holiday pay or any other employee benefits afforded to active employees.

FMLA leave is 'leave without pay'. However, we understand that you are receiving work comp lost time benefits while you recover.

If you would like more information regarding the Family Medical Leave Act, you will find it documented in your red Company Driver Policy Manual on pages 40 – 43.

Feel free to contact me if you have any questions regarding the provisions of the FMLA leave.

Sincerely,

Glory Blood*Artis, SPHR
Human Resources Manager

CC: Char Lewis, RN, Seamus Molloy, Benefits Specialist



TRUCKING, INC.

CORPORATE OFFICE
P.O. Box 5328
Missoula, MT 59807
Direct (406) 532-6462
Toll free (800) 548-8895
Direct fax (406) 532-6508
E-mail kristen@wsh.com

October 29, 2007

Josiah Osinski

Pelion, SC 29123

RE: SAFETY AWARD

Dear Joseph:

It is our pleasure to inform you that you have qualified for a 1 Year Watkins and Shepard Trucking Safe Driving Award. It is with sincere respect and admiration that we congratulate you.

We appreciate your professionalism and the fact that you have chosen to work with Watkins & Shepard Trucking. Thanks to you, Watkins and Shepard Trucking continues to grow and prosper, which in turn provides non-driving positions throughout our network. You are the heart of the operation.

Our business future includes you as a major contributor to our continued success. Your hard work and dedication is greatly appreciated. Keep up the good work!

Thank you.

Sincerely,

WATKINS AND SHEPARD TRUCKING INC.

Ray Kuntz, CEO



TRUCKING, INC.

CORPORATE OFFICE

N6400 Hwy 10 West

P.O. Box 5328

Missoula, MT 59806

Direct (406) 532-6461

Toll free (800) 548-8895 x 461

Direct fax (406) 532-6561

E-Mail glorya@wksh.com

January 30, 2007

JOSEPH A OSMANSKI

PELION SC 29123

Dear Joseph:

The Executive Safety Committee recently reviewed your work performance because you have completed your new hire 90 days driver probation.

The review revealed that your overall work performance meets the standards of Watkins and Shepard Trucking and you are now a regular member of our driving fleet.

Congratulations! You are a pleasure to work with. We appreciate the hard work and dedication you offer Watkins and Shepard Trucking, Inc. We are proud to have you associated with us.

Sincerely,

On Behalf of the Executive Safety Committee:

A handwritten signature in cursive script that reads "Glory Blood Artis". The signature is written in dark ink and is positioned above the printed name and title.

Glory Blood Artis
Human Resources Manager

Progress Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 09/18/09

ID: 1711436 SEX: M AGE: 44

08/25/09 00:00am

MUSC CHARLESTON HAND GROUP RETURN VISIT - WEST ASHLEY

GS1

08/25/2009: JOSEPH OSMANSKI

Orthopaedics Charleston Hand Group

Medical University of South Carolina

RETURN VISIT OFFICE NOTE

Mr. Osmanski is progressing satisfactorily. His wounds have healed on his left elbow following removal of the humeral component of the elbow prosthesis. The component has been reordered and has been manufactured, and he will be contacted as soon as it arrives and consideration of replacement undertaken at that time.

Gerald J. Shealy, MD

GS/am 567 1666045

SIGNED BY: GERALD J SHEALY, M.D. (GS1) 09/14/2009 11:40AM

Progress Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 09/18/09

ID: 1711486 SEX: M AGE: 44

08/03/09 00:00am

MUSC CHARLESTON HAND GROUP RETURN VISIT, WEST ASHLEY

GS1

08/03/2009 JOSEPH OSMANSKI

Orthopaedics Charleston Hand Group

Medical University of South Carolina

RETURN VISIT OFFICE NOTE

Mr. Osmanski is progressing satisfactorily. His wounds have healed to his left elbow. A new prosthesis is being fabricated for reinsertion, and this is discussed with him. Follow up for reevaluation in three to four weeks. He is given a refill on his pain medication.

Gerald J. Shealy, MD

GS/am:567:1637860

Progress Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 09/18/09

ID: 1711486

SEX: M AGE: 44

07/21/09: 00:00am

MUSC CHARLESTON HAND GROUP RETURN VISIT - WEST ASHLEY

GS1

07/21/2009 JOSEPH OSMANSKI

Orthopaedics Charleston Hand Group

Medical University of South Carolina

RETURN VISIT OFFICE NOTE

Mr. Osmanski is progressing well following removal of the humeral component of his right elbow prosthesis. His wounds are healing well. Sutures are removed. No evidence of any infection is noted, and the cultures in the operating room are negative. The possibility of replacement of the humeral component is discussed with him. Unfortunately, DePuy no longer make this particular type of prosthesis and it will need to be specially ordered. He is to resume his activities as tolerated and get medication for pain. Follow up for reevaluation in three to four weeks.

Gerald J. Shealy, MD

GS/am:567:1592969

Discharge/Op Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486

SEX: M AGE: 44

07/10/09 10:04pm

HOSPITAL DISCHARGE SUMMARY

OUT

Accession number: 18252297632

MUSC Medical Center

HOSPITAL DISCHARGE SUMMARY

Patient Name: OSMANSKI, JOSEPH A

MRN: 001711486

Patcom: 493129175

Admitted: 07/08/2009

Discharged: 07/10/2009

Service: Orthopedic Surgery

Attending: Gerald J. Shealy, MD

Referring:

HISTORY OF PRESENT ILLNESS: Mr. Osmanski is a 44-year-old male who presented after sustaining an injury to his left elbow and an injury at work, particularly in 1987. The patient reports he felt 32 feet and sustained a complex fracture to the left elbow, which he underwent surgical treatment. The procedures subsequently failed and in 2000, he underwent prosthesis to his left elbow at the University of Florida. He reports that the prosthesis offered him good relief of his symptoms and he was able to function normally for 9 years, returned to normal work activities until 11/08/2008, at which time, he attempted to lift a heavy object and reinjured his left elbow. Since that time, he reports persistent pain and was diagnosed as having a loosening of the prosthesis. He has undergone multiple procedures ulnar nerve transposition with no resolution of his symptoms. He presented to MUSC clinic for evaluation and consideration for treatment of loose prosthesis and revision of arthroplasty for definite treatment.

PAST MEDICAL HISTORY: Noncontributory.**REVIEW OF SYSTEMS:** None.**PAST SURGICAL HISTORY:** See HPI.**MEDICATIONS:** Lortab. No dose specified.**ALLERGIES:** Penicillin.**FAMILY HISTORY:** Noncontributory.**SOCIAL HISTORY:** Noncontributory.

HOSPITAL COURSE: Mr. Osmanski was taken to the OR on 07/07/2009. See dictated operative note for details of the procedure. The patient recovered in the PACU unit and transferred to the floor without complication. His postoperative course was dictated by the orthopedic postop protocol orders. He had SCDs placed bilaterally and TEDs?? His left arm was placed on _____ elevation. Weightbearing status postoperatively was nonweightbearing left upper extremity.

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Discharge/Op Notes**Page: 2**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486 SEX: M AGE: 44

Postoperative pain medication was managed by a PCA, transitioned to p.o. on postoperative day 1. On physical exam, his left upper extremity was resting on the pillow, not supporting weight. Dressing was overwrapped with an Ace bandage and clean, dry, and intact. The patient was unable to flex or extend his fingers or wrist secondary to nerve block placed intraoperatively. He had minimal sensation to light touch on fingertips in left upper extremity, brisk capillary refill, all compartments were soft. There was no pain on passive range of motion. Drain was productive of moderate sanguineous fluid. Neurovascular exams were _____ throughout his hospital stay, and the nerve block was noted to wear off and neurovascular exam returned to baseline with good sensation and movement. Occupational Therapy was consulted on the patient and followed him throughout the course of his hospital stay. He was placed in a left arm sling. The patient was meeting all therapy goals by the time of discharge. Mr. Osmanski was discharged on 07/10/2009 with a followup appointment with Dr. Shealy in 10-14 days. Weightbearing status on discharge, nonweightbearing left upper extremity.

DISCHARGE MEDICATIONS:

1. Bactrim DS 1 tablet p.o. b.i.d. x10 days
2. Percocet 5/325 mg one to two tablets p.o. q 4 hours p.r.n. pain
3. Ferrous sulfate 325 mg p.o. b.i.d. with meals
4. Senna 8.6 mg p.o. b.i.d.
5. Docusate 100 mg p.o. b.i.d.

DISCHARGE INSTRUCTIONS: The patient was instructed on proper wound and dressing care, was instructed to attend all followup appointments and was discharged.

Dictated by: Bryan Thomas, PGY1

Bryan Thomas, PGY1

Gerald J. Shealy, MD
Attending

297632 / 44076 /

JOB: 9080307

DD: 07/10/09 11:31 AM

DT: 07/10/09 10:01 PM

Additional CC:

Progress Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486

SEX:M AGE:44

05/21/09 : 00:00am

MUSC CHARLESTON HAND GROUP NEW PATIENT EVALUATION-W. ASHLEY

GS1

05/21/2009: JOSEPH OSMANSKI

Orthopaedics Charleston-Hand Group

Medical University of South Carolina

NEW PATIENT EVALUATION

Joseph Osmanski was seen today as a new patient evaluation.

Chief Complaint: Left elbow pain.

History of Present Illness: Mr. Osmanski is a pleasant 44-year-old right-handed male who was previously employed as a truck driver. He sustained an injury to his left elbow in an injury at work which occurred in 1987. He relates he fell 32 feet sustaining a complex fracture of the left elbow for which he underwent surgical treatment. The surgery failed, and therefore in 2000, he underwent prosthesis to his left elbow. This has been performed at the University of Florida. He noted good relief of his symptoms and was able to function normally for nine years. He was able to return to his normal activities as a truck driver until November 9, 2008, when a box caught in a truck, and in an attempt to extricate the box from the truck, he re-injured his left elbow. Since that time, he has had problems with persistent pain in the elbow. He has been diagnosed as having loosening of the prosthesis. He has undergone other surgical procedures including an ulnar nerve transposition with no complete resolution of his symptoms. He was most recently seen in April 2009 in Florida by Dr. Chidgey, who is a hand surgeon. He assessed Mr. Osmanski as having a loose prosthesis which would require revision of the arthroplasty for definitive treatment. He presents today for evaluation and consideration of further treatment. He is presently living in South Carolina.

Past Medical History/Review of Systems: Negative.

Surgery: None other than noted.

Medications: Lortab.

Allergies: Penicillin.

Family History: Negative.

Physical Examination: Physical examination is unremarkable with the exception of the left elbow revealing swelling, tenderness, and limited range of motion. The patient has approximately 30 to 45 degrees of motion in the elbow with pain noted. In addition, he has no active flexion of the elbow indicating he probably has disruption of the biceps insertion anteriorly.

X-rays are reviewed and demonstrate that there is loosening of the prosthesis primarily in the humeral component, although there does appear to be loosening distally in the ulnar component. No fracture of the prosthesis is noted.

Impression: Status post left total elbow arthroplasty with loosening.

Recommendations: The only option available to this man is to consider a removal and replacement of the prosthesis. I would perform this operation as a two-staged procedure. Initially, I would remove the prosthesis and make certain that there is no evidence of any active infection. We will attach the anterior biceps muscles and wait six to eight weeks before re-implanting a new prosthesis. He understands the proposed surgical treatment, risk, complications, and anticipated results. He would like to have this surgery undertaken, and it will be scheduled as an outpatient at his request.

Progress Notes**Page: 2**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486 SEX: M AGE: 44

Gerald J. Shealy, MD

GS/am:568:1416865

SIGNED BY GERALD J. SHEALY, M.D. (GS1) 06/09/2009 01:27PM

Discharge/Op Notes**Page: 1**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486 SEX: M AGE: 44

07/08/09 5:18pm

OPERATIVE NOTE

OUT

Accession number: 18252271944

MUSC Medical Center

OPERATIVE NOTE

Patient Name: OSMANSKI, JOSEPH A

MRN: 001711486

Patcom: 493129175

Date of Surgery: 07/08/2009

Surgeon: Gerald J. Shealy, MD

Assistant(s): Harvinder Bhatti, MD

PREOPERATIVE DIAGNOSIS: Status post right total elbow prosthesis with loosening of components.

POSTOPERATIVE DIAGNOSIS: Status post right total elbow prosthesis with loosening of components.

PROCEDURES: CPT 24160, removal of humeral component, right elbow prosthesis.

DESCRIPTION OF PROCEDURE: With the patient under adequate general anesthesia in the left lateral decubitus position, the right upper extremity was scrubbed, prepped and draped in a routine sterile fashion. Following elevation and exsanguination, a sterile tourniquet was inflated. Through the previous operative incision over the posterior aspect of the elbow, the skin and subcutaneous tissue were sharply divided. Upon entering the subcutaneous tissue, the ulnar nerve was found; it had been previously transposed, and it was carefully dissected distally. Significant scarring was present about the ulnar nerve. Following dissection of the ulnar nerve, the triceps expansion was taken down from the olecranon by dissecting along the medial aspect of the triceps muscle, extending the incision along the medial epicondyle of the humerus and distally over the olecranon. The triceps muscle was lifted off the distal humerus and retracted in a lateral fashion to allow exposure of the posterior aspect of the elbow joint. The humeral component was noted to be obviously loose; the hinge was taken down from the humeral component, and the component was removed from the humerus without difficulty. In addition, the cement was also removed using curets and osteotomes. Upon removal of the cement from the distal humerus, attempt was made to remove the prosthesis from the ulna; however, it was noted to be fixed well, stable, and the wound did not appear to be infected. Cultures were obtained to ascertain if there was any infection. The wound was copiously irrigated. The ulnar component was left in upon removal of the humeral component. Tobramycin cement was inserted into the humeral shaft. The triceps expansion was closed with 0 Monocryl interrupted figure-of-eight sutures, and the skin closed using 3-0 Vicryl and staples. Sterile dressings were applied with a posterior splint. Patient awakened from general anesthesia and returned to the recovery room in satisfactory condition. He is admitted postoperatively for observation, antibiotics and analgesics.

Discharge/Op Notes**Page: 2**

Name: OSMANSKI, JOSEPH

Date Printed: 07/24/09

ID: 1711486

SEX: M AGE: 44

Dictated by: Gerald J. Shealy, MD

Gerald J. Shealy, MD
Surgeon

271944 / 44076 /

JOB: 9079873

DD: 07/08/09 01:55 PM

DT: 07/08/09 05:15 PM

Additional CC:



UNIVERSITY OF
FLORIDA

OSMANSKI, JOSEPH ARTHUR
STH # 00675885

UF Orthopaedics and Sports Medicine Institute
UF Orthopaedic Clinic

3450 Hull Road
P.O. Box 112733
Gainesville, FL 32611-2733
Clinic (352) 273-7001
Fax (352) 273-7295

SHANDS at UF CLINIC

01/12/2009

The patient returns having had an injury to his left elbow. He has an implant that is in and he right now is having a lot of pain in the elbow. X-rays are unclear as to whether or not he has disrupted the implant. I would like to just have things settle down for the next few weeks in a brace and repeat x-rays in about four weeks of the left elbow. He may have even cracked through the humerus. On some of the views it looks like that may be the case.

Electronically Reviewed and Signed by
Larry K. Chidgey, M.D. 01/22/2009 09:15
Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.
LKC/MDQ 01/12/2009 01/12/2009 11:53 A
UDN: 4045561 Job ID# 004215757

cc:

*

SHANDS HOSPITAL AT UF
RADIOLOGY DEPARTMENT
1600 SW ARCHER ROAD
GAINESVILLE, FL 32610

DIAGNOSTIC RADIOLOGY
CONSULTATION

Phone: (352) 265-0107
Fax:

EXAM: ELBOW LT AP & LAT
EXAM DATE: Jan 12 2009
ORDER DATE: Jan 12 2009 8:01AM
** VERIFIED **
ORDERING MD: CHIDGEY MD, LARRY K
ORD. SERVICE: ORT

NAME: OSMANSKI, JOSEPH ARTHUR
LOC: XRY SEX: M
MRN: 00675885 DOB:
PT NO: 000603809328
ORDER: 90001.001
ORD. LOC: HMP TECH: UAB301

REASON: PREORDER, LT ELBOW PAIN
EXAM DATE: Jan 12 2009 08:51 RMS# / INV#: 90001.001 / 00001-001
Accession#: 8398480

HXR 3840 ELBOW LT AP & LAT

ICD9 CODES: (XXX.X)

FINDINGS:
COMPARISON: None

FINDINGS: Four views of the left elbow were obtained. A left total elbow arthroplasty is noted. The cemented olecranon component appears uncomplicated, however there is a very prominent lucency surrounding the cemented humeral component consistent with loosening. There is also suggestion of a healing fracture of the distal humerus. The radial head has been resected. Reactive bone is noted throughout the soft tissues of the elbow. Two humeral K-wires are noted, one of which appears to be penetrating soft tissue.

IMPRESSION:

1. Loosening suggested within the humeral component of a total elbow arthroplasty.
2. Healing humeral fracture.
3. Humeral K-wire with distal component in soft tissues.

Dictated By: STEINIG, JEFFREY D. M.D.
Dictated Date: Jan 12 2009 11:44AM
Transcriptionist:

Interpreted By:
MONTGOMERY, WILLIAM J. MD
This study was personally reviewed
by me and I agree with the report.
Attending Radiologist
Verified on: Jan 12 2009 11:44AM

STEINIG, JEFFREY D. M.D.
Resident Radiologist

Ordering MD
CHIDGEY MD, LARRY K
BOX 112727

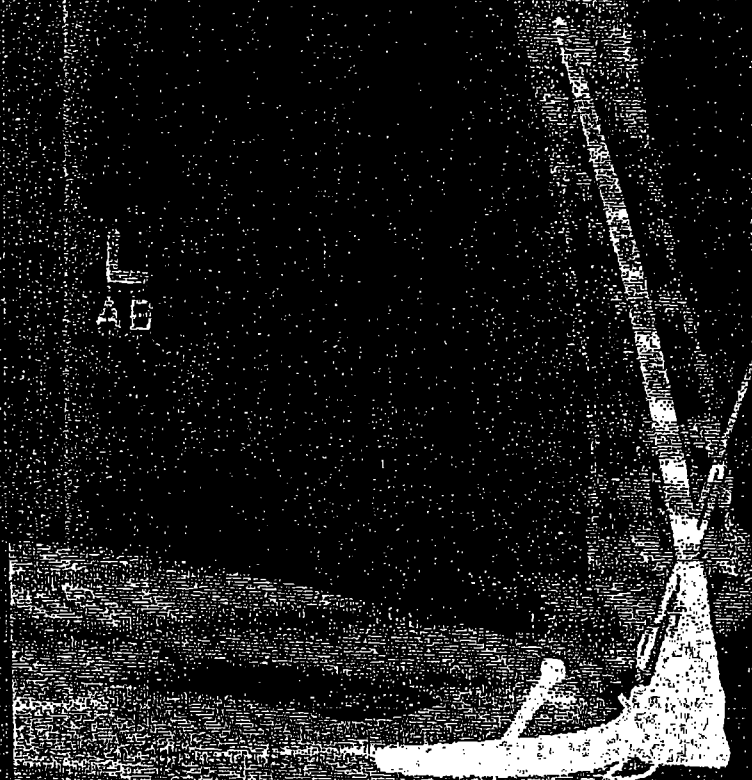
GAINESVILLE, FL 32610

** VERIFIED **
Page: 1

Printed: 01/12/2009 11:45:28

UF
OSMANSKI JOSEPH ARTHUR
DOB 07/06/1946
B8398480
00675385

Series 2
1371



20 cm

KVP 60.00
Exp 3 / Exp Time 5.0
NONE
Dist 0

8:54:36 AM
1/12/2009

Zoom: 0.38
W 1334 L 1039

UF
OSMANSKI JOSEPH ARTHUR
DOB [REDACTED]
B8398480
00675885

Series 3
1371

KVP 60.00
Exp 3 / Exp Time 5.0
NONE
Dist 0

20 cm

8:55:56 AM
1/12/2009

Zoom: 0.18
W 2082 L 1541

UF
OSMANSKI JOSEPH ARTHUR
DOB
88398480
00675885

Series 1
1371

L
AB

10 cm

KVP 57.00
Exp 3 / Exp Time 5.0
NONE
Dist 0

8:54:04 AM
1/12/2009

Zoom: 0.54
W 1600 L 1337

UF
OSMANSKI JOSEPH ARTHUR
DOB [REDACTED]
B8398480
00675885

Series 4

1371

KVP 55.00

Exp 3 / Exp Time 6.0

20 cm

NONE

Dist 0

8:57:13 AM

Zoom: 0.23

1/12/2009

W 2206 L 1678

UF

Series 3

SMANSKI JOSEPH ARTHUR

1371

DOB 02/27/1904

B8490826

00675885

10 cm

KVP 57.00

Exp 3 / Exp Time 5.0

NONE

Dist 0

8:02:25 AM

Zoom: 0.24

2/23/2009

W 2088 L 1617

UF
OSMANSKI JOSEPH ARTHUR
DOB [REDACTED]
B8490326
00675885

Series 2
1371

KVP 64 50
Exp 3 / Exp Time 5.0
NONE
Dist 0

8:01:31 AM
2/23/2009

Zoom 0.33
W 1918 L 1495

20 cm

UF
OSMANSKI JOSEPH ARTHUR
DOB [REDACTED]
B8490826
00675885

Series 1
1371

20 cm

KVP 55.00
Exp 3 / Exp Time 6.0
NONE
Dist 0

8:00 29 AM
2/23/2009

Zoom: 0.30
W 1748 L 1593

**RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460**

PATIENT: OSMANSKI, JOSEPH A

AGE: 44
DCB: 09/24/1964
SEX: M

UNIT/MR NO: M000166905
ACCT NO: H00036770626
SSN: [REDACTED]
REQ NO: 08-0142100
REPORT NO: 1102-0201

ADMITTING DR:
ORDERING DR: ER PHYSICIANS

ROOM:
PT LOCATION: HED
ER PHYS

REPORT STATUS: Signed

ORDERED BY: ER PHYSICIANS
LOCATION: DEP ER HED
STUDY TYPE: 1102-0109 RAD/ELBOW LEFT

DATE OF EXAM: 11/02/08

CLINICAL DATA: 44M, PRIOR ELBOW SURGERY REMOTELY
ELBOW PAIN - HYPEREXTENSION

LEFT ELBOW:

FINDINGS: Three views of the left elbow performed. No prior films for comparison. There is joint replacement for the elbow with distal humeral and proximal ulnar components anatomically aligned. There is heterotopic ossification and cortical thickening for the distal humerus and to a lesser degree of the proximal ulna. Heterotopic ossifications are also present around the joint. Given the post surgical changes performed remotely, it is not possible to assess for joint effusion by plain film. There is a fractured Cerclage wire identified for one of the condyles on the oblique view, it is distal and is not secured within bone. There are other pins protruding through the posterior cortex of the humerus. There is presumed partial resection of the distal humerus and proximal ulna and radius. Without the benefit of prior studies it is difficult to assess for any significant changes in both hardware or surrounding bone.

IMPRESSION: Post surgical changes of joint replacement of the elbow as described above with hardware noted. There are no prior films for comparison thereby making it very difficult to assess for any true acute abnormality. Additionally because of the surgery, I cannot tell if there is joint fusion present either. There is soft tissue swelling posterior to the elbow joint. Otherwise without prior films, the joint is nonspecific.

SDH

EDWIN P PIA MD

REPORT STATUS: Signed

ER PHYSICIANS

OSMANSKI, JOE 76730 FISHER/cmh 10/22/2008 J994051

S: The patient is a 44-year-old white male, here for his 1st visit to our office. He basically comes in for a physical. It has been some time since he had a regular physician. He wanted to get his DOT form completed as well. He generally has been pretty healthy. He does take Flomax regularly for some nocturia and BPH. This has helped significantly. He only gets up about once nightly now to use the bathroom. He is also a smoker. He is not that interested quitting right now. He still drives a truck a good bit, although he is not over the road like he was. He is down to about 1 pack daily right now. Unsure when his last tetanus was given. He does have a history of a fall, in 1987, when he was about 23. He had a good bit of problems. He had a pretty bad injury in his left elbow and wrist, particularly. He still has some limited range of motion of elbow as far as supination but otherwise he lifts furniture and does not have any other residual problems. He has recently been seen for some kidney stones by Dr. Brightbill. He had an IVP, which was negative, because he was having some mild persistent pain but he is doing pretty well right now without any significant symptoms. He is allergic to penicillin. FH: Father, some kind of blood disorder in his 50s, did not know exactly what it was. Otherwise unremarkable. PMH: See chart for the rest. ROS: Negative for allergies. Not complaining of chest pain or shortness of breath. No recent bowel changes. Urine as discussed above. No skin problems. Never had any restriction from DOT physical in the past.

O: VITAL SIGNS: Blood pressure 136/84, heart rate 84, weight 273 (reports losing about 70 lbs. this past year from just dietary changes). GENERAL: Alert. HEENT: See visual acuity. Eyes clear. TMs clear. Mouth with deteriorating tooth in the left lower jaw, otherwise clear. NECK: Supple, good pulses, no bruits. No masses. HEART: Regular rate and rhythm without murmurs. LUNGS: Clear to auscultation bilaterally. BACK: Without tenderness. ABDOMEN: Mildly obese, soft, nontender, no masses noted. EXTREMITIES: Without edema, good pulses. GU: Bilateral descended testicles. Very mild hernia on right side. Left clear. RECTAL: Moderately enlarged prostate, smooth, symmetric. SKIN: Clear with few non atypical appearing nevi. DIAGNOSTIC STUDIES: EKG: See chart. Executive profile to be done. Fasting today.

A

1. Physical examination performed in a 44-year-old white male.
2. Department of Transportation physical performed, no obvious restrictions.
3. History of benign prostatic hypertrophy, has done well with Flomax.
4. Tobacco dependence. Encouraged to quit smoking. Do not think he really feels like he is ready right now.
5. Persistent lack of supination, left elbow, status post injury at 23 years old.
6. Some obesity in the past, significantly improved with just dietary changes.

P: Tetanus updated today. DOT form completed. Executive profile and PSA. Proceed as needed on the. Encouraged to quit smoking once again. Did not need refills on Flomax. Follow up p.r.n.

ADDENDUM: Cyst between the DIP and PIP on right ring finger, has gotten a little bit larger, about 3 x 1 cm. Needs further evaluation, excision. Will send to orthopedist for evaluation.

OSMANSKI, JOE 76730 FISHER/cmh 11/13/2008 J911872

S: The patient is a 44-year-old white male who comes in to followup some labs. He has mildly increased cholesterol. He has not been told this in the past. He was also noted to have mildly increased liver functions. He rarely takes Tylenol at home. He drinks a little bit of on the weekends but not regularly. He is not on any medicines except Flomax. He has never been told his liver functions were elevated.

O: VITAL SIGNS: Blood pressure 130/88, weight 270. HEART: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Soft, no right upper quadrant tenderness. No obvious swelling or masses. DIAGNOSTIC STUDIES: See chart for labs.

A

1. Mildly increased triglycerides, low HDL. Ratio slight high.
2. Mildly increased liver functions.

P: Given low triglyceride diet sheet. Talked a little bit about omega-3 fatty acids. Would like to check cholesterol and liver functions in 3 months, sooner if he has any particularly symptoms. Follow up otherwise p.r.n.

Joseph Osmański

(Name of Drive)

Social Security Number

(Signature of Driver)

I certify that the above driver, as defined in §390.5 is regularly driving a vehicle operated by the below named carrier and is fully qualified under Part 391, Federal Motor Carrier Safety Regulations. The current medical examiners certificate expires on 10/22/2010 his certificate expires: (Date not later than expiration date of medical certificate) 10/22/2010

Issued on

(Dátum)

Issued by

(Name of Carrier)

Address

(1419)

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Joseph C. Smolenski
in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge
of the driving duties. I find this person is qualified; and, if applicable, only when:

☐ wearing corrective lenses ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident

☐ wearing hearing aid ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident

☐ accompanied by a ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident ☐ U.S. citizen or permanent resident

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment encloses my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER

TELEPHONE

DATE

MEDICAL EXAMINER'S NAME (PRINT)

INQ 100-441 - Q DC

Physical
Assessment

☐ Advanced Practice

*MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. /ISSUING STATE

SIGNATURE OF DRIVER

DRIVER'S LICENSE NO.

STATE

100

DAVEN'S LICENSE NO.
110610508

STATE
§

MEDICAL CERTIFICATE SUBSIDIARY

435

Columbia Orthopaedic Specialists, LLC
1301 Taylor Street, Suite 3-O
Columbia, SC 29202-0306

DATE: 12/23/08

PATIENT: Joseph A. Osmanski

SSN:

CHIEF COMPLAINT: Left elbow injury.

PRESENT ILLNESS: This is a 44-year-old truck driver, who dropped a recliner in a box on his left elbow at work November 1st, 2008. He states that initially he was seen at Lexington Medical Center in Lexington and apparently the diagnosis of a torn biceps was made.

He was then seen by Dr. McIntosh on three different occasions. He has not had any physical therapy. At one point he was wearing a sling.

In 1987 he apparently underwent surgery on his left elbow for a severe fracture. In 2000 he underwent a left elbow replacement, which was done in Gainesville, Florida. In 2004 he had a left ulnar transposition done.

The patient states that because the pain is so severe that he still finds it necessary to take Vicodin, which he uses mainly at night. He has yet to return to any type of work.

Today he was kindly sent here for consultation.

PAST MEDICAL HISTORY: He did not mention any other medication and he is allergic to Penicillin. He has also had a right ulnar nerve transposition. Three surgeries have been done on his left shoulder and two have been done on his right shoulder. His only other surgery was a right radial head excision.

PHYSICAL EXAMINATION: General appearance is that of a pleasant 5'11" 270 lb. male, who has considerable discomfort with any attempt at movement of his left elbow. Passive range of motion at the left elbow is possible from 60° to 90° of flexion before pain becomes too much for him. At the posterior medial aspect of his left elbow there is a well-healed 22 cm surgical incision. At the posterolateral aspect there was a well-healed 14 cm surgical incision. Distal neurovascular status was intact, except for some partial numbness of the left little finger.

12/23/08
Joseph A. Osmanski
Page 2

RADIOGRAPHS: AP, lateral and oblique x-rays of his left elbow revealed an elbow replacement to be in place, without any obvious complicating feature.

There was one broken wire, as well as a single pin, which was too long posteriorly. There was also a screw.

IMPRESSION: LEFT ELBOW INJURY.

DISPOSITION: I will see if an MRI scan can be done to assess his biceps at his left elbow. However, I do have my doubts that it can be done.

He is not to perform any work involving the left upper extremity.

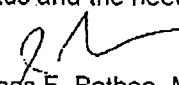
I did write a prescription for (#60) Vicodin to be taken one every four hours as needed for pain without a refill.

I think that it would be prudent to refer him back to Dr. Chidgey in Gainesville for an evaluation, since Dr. Chidgey performed his elbow replacement in 2000.

No definite return appointment was made for him here.

I do not know of any orthopaedic surgeon in this state who is performing this surgery frequently.

I did have a discussion with the case manager concerning Mr. Osmanski's work status and the need for a referral back to the surgeon in Florida.


James F. Bethea, M.D.
JFB/prf

(Next Appointment p.r.n.)

File #: 280 00 63420

Cc: Zurich North America
P.O. Box 195008
Charlotte, NC 28219-5008

Carol Chester, RN, CRRN, CCM
Zurich Services Corporation
P.O. Box 602
Warrenton, GA 30828

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169

PATIENT: OSMANSKI, JOE		VISIT DATE:
PATIENT #: 00001529860	XXX-X7-6730	D: 11/06/2008 8:51 AM
PHYSICIAN: JAMES C. MCINTOSH, MD		T: 11/07/2008 6:10 AM / cir
		DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: Patient presents today for workmen's comp injury to his left elbow. He is a truck driver and had a hyperextension injury last week with immediate onset of pain. He went to the Emergency Department and was evaluated. He has a very complicated history with his left elbow. Apparently he had a comminuted fracture. They attempted what sounds like an interpositional arthroplasty that ultimately failed. Back in late 1990s, he underwent a total elbow arthroplasty in his 30s. This was all done in FL. He is a truck driver and has been doing this for some time. He is right-hand dominant. Ever since the injury, he has had some numbness. He has had transposition of ulnar nerves in the past. Little bit of tingling. It has always been painful, but this is a little bit more. Feels like arm is dead and he cannot move it. It sounds basically like he had a hyperextension injury with some crepitance and onset of pain. Not that uncomfortable today. Still has difficulty moving the arm. Some numbness and tingling in his ring and small fingers. No other injuries reported. We saw him just recently for a mass on his right ring finger. Health otherwise is good. No change since we saw him last week.

PHYSICAL EXAMINATION

GENERAL: Mildly obese black male in no apparent cardiopulmonary distress, alert and oriented x3.

ELBOW: Some mild swelling. I really cannot palpate his biceps very well. He has a 1 bone forearm so he cannot supinate. Ulnar nerve function appears to be intact. Decreased sensation in ulnar distribution. Radial and medial nerve function appears to be intact. Good capillary refill. Several scars on posterior aspect of elbow. No obvious crepitance. Actually fairly good motion. Nearly full extension. Flexion to about 125-130. Elbow showed implant in place; several wires present. No obvious evidence of implant loosening. Some asymmetry at the bushing, which is consistent with wear. Do not see any obvious implant loosening.

ASSESSMENT: Left elbow strain; difficult to tell what is going on with him. His implant appears to be intact. Pins extending at the posterior aspect of the elbow. I do not know if this is old or new.

PLAN: I asked him to continue same range of motion exercises and work status. No use of left arm. Also asked him to get old notes or x-rays to see if we can compare to past films. Recheck and reexamine in 3 weeks.

JAMES C. MCINTOSH, MD

cc:

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140

West Columbia, South Carolina 29169

PATIENT: OSMANSKI, JOE		VISIT DATE:	
PATIENT #:	00001529860	XXX-X7-6730	D: 11/20/2008 5:15 PM
PHYSICIAN: JAMES C. MCINTOSH, MD		T: 11/24/2008 2:45 PM / cgu	
		DATE OF BIRTH:	

HISTORY OF PRESENT ILLNESS: The patient returns today. He seems like he may be doing just a tiny bit better. He still has difficulty actively contracting his arm. He may be getting a tiny bit better with his pain. No new numbness or tingling.

PHYSICAL EXAMINATION: ARM: No significant swelling or discoloration. I cannot really palpation his biceps. Not contracting very well. Some swelling and ecchymosis. No crepitation.

DISCUSSION: We asked him on his last visit to try to get some of his old records and films. He was unable to produce either. Again a difficult time for me to tell exactly what is going on. He had a complex elbow injury. I do not see any true objective findings. His films do show a longstanding elbow implant. There is some prominent hardware but I am not sure if this is new or old.

PLAN: We are going to try once again to get his previous films. Return in 3 weeks. Work status, no use of left arm.

JAMES C. MCINTOSH, MD

cc:

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169

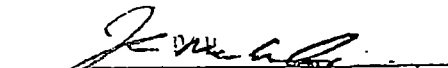
PATIENT: OSMANSKI, JOE		VISIT DATE:
PATIENT #: 00001529860	XXX-X7-6730	D: 12/15/2008 12:45 PM
PHYSICIAN: JAMES C. MCINTOSH, MD		T: 12/15/2008 3:50 PM / AM
		DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: The patient returns today. He is doing about the same. He still has a fair amount of pain. He is no better, no worse. We still have no information.

PHYSICAL EXAMINATION: ELBOW: No swelling or discoloration. No crepitance. Limited range of motion. Painful with all activities. Intact neurovascular exam otherwise.

RECOMMENDATIONS: Again, I am not sure. We have asked him to try to get the old notes and old x-rays to try to determine what is going on with him. MRI will not be helpful. He has a total elbow implant which will create artifact. We have asked several times to get information and they are not able to produce it. The only thing I can offer him is to send him back to Florida where his surgery was done to try to figure out what was done. I cannot tell the patient nor the insurance company what is going on with his arm because I do not know what his baseline level is. Return on a p.r.n. basis.

WORK STATUS/WORK RESTRICTIONS: Will continue work status.


JAMES C. MCINTOSH, MD

cc:

DEPARTMENT OF HOPAEDICS
College of Medicine
University of Florida

Box J-246 JHM Health Center
Gainesville, Florida 32610
Telephone: 904-392-4251
FAX: 904-392-8637

August 09, 1988

L.K. Chidgey, M.D.
General Orthopaedic Surgery,
Hand and Microsurgery

P.C. Dell, M.D.
General Orthopaedic Surgery,
Hand and Microsurgery

W.F. Enneking, M.D.
General Orthopaedic Surgery
Oncology

P.M. Fry, M.D.
General Orthopaedic Surgery

P.F. Gearen, M.D.
General Orthopaedic Surgery
Joint Implant Surgery

T.C. Haare, M.D.
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General Orthopaedic Surgery
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M. Mac Millan, M.D.
General Orthopaedic Surgery
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E.G. McFarland, M.D.
General Orthopaedic Surgery
Sports Medicine

R.W. Perly, M.D.
Chairman
General Orthopaedic Surgery
Joint Implant Surgery

S. S. Spanier, M.D.
Pathology

C.M. Tylkowski, M.D.
General Orthopaedic Surgery
Pediatrics

R.A. Vander Griend, M.D.
General Orthopaedic Surgery
Oncology

INVESTIGATIVE FACULTY

F.P. Glowczewski, Jr.
Tissue Bank

G.J. Miller, Ph.D.
Biomechanics

N.L. Scarborough, Ph.D.
Pharmacology

George J. Haas, M.D.
501 E. Osceola Street
Stuart, FL 33494

RE: OSMANSKI, Joseph Arthur
STH # 67-58-85
Clinic: 8/05/88

Dear Dr. Haas:

We had the pleasure of seeing Joseph Osmanski in Clinic today. As you recall, this is a 23-year-old right-hand dominant carpenter who fell approximately 22' on 12/18/87. This accident occurred in New Jersey and apparently he had several surgical procedures on the upper extremity fractures he sustained from the fall. Apparently on the right-side he had a radial head fracture and had the radial head excised acutely. On the left-side, he had a lateral condylar fracture and a radial head fracture requiring open reduction of the lateral condylar fracture and excision of the radial head fracture. Apparently, over the ensuing weeks, he developed considerable settling of the left radius with ulnar impingement.

Reviewing his old x-rays show that he apparently developed well over 1.0 cm of ulnar positive wrist. A Darrach procedure was performed to try and give him some relief of the subsequent left wrist pain which developed.

He has since been going with Physical Therapy and apparently has been making minimal progress with the left arm pain being worse than the right. He lacks about the last 30 degrees of extension of both elbows and has approximately an 80 degree arc of supination and pronation on the right and only about a 30 degree arc on the left. On the left-side he has considerable pain over the wrist by palpation in the area of the distal radial ulnar joint region. He also has considerable tenderness over the elbow, both medially and laterally with the lateral pain much worse than medially. He has pain with any attempt at motion of the elbow, especially extension, supination, and pronation. The pain on the right-side is mainly over the radial head excision site with some very mild pain over the distal radial ulnar joint distally. His sensation seems to be completely intact as well as his vascular supply.

X-rays taken today reveal considerable settling on the left-side with the proximal radius impinging upon the capitellum and also with some callus formation at the end of the ulna, which may be causing some impingement distally.

George J. J., M.D.
August 9, 1988

RE: O' SKI, Joseph A.
STH 67-58-85
Clinic 8/05/88

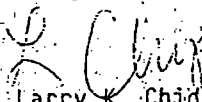
page two

We feel this represents an Essex-Lopresti type injury and he has developed considerable settling problems. With continued attempts at excision of the radius on the right, we feel that he would continue to settle down and would continue to have problems with impingement at the wrist level. There are no good options for this particular problem with only one I think should be considered would be the creation of a one bone forearm. I feel that no arthroplasty procedures would offer him any help in his young age and he would tear them up in a matter of a few years.

On the right side, I feel that I would continue to follow this conservatively as he feels he may be getting some mild improvement on the right side. He is developing some minor degree of settling on this side as well several mm of an ulnar positive variant. We discussed these options with Joseph and he would like to think about it and get back in touch with us if he decides to go ahead with the procedure.

Thank you for this consult.

Sincerely,


Larry K. Chidgey, M.D.
Assistant Professor
Hand and Microsurgery

LKC/dmg

cc: WC

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

DISCHARGE SUMMARY

SHANDS at UF

ADMISSION DATE: 02/17/2000

DISCHARGE DATE: 02/19/2000

ADMISSION DIAGNOSIS: (1) Degenerative joint disease, left elbow.

DISCHARGE DIAGNOSIS: (1) Degenerative joint disease, left elbow.

PROCEDURES: (1) Left elbow fascia lata interpositional graft on 2/17/00. CONSULTATIONS: (1) Physical Therapy.

HISTORY AND PHYSICAL: Please see the chart for the complete H&P.

HOSPITAL COURSE: The patient is a 35-year-old white male with a history of left elbow DJD. He was admitted on 2/17/00 following the aforementioned procedure which was performed at Florida Surgical Center on 2/17/00. The patient tolerated the procedure well and was placed on a morphine PCA for pain control until postop day two. He was switched over to oral pain medication at that time and tolerated that well. His Hemovac drain was discontinued with minimal drainage on the day of discharge on postop day two. He had no fevers and was tolerating a regular diet.

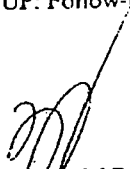
DISCHARGE CONDITION: Stable.

DISPOSITION: Home.

DISCHARGE MEDICATIONS: (1) Tylox one to two PO q.4-6h. PRN pain. (2) Oxycodone 5-10 mg PO q.4-6h. PRN breakthrough pain. (3) Clindamycin 600 mg one PO t.i.d. x 1 day.

DISCHARGE INSTRUCTIONS: The patient should notify us for a temperature greater than 35, increased drainage from his wound, pain uncontrolled with pain medication, numbness, tingling or weakness in his extremity. He was given physical therapy for a walking device as directed by PT.

FOLLOW-UP: Follow-up will be with Dr. Chidgey at Hampton Oaks and the Surgery Clinic in two weeks.


Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jason W. Thackeray, M.D.
JWT/344 02/19/2000:02/20/2000 5:17 P

DISCHARGE SUMMARY

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH R

PTNY MOW. 00675885

DOB:

M

EAD SSN.

SHANDS-UF

Orthoped 09/14/00

DATE OF SURGERY: 09/14/2000

PREOPERATIVE DIAGNOSIS: Left elbow arthritis.

POSTOPERATIVE DIAGNOSIS: Left elbow arthritis.

OPERATION PERFORMED: Left total elbow arthroplasty.

SURGEON: Chidgey.

ASSISTANT:

ANESTHESIOLOGIST:

ASSISTANT:

ANESTHESIA: General.

DESCRIPTION OF PROCEDURE: The patient was taken to the Operating Room. After adequate general anesthesia was established, the arm was prepped and sterilely draped. The limb was exsanguinated and a tourniquet around the upper arm inflated to 250 mmHg. A posterior incision was utilized. The triceps was dissected off of the ulna and kept intact with the forearm fascia. It was dissected subperiosteally off of the tip of the olecranon. The patient had a previous anterior transposition of the ulnar nerve. Therefore, the nerve did not have to be dissected out. The patient had no articular cartilage left on either side of the joint as he had a previous fascial arthroplasty which had failed. There was no sign of any infection. The patient had also had a previous one bone forearm with a radial head excision so the radial head did not have to be dealt with. The ulna was prepared with a power saw and a combination of the reamers to prepare the canal. The trial was then fitted. The saw was then utilized to prepare the distal humerus and the canal reamed; and a trial reduction with the trial implant was carried out and found to be good, lacking only the last 20 degrees from full extension. The ulnar component was then cemented into place. The humeral component was then cemented into place. During the cementing process, there was trouble with the articulating pin. In an effort to try and get the pin articulated properly, the cement hardened sufficiently that it could not be fully seated. Therefore, the humeral component was taken back out and the canal cleaned of the cement. Another attempt was then made filling the humeral canal with cement. At this time, the humeral component seated well with the ulnar component and the pin articulated appropriately. The humeral component was then fully seated in the humerus. Once the cement hardened, the triceps was reattached to the ulna through drill holes utilizing #2 Ethibond suture. It should also be mentioned that the lateral epicondylar area fractured off and had to be secured back down with two K-wires and a figure-of-eight tension band wire. A drain was then placed through a separate stab wound and the wound closed.

Requested by HENDEP on 01/12/09 at 09:03 From M173 Page 1

NM800701

Shands HealthCare

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Not an Original

OSMANSKI

JOSEPH ANTHUR

DOB:

M

EAD SSN:

PIDX MRN: 00675885

SHANDS-UF

in layers. A sterile dressing was then applied followed by a splint. The patient tolerated the procedure well and was taken to the Recovery Room in stable condition. Good vascular status returned to the hand after tourniquet deflation.

Larry K. Chidgey, M.D.

Associate Professor, Hand Surgery

Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.

LKC/344 09/14/2000:09/14/2000 6:10 P

Requested by HENDEP on 01/12/09 at 09:03 From M173 Page 2

JM800701

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

DATE OF SURGERY: 11/01/2001

PREOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

POSTOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

OPERATION PERFORMED: Left ulnar nerve transposition and neurolysis

SURGEON: Chidgey
ASSISTANT: Gilmore

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: The patient initially had a cubital tunnel syndrome of the left ulnar nerve. He sustained paresthesias and sensation difficulties in the ulnar distribution of his hand. The initial procedure was a left ulnar nerve transposition. He did return complaining of continued pain and paresthesias about his arm. He had developed a significant amount of scar tissue after multiple surgical procedures to his left elbow. It was deemed he would need a revision of the transposition and likely neurolysis.

DESCRIPTION OF PROCEDURE: The patient was appropriately identified, as well as the extremity was identified. He was taken to the operative suite, and general anesthesia was obtained. Next sterile dressings were applied, along with a sterile tourniquet. The total tourniquet time was approximately 1 hour and 6 minutes. Before the tourniquet was inflated the arm was exsanguinated.

Next the previous scar was identified on the medial ulnar aspect of his left elbow. The incision was made over the previous scar site. It was extended approximately 3 cm proximal and distal from that site. Dissection was then performed down through the skin with a knife in the subcutaneous tissue. Next tenotomies were used to clear some of the scar tissue, and the ulnar nerve was identified distally just underneath the subcutaneous tissue. It was mobilized both distally and proximally across the elbow.

It was noted there was a significant amount of scar tissue on the floor of the nerve, and the nerve was released from the scar tissue with neurolysis. It was determined that instead of dissecting through the abundance and thickness of the scar tissue that it would best serve the ulnar nerve to lie above this tissue with an overlying subcutaneous tissue for cushion. As this layer was sutured over top of the ulnar nerve, it was determined that the ulnar nerve was mobile and free. The rest of the suture line was drawn with 2-

FSC OPERATIVE REPORT

Page 1

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

O'Polysorb. This was done in inverted interrupted fashion. Next skin was stapled. The patient then had sterile dressings applied.

Next the patient was awakened. The tourniquet was deflated, and the patient was taken to the Recovery Room without difficulty. He remained neurovascularly intact postoperatively. He will be admitted to the hospital postoperatively for observation overnight. His pain is under good control with the use of Tylox and morphine.

Dr. Chidgey was present for the entire procedure and participated in the case.



Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/448-11/01/2001 11:01/2001 10:33 P
Job ID# 001087363

cc:

FSC OPERATIVE REPORT

WATKINS & SHEPARD TRUCKING, INC.
POST JOB OFFER QUESTIONNAIRE

1. After receiving a copy of our job description, essential job functions and minimum qualification standards for over the road drivers and upon review of it, can you complete all essential job functions listed in the Job Description?
Yes ☒
No ☐
2. If no, which essential job function(s) can you not perform and why? Do you need an accommodation to complete the Essential Job Function(s)? What accommodation do you feel you need?
n/a
3. Have you had any non-work related injuries or illnesses (such as broken bones, surgeries, hospitalizations, heart attacks, tuberculosis, etc.) which may affect your ability to perform the Essential Job Functions? If yes, what is the date(s) and type of injury or illness?
no
4. Have you been injured or suffered an occupational disease (such as broken bones, surgeries, hospitalizations, etc.) while working for another employer? If yes, what is the date(s) and type of injury or occupational disease?
no
5. Do you have any physical limitation(s) or restriction(s) (such as lifting, squatting, bending, kneeling, etc.) that would prevent you from performing the Essential Job Functions? If so what?
no
6. Are you currently being prescribed any medication by a physician which may affect your ability to perform the Essential Job Functions? If so, what medications?
no
7. Have you been certified by any Subsequent Injury Fund of any states Department of Labor and Industry (such as an impairment rating from a disability or a settlement from a claim)? If so, when and for what condition or limitation?
n/a
8. Do you currently have or previously had a D.O.T. waiver? If yes, attach documentation from the D.O.T. This is a special medical permit that the Department of Transportation issues for specific physical and or medical conditions.
no

My signature below certifies that this questionnaire is true and complete to the best of my knowledge.

Joseph Osmański
Printed Name

10-30-06
Date

by phone
Signature

Debi Houle
Interviewer

Please fax this immediately to Debi Houle or Janice Peterson in the Missoula Safety Department.

Revised 04/15/05

Shepard \$408.79

2		Driver completes this section, but medical examiner is encouraged to discuss with driver.						
YES	NO		YES	NO		YES	NO	
☐	☒	Any illness or injury in last 5 years?	☐	☒	Lung disease, emphysema, asthma, chronic bronchitis	☐	☒	Pneumonia, tuberculosis
☐	☒	Head/brain injuries, disorders or illnesses	☐	☒	Kidney disease, dialysis	☐	☒	Stomach disorders, problems in breathing while asleep, sleeping sleep apnea, loud snoring
☐	☒	Seizures, epilepsy ☐ medication	☐	☒	Liver diseases	☐	☒	Breasts or prostate
☐	☒	Eye disorders or impaired vision (except corrective lenses)	☐	☒	Cancer or leukemia	☐	☒	Hearing or impaired hearing, ears, foot,
☐	☒	Ear disorders, loss of hearing or balance	☐	☒	Treatment of alcoholism (not under control) by:	☐	☒	leg, finger, toes
☐	☒	Heart disease or heart attack; other cardiovascular condition ☐ medication	☐	☒	drugs	☐	☒	Spiral injury or disease
☐	☒	Heart surgery (valve replacement, bypass, angioplasty, pacemaker)	☐	☒	insulin	☐	☒	Chronic low back pain
☐	☒	High blood pressure ☐ medication	☐	☒	Nervous or psychiatric disorders, e.g., severe depression	☐	☒	Fingernails, fingernail alcohol use
☐	☒	Major depressive disorder	☐	☒	☐ Medication	☐	☒	Marijuana or hash smoking (drug use)
☐	☒	Shortness of breath	☐	☒	Loss of, or altered consciousness			

[The following text is extremely faint and largely illegible due to poor scan quality. It appears to be a multi-line document or form.]

1/24/06
Driver's Signature

Smoker

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 75 per cent of peripheral vision in each eye.

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective Lenses ☒ Vision Aids ☐ Neither Vision Aids nor Corrective Lenses ☐ Yes ☐ No

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

Date of Examination	Name of Ophthalmologist or Optometrist (print)	Tel No.	License No./State of Issue	Signature
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INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

a) Record distance from individual at which	Right Ear	Left Ear	b) If audiometer is used, record hearing loss in	01	05	26	00	15	6
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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 08-14-2010 BY 60322 UCBAW

Driver's license # 140-150000-00 140-150000-00 1 year One-time certificate for 3 months

180-178/100-100	Stage 2	One-time contribution for 3 months	1 year from 2000
			6 months from 2000

B-1 **ANALYSIS OF THE RESULTS:** "Theoretical reaction rate has occurred."

Shands HealthCare

Confidential

Not an Original

OSMANSKI

THUR

DOB:

M

RAD SSN:

SHANDS-ITF

Clinic N 01/10/01

SHANDS at UF CLINIC

01/10/2001

OSMANSKI, JOSEPH STH#00-67-58-85

CHIEF COMPLAINT: Followup surgery of left elbow.

HISTORY OF PRESENT ILLNESS: Mr. Osmanski is well known to our service. He is now approximately three-and-a-half months after a complex left total arthroplasty. He also had a previous radial ulnar synostosis. He has been wearing his Bledsoe brace and working on motion. He does complain of occasional popping noises coming from that elbow, and lack of strength.

PHYSICAL EXAMINATION: The surgical wounds are well healed. There are no signs of infection. Range of motion actually is fairly good considering what he has been through. It is from approximately 40 degrees to 110 degrees. He can fully flex extend his fingers and his wrist, and abduct and extend his thumb. Light touch sensation is intact to his fingers, however, he complains of numbness on the dorsal side of his hand and forearm. He is able to actively flex and extend his elbow but with minimal strength, compared to the other side.

X-RAYS: X-rays, radiographs obtained again today show the prosthesis in position with tension band construct on the lateral condyle. A line is seen around the cement area which may or may not be related to loosening of the cement, but rather the technique.

IMPRESSION: Status post complex left salvage total hip arthroplasty.

PLAN: The patient was seen and evaluated today with Dr. Chidgey. We again reiterated no more narcotics and will continue the Ultram and Neurontin. He does feel a difference with both of these medications. We again stressed the importance of limited use of his left arm to increase the longevity of this prosthesis. He can work on gentle exercises and motion, and a lot of that popping he is feeling is suspected to be scar tissue which will loosen over time. He will always have a 15 pound weight limit restriction for the left upper extremity. He should also avoid situations where he might fall or excessively stress his left arm. We stressed this multiple times today, and the patient stated he understands. Overall, his wife stated that she feels he has made significant improvements, and is much better than he was prior to this last surgery. All questions were answered. We will see him again in three months with pre-clinic x-rays of the left elbow.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery

Requested by WHEDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8630

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PIDX MRN:
DOR: M	SHANDS-UF
CLINIC N 02/11/02	HEAD SSN:

SHANDS at UF CLINIC
02/11/2002

OSMANSKI, JOSEPH STH#00-67-58-85

Joseph returns today for evaluation status post ulnar nerve neurolysis on 11/01/01. On exam, his incision is well-healed. Sensation is unchanged. X-rays are not obtained. His elbow range of motion is approximately 0 to 120 degrees of flexion, minimal pronation and supination.

Assessment: Status post left ulnar nerve neurolysis following transposition.

Plan: The plan will be to obtain a functional capacity evaluation. This was written today to set permanent impairment. We have indicated, however, that he will be at a 10-pound lifting restriction indefinitely for his left upper extremity due to this total elbow arthroplasty on that side. We will see him back after functional capacity evaluation again to set his permanent impairment grading. Work restrictions were given (again, a 10-pound lifting restriction). The patient was seen and examined by Dr. Chidgey.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Thomas F. Saylor, MD
02/11/2002:02/11/2002 9:58 P
Job ID# 001188532

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8640

Shands HealthCare

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Not an Original

OSMANSKI, JOSEPH ARTHUR

DOB: 09/24/1964 M

EAD SSN.

SHANDS-UT

Clinic N 03/22/02

SHANDS at UF CLINIC

03/22/2002

OSMANSKI, JOSEPH STH#00-67-58-85

DIAGNOSIS: Status post left total elbow arthroplasty and left ulnar nerve neurolysis and transposition.

INTERVAL HISTORY: The patient returns today for repeat evaluation following his functional capacity evaluation. We agree with the findings and work recommendations which include a conditioning program as well as teaching techniques to promote good biomechanics. We also agree with them limiting his workload and emphasized that he cannot lift more than 10 or 15 pounds with his left arm due to his total elbow arthroplasty. We will place him at MMI today for his left elbow with a PPI of 14%. This combined with his 6% for his right shoulder gives him a total PPI of 20%.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Daniel A. Worrel, M.D.
DAW/329 03/22/2002:03/26/2002 2:17 P
Job ID# 001232836

cc:

Requested by WHIDDS on 01/07/09 at 10:08 From M009 Page 1

NL1E8641

OSMANSKI, JOE 76730 FISHER/cmh 10/22/2008 J994051

S: The patient is a 44-year-old white male, here for his 1st visit to our office. He basically comes in for a physical. It has been some time since he had a regular physician. He wanted to get his DOT form completed as well. He generally has been pretty healthy. He does take Flomax regularly for some nocturia and BPH. This has helped significantly. He only gets up about once nightly now to use the bathroom. He is also a smoker. He is not that interested quitting right now. He still drives a truck a good bit, although he is not over the road like he was. He is down to about 1 pack daily right now. Unsure when his last tetanus was given. He does have a history of a fall, in 1987, when he was about 23. He had a good bit of problems. He had a pretty bad injury in his left elbow and wrist, particularly. He still has some limited range of motion of elbow as far as supination but otherwise he lifts furniture and does not have any other residual problems. He has recently been seen for some kidney stones by Dr. Brightbill. He had an IVP, which was negative, because he was having some mild persistent pain but he is doing pretty well right now without any significant symptoms. He is allergic to penicillin. FH: Father, some kind of blood disorder in his 50s, did not know exactly what it was. Otherwise unremarkable. PMH: See chart for the rest. ROS: Negative for allergies. Not complaining of chest pain or shortness of breath. No recent bowel changes. Urine as discussed above. No skin problems. Never had any restriction from DOT physical in the past.

O: VITAL SIGNS: Blood pressure 136/84, heart rate 84, weight 273 (reports losing about 70 lbs. this past year from just dietary changes). GENERAL: Alert. HEENT: See visual acuity. Eyes clear. TMs clear, mouth with deteriorating tooth in the left lower jaw, otherwise clear. NECK: Supple, good pulses, no bruits. No masses. HEART: Regular rate and rhythm without murmurs. LUNGS: Clear to auscultation bilaterally. BACK: Without tenderness. ABDOMEN: Mildly obese, soft, nontender, no masses noted. EXTREMITIES: Without edema, good pulses. GU: Bilateral descended testicles. Very mild hernia on right side. Left clear. RECTAL: Moderately enlarged prostate, smooth, symmetric. SKIN: Clear with a few non atypical appearing nevi. DIAGNOSTIC STUDIES: EKG: See chart. Executive profile to be done. Fasting today.

A

1. Physical examination performed in a 44-year-old white male.
 2. Department of Transportation physical performed, no obvious restrictions.
 3. History of benign prostatic hypertrophy, has done well with Flomax.
 4. Tobacco dependence. Encouraged to quit smoking. Do not think he really feels like he is ready right now.
 5. Persistent lack of supination, left elbow, status post injury at 23 years old.
 6. Some obesity in the past, significantly improved with just dietary changes.
- P: Tetanus updated today. DOT form completed. Executive profile and PSA. Proceed as needed on that. Encouraged to quit smoking once again. Did not need refills on Flomax. Follow up p.r.n.

ADDENDUM: Cyst between the DIP and PIP on right ring finger, has gotten a little bit larger, about 3 x 1 cm. Needs further evaluation, excision. Will send to orthopedist for evaluation.

OSMANSKI, JOE 76730 FISHER/cmh 11/13/2008 J911872

S: The patient is a 44-year-old white male who comes in to followup some labs. He has mildly increased cholesterol. He has not been told this in the past. He was also noted to have mildly increased liver functions. He rarely takes Tylenol at home. He drinks a little bit of on the weekends but not regularly. He is not any medicines except Flomax. He has never been told his liver functions were elevated.

O: VITAL SIGNS: Blood pressure 130/88, weight 270. HEART: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Soft, no right upper quadrant tenderness. No obvious swelling or masses. DIAGNOSTIC STUDIES: See chart for labs.

A

1. Mildly increased triglycerides, low HDL. Ratio slight high.
 2. Mildly increased liver functions.
- P: Given low-triglyceride diet sheet. Talked a little bit about omega-3 fatty acids. Would like to check cholesterol and liver functions in 3 mont - 6 - oner if he has any particularly symptoms. Follow up

LEXINGTON FAMILY PRACTICE, L.L.C.

NAME Joseph A Osmanski

NO. _____

DATE 10/22/08

LIFESTYLE

Circle The Correct Answer

- YES ☒ NO ☐ 1. Do you use tobacco regularly?
cigarette ☒ pipe ☐ cigar ☐ chew ☐
If yes, how long _____, how much _____
- YES ☒ NO ☐ 2. Do you drink over 6 cups of coffee a day?
- YES ☒ NO ☐ 3. Do you drink alcohol regularly?
1 oz./d ☐ 2 oz./d ☐ 4 oz./d ☐ Over 4 oz./d ☐
Beer - 1 bottle/d ☐ 2 bottles/d ☐
over 2 bottles/d ☐
- YES ☒ NO ☐ a. Have you felt the need to cut down on your drinking?
- YES ☒ NO ☐ b. Have you felt annoyed by criticism about your drinking?
- YES ☒ NO ☐ c. Have you had guilty feelings about your drinking?
- YES ☒ NO ☐ 4. Do you wear a seat belt regularly?
- YES ☒ NO ☐ 5. Do you have much stress in your life?
- YES ☒ NO ☐ 6. Do you often feel depressed or down for more than a few days with no apparent cause?
- Did you have frequent episodes (more than 3 times) of any of the following during the past year?
- YES ☒ NO ☐ 7. Constipation (trouble passing stool)
- YES ☒ NO ☐ 8. Indigestion (stomach trouble)
- YES ☒ NO ☐ 9. Difficulty urinating (pain, trouble starting stream, dribbling, losing water)
- YES ☒ NO ☐ 10. Persistent hoarseness or a cough
- YES ☒ NO ☐ 11. Rectal bleeding (blood on your toilet paper, red colored water in the bowl, black or tarry stool.
- YES ☒ NO ☐ 12. Freckle, mole or skin growths that get bigger or change color.

List medications you take regularly:

Flomax

List allergies to medications:

Penicillin

FAMILY HISTORY

Please relate to blood relatives and if yes describe relation- i.e. brother, mother, etc.

YES ☐ NO ☐ Anyone in the family with allergies or asthma?

YES ☒ NO ☐ Anyone in the family with diabetes mellitus (or sugar)?

YES ☒ NO ☐ Anyone in the family with heart disease (heart attack/heart failure)?

YES ☒ NO ☐ Anyone in the family with hypertension (or high blood pressure or stroke)

YES ☒ NO ☐ Anyone in the family with cancer or tumor (please discuss the kind of cancer or tumor)

PAST HISTORY

List operations in the past. (include the year the surgery occurred)

1987 E/Bow surgery (BPH)

List serious diseases requiring hospitalization or not, and the year.

List serious injuries or accidents & the year.

- OVER -

Please Fill Out Other Side

(A) SKIN

1. Have you ever had any serious skin trouble—rashes, eczema, acne, skin cancer? YES ___ NO ☒

(B) HEAD

2. Do you have severe headaches? YES ___ NO ☒
 3. Do you have episodes of dizziness or numbness, tingling, or weakness in any part of your body? YES ___ NO ☒
 4. Have you ever had fits, spells, seizures, or convulsions? YES ___ NO ☒
 5. Do you have any other head problems? YES ___ NO ☒

(C) EYES - EARS

6. Do you wear glasses or contacts? YES ___ NO ☒
 7. Do you ever see double or does your eyesight ever black out? YES ___ NO ☒
 8. Do you have trouble hearing? YES ___ NO ☒
 9. Do you have any other ear or eye problems? YES ___ NO ☒

(D) NOSE

10. Do you have problems with allergy, sneezing, or sinus trouble? YES ___ NO ☒
 11. Do you have any other nose problems? YES ___ NO ☒

(E) MOUTH

12. Do you have any mouth problems? YES ___ NO ☒

(F) CHEST

13. Do you now have asthma? YES ___ NO ☒
 14. Do you cough a lot? YES ___ NO ☒
 15. Do you cough up sputum or phlegm? YES ___ NO ☒
 16. Have you ever coughed up blood? YES ___ NO ☒
 17. Have you ever had tuberculosis or lived with someone who had tuberculosis? YES ___ NO ☒
 18. Do you get short of breath with activity? YES ___ NO ☒
 19. Do you have any other chest problems? YES ___ NO ☒

(G) CARDIOVASCULAR (HEART)

20. Have you ever had high blood pressure? YES ___ NO ☒
 21. Have you ever had a heart attack? YES ___ NO ☒
 22. Do you have pains in your chest (angina) when walking, working, or climbing stairs? YES ___ NO ☒
 23. Does your heart beat peculiarly or rapidly? YES ___ NO ☒
 24. Do you ever have to prop up in bed at night to breathe? YES ___ NO ☒
 25. Are your ankles often swollen? YES ___ NO ☒
 26. Do you have cramping in your calves or thighs after walking? YES ___ NO ☒
 27. Do you have any other cardiovascular problems? YES ___ NO ☒

(H) GASTROINTESTINAL (STOMACH)

28. Have you ever had stomach ulcers? YES ___ NO ☒
 29. Have you ever had gallstones or gallbladder trouble? YES ___ NO ☒
 30. Have you ever had jaundice (yellow eyes) or hepatitis? YES ___ NO ☒
 31. Have you ever had rectal hemorrhoids? YES ___ NO ☒
 32. Do you have any other gastrointestinal problems? YES ___ NO ☒

(I) GENITO-URINARY (KIDNEY)

33. Have you ever had blood in your urine? YES ___ NO ☒
 34. Do you have trouble starting or stopping your stream? YES ___ NO ☒
 35. Do you have to get up more than once during the night to urinate? YES ☒ NO ___
 36. Do you sometimes lose control of your bladder? YES ___ NO ☒
 37. Do you have any other genito-urinary (kidney) problems? YES ___ NO ☒

(J) BONES - JOINTS - MUSCLES

38. Are your joints often painfully swollen or stiff? YES ___ NO ☒
 39. Have you ever had serious back trouble? YES ___ NO ☒

(K) ENDOCRINE (GLANDS)

40. Have you gained or lost weight recently without trying? YES ___ NO ☒
 41. Are you usually hungry or thirsty at all times? YES ___ NO ☒
 42. Do you urinate more than you think you should? YES ___ NO ☒
 43. Have you ever had any thyroid trouble? YES ___ NO ☒
 44. Have you ever had gout? YES ___ NO ☒

(L) GENERAL

45. Have you noticed any swelling or a lump in your neck, armpits, or groin? YES ___ NO ☒
 46. Do you have trouble falling or staying asleep? YES ___ NO ☒
 47. Have you ever had a nervous breakdown? YES ___ NO ☒
 48. Are there any sexual problems you want to discuss? YES ___ NO ☒

(M) ADDITIONAL QUESTIONS FOR MEN ONLY

49. Have you ever had any prostate gland trouble? YES ___ NO ☒
 50. Do you have any other male problems? YES ___ NO ☒

(N) ADDITIONAL QUESTIONS FOR WOMEN ONLY

51. When was the first day of your last period? _____
 52. When was your last period before that? _____
 53. Are your periods frequently irregular? YES ___ NO ___
 54. Do you have a lot of cramping with your period? YES ___ NO ___
 55. Have you, within the past year, had vaginal bleeding other than at the time of a period? YES ___ NO ___
 56. Have you ever been pregnant? YES ___ NO ___
 If yes, how many times _____
 57. Number of living children _____
 58. Have you ever had a lump in your breast? YES ___ NO ___
 59. Do you have any other female problems? YES ___ NO ___

(O) DENTAL

60. Have you had any pain in your jaw joints (pain in front of your ear)? YES ___ NO ☒

Medical Examination Report

FOR COMMERCIAL DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION								Driver completes this section		
Driver's Name (Last, First, Middle) Osman, Joseph A			Social Security No. 1-1-1-1-1-1-1-1-1-1		Age 44	Sex ☒ M ☐ F	☐ New certification ☒ Recertification ☐ Follow Up	Date of Exam 10/22/08		
Address ~		City, State, Zip Code Pelion SC 29123		Work Tel: (803) 894-7601 Home Tel: ()		Driver License No. 100560509		License Class ☐ A ☐ C ☐ B ☐ D ☐ Other	State of Issue SC	
2. HEALTH HISTORY										Driver completes this section, but medical examiner is encouraged to discuss with driver.
Yes No ☐ ☒ Any illness or injury in last 5 years? ☐ ☒ Head/Brain injuries, disorders or illnesses ☐ ☒ Seizures, epilepsy ☐ medication _____ ☐ ☒ Eye disorders or impaired vision (except corrective lenses) ☐ ☒ Ear disorders, loss of hearing or balance ☐ ☒ Heart disease or heart attack; other cardiovascular condition ☐ medication _____ ☐ ☒ Heart surgery (valve replacement/bypass, angioplasty, pacemaker) ☐ ☒ High blood pressure ☐ medication _____ ☐ ☒ Muscular disease ☐ ☒ Shortness of breath			Yes No ☐ ☒ Lung disease, emphysema, asthma, chronic bronchitis ☐ ☒ Kidney disease, dialysis ☐ ☒ Liver disease ☐ ☒ Digestive problems ☐ ☒ Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin ☐ ☒ Nervous or psychiatric disorders, e.g., severe depression ☐ Medication _____ ☐ ☒ Loss of, or altered consciousness			Yes No ☐ ☒ Fainting, dizziness ☐ ☒ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring ☐ ☒ Stroke or paralysis ☐ ☒ Missing or impaired hand, arm, foot leg, finger, toe ☐ ☒ Spinal injury or disease ☐ ☒ Chronic low back pain ☐ ☒ Regular, frequent alcohol use ☐ ☒ Narcotic or habit forming drug use				
For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently. _____ _____ _____										

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature

Date

Medical Examiners Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving)

Name _____

Social Security No. _____

TESTING (Medical Examiner completes Section 3 through 7)

3. VISION Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/ 40	20/	Right Eye °
Left Eye	20/ 30	20/	Left Eye °
Both Eyes	20/ 20	20/	°

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing:

☐ Corrective Lenses

Monocular Vision: ☐ Yes ☐ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist.

Date of Examination _____

Name of Ophthalmologist or Optometrist (print) _____

Tel No. _____

License No./State of Issue _____

Signature _____

4. HEARING

Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear
	5 Feet	5 Feet

b) If audiometer is used, record hearing loss in decibels (acc. to ANSI Z24.5-1951)

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

5. BLOOD PRESSURE/PULSE RATE

Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic	Diastolic
	130	84

Driver qualified if $\leq 140/90$.

Pulse Rate	☒ Regular
	☐ Irregular

Record Pulse Rate: 84

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if $\leq 140/90$. One time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One time certificate for 3 months.	1 year from date of exam if $\leq 140/90$.
$\geq 180/110$	Stage 3	6 months from date of exam if $\leq 140/90$.	6 months if $\leq 140/90$.

6. LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing (Describe and record)

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
	1.015	neg	neg	100

7. PHYSICAL EXAMINATION

Height: 5'11" (In.)

Weight: 273.6 (lbs.)

Social Security No. _____

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See Instructions To The Medical Examiner for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight; tremor, signs of alcoholism, problem drinking, or drug abuse.		✓	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		✓
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.		✓	8. Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits; varicose veins.		✓
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.		✓	9. Genito-urinary system	Hernias.		✓
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.		✓	10. Extremities - Limb	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		✓
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker.		✓	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		✓
6. Lungs and chest, not including breast examination.	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales; impaired respiratory function; dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest.		✓	12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.		✓

* COMMENTS:

Note certification status here. See Instructions to the Medical Examiner for guidance.

- ☒ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate.
- ☐ Does not meet standards.
- ☐ Meets standards, but periodic evaluation required.
- Due to _____ driver qualified only for:
 - ☐ 3 months
 - ☐ 1 year
 - ☐ 6 months
 - ☐ Other

☐ Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on: _____

If meets standards, complete a Medical Examiner's Certificate according to 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt Intracity zone.
- ☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's Signature _____
 Medical Examiner's Name (print) John H. Fisher M.D.
 Address 3314 Platt Springs Road
West Columbia, SC 29170
 Telephone Number (803) 791-3494



Lexington Medical Center
Patient History Form

PATIENT LABEL

Patient Name: Joseph Osmanski Date of Birth: _____

Social History (circle the most accurate choice):

Primary Language: English Spanish Other (specify) _____
Marital Status: Single Married Divorced Separated Widowed
Occupation: Truck Driver Disabled: No Yes What condition? _____
Alcohol Use: Never Rarely Weekly Daily -- Drinks per day? _____
Caffeine Use: Never Rarely Weekly Daily -- Drinks per day? 1
Tobacco Use: No Yes -- Chew? Smoke? Packs per day 1
Drug Use: Marijuana Other Drugs (specify): _____

Advanced Directives (Living Will): Yes No

Environmental/Occupational Exposure:

Tobacco Smoke: _____ Asbestos: _____ Chemicals/Pesticides: _____

PATIENT Medical History (PLEASE SPECIFY CONDITION!):

Heart Problems: _____	Stomach/Intestinal/Hepatitis: _____
Lung Problems: _____	Thyroid Problems: _____
Diabetes: _____	Kidney Problems: _____
High Blood Pressure: _____	Bleeding Problems: _____
High Cholesterol: _____	Seizure Disorder: _____
Obesity: _____	Hereditary Disorder: _____
Arthritis: _____	TB: _____
Cancer: _____	Sex Transmit. Diz: _____
Depression/Anxiety: _____	HIV/AIDS: _____
Other Psychiatric Conditions: _____	Chronic Pain: _____
	Other Problems: _____

FAMILY History (Do any of the above medical conditions run in your family?):

Which ones? NO

Surgeries (Please be specific as possible!):

Abdominal: _____
Gyn (female): _____
Heart (including catheterization): _____
Orthopedic: Left Elbow Implant
Other: _____

Medications: (Please include over the counter meds and nutritional supplements.):

IB Profen

ALLERGIES: Penic

SIGNATURE [Signature] (Relation to Patient) Self DATE: Nov 22 2008

**LEXINGTON
MEDICAL CENTER**
LEXINGTON
811 Main Street
Lexington, South Carolina 29072
803-358-6100

PATIENT: OSMANSKI, JOSEPH A	VISIT DATE: 11/04/2008
ADM. #: X00004373411	M.R. #: M000166905
PHYSICIAN: SALLY L HERPST, MD	D: 11/07/2008 7:33 PM
DATE OF BIRTH:	T: 11/10/2008 8:25 AM / mwl

URGENT CARE

CC: Elbow pain.

S: Patient states that on Saturday November 1st, he had a forceful hyperextension of his left arm at the elbow. A box containing a lazy boy chair came unbalanced from the top of a pile. He tried to brace it as it fell but the weight of it caused his left elbow to suddenly hyperextend. He has a history of left elbow implanted prosthesis. He shattered the elbow in a fall in 1987. He had several surgeries culminating in hardware replacement of the elbow in 1999. Since the injury, he has been unable to actively flex his left arm at the elbow. He can do a passive range of motion with assistance from the right hand. He was seen in the Emergency Department on Sunday November 2nd. He had a normal x-ray taken and was given a sling. He still notes a lot of pain with pain radiating from elbow up to anterior shoulder. He denies any other areas of injury. **PMH:** Healthy. **CURRENT MEDICATIONS:** None. **DRUG ALLERGIES:** None known. **PMD:** Dr. Fisher. He has seen Dr. McIntosh for a different, unrelated orthopaedic concern. He was not the original operating surgeon. **SH:** Married. Works as driver delivery person. Smokes cigarettes, 1 pack/day.

O: **VITAL SIGNS:** TEMP 98.7, pulse 90, respirations 18, blood pressure 151/97, O2 SAT 99% on room air. **GENERAL:** Pleasant. Well-developed, well-nourished 44-year-old white male, established patient. Alert, nontoxic appearing. **SKIN:** No rash or jaundice. **HEENT:** Oral mucosa moist. **EXTREMITIES:** Initially wearing sling on his left arm. When sling is removed, he has some soft tissue fullness that he states is his normal around the area. It has been this way since his surgery. He holds the arm in partial extension in his lap. He is not able to do any active flexion at the left elbow. He requires the use of his right hand to lift up the arm if this movement is needed. Able to extend actively at the elbow. His pain is at the area of the supracondylar notches of the humerus although he no longer possesses these bony. Radiates anterolaterally up toward the mid deltoid area. Some pain to palpation in posterior aspect of elbow as well. No pain to palpation of any part of the shoulder joint. No pain to palpation of mid or distal left forearm. Hand, notes some slight tingling in the left 4th and 5th fingers, although is able to flex/extend as well as abduct and adduct all fingers. Capillary refill 1 second at each fingertip of this hand. More pain with supination of the forearm as well. He states he was not able to achieve 180 degrees of extension with the left arm prior to his injury, although the arm can be made to extend now to about 175 degrees. Previously 135 degrees was about his range of movement. **DIAGNOSTIC STUDIES:** X-ray re-obtained of left elbow and entire humerus, shows implanted prosthesis with good bit of accessory ossification now around the soft tissues of the elbow. Difficult to tell if there could be a fracture or movement of the prosthetic part. X-rays appear similar to those taken in Emergency Department 2 days ago. We do not have any x-rays that pre-date his injury. Appears there could be an effusion within the elbow joint area. Radiologist concurred that there were no evidences of actual fracture, although this

LEXINGTON MEDICAL CENTER - LEXINGTON
PAGE 1 OF 2



PATIENT: OSMANSKI, JOSEPH A	
M.R. #: M000166905	

call is made difficult by the lack of previous films. I suspect the patient has ruptured the distal insertion of his biceps tendon, which may account for his inability to actively flex his elbow.

A. Hyperextension injury, left elbow, rule out complete biceps tear.

P. Patient clearly needs to be seen by an orthopaedist. As this is a worker's comp injury, I am not able to make this referral. I have written on the paperwork that I have asked him to take immediately to his worker's comp personnel, that he needs to be seen preferably this week. I am going to remove him from all work until cleared to return in any function by the orthopaedist. Recommend use of sling during waking hours. Rx Vicodin every 4-6 hours p.r.n. severe pain (#20, no refill). Discharged stable condition.

S. Herpst, MD
 SALLY L HERPST, MD

cc:

LEXINGTON MEDICAL CENTER - LEXINGTON
 PAGE 2 OF 2



- 14 -

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER - LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT: OSMANSKI, JOSEPH A

UNIT/MR NO: M000168905

ACCT NO: Y000004272111

AGE: 44

SSN:

DOB: 09/24/1964

REQ NO: 08-0027188

SEX: M

REPORT NO: 1105-0033

ORDERING DR: SALLY L HERPST MD

PT LOCATION: LEXURG
HERSAL EM

REPORT STATUS: Signed

ORDERED BY: SALLY L HERPST MD

LOCATION: DEP ER LEXURG

STUDY TYPE: 1104-0005 LRAD/HUMERUS LEFT

DATE OF EXAM: 11/04/08

CLINICAL DATA: 44M, PATIENT INJURED ELBOW BY HYPEREXTENDING ARM LIFTING BOXES

LEFT HUMERUS:

FINDINGS: AP and lateral views of the left humerus demonstrate the patient's previously noted left elbow prosthesis. The humerus appears intact with no acute fracture seen.

MK

CLARENCE S DAVIS MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 1104-0005 LRAD/HUM (73060TC)

EXAM TECH: DELWEA

REP RELEASED BY: DAVCLA RAD 11/05/08 1025

ADD RELEASED BY:

DISC DATE: 11/04/08

ED DISC DIAG: 00

PT LOC/ROOM: LEXURG/

OSMANSKI, JOSEPH A

Patient Location's copy

Page 1 of 1

- 15 -

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER -- LEXINGTON
811 WEST MAIN STREET
LEXINGTON, SC 29073
PHONE: (803) 358-6120

PATIENT: OSMANSKI, JOSEPH A

UNIT/MR NO: M000166905

ACCT NO: X00004373411

AGE: 44

SSN:

DOB: 09/24/1964

REQ NO: 08-0027189

SEX: M

REPORT NO: 1105-0032

ORDERING DR: SALLY L HERPST MD

PT LOCATION: LEXURG
HERSAL EM

REPORT STATUS: Signed

ORDERED BY: SALLY L HERPST MD

LOCATION: DEP ER LEXURG

STUDY TYPE: 1104-0006 LRAD/ELBOW LEFT

DATE OF EXAM: 11/04/08

CLINICAL DATA: 44M, PATIENT INJURED ELBOW BY HYPEREXTENDING ARM LIFTING BOXES

LEFT ELBOW:

COMPARISON: AP, lateral, and oblique views of the left elbow are compared to the prior study of 11/02/2008.

FINDINGS: There are extensive postoperative changes consistent with previous placement of a prosthetic left elbow. Heterotopic new bone is seen about the elbow joint. There is no significant change in the alignment or positioning of the metallic hardware or fixation pins or suture wires since the previous study. Again, the possibility of elbow joint effusion cannot be excluded.

IMPRESSION: Extensive postoperative changes about the left elbow with evidence of a left elbow prosthesis. Heterotopic new bone formation is seen. There is no definite acute fracture detected on this study. The possibility of a joint effusion, again, cannot be excluded.

MK

CLARENCE S DAVIS MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 1104-0006 LRAD/ELB (73080TC)

EXAM TECH: DELWEA

REP RELEASED BY: DAVCLA RAD 11/05/08 1025

ADD RELEASED BY:

DISC DATE: 11/04/08

ED DISC DIAG: 50

PT LOC/ROOM: LEXURG/

OSMANSKI, JOSEPH A

Patient Location's copy

Page 1 of 2

- 16 -

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169

PATIENT: OSMANSKI, JOE		VISIT DATE: 11-5-08
PATIENT #: 00001529860	XXX-X7-6730	D: 11/06/2008 8:51 AM
PHYSICIAN: JAMES C. MCINTOSH, MD		T: 11/07/2008 6:10 AM / cir
		DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: Patient presents today for workmen's comp injury to his left elbow. He is a truck driver and had a hyperextension injury last week with immediate onset of pain. He went to the Emergency Department and was evaluated. He has a very complicated history with his left elbow. Apparently he had a comminuted fracture. They attempted what sounds like an interpositional arthroplasty that ultimately failed. Back in late 1990s, he underwent a total elbow arthroplasty in his 30s. This was all done in FL. He is a truck driver and has been doing this for some time. He is right-hand dominant. Ever since the injury, he has had some numbness. He has had transposition of ulnar nerves in the past. Little bit of tingling. It has always been painful, but this is a little bit more. Feels like arm is dead and he cannot move it. It sounds basically like he had a hyperextension injury with some crepitation and onset of pain. Not that uncomfortable today. Still has difficulty moving the arm. Some numbness and tingling in his ring and small fingers. No other injuries reported. We saw him just recently for a mass on his right ring finger. Health otherwise is good. No change since we saw him last week.

PHYSICAL EXAMINATION

GENERAL: Mildly obese black male in no apparent cardiopulmonary distress, alert and oriented x3.

ELBOW: Some mild swelling. I really cannot palpate his biceps very well. He has a 1 bone forearm so he cannot supinate. Ulnar nerve function appears to be intact. Decreased sensation in ulnar distribution. Radial and medial nerve function appears to be intact. Good capillary refill. Several scars on posterior aspect of elbow. No obvious crepitation. Actually fairly good motion. Nearly full extension. Flexion to about 125-130. Elbow showed implant in place; several wires present. No obvious evidence of implant loosening. Some asymmetry at the bushing, which is consistent with wear. Do not see any obvious implant loosening.

ASSESSMENT: Left elbow strain; difficult to tell what is going on with him. His implant appears to be intact. Pins extending at the posterior aspect of the elbow. I do not know if this is old or new.

PLAN: I asked him to continue same range of motion exercises and work status. No use of left arm. Also asked him to get old notes or x-rays to see if we can compare to past films. Recheck and reexamine in 3 weeks.

JAMES C. MCINTOSH, MD

cc:

Lexington Orthopaedics
PAGE 1 OF 1

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169

PATIENT: OSMANSKI, JOE		VISIT DATE:
PATIENT #: 00001529860	XXX-X7-6730	D: 11/20/2008 5:15 PM
PHYSICIAN: JAMES C. MCINTOSH, MD		T: 11/24/2008 2:45 PM / cgu
		DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: The patient returns today. He seems like he may be doing just a tiny bit better. He still has difficulty actively contracting his arm. He may be getting a tiny bit better with his pain. No new numbness or tingling.

PHYSICAL EXAMINATION: ARM: No significant swelling or discoloration. I cannot really palpation his biceps. Not contracting very well. Some swelling and ecchymosis. No crepitation.

DISCUSSION: We asked him on his last visit to try to get some of his old records and films. He was unable to produce either. Again a difficult time for me to tell exactly what is going on. He had a complex elbow injury. I do not see any true objective findings. His films do show a longstanding elbow implant. There is some prominent hardware but I am not sure if this is new or old.

PLAN: We are going to try once again to get his previous films. Return in 3 weeks. Work status, no use of left arm.

JAMES C. MCINTOSH, MD

cc:

Lexington Orthopaedics

PAGE 1 OF 1

Shands HealthCare

Confidential

Not an Original

OSMANSKI	THUR		
DOR:	M	EAD ASN:	SHANDS-UP
Clinic N 02/19/92 23:59			

February 19, 1992

DIAGNOSIS: Left upper extremity fracture with resultant one bone forearm.

HISTORY: Mr. Osmanski returns today with complaints of new onset left elbow pain beginning last Sunday when he picked up an empty cooler. He said the pain persisted with motion of his elbow with temporary relief with the use of Feldene. Since then, however, the pain has been persistent and he has been wearing an arm sling to relieve the discomfort.

PHYSICAL EXAMINATION: He has essentially full range of motion of his elbow. However, it is painful. He also has a significant amount of tenderness over the left cubital tunnel in the ulnar nerve region. He has no tenderness over his forearm.

TEST RESULTS: X-ray examination of his left elbow today demonstrates that he has evidence of degenerative joint changes and has had progression of some of his heterotopic ossification. He also has several osteophytes which have formed specifically in the cubital tunnel region.

DISPOSITION: Mr. Osmanski is experiencing some irritation of his ulnar nerve, probably from irritation by the heterotopic bone and osteophytes. We recommended he be put into a resting elbow splint and resume taking Feldene 20 mg PO q day. We hope that he will improve on this regimen and we will see him back in approximately three to four weeks for follow up and no new x-rays are needed.

Larry K. Chidgey, M.D.
Assistant Professor
Hand and Microsurgery
Department of Orthopaedics
Box 100246
Phone: 904-392-4251

Dictated by: A. Wong, M.D.
LKC/AW/vbs 02-19/02-21-92

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8608

01/08/2009 11:51 FAX 352 273 1 14

Ortho Medical Records

@005/038

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH	THUR	DATE WRN:
DOR: M	EAD SEN:	SHANDS-UP
Clinic N 11/04/98 23:59		

UNIVERSITY OF
FLORIDAOSMANSKI, JOSEPH
STH #00-67-58-85SHANDS CLINIC at Hampton Oaks
32607200-B SW 62nd Blvd.
Gainesville, FL

(352) 395-0647

11/04/98

SHANDS CLINIC at Hampton Oaks

SUBJECTIVE: Patient is a 34 year old male status post fall back in 1987. Patient has been disabled since that time. He has had bilateral shoulder dislocations at that time as well as bilateral elbow fractures. He has had multiple procedures to his left upper extremity including ulnar nerve transposition x 2 to his left elbow. He has most recently had a shoulder scope with repair of an apparent labral lesion with shrinkage of his capsule. He has had removal of bony fragments from his left wrist and two previous arthroscopic procedures to his left shoulder. He has had also a one bone forearm procedure to his left elbow. Patient is here today for evaluation of his left shoulder and his left elbow.

PAST MEDICAL HISTORY: He denies any hypertension, diabetes, coronary artery disease, seizures, or history of cancer.

PAST SURGICAL HISTORY: Multiple reconstructive surgeries to his left shoulder, left elbow, and right elbow.

ALLERGIES: Penicillin.

SOCIAL HISTORY: He smokes one pack per day. Ethanol: Denies.

OBJECTIVE: On physical examination of his left shoulder, patient, due to pain, is only able to abduct his shoulder about 20 or 30 degrees. He is only able to elevate his shoulder about 10 degrees. He has significant tenderness to any passive range of motion beyond these extremes. Right upper extremity reveals he has full range of motion of his shoulder. On his left shoulder, he is unable to axially rotate his arm any further than to his pocket and he only externally rotates to neutral. Patient's sensation is grossly intact. He has tenderness over his previous ulnar nerve transposition sites. He has about 60 degree range of motion from 30

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8609

Shands HealthCare

Confidential

Not an Original

OSMANSKI	HUR	ARN:
DOB:	M	30
RAD SSN:		SHANDR-UF

degrees loss of extension to about 120 degrees of flexion. He only supinates to neutral and he has good distal refill and good sensation distally.

X-RAYS: His left elbow x-rays show he has significant arthritis, post traumatic, of his elbow with loss of his joint space. His left shoulder x-rays show some erosion along the anterior glenoid and some arthritic changes in the glenohumeral joint.

ASSESSMENT & PLAN: Patient with severe post traumatic arthritis of his left elbow. Patient was explained that there are a few options at this point for his left elbow. One was to continue with conservative management with nonsteroidals and the second choice was to do an inner position arthroplasty of his left elbow versus a total elbow. We did not feel that he is a good candidate for a total elbow due to his age and the fact that he will probably wear it out very quickly. His best option for his elbow would probably be an inner position arthroplasty. Patient states that he would like to think about that procedure. For his left shoulder difficulty, Dr. Chidgey would like to have Joseph referred to Dr. Wright due to the complex nature of his shoulder. He has had two previous arthroscopies including a labral repair and capsular shrinkage and he has very minimal range of motion and very painful with any range of motion to his shoulder. Patient will follow up with us after he has had his shoulder evaluated.

TEACHING PHYSICIAN'S STATEMENT: I was present during all activities documented above, agree with the above documentation, and participated in the entire history, physical exam, and medical decision-making of this patient.

Larry K. Chidgey, M.D.
Associate Professor
Department of Orthopaedics

Dictated by: Jeffrey A. Baker, M.D.

JAB/tra 11/04:11/04/98 c:td 11/13/98

cc:

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 2

NL1E8609

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH, M.D.

DOB:

M

EAD:SEN

PIDX:MRN:

SHANDS-ITP

Clinic N 06/23/99

06/23/1999

HPI: Joseph is being followed for two problems, his left elbow arthritis as well as his left shoulder. He was previously seen in November and we referred him to Dr. Wright for his complex left shoulder injury and we have recommended that he undergo an interpositional arthroplasty of his left elbow. The patient has run up against some road blocks with his insurance company and would like to proceed with the elbow surgery, however, he has not been able to get the referral for the shoulder. So, today we will make a referral for the patient to see Dr. Wright with regards to his complex shoulder injury. We would like to know what Dr. Wright has to say with regards to his treatment plan and whether any further plans for surgery would be needed. Following this evaluation and his recommendations, we will then appropriately schedule the patient for any surgery on his elbow.

TEACHING PHYSICIAN STATEMENT: I was present during all activities documented above, agree with the above documentation, and participated in the entire history, physical exam and medical decision making of this patient.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Anthony J. Leone, M.D.
AJL/tra 06/23/1999:06/23/1999 3:53 P

Requested by WHEDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8610

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH *THUR

DOB: 08/72

EAD SSN:

PIDX MRN:

SHANDS-UP

Clinic N 01/10/00

SHANDS at UP CLINIC

01/10/2000

Joseph is here today for follow-up of left elbow pain. He has a long history of left upper extremity issues, the most recent of which was creation of a one bone forearm after an Essex-Lopresti injury. He has had progressive elbow degenerative joint disease over time. This pain is now disabling and barely tolerable. He is unable to use the arm for any significant activity due to elbow pain.

PHYSICAL EXAMINATION: No distress. Examination of the left upper extremity reveals tenderness about the joint line of the left elbow. Any pronation-supination force applied to the forearm exacerbates the pain.

IMPRESSION: Advanced degenerative joint disease of the left elbow after one bone forearm procedure. The treatment options were discussed extensively with the patient. They include left total elbow arthroplasty, left elbow arthrodesis, left elbow interpositional arthroplasty. The most viable option for this young, potentially active, patient is the interpositional arthroplasty. He wishes to proceed with this procedure. He was referred to the surgery scheduling office today.

The patient was seen and examined with Dr. Chidgey.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Drew E. Kiernan, M.D.
DEK/460 01/10/2000:01/10/2000 1:52 P

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page. 1

NL1E8616

Shands HealthCare

Confidential

Not an Original

OSMANSKI

IUR

PIDX MRN:

DOB:

M

EAD SAN

0

SHANDS-UF

Clinic N 02/16/00

SHANDS at UF CLINIC

02/16/2000

Mr. Osmanski is a 35 year old gentleman who had previous Essex-Lopresti injury of the left forearm after a 32 foot fall on his construction job. He has subsequently undergone left long bone forearm fusion and he has developed severe degenerative joint disease of the left elbow. He is here for preoperative evaluation for a left elbow fascia lata, fascial interposition arthroplasty. All questions were answered, informed consent was obtained after discussion of risks, benefits and alternatives to surgical procedure. The patient will undergo his surgery on 2/17/00.

Larry K. Chidgey, M.D.

Associate Professor, Hand Surgery

Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.

JDS/367 02/16/2000 02/17/2000 8:47 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8617

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PIDX MRN:
DOB: 02/1954 M	EAD SSN:
Clinic N 02/28/00	SHANDS-UF

SHANDS at UF CLINIC

02/28/2000

Mr. Osmanski is a 35-year-old gentleman who presents today for his postoperative visit following left elbow fascia lata interpositional arthroplasty performed on 02/17/00. Overall, he has had significant amount of postoperative pain and has required a significant amount of pain medication but this is not totally surprising given the extent of his surgery.

REVIEW OF SYSTEMS: Has remained unchanged.

PHYSICAL EXAMINATION: Splint was removed from his left elbow. The incision was well-healed. Staples were removed and Steri-Strips applied. His radial ulnar and medial nerve distributions are grossly intact in motor and sensory and capillary refill is less than two seconds with palpable pulses. His left fascia lata donor site had evidence of seroma. The incision was well healed and staples were removed followed by application of Steri-Strips. Approximately 50 cc of seroma was drained from the left thigh and a compressive Ace bandage was applied to the leg. He will keep this compressive wrap on the leg and elevate his leg with pillows in the supine position. He was given a prescription for Mepergan Fortis, number 45, to be taken for pain and he will follow-up with us in 10 to 14 days. At this time he is in a anterior splint of the left elbow at 90 degrees and at his next visit we will have him converted to a hinged elbow brace to begin on flexion and extension exercises but this will provide him with medial and lateral stability. Patient will continue to be temporarily totally disabled from work, but we would anticipate that in six to eight weeks he might be able to return to work in a light-duty capacity, continued no use of the left upper extremity and given the leg surgery, he would probably be a sedentary clerical-type of position.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/496 02/28/2000:02/29/2000 8:21 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8619

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JACOB HUR

PIDX MRN:

DOB:

M

FAD SSN:

SHANDS-UF

Clinic N 03/13/00

SHANDS at UF CLINIC

03/13/2000

SUBJECTIVE: Mr. Omanski is a 35 year old gentleman who had severe post traumatic end stage degenerative joint disease of the left elbow and underwent fascilata interpositional arthroplasty of his left elbow performed on 2/17/00. He presents today for a second postoperative visit. He states that he has been wearing his Ace spica wrap around his left thigh, however, the fluid in his thigh has recollected at the site of fascilata donor harvest. He has been taking the Mephergan 4 tabs and states that this is too strong for him and he would like something less powerful. Review of systems has remained unchanged.

OBJECTIVE: On physical examination his elbow incision is well healed. he is neurovascularly intact distally. His range of motion at this time just when gently tested was from 80 to 95 degrees. He had a significant fluid collection in his thigh region. this incision is well healed. 500 cc of serosanguinous fluid was aspirated from this thigh region after sterile prep. Following this a Triple A spica wrap was placed around his entire left thigh and hip region

IMPRESSION: Overall doing well. At this time we are sending him to therapy to obtain a hinged elbow brace and he will begin on active assist and passive range of motion in his elbow in the splint. He will not remove the brace except for bathing and is aware of the need to protect the elbow for continued ligamentous soft tissue healing. With regards to the thigh we have given him a prescription of Keflex 50 mg p.o. q.i.d. for 7 days just as prophylaxis given the fact that we aspirated a significant amount of fluid here in the office. He will continue with the Ace spica wrap as well as frequent elevation of the leg above the level of his heart. He will follow up with us in 4-5 weeks for repeat evaluation. We also gave him a prescription for Lortab 10s #50 1-2 p.o. q. 6 hours p.r.n. As far as work is concerned he will remain temporarily totally disabled as he cannot be up on his feet given the seroma collection nor can he use his left upper extremity. At his next visit we should obtain x-rays of his left elbow AP and lateral.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8620

Shands HealthCare

Confidential

Not an Original

OSMANSKI

PIDX MRN:

DOB:

M

EAD SSN: 264

1

SHANDS-UF

Clinic N 04/19/00
SHANDS at UF CLINIC

04/19/2000

Mr. Osmanski is now three months status post fascia lata interposition arthroplasty of his left elbow. Overall he feels that he is improved somewhat. He still has a fair amount of significant pain. He still has only 75-100 degrees range of motion with pain at the end of each arch. He has less pain with extension and more discomfort with elbow flexion. His incision is well healed and he is neurovascularly intact distally.

IMPRESSION: Progressing slowly. X-rays show no significant interval change and overall the elbow joint appears to be grossly located.

PLAN: The plan will be to progress slowly. The patient would like to begin with physical therapy for range of motion exercises and we will begin this and he will perform these exercises as tolerated. We have discussed the future options which would include possibly living with the discomfort and loss of motion versus total elbow arthroplasty which in a man of his age and size may not last very long and suffer severe wear and tear versus possible elbow fusion. All of the above have significant disadvantages and we have discussed these with the patient and at this time he would like to proceed with therapy and we will follow his progress. He was given a refill for Lortab 7.5 and as far as work is concerned he will continue to be absolutely no use of the left upper extremity.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/422 04/19/2000:04/20/2000 7:44 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL138622

Shands HealthCare *Confidential* Not an Original

OSMANSKI JOSEPH ARTHUR

PIDX MRN:

DOB:

EAD SSN:

SHANDS-UP

Clinic N 05/17/00

SHANDS at UF CLINIC

05/17/2000

Follow-up for elbow fascia lata interposition on 02/17/00. He is having an extreme amount of pain in his elbow. Very unhappy because of the amount of discomfort he is having. Review of systems, past medical history is unchanged.

PHYSICAL EXAM: Well-developed, well-nourished male in some distress because of the pain. His range of motion, he can flex passively to 90, extend with gravity for a total of about -40 degrees, but still has quite a bit of discomfort at this time. His neurovascular status is intact. He wears a Bledsoe brace for support.

At this time we want to just monitor and try to manage him with pain medicine. Gave him OxyContin 20 mg to take two p.o. q. 12 hours. Gave him pain pills and some Vicxx 25 mg. As far as his work is concerned, he is not really to use that left arm, definitely no lifting greater than 5-10 pounds at this time. We mentioned that the only options would be to leave it alone, fuse it, or replace the joint, but because of his age it would be not a good option at this time. We will see him back in about two months to see how he is doing.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/362 05/17/2000:05/18/2000 10:42 A
c:pjh 5/25/00

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8623

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDX MRN:

DOB:

M

EAD SSM-

SHANDS-UF

Clinic N 06/28/00

SHANDS at UF CLINIC

06/28/2000

DIAGNOSIS: Status post left elbow fascia lata interpositional graft.

DATE OF PROCEDURE: 02/17/00

INTERVAL HISTORY: Mr. Osmanski returns for follow-up with his ongoing problem. He continues to have pain and stiffness in his left elbow with decreased range of motion. He is taking Oxycontin 40 mg b.i.d. with good relief of his pain. However, he has been unable to work and has been in a bledsoe brace. He has no history of further trauma.

PHYSICAL EXAM: Examination reveals exquisite tenderness about the entire elbow. He had some mild swelling associated with that. Range of motion of the elbow is about almost full extension to approximately 90 degrees of flexion passively. Actively, he almost has no elbow motion actively. Light touch is normal throughout the extremity. Supination and pronation is extremely limited.

IMPRESSION/PLAN: We have had a long discussion with Mr. Osmanski at this time. Due to his young age and acute atypical postoperative course, we think that he may have difficulties with a total elbow arthroplasty, but will give us his best chance of relieving some of his pain and possibly regaining some more function. Patient has been thinking about this for some time and after answering all of his questions, he has elected to undergo total elbow arthroplasty. This will be done sometime in August, and we will see him back for his preoperative visit at that time.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Christopher Sforzo, M.D.
CS/pjs 06/28/2000:07/03/2000 3:09 P
c: pjh 7/3/00

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1B8625

Shands HealthCare***Confidential*****Not an Original**OSMANSKI, JOSEPH ARTHUR
DOB: [REDACTED] MFEB 18 1954
RAD SSN: [REDACTED]

PIDX MRN: [REDACTED]

SHANDS-ITF

Clinic N: 09/13/00

SHANDS at UF CLINIC
09/13/2000

Joseph comes in today for preop to have left total elbow arthroplasty.
Consent was signed. Questions answered. He will return for suture removal
and x-ray of elbow at that time.

As far as work is concerned, TTD.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/312 09/13/2000:09/14/2000 4:58 P
c:cjt 9/29/00

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8626

Shands HealthCare

Confidential

Not an Original

OSMANSKI

HUR

PIDX MRN:

DOB:

M

RAD SSN:

SHANDS-UF

Clinic N 09/27/00

SHANDS at UF CLINIC

09/27/2000

Joseph is followed for total elbow arthroplasty, left elbow. We went ahead and removed the staples and got him in a posterior splint that he can start taking off and working on active motion, not flexing completely. His x-rays showed that the prosthesis was in excellent alignment.

ADDENDUM: Joseph had requested pain medication and we are going to decrease his Oxycontin to 40 mg. only once a day and not twice a day. We gave him 50 pills today. He is to taper off this medication and the next visit we need to get him off the pain medication.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/344 09/27/2000:09/28/2000 10:54 A add:ker09/27/00

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8628

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PID# MRN:

DOB:

A M

RAD SSN:

SHANDS-UP

Clinic: 11/01/00

SHANDS at UF CLINIC

11/01/2000

Joseph comes in today for a postop follow-up for his total elbow arthroplasty. He is complaining of pain in his forearm region.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY: Unchanged.

PHYSICAL EXAM: Well-developed, well-nourished man in no distress. Examination of his arm reveals he is tender over the posterior osseous nerve. Looking at x-rays, there is nothing that appears to have loosened.

IMPRESSION: Status post above surgery with pain over his posterior osseous nerve.

PLAN: We are going to give him some Ultram, no more narcotics for him, and Neurontin. We are going to increase the dose to two pills three times a day. As far as work is concerned, TTD still.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/427 11/01/2000 11/02/2000 10:37 A

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NLLE8629

Shands HealthCare***Confidential***

Not an Original

OSMANSKI, JOSEPH STH#00-67-58-85	DOB: M	EAD SSN: 354-1-67-11	SHANDS-UP
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Clinic N 04/04/01
SHANDS at UP CLINIC
04/04/2001

OSMANSKI, JOSEPH STH#00-67-58-85

CHIEF COMPLAINT: Follow-up surgery of left elbow.

DATE OF SURGERY: Total elbow arthroplasty preformed on 09/14/00.

HISTORY: Mr. Osmanski continues to complain of ulnar nerve-type pain status post the above procedure.

PHYSICAL EXAM: On exam, his wounds are remain well-healed. There is no significant change in range of motion which remains fairly good from approximately 35-110 degrees. He can fully flex and extend his fingers and his wrist as well as abduct and extend his thumb. Light touch is intact throughout.

RADIOGRAPHIC DATA: Radiographs again show today that the elbow prosthesis is in good position with a line seen around the cement area which may or may not be related to loosening of cement but rather the technique.

IMPRESSION: Continued nerve-like pain status post complex left salvage total elbow arthroplasty.

PLAN: At this point in time we would recommend that Mr. Osmanski continue with the hinged-elbow brace. We would like him to continue to work on range of motion. He will not be able to lift any heavy weights. With respect to work status, the patient is not recommended to be employed at this time until he is able to see the Pain Management Clinic for possible suggestions regarding his continuing difficult-to-manage ulnar nerve-type pain. At this point, we have filled out a referral for Dr. Sassano in the Pain Management Clinic and will await his recommendations.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Timothy S. Bollom, M.D.
TSB/496 04/04/2001:04/05/2001 11:26 A
Job ID# 871474

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8631

Shands HealthCare

Confidential

Not an Original

OSMANSKI , JOSEPH ARTHUR

DOE:

M 1072-CP-RAD-88N.

PIDX MRN:

SHANDS-TP

Clinic - 05703701
SHANDS at UP CLINIC
09/05/2001

OSMANSKI, JOSEPH STH#00-67-58-85

DIAGNOSIS: (1) Status post left total elbow arthroplasty by Dr. Chidgey on 09/14/00. (2) Status post left shoulder arthroscopy with subacromial decompression via Dr. Wright in 1999.

INTERVAL HISTORY: Mr. Osanski returns to clinic for repeat evaluation. He reports that he has continued to have numbness and burning pain and tingling in his left forearm and hand. He reports that this has been significantly improved with Neurontin, although he was taking 900 mg three times a day and reported erectile dysfunction and loss of sex drive due to the medication. He has slowly titrated himself down and is still having some ulnar nerve symptoms, but has had some improvement in his erectile dysfunction.

PHYSICAL EXAMINATION: He is tender to palpation over the ulnar nerve and has some swelling and tenderness about the elbow. His incisions are all well healed. His range of motion is 5 degrees to 120 degrees of flexion. He has no supination or pronation due to both bone forearm fusion.

IMPRESSION: Left ulnar neuritis.

PLAN: At this point, we had a discussion of re-exploring and performing a neurolysis of his ulnar nerve. Mr. Osmanski is thinking seriously about that. The paperwork was filled out today and he will meet with Teresa. He has temporary total disability regarding his work status.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Daniel A. Worrel, M.D.
DAW/370 09/05/2001:09/05/2001 4:51 P
Job ID# 001026333

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NLEB634

Shands HealthCare***Confidential*****Not an Original**

OSMANSKI	ARTHUR	DATE	SHANDS-IT
DOR	64 M	RAD SSN	

Clinic N 10/24/01

SHANDS at UF CLINIC
10/24/2001

OSMANSKI, JOSEPH STH#00-67-58-85

Joseph comes in today for a preop to have an ulnar nerve exploration. Previous transposition in the past for neurolysis. He understands the postoperative course. He understands the risk of possible nerve damage. We will plan on seeing him back for postop followup approximately two weeks after surgery for suture removal. He will be in house for 23 hours postop for postop pain.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/338 10/24/2001:10/25/2001 11:56 A
Job ID# 001078276

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8635

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

DOB: 09/24/79 M

EAD SNV

PIDX MRN:

SHANDS-NE

Clinic N. 11/09/01

SHANDS at UF CLINIC

11/09/2001

OSMANSKI, JOSEPH STH#00-67-58-85

Mr. Osmanski is follow-up for transposition of ulnar nerve neurolysis performed by Dr. Chidgey on 11/01/01. Unfortunately he has developed quite a bit of swelling. His wound is slightly erythematous. We are going to go through nerve gliding today with him but wait to take the staples out in two weeks because he is still swollen. He understands that if his wound looks worse before then to come back sooner. We are going to give him some Keflex prophylactically, gave him some more pain medication, Lorcet 10, #50 pills. As far as work is concerned, he is really going to be off for next two weeks until we see him again.

Debbie M. Rafanan, PA

Hand Surgery

Dept. of Orthopaedics & Rehabilitation

Dictated by: Debbie M. Rafanan, PA

DMR/418 11/09/2001:11/11/2001 2:56 P

Job ID# 001095876

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8637

Shands HealthCare

Confidential

Not an Original

OSMANSKI

THOR

FIDX MRN:

DOB:

M

EAD SSN:

SHANDS-IT

Clinic N 11/26/01

SHANDS at UF CLINIC

11/26/2001

OSMANSKI, JOSEPH STH#00-67-58-85

PROBLEM: Status post left ulnar nerve decompression and neurolysis on 11/01/01.

HISTORY: Joseph returns. He complains of some problems with the wound. He denies fevers or chills. He states that he was given Keflex last week after calling the office and is currently on that. He says that he no longer has the pins and needle sensation in the ulnar nerve distribution on the right, although he still has some decreased sensation.

PHYSICAL EXAMINATION: His surgical incision has intact staples over the bulk of it. Just distal to the elbow, there is a region approximately 2 x 2 cm in size of wound dehiscence. There is no evidence of infection. No radiographs were taken.

ASSESSMENT: Wound dehiscence status post ulnar nerve decompression.

PLAN: We are going to treat this with b.i.d. wet-to-dry dressing changes as Joseph has an elbow prosthesis on that side, and we will continue his Keflex for seven days. We will bring him back in one week for a repeat wound check.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Joel D. Thompson, MD
/466 11/26/2001:11/26/2001 1:02 P
Job ID# 001109398

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NLLE8638

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

DOB:

M

EAD RSN:

PIDX MRN:

SHANDS-ITP

Clinic N 01/14/02

SHANDS at UF CLINIC

01/14/2002

OSMANSKI, JOSEPH STH#00-67-58-85

PROBLEM: Status post ulnar nerve decompression and neurolysis on 11/01, with postop wound dehiscence.

HISTORY: Mr. Osmanski returns. He says the pins and needles sensation that existed in his hand preoperatively is gone; however, sensation is not normal. He complains of continued pain in the elbow secondary to his arthritis, but he generally says he feels pretty good. He denies fevers or chills.

EXAM: His ulnar wound is near completely healed. There is a small area of eschar approximately 2 cm in diameter just proximal to the medial epicondyle. There is no evidence of infection. Hand intrinsics are intact. Sensation to light touch is diminished in the ulnar nerve distribution. His elbow range of motion is extremely limited and his elbow is swollen. He has minimal pronation/supination.

ASSESSMENT: Stable course.

PLAN: Mr. Osmanski is about to baseline. His wound is not fully healed and will reevaluate him in one month. At that time, we will refer him for FCE, and place him at MMI regarding his elbow.

We will see him in four weeks.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Joel D. Thompson, MD
/424 01/14/2002 01/14/2002 7:21 P
Job ID# 001158523

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8639



SHANDS HOSPITAL AND CLINICS
at the University of Florida
OPERATIVE REPORT

OSMANSKI, JOSEPH
#67-58-85

08-23-88

SERVICE: ORTHOPAEDICS	DAYS:	VOUCHER # 1892	I.P.	O.P.
SURGEON: Dr. Chidgey		ASSISTANT: Dr. McCormick		
ANESTHESIOLOGIST: Dr. DePadua		ASSISTANT: Dr. Winston/Raessler/Fontenot		
PREOPERATIVE DIAGNOSIS: Essex-Lopresh Fracture status post radial head excision plus Darrach procedure				
POSTOPERATIVE DIAGNOSIS: Same				
OPERATION PERFORMED: Fusion left distal radial ulna joint and fusion of proximal radial ulna joint and creation of synostosis with iliac bone graft left radius and ulna				
1. SCRUB: C. Brannan, CST		2. SCRUB: M. Holsbeke		RELIEF:
1. CIRCULATOR: S. Bingham, RN		2. CIRCULATOR: Donovan, RN		RELIEF:
BLOOD LOST:		BLOOD REPLACED:		
FLUID LOST:		FLUID REPLACED:		
SPONGE COUNT yes ☒		SPECIMEN: yes ☐		
CORRECT: no ☐		no: ☒		

SUMMARY OF PROCEDURE: The patient was taken to the Operating Room and after adequate general anesthesia was established, the tourniquet was placed on the upper left arm and the limb prepped and sterilely draped. The right hip area was also prepped and sterilely draped for an iliac bone graft. The left arm was then exsanguinated with an Esmarch bandage and the tourniquet inflated to 250 mm. of Mercury. The patient had an previous ulnar longitudinal incision over the distal ulna for the previous Darrach procedure. This incision was incorporated into an S-type incision over the dorsal distal forearm. Blunt dissection was carried through the subcutaneous tissue and all superficial veins that could be protected, were retracted out of the way. Blunt dissection was continued down to deep fascia which was split longitudinally. The fourth compartment muscles were retracted radialward and the ulna was identified just on the radial side of the extensor carpi ulnaris. The ulna was also identified between the flexor carpi ulnaris and the extensor carpi ulnaris thus mobilizing the extensor carpi ulnaris such that full access to the excised distal radius was achieved. The fourth and fifth compartment muscles were then retracted radialward and the distal portion of the radius dorsally was exposed subperiosteally along its ulnar border. A small drill was used to make multiple drill holes and an osteotome connecting the drill holes used to create a window in the ulnar side of the radius. The cortical margins of the ulna were then rongueured to reveal cancellous bone and the ulna transposed radialward into the slot in the radius. Two 40 mm. length 3.5 screws were then used to fix the distal ulna to the radius. Attention had been turned slightly more proximally where the dorsal portions of the radius and ulna were exposed. 2 1/2 cm wide slot was then cut in both the dorsal one-third of the distal ulna and the dorsal one-third of the distal radius to accept an iliac bone cortical cancellous graft.



Page 2 OPERATIVE REPORT
SHANDS HOSPITAL AND CLINICS
at the University of Florida

OSMANSKI, JOSEPH
#67-58-85
08-23-88

Attention was then turned to the iliac crest on the right side which had been previously draped sterilely and through an oblique incision overlying the iliac crest, blunt dissection continued down to the deep fascia which was incised and the external musculature from the iliac wing dissected from the iliac wing and a 2 1/2 cm. x 4 cm. corticocancellous graft was harvested from the external table of the iliac wing. A generous supply of cancellous bone was also harvested. A Gelfoam was then placed over the defect in the iliac wing and the deep fascia was closed with interrupted 0-Vicryl, followed by closure of the subcutaneous tissue with 2-0 Vicryl and closure of the skin with staples. A Jackson-Pratt drain had been placed down through a separate stab wound at the hip. Attention was then turned to the forearm and the cortical cancellous bone "plate" was inserted into the slot prepared in the distal radius and ulna. 3.5 mm. screws were then used to secure the dome plate across the radius and ulna. Two were placed into the radius and two into the ulna through the bone graft. A generous supply of cancellous bone was then packed on the cortical cancellous bone "plate" and the distal ulna and radius synostosis site. It should be noted that prior to securing the radius to the ulna, the rotation of the forearm was set at neutral. The tourniquet was then deflated during the harvesting of the bone graft and had been reinflated prior to completing the procedure on the forearm. After the distal forearm procedure had been performed, attention was turned to the proximal forearm. A previous radial incision over the radial head region had been used for the previous radial head excision. This incision was re-entered and blunt dissection carried through the subcutaneous tissue. This incision was re-entered and blunt dissection carried through the subcutaneous tissue. The scar overlying the interval between the inconeus and extensor carpi ulnaris was then entered and the proximal radial region identified. The radial head region was exposed subperiosteally revealing the proximal 1-2 cm. of the proximal radius. The interval between the radius and ulna was cleaned out with a rongeur and cancellous bone exposed on both the ulna notch region as well as the proximal radius. A 3.5 mm. screw was then inserted across the proximal radial and ulna joint and cancellous bone was packed around this synostosis region. Drains had been placed down through separate stab wounds in both proximal and distal forearm wounds and the interval between the inconeus and extensor carpi ulnaris closed with interrupted 4-0 Vicryl followed by closure of the subcutaneous tissue with 4-0 Vicryl and closure of the skin with staples. Attention was then turned to the distal wound which was closed with interrupted subcu 4-0 Vicryl followed by closure of the skin with staples. Sterile dressings were then applied both to the hip and arms and a long arm bulky hand dressing incorporating long arm splints was applied to the arm. The tourniquet was inflated with good vascular status returning to the hand. The patient tolerated the procedure well, was taken to the Recovery Room in stable condition.

LC
Larry Chidgey, M.D.
Assistant Professor
Department of Orthopaedics

LC/ss 08-23-88/08-25-88

**SHANDS HOSPITAL**

at the University of Florida
Gainesville, Florida 32610

August 31, 1988

OSMANSKI, JOSEPH

67-58-85

ADMISSION: 08-23-88

DISCHARGE: 08-29-88

DIAGNOSIS:

1. Left Essex-Lopresti fracture.

OPERATIONS/MAJOR PROCEDURES WITH DATES:

1. Left one bone forearm with right iliac crest bone grafting,
08-23-88.

CONSULTATIONS: Physical Therapy.

BRIEF HISTORY: Mr. Osmanski is a 23 year old, right hand dominant white male, presently unemployed (previously a carpenter) who, on December 18, 1987 fell from a ladder approximately 22 feet landing on outstretched both arms. At that time he suffered a right radial head fracture and an Essex-Lopresti fracture on the left. The patient was treated on December 18 with open reduction and internal fixation of the humerus fracture and a radial head excision of the left elbow.

Subsequently the patient developed a ulnar positive wrist on the left which was painful, largely symptomatic and for this the patient underwent Darrach procedure with ipsilateral radial head excision and Darrach procedure. The patient developed an unstable above forearm with proximal migration of the carpus and progressive pain and decreased range of motion. He was admitted for elective radial ulnar synostosis/one bone forearm.

PAST MEDICAL HISTORY: Essentially unremarkable. The patient denies any history of cardiopulmonary, gastrointestinal, renal, endocrine, or hemopoietic diseases. He denies taking any medications at the time of admission.

THE PATIENT IS ALLERGIC TO PENICILLIN.

PHYSICAL EXAMINATION: Examination at the time of admission is essentially within normal limits with the exception of the right forearm. There are well healed scars of the left elbow and wrist, has decreased grip and pinch strength. Range of motion of the elbow is 30-115°, with 45° supination and 60° pronation with marked pain at the extremes of motion. He is significantly swollen over wrist and elbow. There is no evidence of inflammation or infection.

DISCHARGE SUMMARY

**SHANDS HOSPITAL**

at the University of Florida
Gainesville, Florida 32610

Page 2

OMANSKI, JOSEPH
67-58-85

08-31-88

LABORATORY: Routine preoperative evaluation revealed no contraindications for surgery.

The patient was then counseled regarding the relative risks and benefits of the radial ulnar synostosis/one bone forearm with iliac crest bone grafting. Understanding these, and given no guarantees were made or implied, the patient consented to proceeding with this elective procedure.

HOSPITAL COURSE: Therefore on 8-23-88 he was taken to the major Operating Room where under general endotracheal anesthesia he underwent the formation of a one bone forearm to the left upper extremity. Iliac crest bone grafting was utilized. The patient tolerated the procedure well. Estimated blood loss was 300 cc. Total tourniquet time was 151/130. The patient received 1,900 cc of crystalloid intraoperatively.

The patient tolerated the procedure well and was extubated in the Operating Room and returned to the Recovery Room in good condition.

After routine stabilization in the Recovery Room the patient as returned to the orthopedic ward. There a Physical Therapy consultation was obtained and the patient was instructed in partial weight bearing ambulation. Postoperative drainage was moderate and his wound drain was removed on the second postoperative day. All perioperative antibiotics were discontinued subsequent to this. The patient's only complaint postoperatively was of persistent pain. His neurovascular exams were normal.

On 8-26-88 it was felt that the patient had obtained full hospital benefits. He is therefore discharged in good condition.

Current medications include Tylox 3 p.o. q 3 hours p.r.n. pain.

DISCHARGE SUMMARY

**SHANDS HOSPITAL**at the University of Florida
Gainesville, Florida 32610

Page 3

OMANSKI, JOSEPH

67-58-85

08-31-88

We will see the patient back in the Clinic on 09-02-88 at which time x-rays should be obtained of the forearm. At that time he will be changed from his coaptation splint to a long arm cast.

LARRY CHIDGEY, M.D.
Assistant Professor
Department of Orthopaedics

Dictated by: Michael McCormick, M.D.
MTS110 #1456 08-22/08-31-88

REFERRING PHYSICIAN

George Haaf, M.D.
109 S. E. Riverside Avenue
Stuart, FL 34994

DISCHARGE SUMMARY

Osmanski, Joseph Arthur

Sex: M

BD:

MR#: 00675885

Print this Page

PTS: 603809323

Oper Note Orthopedic Hand P

Nov 09, 1999

DATE OF SURGERY: 11/09/1999

PREOPERATIVE DIAGNOSIS: Left shoulder pain, possible instability.

POSTOPERATIVE DIAGNOSIS: Left shoulder arthritis.

OPERATION PERFORMED: 1) Left shoulder arthroscopy and synovectomy. 2) Left shoulder complete bursectomy.

SURGEON: Wright

ASSISTANT: Kiernan

ANESTHESIOLOGIST:

ASSISTANT:

INDICATIONS FOR PROCEDURE: Joseph Osmanski is a gentleman who has had significant problems with his left shoulder consistent with instability. He previously had an arthroscopic shrinkage and Bankart repair. He still has significant pain and feels that he is unstable. It was therefore, felt that evaluation under anesthesia and arthroscopy was indicated. Repair of appropriately disrupted structures would be performed at the same time. The risks, benefits, alternatives and rehab course were fully discussed preoperatively.

PROCEDURE: The patient was placed on the operating room table in a supine position. General endotracheal anesthesia was induced. The patient was then placed in a full beach-chair position. Examination of his left arm under anesthesia showed that he had 45 degrees of external rotation with his arm by his side, 160 degrees of passive elevation. The arm was not dislocatable anteriorly or posteriorly. There was a negative sulcus sign. There was no significant increase in translation of the humeral head on the glenoid. The arm was then sterilely prepped and draped. The 4.5 30 degree arthroscope was introduced posteriorly. Using a Weisinger rod, a second portal was then placed above the subscapularis and rotator cuff interval, lateral to the conjoined tendon. Through this, a 4.5 Aggressor meniscal shaver was introduced. Evaluation of the joint showed a large amount of fibrillated and fibrinous material. Using the shaver, this was debrided. There was a moderate to significant synovitis throughout. A synovectomy was performed of the anterior capsule, undersurface of rotator cuff and along the labrum. The biceps anchor was palpated with the shaver and was noted to be stable with no evidence of a SLAP lesion. The anterior labrum was well-attached on the glenoid rim; although it was hypoplastic, it was definitely well-attached and the anterior inferior glenohumeral ligament which, again was hypoplastic, was attached appropriately. There was no real significant large middle glenohumeral ligament. Evaluation of the humeral head showed there was no Hill-Sachs lesion posteriorly. Anteriorly and superiorly, however, there was a 1 cm by 5 mm osteochondral defect all the way down to cortical cancellous bone. The rest of the humeral head - at least the anterior two-thirds of it; was covered with grade II and possibly grade III chondromalacia. The glenoid likewise had chondromalacia grade II at least throughout. There was a negative drive-through sign. Under direct arthroscopic visualization, the humeral head was not dislocatable anteriorly or posteriorly. There was some tendency to it - just slightly inferiorly and anteriorly subluxate, but this would not be considered pathologic. With even significant pressure, I could not get the head to come outside of the labrum. It was, therefore, our feeling that the patient's problem was not instability but was likely secondary to arthritis. The rotator cuff was nicely funneled through its insertion. There was no evidence of undersurface cuff tear after debridement of the synovitis. In the area, the cuff appeared to be totally normal and its

Page 1 of 2

attachment appeared to be totally normal. Therefore, the arthroscope was then placed into the subacromial space. A third portal was then placed laterally through which the shaver was placed. A significant bursitis was noted with very hypertrophic globules of synovium. The synovium was removed. The acromial undersurface was palpated. The anterior lateral cord could easily be palpated with the shaver and there was absolutely no hook consistent with having a previous acromioplasty. There was no reason to denude bone again from our standpoint. A complete bursectomy was performed and rotator cuff appeared normal from this superior side. It was our conclusion at the end of the operative procedure that 90% of the patient's pathology could be attributed to glenohumeral arthritis. The arthroscope was then removed from the joint. The wounds were closed with 4-0 nylon. The wound was dressed with a sterile compressive dressing. The patient had a scalene block postoperatively. The patient was placed in a sling and transferred to the recovery room in stable condition.

Thomas Wright, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Thomas Wright, M.D.
TW/385 11/09/1999 11/09/1999 10:45 A

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PIDK MRN:
DOB: M	EAD SSN:
Oper No: 02/17/00	SHANDS-ITP

DATE OF SURGERY: 02/17/2000

PREOPERATIVE DIAGNOSIS: Post-traumatic end-stage degenerative joint disease, left elbow.

POSTOPERATIVE DIAGNOSIS: Post-traumatic end-stage degenerative joint disease, left elbow.

OPERATION PERFORMED: Fascia lata interposition arthroplasty, left elbow.

SURGEON: Chidgey

ASSISTANT: Stone

ANESTHESIA: General endotracheal anesthesia.

ANESTHESIOLOGIST:

ASSISTANT:

INDICATIONS FOR SURGERY: Briefly, Joseph Ozanski is a 35-year-old, right-hand dominant gentleman, who sustained an injury of his left forearm and wrist after a fall approximately 30 ft. from a scaffolding. He underwent multiple procedures, including distal ulnar resection and one-bone forearm fusion, and he has continued to progress to severe degenerative joint disease of the left elbow. His pain and stiffness have been severely limiting to his activities of daily living. Upon discussion of risks, benefits, and alternatives to the above procedure, the patient provided informed consent.

DESCRIPTION OF OPERATION: The patient was properly identified and brought into the operating room and placed in the supine position on the operating table, at which time he underwent administration of general endotracheal anesthesia. Following successful administration of general endotracheal anesthesia, the patient's left leg and left upper extremity were prepped with Hibiclens x 3 and then draped in a usual sterile fashion. A sterile tourniquet was then placed on the upper extremity. The left arm was then exsanguinated with an Esmarch graft and tourniquet was inflated to 350 mmHg. A straight posterior incision that was curved medially so as not to cross the posterior aspect of the olecranon, hip was outlined and made with a 10-blade knife, again curving somewhat medially around the tip of the olecranon and then brought back to straight posterior midline. Incision was made approximately 15 to 20 cm in length. Subcutaneous tissue was then bluntly dissected in line with the incision with scissors. Electrocautery was used to obtain hemostasis where necessary. The triceps muscle was identified and the subcutaneous tissue was elevated off of the triceps fascia to its medial border. At the medial aspect of the triceps and the proximal aspect of the wound, the ulnar nerve was identified where it pierces the lateral intermuscular septum and traced distally. Because the

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NLE8618

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Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDX MRN:

DOB:

954 M

RAD SSN:

SHANDS-ITE

ulnar nerve had been previously transposed, it was embedded in a fair amount of scar tissue, but it had already been transposed anteriorly. Therefore, having taken great care to dissect free the ulnar nerve far enough past the elbow to ensure that it would be elevated safely with the subcutaneous and then periosteal flap, the humerus was approached through the posteromedial interval by elevating the triceps off of the posterior aspect of the humerus and reflecting it laterally. Again, the ulnar nerve and medial tissues were taken medially and protected. Dissection was then carried down to subperiosteal plane, down to the posterior capsule, and the capsule was incised and elevated off of the distal humerus. The dissection was carried down across the posterior aspect of the elbow joint, again by elevating the medial structures off in a subperiosteal plane, including the significantly scarred ligamentous tissues as well. An osteotome was used to remove a sliver of the tip of the olecranon so that the triceps fascia could be taken with this piece of bone laterally. This dissection was aided by extending the incision along the ulna with the knife down through periosteum and the proximal ulna was also exposed in a subperiosteal plane with blunt and sharp dissection using elevators and a 15-blade knife, reflecting the majority of the periosteum with the triceps fascia laterally and the medial periosteum and medial structures medial.

Following exposure of the elbow joints, on its posterior aspect there was evidence there was severe osteophyte formation and loose bodies within the joint, as well as near complete loss of articular cartilage and severe aburnation of bone. Having elevated the ligaments as well in the subperiosteal plane off the lateral side, as well as the scarred ligaments on the medial side, The elbow could not be easily subluxed. A bur was then used to bur down through the eburnated subchondral bone of the distal humerus, creating a barrel-shaped contour of the distal humerus. The severely enlarged portion of the radial head, which had been fused to the ulna due to reactive bone as well as was resected sharply with rongeur and osteotomes. Then, osteotomes and a bur were used to remove the severely eburnated bone from the olecranon articular surface as well.

Following this, the two joint surfaces were evaluated for smoothness of contouring and congruency of fit now that subchondral bone was exposed with bleeding bone via the bur. The size of the distal humerus and olecranon were then measured, and it was felt that a 9 x 25 cm piece of fascia lata was needed for the fascia lata autograft to be used for interposition.

At this time approximately a 20 to 25 cm lateral incision was made on the thigh with a 15-blade knife. Subcutaneous tissue was sharply dissected in line with the incision with a knife down to the fascia lata. A key elevator was used to elevate the subcutaneous tissue, both medially and laterally and anteriorly and posteriorly off of the fascia lata. A 9 x 25 cm rectangular portion of the fascia lata was outlined and then heavy Mayo scissors were used to sharply excise the fascia lata carefully elevating it

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Not an Original

OSMANSKI, JORDEN, ARTHUR

PIDX MRN:

DOB:

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EAD SSN:

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SHANDS-11F

off of the underlying vastus lateralis musculature and fascia. The fascia lata was then removed from the leg after sharp dissection and tagged with sutures for orientation and placed in a saline-soaked gauze on the back table.

This wound was then irrigated. A medium Hemovac drain was placed and the wound was closed in layers with 2-0 Vicryl sutures followed by staples. Attention was now turned back to the left elbow and a drill was used to make three holes from posterior to anterior on both the medial and lateral sides of the distal humerus and these were stepwise brought down along the distal humerus. They were also taken cleanly from posterior to anterior.

0 Ethibond sutures were then used to secure the fascia lata autograft with its mucosal surface facing toward the joint space, and this was wrapped around the distal humerus and secured with the 0 Ethibond sutures, both medially and laterally utilizing three sutures on each side with inverted horizontal mattress sutures, which were placed so that the knots would be buried beneath the fascia.

Following successful suturing of the fascia lata autograft to the distal humerus, the fascia lata was then carried down to the olecranon and laid out such that it would fit appropriately onto the olecranon. A drill bit was then used to create multiple holes in both the anterior portion where the coronoid had been resected of osteophytes. Drill holes were also placed through the posterior aspect of the olecranon as well in the region where it had been debrided of osteophytes also. Three holes were placed anteriorly and three holes were placed posteriorly and the fascia lata was secured with inverted horizontal mattress sutures, burying the knots away from the joint space. Then, 0 Vicryl sutures were used to suture the loose ends of the fascia lata on both the medial and lateral sides, thus further fine-tuning the contouring and fit of the fascia lata autograft.

Following this, the elbow joint was reduced and was taken through full extension to 0 degrees and flexion to 145 degrees with smooth motion. Future drill holes were then placed through both the lateral aspect of the ulna and the medial aspect of the humeral medial epicondyle and 0 Ethibond sutures were then used to repair the collateral ligaments back down to bone through these bone holes from where they had been elevated in the subperiosteal plane. Again, the elbow was noted to be with satisfactory reduction and taken through full extension to 145 degrees of flexion without any evidence of subluxation or medial lateral instability. 0 Vicryl sutures were then used to close the remainder of the periosteal full-thickness medial and lateral flaps along the olecranon and this was carried up completely closing the interval. Again, the ulnar nerve was observed throughout this time to take great care not to create any tethering of the nerve. The nerve was released more proximally of adherent tissue and a portion of the intermuscular septum was sharply excised to

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 3

NL1E8618

Shands HealthCare***Confidential*****Not an Original**

OSMANSKI, JOSEPH EDWARD	N:
DOB: M EAD SSN: 0	SHANDS-UP

remove any possible impingement upon the nerve more proximally as well. A drain had been inserted into the elbow joint prior to closure of the periosteal flaps and capsule.

The wound was then irrigated with antibiotic irrigation solution and the skin was closed in layers with 2-0 Vicryl sutures followed by staples. Sterile dressing was applied to both wounds. A long-arm splint was placed posteriorly on the elbow and upper extremity and was appropriately padded. Prior to application of the splint, the tourniquet was deflated and removed and patient had palpable radial and ulnar pulses with capillary refill less than 2 seconds in all digits.

Patient was extubated in the operating room and taken to the surgical recovery room in good condition.

The plan for this patient was to admit him for pain control and observation of his drains and IV antibiotics postoperatively.

Dr. Larry Chidgey, the attending surgeon, was present and scrubbed throughout all key portions of the surgical procedure and immediately available for opening and closing.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/417 02/19/2000:02/20/2000 7:56 P

CC:

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 4

NL1E8618

OSMANSKI, JOSEPH
00-67-58-85

DISCHARGE SUMMARY

SHANDS at UF

ADMISSION DATE: 02/17/2000
DISCHARGE DATE: 02/19/2000

ADMISSION DIAGNOSIS: (1) Degenerative joint disease, left elbow.

DISCHARGE DIAGNOSIS: (1) Degenerative joint disease, left elbow.

DISCHARGE DIAGNOSIS: (1) Left elbow fascial interpositional graft on 2/17/00. CONSULTATIONS: (1) Physical Therapy.

HISTORY AND PHYSICAL: Please see the chart for the complete H&P.

HOSPITAL COURSE: The patient is a 35-year-old white male with a history of left elbow DJD. He was admitted on 2/17/00 following the aforementioned procedure which was performed at Florida Surgical Center on 2/17/00. The patient tolerated the procedure well and was placed on a morphine PCA for pain control until postop day two. He was switched over to oral pain medication at that time and tolerated that well. His Hemovac drain was discontinued with minimal drainage on the day of discharge on postop day two. He had no fevers and was tolerating a regular diet.

DISCHARGE CONDITION: Stable.

DISPOSITION: Home.

DISCHARGE MEDICATIONS: (1) Tylox one to two PO q.4-6h. PRN pain. (2) Oxycodone 5-10 mg PO q.4-6h. PRN breakthrough pain. (3) Clindamycin 600 mg one PO t.i.d. x 1 day.

DISCHARGE INSTRUCTIONS: The patient should notify us for a temperature greater than 35, increased drainage from his wound, pain uncontrolled with pain medication, numbness, tingling or weakness in his extremity. He was given physical therapy for a walking device as directed by PT.

FOLLOW-UP: Follow-up will be with Dr. Chidgey at Hampton Oaks and the Surgery Clinic in two weeks.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jason W. Thackeray, M.D.
JWT/344 02/19/2000:02/20/2000 5:17 P

DISCHARGE SUMMARY

Shands HealthCare

Confidential

Not an Original

OSMANSKI	ARTHUR	PIDK MRN:	SHANDS-ITF
DOB:	M	EAD SN:	

Oper Not 09/14/00

DATE OF SURGERY: 09/14/2000

PREOPERATIVE DIAGNOSIS: Left elbow arthritis.

POSTOPERATIVE DIAGNOSIS: Left elbow arthritis.

OPERATION PERFORMED: Left total elbow arthroplasty.

SURGEON: Chidgey.

ASSISTANT:

ANESTHESIOLOGIST:

ASSISTANT:

ANESTHESIA: General.

DESCRIPTION OF PROCEDURE: The patient was taken to the Operating Room. After adequate general anesthesia was established, the arm was prepped and sterilely draped. The limb was exsanguinated and a tourniquet around the upper arm inflated to 250 mmHg. A posterior incision was utilized. The triceps was dissected off of the ulna and kept intact with the forearm fascia. It was dissected subperiosteally off of the tip of the olecranon. The patient had a previous anterior transposition of the ulnar nerve. Therefore, the nerve did not have to be dissected out. The patient had no articular cartilage left on either side of the joint as he had a previous fascial arthroplasty which had failed. There was no sign of any infection. The patient had also had a previous one bone forearm with a radial head excision so the radial head did not have to be dealt with. The ulna was prepared with a power saw and a combination of the reamers to prepare the canal. The trial was then fitted. The saw was then utilized to prepare the distal humerus and the canal reamed, and a trial reduction with the trial implant was carried out and found to be good, lacking only the last 20 degrees from full extension. The ulnar component was then cemented into place. The humeral component was then cemented into place. During the cementing process, there was trouble with the articulating pin. In an effort to try and get the pin articulated properly, the cement hardened sufficiently that it could not be fully seated. Therefore, the humeral component was taken back out and the canal cleaned of the cement. Another attempt was then made filling the humeral canal with cement. At this time, the humeral component seated well with the ulnar component and the pin articulated appropriately. The humeral component was then fully seated in the humerus. Once the cement hardened, the triceps was reattached to the ulna through drill holes utilizing #2 Ethibond suture. It should also be mentioned that the lateral epicondylar area fractured off and had to be secured back down with two K-wires and a figure-of-eight tension band wire. A drain was then placed through a separate stab wound and the wound closed.

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8627

Shands HealthCare

Confidential

Not an Original

OBMAWSKI JOSEPH ARTHUR

D.D.Y. MRN:

DOB:

M

FAD SSN:

0

SHANDS-IT

in layers. A sterile dressing was then applied followed by a splint. The patient tolerated the procedure well and was taken to the Recovery Room in stable condition. Good vascular status returned to the hand after tourniquet deflation.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.
LKC/344 09/14/2000:09/14/2000 6:10 P

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 2

NL1E8627

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

DATE OF SURGERY: 11/01/2001

PREOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

POSTOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

OPERATION PERFORMED: Left ulnar nerve transposition and neurolysis

SURGEON: Chidgey
ASSISTANT: Gilmore

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: The patient initially had a cubital tunnel syndrome of the left ulnar nerve. He sustained paresthesias and sensation difficulties in the ulnar distribution of his hand. The initial procedure was a left ulnar nerve transposition. He did return complaining of continued pain and paresthesias about his arm. He had developed a significant amount of scar tissue after multiple surgical procedures to his left elbow. It was deemed he would need a revision of the transposition and likely neurolysis.

DESCRIPTION OF PROCEDURE: The patient was appropriately identified, as well as the extremity was identified. He was taken to the operative suite, and general anesthesia was obtained. Next sterile dressings were applied, along with a sterile tourniquet. The total tourniquet time was approximately 1 hour and 6 minutes. Before the tourniquet was inflated the arm was exsanguinated.

Next the previous scar was identified on the medial ulnar aspect of his left elbow. The incision was made over the previous scar site. It was extended approximately 3 cm proximal and distal from that site. Dissection was then performed down through the skin with a knife in the subcutaneous tissue. Next, tenotomies were used to clear some of the scar tissue, and the ulnar nerve was identified distally just underneath the subcutaneous tissue. It was mobilized both distally and proximally across the elbow.

It was noted there was a significant amount of scar tissue on the floor of the nerve, and the nerve was released from the scar tissue with neurolysis. It was determined that instead of dissecting through the abundance and thickness of the scar tissue that it would best serve the ulnar nerve to lie above this tissue with an overlying subcutaneous tissue for cushion. As this layer was sutured over top of the ulnar nerve, it was determined that the ulnar nerve was mobile and free. The rest of the suture line was drawn with 2-

FSC OPERATIVE REPORT

Page 1

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

0 Polysorb. This was done in inverted interrupted fashion. Next skin was stapled. The patient then had sterile dressings applied.

Next the patient was awakened. The tourniquet was deflated, and the patient was taken to the Recovery Room without difficulty. He remained neurovascularly intact postoperatively. He will be admitted to the hospital postoperatively for observation overnight. His pain is under good control with the use of Tylox and morphine.

Dr. Chidgey was present for the entire procedure and participated in the case.



Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/448-11/01/2001-11/01/2001 10:33 P
Job ID# 001087363

cc:

FSC OPERATIVE REPORT

Page 2

Shands HealthCare***Confidential***

Not an Original

OSMANSKI, JOSEPH ARTHUR	PID# MRN:
DOB: 08 54 M	0 SHANDS-UP

Oper Not 11/01/01

DATE OF SURGERY: 11/01/2001

OSMANSKI, JOSEPH STH#00-67-58-85

PREOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

POSTOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

OPERATION PERFORMED: Left ulnar nerve transposition and neurolysis

SURGEON: Chidgey
ASSISTANT: Gilmore

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: The patient initially had a cubital tunnel syndrome of the left ulnar nerve. He sustained paresthesias and sensation difficulties in the ulnar distribution of his hand. The initial procedure was a left ulnar nerve transposition. He did return complaining of continued pain and paresthesias about his arm. He had developed a significant amount of scar tissue after multiple surgical procedures to his left elbow. It was deemed he would need a revision of the transposition and likely neurolysis.

DESCRIPTION OF PROCEDURE: The patient was appropriately identified, as well as the extremity was identified. He was taken to the operative suite, and general anesthesia was obtained. Next sterile dressings were applied, along with a sterile tourniquet. The total tourniquet time was approximately 1 hour and 6 minutes. Before the tourniquet was inflated the arm was exsanguinated.

Next the previous scar was identified on the medial ulnar aspect of his left elbow. The incision was made over the previous scar site. It was extended approximately 3 cm proximal and distal from that site. Dissection was then performed down through the skin with a knife in the subcutaneous tissue. Next tenotomies were used to clear some of the scar tissue, and the ulnar nerve was identified distally just underneath the subcutaneous tissue. It was mobilized both distally and proximally across the elbow.

It was noted there was a significant amount of scar tissue on the floor of the nerve, and the nerve was released from the scar tissue with neurolysis. It was determined that instead of dissecting through the abundance and thickness of the scar tissue that it would best serve the ulnar nerve to lie above this tissue with an overlying subcutaneous tissue for cushion. As this layer was sutured over top of the ulnar nerve, it was determined

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NL1E8636

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

DOB:

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EAD SSN:

PIDX MRN:

SHANDS-ITF

that the ulnar nerve was mobile and free. The rest of the suture line was drawn with 2-0 Polysorb. This was done in inverted interrupted fashion. Next skin was stapled. The patient then had sterile dressings applied.

Next the patient was awakened. The tourniquet was deflated, and the patient was taken to the Recovery Room without difficulty. He remained neurovascularly intact postoperatively. He will be admitted to the hospital postoperatively for observation overnight. His pain is under good control with the use of Tylox and morphine.

Dr. Chidgey was present for the entire procedure and participated in the case.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/44811/01/2001 11/01/2001 10:33 P
Job ID# 001087363

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 2

NL1E8636

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

DISCHARGE SUMMARY

SHANDS at UF

ADMISSION DATE: 11/01/2001

DISCHARGE DATE: 11/02/2001

PRINCIPAL DIAGNOSIS: Ulnar nerve neuritis and neuropathy.

DISCHARGE DIAGNOSIS: Status post revision of an ulnar nerve transposition and neurolysis.

HOSPITAL COURSE: The patient was admitted to the hospital postop for pain control. He was placed on Tylox and OxyContin. He tolerated this well. His pain has been under good control. His arm has remained elevated. He is eating a regular diet without any difficulties.

DISCHARGE INSTRUCTIONS: He will follow up with Dr. Chidgey on 11/09/01. An appointment has already been scheduled. He should call for confirmation. He will also be discharged on Lorab and OxyContin along with clindamycin p.o. for 7 days.



Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/426 11/02/2001:11/02/2001 11:04 A
Job ID# 001088525

cc:

DISCHARGE SUMMARY

Page 1

Lexington Orthopaedics

West Columbia

146 North Hospital Drive, Suite 140
West Columbia, South Carolina 29169

PATIENT: OSMANSKI, JOE	VISIT DATE: 11-5-08
PATIENT #: 00001529860 XXX-X7-6730	D: 11/06/2008 8:51 AM
PHYSICIAN: JAMES C. MCINTOSH, MD	T: 11/07/2008 6:10 AM / cir
	DATE OF BIRTH: 01

HISTORY OF PRESENT ILLNESS: Patient presents today for workmen's comp injury to his left elbow. He is a truck driver and had a hyperextension injury last week with immediate onset of pain. He went to the Emergency Department and was evaluated. He has a very complicated history with his left elbow. Apparently he had a comminuted fracture. They attempted what sounds like an interpositional arthroplasty that ultimately failed. Back in late 1990s, he underwent a total elbow arthroplasty in his 30s. This was all done in FL. He is a truck driver and has been doing this for some time. He is right-hand dominant. Ever since the injury, he has had some numbness. He has had transposition of ulnar nerves in the past. Little bit of tingling. It has always been painful, but this is a little bit more. Feels like arm is dead and he cannot move it. It sounds basically like he had a hyperextension injury with some crepitance and onset of pain. Not that uncomfortable today. Still has difficulty moving the arm. Some numbness and tingling in his ring and small fingers. No other injuries reported. We saw him just recently for a mass on his right ring finger. Health otherwise is good. No change since we saw him last week.

PHYSICAL EXAMINATION

GENERAL: Mildly obese black male in no apparent cardiopulmonary distress, alert and oriented x3.

ELBOW: Some mild swelling. I really cannot palpate his biceps very well. He has a 1-bone forearm so he cannot supinate. Ulnar nerve function appears to be intact. Decreased sensation in ulnar distribution. Radial and medial nerve function appears to be intact. Good capillary refill. Several scars on posterior aspect of elbow. No obvious crepitance. Actually fairly good motion. Nearly full extension. Flexion to about 125-130. Elbow showed implant in place; several wires present. No obvious evidence of implant loosening. Some asymmetry at the bushing, which is consistent with wear. Do not see any obvious implant loosening.

ASSESSMENT: Left elbow strain; difficult to tell what is going on with him. His implant appears to be intact. Pins extending at the posterior aspect of the elbow. I do not know if this is old or new.

PLAN: I asked him to continue same range of motion exercises and work status. No use of left arm. Also asked him to get old notes or x-rays to see if we can compare to past films. Recheck and reexamine in 3 weeks.

JAMES C. MCINTOSH, MD

cc:

Lexington Orthopaedics
PAGE 1 OF 1

OSMANSKI, JOE

76730

FISHER/cmh

10/22/2008 J994051

- S: The patient is a 44-year-old white male, here for his 1st visit to our office. He basically comes in for a physical. It has been some time since he had a regular physician. He wanted to get his DOT form completed as well. He generally has been pretty healthy. He does take Flomax regularly for some nocturia and BPH. This has helped significantly. He only gets up about once nightly now to use the bathroom. He is also a smoker. He is not that interested quitting right now. He still drives a truck a good bit, although he is not over the road like he was. He is down to about 1 pack daily right now. Unsure when his last tetanus was given. He does have a history of a fall, in 1987, when he was about 23. He had a good bit of problems. He had a pretty bad injury in his left elbow and wrist, particularly. He still has some limited range of motion of elbow as far as supination but otherwise he lifts furniture and does not have any other residual problems. He has recently been seen for some kidney stones by Dr. Brightbill. He had an IVP, which was negative, because he was having some mild persistent pain but he is doing pretty well right now without any significant symptoms. He is allergic to penicillin. FH: Father, some kind of blood disorder in his 50s, did not know exactly what it was. Otherwise unremarkable. PMH: See chart for the rest. ROS: Negative for allergies. Not complaining of chest pain or shortness of breath. No recent bowel changes. Urine as discussed above. No skin problems. Never had any restriction from DOT physical in the past.
- O: VITAL SIGNS: Blood pressure 136/84, heart rate 84, weight 273 (reports losing about 70 lbs. this past year from just dietary changes). GENERAL: Alert. HEENT: See visual acuity. Eyes clear. TMs clear, mouth with deteriorating tooth in the left lower jaw, otherwise clear. NECK: Supple, good pulses, no bruits. No masses. HEART: Regular rate and rhythm without murmurs. LUNGS: Clear to auscultation bilaterally. BACK: Without tenderness. ABDOMEN: Mildly obese, soft, nontender, no masses noted. EXTREMITIES: Without edema, good pulses. GU: Bilateral descended testicles. Very mild hernia on right side. Left clear. RECTAL: Moderately enlarged prostate, smooth, symmetric. SKIN: Clear with a few non atypical appearing nevi. DIAGNOSTIC STUDIES: EKG: See chart. Executive profile to be done. Fasting today.

A

1. Physical examination performed in a 44-year-old white male.
 2. Department of Transportation physical performed, no obvious restrictions.
 3. History of benign prostatic hypertrophy, has done well with Flomax.
 4. Tobacco dependence. Encouraged to quit smoking. Do not think he really feels like he is ready right now.
 5. Persistent lack of supination, left elbow, status post injury at 23 years old.
 6. Some obesity in the past, significantly improved with just dietary changes.
- P: Tetanus updated today. DOT form completed. Executive profile and PSA. Proceed as needed on that. Encouraged to quit smoking once again. Did not need refills on Flomax. Follow up p.r.n.

ADDENDUM: Cyst between the DIP and PIP on right ring finger, has gotten a little bit larger, about 3 x 1 cm. Needs further evaluation, excision. Will send to orthopedist for evaluation.

OSMANSKI, JOE

76730

FISHER/cmh

11/13/2008 J911872

- S: The patient is a 44-year-old white male who comes in to followup some labs. He has mildly increased cholesterol. He has not been told this in the past. He was also noted to have mildly increased liver functions. He rarely takes Tylenol at home. He drinks a little bit of on the weekends but not regularly. He is not on any medicines except Flomax. He has never been told his liver functions were elevated.
- O: VITAL SIGNS: Blood pressure 130/88, weight 270. HEART: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Soft, no right upper quadrant tenderness. No obvious swelling or masses. DIAGNOSTIC STUDIES: See chart for labs.
- A
1. Mildly increased triglycerides, low HDL. Ratio slight high.
 2. Mildly increased liver functions.
- P: Given low triglyceride diet sheet. Talked a little bit about omega-3 fatty acids. Would like to check cholesterol and liver functions in 3 m - 5 9 - mer if he has any particularly symptoms. Follow up

Shands HealthCare

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Not an Original

OSMANSKI, ARTHUR	PID# MRN:
DOR: A M	RAD SSN:
Clinic N 02/19/92 23:59	SHANDS-UP

February 19, 1992

DIAGNOSIS: Left upper extremity fracture with resultant one bone forearm.

HISTORY: Mr. Osmanski returns today with complaints of new onset left elbow pain beginning last Sunday when he picked up an empty cooler. He said the pain persisted with motion of his elbow with temporary relief with the use of Feldene. Since then, however, the pain has been persistent and he has been wearing an arm sling to relieve the discomfort.

PHYSICAL EXAMINATION: He has essentially full range of motion of his elbow. However, it is painful. He also has a significant amount of tenderness over the left cubital tunnel in the ulnar nerve region. He has no tenderness over his forearm.

TEST RESULTS: X-ray examination of his left elbow today demonstrates that he has evidence of degenerative joint changes and has had progression of some of his heterotopic ossification. He also has several osteophytes which have formed specifically in the cubital tunnel region.

DISPOSITION: Mr. Osmanski is experiencing some irritation of his ulnar nerve, probably from irritation by the heterotopic bone and osteophytes. We recommended he be put into a resting elbow splint and resume taking Feldene 20 mg PO q day. We hope that he will improve on this regimen and we will see him back in approximately three to four weeks for follow up and no new x-rays are needed.

Larry R. Chidgey, M.D.
Assistant Professor
Hand and Microsurgery
Department of Orthopaedics
Box 100246
Phone: 904-392-4251

Dictated by: A. Wong, M.D.
LKC/AW/vbs 02-19/02-21-92

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8608

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Not an Original

OBMAANSKI	DOB: 11/04/98	MRN: 23359	STATUS: 23:59
DOB: 11/04/98	MRN: 23359	STATUS: 23:59	STATUS: 23:59
Clinic N	11/04/98	23:59	23:59

UNIVERSITY OF
FLORIDA

OSMANSKI, JOSEPH
STH #00-67-5B-85

SHANDS CLINIC at Hampton Oaks

200-B SW 62nd Blvd.
Gainesville, FL

32607

(352) · 395-0647

11/04/98

SHANDS CLINIC at Hampton Oaks

[illegible]

PAST MEDICAL HISTORY: He denies any hypertension, diabetes, coronary artery disease, seizures, or history of cancer.

PAST SURGICAL HISTORY: Multiple reconstructive surgeries to his left shoulder, left elbow, and right elbow.

ALLERGIES: Penicillin.

SOCIAL HISTORY: He smokes one pack per day. Ethanol: Denies.

OBJECTIVE: On physical examination of his left shoulder, patient, due to pain, is only able to abduct his shoulder about 20 or 30 degrees. He is only able to elevate his shoulder about 10 degrees. He has significant tenderness to any passive range of motion beyond these extremes. Right upper extremity reveals he has full range of motion of his shoulder. On his left shoulder, he is unable to axially rotate his arm any further than to his pocket and he only externally rotates to neutral. Patient's sensation is grossly intact. He has tenderness over his previous ulnar nerve transposition sites. He has about 60 degree range of motion from 30

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8609

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PID# MRN:
DOB: M	EAD SSN: 0 SHANDS-DE

degrees loss of extension to about 120 degrees of flexion. He only supinates to neutral and he has good distal refill and good sensation distally.

X-RAYS: His left elbow x-rays show he has significant arthritis, post traumatic, of his elbow with loss of his joint space. His left shoulder x-rays show some erosion along the anterior glenoid and some arthritic changes in the glenohumeral joint.

ASSESSMENT & PLAN: Patient with severe post traumatic arthritis of his left elbow. Patient was explained that there are a few options at this point for his left elbow. One was to continue with conservative management with nonsteroidals and the second choice was to do an inner position arthroplasty of his left elbow versus a total elbow. We did not feel that he is a good candidate for a total elbow due to his age and the fact that he will probably wear it out very quickly. His best option for his elbow would probably be an inner position arthroplasty. Patient states that he would like to think about that procedure. For his left shoulder difficulty, Dr. Chidgey would like to have Joseph referred to Dr. Wright due to the complex nature of his shoulder. He has had two previous arthroscopies including a labral repair and capsular shrinkage and he has very minimal range of motion and very painful with any range of motion to his shoulder. Patient will follow up with us after he has had his shoulder evaluated.

TEACHING PHYSICIAN'S STATEMENT: I was present during all activities documented above, agree with the above documentation, and participated in the entire history, physical exam, and medical decision-making of this patient.

Larry K. Chidgey, M.D.
Associate Professor
Department of Orthopaedics

Dictated by: Jeffrey A. Baker, M.D.

JAB/tra 11/04:11/04/98 c:td 11/13/98

CC:

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 2

NL1E8609

01/08/2009 11:52 FAX 352 273 1154

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007/035

Shands HealthCare

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Not an Original

OSMANSKI JOSEPH ARTHUR

PIDK MRN:

DOB:

64

M

KAD SSN:

730

SHANDS-ITF

Clinic N 05/23/99
06/23/1999

HPI: Joseph is being followed for two problems, his left elbow arthritis as well as his left shoulder. He was previously seen in November and we referred him to Dr. Wright for his complex left shoulder injury and we have recommended that he undergo an interpositional arthroplasty of his left elbow. The patient has run up against some road blocks with his insurance company and would like to proceed with the elbow surgery, however, he has not been able to get the referral for the shoulder. So, today we will make a referral for the patient to see Dr. Wright with regards to his complex shoulder injury. We would like to know what Dr. Wright has to say with regards to his treatment plan and whether any further plans for surgery would be needed. Following this evaluation and his recommendations, we will then appropriately schedule the patient for any surgery on his elbow.

TEACHING PHYSICIAN STATEMENT: I was present during all activities documented above, agree with the above documentation, and participated in the entire history, physical exam and medical decision making of this patient.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Anthony J. Leone, M.D.
AJL/tra 06/23/1999:06/23/1999 3:53 P

Requested by WHIDDS on 01/07/09 at 10:05 From M009 Page 1

NL1E8510

01/08/2009 11:52 FAX 352 273 4

Ortho Medical Records

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Shands HealthCare

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Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDY MRN:

DOB:

M

EAD SHW:

26730

SHANDS-UP

Clinic N 01/10/00
SHANDS at UF CLINIC

01/10/2000

Joseph is here today for follow-up of left elbow pain. He has a long history of left upper extremity issues, the most recent of which was creation of a one bone forearm after an Essex-Lopresti injury. He has had progressive elbow degenerative joint disease over time. This pain is now disabling and barely tolerable. He is unable to use the arm for any significant activity due to elbow pain.

PHYSICAL EXAMINATION: No distress. Examination of the left upper extremity reveals tenderness about the joint line of the left elbow. Any pronation-supination force applied to the forearm exacerbates the pain.

IMPRESSION: Advanced degenerative joint disease of the left elbow after one bone forearm procedure. The treatment options were discussed extensively with the patient. They include left total elbow arthroplasty, left elbow arthrodesis, left elbow interpositional arthroplasty. The most viable option for this young, potentially active, patient is the interpositional arthroplasty. He wishes to proceed with this procedure. He was referred to the surgery scheduling office today.

The patient was seen and examined with Dr. Chidgey.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Drew E. Kiernan, M.D.
DEK/460 01/10/2000:01/10/2000 1:52 P

Requested by WHIDDS on 01/07/09 at 10:06 From MD09 Page 1

NLE8616

Shands HealthCare

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Not an Original

OSMANSKI, THOMAS ARTHUR	PTDX MEN:
DOB: M	FAD SSN:
SHANDS-UF	

Clinic N 02/16/00
SHANDS at UF CLINIC

02/16/2000

Mr. Osmanski is a 35 year old gentleman who had previous Essex-Lopresti injury of the left forearm after a 32 foot fall on his construction job. He has subsequently undergone left long bone forearm fusion and he has developed severe degenerative joint disease of the left elbow. He is here for preoperative evaluation for a left elbow fascia lata, fascial interposition arthroplasty. All questions were answered, informed consent was obtained after discussion of risks, benefits and alternatives to surgical procedure. The patient will undergo his surgery on 2/17/00.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/367 02/16/2000:02/17/2000 8:47 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8617

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PID# MRN:
DOB: 154 M	EAD SSN: 70 SHANDS-UF

Clinic N 02/28/00
SHANDS at UF CLINIC

02/28/2000

Mr. Osmanski is a 35-year-old gentleman who presents today for his postoperative visit following left elbow fascia lata interpositional arthroplasty performed on 02/17/00. Overall, he has had significant amount of postoperative pain and has required a significant amount of pain medication but this is not totally surprising given the extent of his surgery.

REVIEW OF SYSTEMS: Has remained unchanged.

PHYSICAL EXAMINATION: Splint was removed from his left elbow. The incision was well-healed. Staples were removed and Steri-Strips applied. His radial ulnar and medial nerve distributions are grossly intact in motor and sensory and capillary refill is less than two seconds with palpable pulses. His left fascia lata donor site had evidence of seroma. The incision was well healed and staples were removed followed by application of Steri-Strips. Approximately 50 cc of seroma was drained from the left thigh and a compressive Ace bandage was applied to the leg. He will keep this compressive wrap on the leg and elevate his leg with pillows in the supine position. He was given a prescription for Mepergan Fortis, number 45, to be taken for pain and he will follow-up with us in 10 to 14 days. At this time he is in a anterior splint of the left elbow at 90 degrees and at his next visit we will have him converted to a hinged elbow brace to begin on flexion and extension exercises but this will provide him with medial and lateral stability. Patient will continue to be temporarily totally disabled from work, but we would anticipate that in six to eight weeks he might be able to return to work in a light-duty capacity, continued no use of the left upper extremity and given the leg surgery, he would probably be a sedentary clerical-type of position.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/496 02/28/2000:02/29/2000 8:21 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8619

Shands HealthCare

Confidential

Not an Original

OSMANSKI	DOB:	M	EAD SRN:	30	SHANDS-ITF
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Clinic N 03/13/00
SHANDS at UP CLINIC

03/13/2000

SUBJECTIVE: Mr. Omanski is a 35 year old gentleman who had severe post traumatic end stage degenerative joint disease of the left elbow and underwent fasciata interpositional arthroplasty of his left elbow performed on 2/17/00. He presents today for a second postoperative visit. He states that he has been wearing his Ace spica wrap around his left thigh, however, the fluid in his thigh has recollected at the site of fasciata donor harvest. He has been taking the Mephergan 4 tabs and states that this is too strong for him and he would like something less powerful. Review of systems has remained unchanged.

OBJECTIVE: On physical examination his elbow incision is well healed. he is neurovascularly intact distally. His range of motion at this time just when gently tested was from 80 to 95 degrees. He had a significant fluid collection in his thigh region. this incision is well healed. 500 cc of serosanguinous fluid was aspirated from this thigh region after sterile prep. Following this a Triple A spica wrap was placed around his entire left thigh and hip region

IMPRESSION: Overall doing well. At this time we are sending him to therapy to obtain a hinged elbow brace and he will begin on active assist and passive range of motion in his elbow in the splint. He will not remove the brace except for bathing and is aware of the need to protect the elbow for continued ligamentous soft tissue healing. With regards to the thigh we have given him a prescription of Keflex 500 mg p.o. q.i.d. for 7 days just as prophylaxis given the fact that we aspirated a significant amount of fluid here in the office. He will continue with the Ace spica wrap as well as frequent elevation of the leg above the level of his heart. He will follow up with us in 4-5 weeks for repeat evaluation. We also gave him a prescription for Lortab 10s #50 1-2 p.o. q. 6 hours p.r.n. As far as work is concerned he will remain temporarily totally disabled as he cannot be up on his feet given the seroma collection nor can he use his left upper extremity. At his next visit we should obtain x-rays of his left elbow AP and lateral.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8620

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSHUA	THUR	PID# MRN	10	SHANDS-UP
DOR	M	EAD SSN		

Clinic N 04/19/00
SHANDS at UF CLINIC

04/19/2000

Mr. Osmanski is now three months status post fascia lata interposition arthroplasty of his left elbow. Overall he feels that he is improved somewhat. He still has a fair amount of significant pain. He still has only 75-100 degrees range of motion with pain at the end of each arch. He has less pain with extension and more discomfort with elbow flexion. His incision is well healed and he is neurovascularly intact distally.

IMPRESSION: Progressing slowly. X-rays show no significant interval change and overall the elbow joint appears to be grossly located.

PLAN: The plan will be to progress slowly. The patient would like to begin with physical therapy for range of motion exercises and we will begin this and he will perform these exercises as tolerated. We have discussed the future options which would include possibly living with the discomfort and loss of motion versus total elbow arthroplasty which in a man of his age and size may not last very long and suffer severe wear and tear versus possible elbow fusion. All of the above have significant disadvantages and we have discussed these with the patient and at this time he would like to proceed with therapy and we will follow his progress. He was given a refill for Lortab 7.5 and as far as work is concerned he will continue to be absolutely no use of the left upper extremity.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/422 04/19/2000:04/20/2000 7:44 A

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NLLE8622

01/08/2008 11:55 FAX 362-273-7244

Ortho Medical Records

018/038

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH - CHUR
DOB: M

WAD SSN:

SHANDS-UP

Clinic N 05/17/00
SHANDS at UP CLINIC

05/17/2000

Follow-up for elbow fascia lata interposition on 02/17/00. He is having an extreme amount of pain in his elbow. Very unhappy because of the amount of discomfort he is having. Review of systems, past medical history is unchanged.

PHYSICAL EXAM: Well-developed, well-nourished male in some distress because of the pain. His range of motion, he can flex passively to 90, extend with gravity for a total of about -40 degrees, but still has quite a bit of discomfort at this time. His neurovascular status is intact. He wears a Bledsae brace for support.

At this time we want to just monitor and try to manage him with pain medicine. Gave him OxyContin 20 mg to take two p.o. q. 12 hours. Gave him pain pills and some Vicxx 25 mg. As far as his work is concerned, he is not really to use that left arm, definitely no lifting greater than 5-10 pounds at this time. We mentioned that the only options would be to leave it alone, fuse it, or replace the joint, but because of his age it would be not a good option at this time. We will see him back in about two months to see how he is doing.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/362 05/17/2000:05/18/2000 10:42 A
c:pjh 5/25/00

Requested by WHEDDS on 01/07/09 at 10:06 From M009 Page 1

NLEB623

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	PID# MRN:
DOR: M EAD SSN:	SHANDS-UF

Clinic N 06/28/00
SHANDS at UF CLINIC

06/28/2000

DIAGNOSIS: Status post left elbow fascia lata interpositional graft.

DATE OF PROCEDURE: 02/17/00

INTERVAL HISTORY: Mr. Osmanski returns for follow-up with his ongoing problem. He continues to have pain and stiffness in his left elbow with decreased range of motion. He is taking Oxycontin 40 mg b.i.d. with good relief of his pain. However, he has been unable to work and has been in a bledsoe brace. He has no history of further trauma.

PHYSICAL EXAM: Examination reveals exquisite tenderness about the entire elbow. He had some mild swelling associated with that. Range of motion of the elbow is about almost full extension to approximately 90 degrees of flexion passively. Actively, he almost has no elbow motion actively. Light touch is normal throughout the extremity. Supination and pronation is extremely limited.

IMPRESSION/PLAN: We have had a long discussion with Mr. Osmanski at this time. Due to his young age and acute atypical postoperative course, we think that he may have difficulties with a total elbow arthroplasty, but will give us his best chance of relieving some of his pain and possibly regaining some more function. Patient has been thinking about this for some time and after answering all of his questions, he has elected to undergo total elbow arthroplasty. This will be done sometime in August, and we will see him back for his preoperative visit at that time.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Christopher Sforzo, M.D.
CS/pjs 06/28/2000:07/03/2000 3:09 P
c: pjh 7/3/00

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL138625

09/08/2008 11:55 FAX 352 273 7224

Ortho Medical Records

020/036

Shands HealthCare		Confidential		Not an Original	
CEMANEKI	ARTHUR	PTDX MRN:	SHANDS-IT		
DOB:	54 M	FAD SHN:			

Clinic N 09/13/00
SHANDS at UF CLINIC
09/13/2000

Joseph comes in today for preop to have left total elbow arthroplasty.
Consent was signed. Questions answered. He will return for suture removal
and x-ray of elbow at that time.

As far as work is concerned, TTD.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by Debbie M. Rafanan, PA
DMR/312 09/13/2000:09/14/2000 4:58 P
c:cjt 9/29/00

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

NL1E8626

01/06/2009 11:58 FAX 352-273

Ortho Medical Records

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Shands HealthCare

Confidential

Not an Original

OBMAANSKI, JOSEPH ARTHUR

PIDU MRN:

DOB:

64 M

EAD RSN:

0

SHANDS-UF

Clinic N 09/27/00

SHANDS at UF CLINIC

09/27/2000

Joseph is followed for total elbow arthroplasty, left elbow. We went ahead and removed the staples and got him in a posterior splint that he can start taking off and working on active motion, not flexing completely. His x-rays showed that the prosthesis was in excellent alignment.

ADDENDUM: Joseph had requested pain medication and we are going to decrease his Oxycontin to 40 mg only once a day and not twice a day. We gave him 50 pills today. He is to taper off this medication and the next visit we need to get him off the pain medication.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/344 09/27/2000:09/28/2000 10:54 A add:ker09/27/00

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NLE8628

01/08/2009 11:56 FAX 352 273 744

Ortho Medical Records

024/038

Shands HealthCare		*Confidential*		Not an Original	
OSMANSKI	JOSEPH ARTHUR	PID#	MRN#		
DOB: 09/24/1964	M	RAD SSN#	730	SHANDS-UP	
Clinic N 11/01/00					
SHANDS at UF CLINIC					
11/01/2000					

Joseph comes in today for a postop follow-up for his total elbow arthroplasty. He is complaining of pain in his forearm region.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY: Unchanged.

PHYSICAL EXAM: Well-developed, well-nourished man in no distress. Examination of his arm reveals he is tender over the posterior osseous nerve. Looking at x-rays, there is nothing that appears to have loosened.

IMPRESSION: Status post above surgery with pain over his posterior osseous nerve.

PLAN: We are going to give him some Ultram, no more narcotics for him, and Neurontin. We are going to increase the dose to two pills three times a day. As far as work is concerned, TTD still.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/427 11/01/2000:11/02/2000 10:37 A

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1EB629

Shands HealthCare *Confidential* Not an Original
OSMANSKI, JOSEPH ARTHUR PIDX MRN: SHANDS-UF
DOB: 1 M EAD SRN: 0
Clinic N 04/04/01
SHANDS at UF CLINIC OSMANSKI, JOSEPH STH#00-67-58-85
04/04/2001

CHIEF COMPLAINT: Follow-up surgery of left elbow.

DATE OF SURGERY: Total elbow arthroplasty performed on 09/14/00.

HISTORY: Mr. Osmanski continues to complain of ulnar nerve-type pain status post the above procedure.

PHYSICAL EXAM: On exam, his wounds are remain well-healed. There is no significant change in range of motion which remains fairly good from approximately 35-110 degrees. He can fully flex and extend his fingers and his wrist as well as abduct and extend his thumb. Light touch is intact throughout.

RADIOGRAPHIC DATA: Radiographs again show today that the elbow prosthesis is in good position with a line seen around the cement area which may or may not be related to loosening of cement but rather the technique.

IMPRESSION: Continued nerve-like pain status post complex left salvage total elbow arthroplasty.

PLAN: At this point in time we would recommend that Mr. Osmanski continue with the hinged-elbow brace. We would like him to continue to work on range of motion. He will not be able to lift any heavy weights. With respect to work status, the patient is not recommended to be employed at this time until he is able to see the Pain Management Clinic for possible suggestions regarding his continuing difficult-to-manage ulnar nerve-type pain. At this point, we have filled out a referral for Dr. Sassano in the Pain Management Clinic and will await his recommendations.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Timothy S. Bollom, M.D.
TSB/496 04/04/2001:04/05/2001 11:26 A
Job ID# 871474

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NLLE8631

Shands HealthCare

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Not an Original

OSMANSKI, JOSEPH ARTHUR
DOB: 1964 M

EAD SSN:

PIDX MRN:

30

SHANDS-IT

Clinic N 09/05/01
SHANDS at UP CLINIC
09/05/2001

OSMANSKI, JOSEPH STH#00-67-58-85

DIAGNOSIS: (1) Status post left total elbow arthroplasty by Dr. Chidgey on 09/14/00. (2) Status post left shoulder arthroscopy with subacromial decompression via Dr. Wright in 1999.

INTERVAL HISTORY: Mr. Osmanski returns to clinic for repeat evaluation. He reports that he has continued to have numbness and burning pain and tingling in his left forearm and hand. He reports that this has been significantly improved with Neurontin, although he was taking 900 mg three times a day and reported erectile dysfunction and loss of sex drive due to the medication. He has slowly titrated himself down and is still having some ulnar nerve symptoms, but has had some improvement in his erectile dysfunction.

PHYSICAL EXAMINATION: He is tender to palpation over the ulnar nerve and has some swelling and tenderness about the elbow. His incisions are all well healed. His range of motion is 5 degrees to 120 degrees of flexion. He has no supination or pronation due to both bone forearm fusion.

IMPRESSION: Left ulnar neuritis.

PLAN: At this point, we had a discussion of re-exploring and performing a neurolysis of his ulnar nerve. Mr. Osmanski is thinking seriously about that. The paperwork was filled out today and he will meet with Teresa. He has temporary total disability regarding his work status.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Daniel A. Worrel, M.D.
DAW/370 09/05/2001:09/05/2001 4:51 P
Job ID# 001026333

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1EB634

01/08/2009 11:57 FAX 352 273

Ortho Medical Records

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Shands HealthCare

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Not an Original

OSMANSKI, JOSEPH ARTHUR

PTDX MEN:

SHANDS-UF

DOR:

RED-SEN:

Clinic N 10/24/01
SHANDS at UF CLINIC
10/24/2001

OSMANSKI, JOSEPH STH#00-67-58-85

Joseph comes in today for a preop to have an ulnar nerve exploration. Previous transposition in the past for neurolysis. He understands the postoperative course. He understands the risk of possible nerve damage. We will plan on seeing him back for postop followup approximately two weeks after surgery for suture removal. He will be in house for 23 hours postop for postop pain.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/338 10/24/2001:10/25/2001 11:56 A
Job ID# 001078276

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

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01/08/2009 11:58 FAX 352 273 7154

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Not an Original

OSMANSKI, JOSEPH ARTHUR

PTNY MRN:

DOB: 09/24/54 M

KAD SSN: 2

10

SHANDS-UF

Clinic N 11/09/01
SHANDS at UF CLINIC
11/09/2001

OSMANSKI, JOSEPH STH#00-67-58-85

Mr. Osmanski is follow-up for transposition of ulnar nerve neurolysis performed by Dr. Chidgey on 11/01/01. Unfortunately he has developed quite a bit of swelling. His wound is slightly erythematous. We are going to go through nerve gliding today with him but wait to take the staples out in two weeks because he is still swollen. He understands that if his wound looks worse before then to come back sooner. We are going to give him some Keflex prophylactically, gave him some more pain medication, Lorcet 10, #50 pills. As far as work is concerned, he is really going to be off for next two weeks until we see him again.

Debbie M. Rafanan, PA
Hand Surgery
Dept. of Orthopaedics & Rehabilitation

Dictated by: Debbie M. Rafanan, PA
DMR/418 11/09/2001:11/11/2001 2:56 P
Job ID# 001095876

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

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01/08/2009 11:58 FAX 352 273 34

Ortho Medical Records

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Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PTX MRN:

DOB:

11/26/01

ED SSN:

00-67-58-85

SHANDS-ITP

Clinic N 11/26/01

SHANDS at UF CLINIC

11/26/2001

OSMANSKI, JOSEPH STH#00-67-58-85

PROBLEM: Status post left ulnar nerve decompression and neurolysis on 11/01/01.

HISTORY: Joseph returns. He complains of some problems with the wound. He denies fevers or chills. He states that he was given Keflex last week after calling the office and is currently on that. He says that he no longer has the pins and needle sensation in the ulnar nerve distribution on the right, although he still has some decreased sensation.

PHYSICAL EXAMINATION: His surgical incision has intact staples over the bulk of it. Just distal to the elbow, there is a region approximately 2 x 2 cm in size of wound dehiscence. There is no evidence of infection. No radiographs were taken.

ASSESSMENT: Wound dehiscence status post ulnar nerve decompression.

PLAN: We are going to treat this with b.i.d. wet-to-dry dressing changes as Joseph has an elbow prosthesis on that side, and we will continue his Keflex for seven days. We will bring him back in one week for a repeat wound check.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Joel D. Thompson, MD
/466 11/26/2001:11/26/2001 1:02 P
Job ID# 001109398

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

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01/08/2009 11:58 FAX 352 273 1144

Ortho Medical Records

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Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ETHUR

PIDX MRN:

DOR:

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EAD REN:

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SHANDS-UF

Clinic N 01/14/02

SHANDS at UF CLINIC
01/14/2002

OSMANSKI, JOSEPH STH#00-67-58-85

PROBLEM: Status post ulnar nerve decompression and neurolysis on 11/01, with postop wound dehiscence.

HISTORY: Mr. Osmanski returns. He says the pins and needles sensation that existed in his hand preoperatively is gone, however, sensation is not normal. He complains of continued pain in the elbow secondary to his arthritis, but he generally says he feels pretty good. He denies fevers or chills.

EXAM: His ulnar wound is near completely healed. There is a small area of eschar approximately 2 cm in diameter just proximal to the medial epicondyle. There is no evidence of infection. Hand intrinsic are intact. Sensation to light touch is diminished in the ulnar nerve distribution. His elbow range of motion is extremely limited and his elbow is swollen. He has minimal pronation/supination.

ASSESSMENT: Stable course.

PLAN: Mr. Osmanski is about to baseline. His wound is not fully healed and will reevaluate him in one month. At that time, we will refer him for PCR, and place him at MMI regarding his elbow.

We will see him in four weeks.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Joel D. Thompson, MD
/424 01/14/2002:01/14/2002 7:21 P
Job ID# 001158523

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Requested by WHEDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8639

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDX MRN:

SHANDS-ITF

DOB:

HEAD RES.

Clinic: -- Day 10/01
SHANDS at UF CLINIC

OSMANSKI, JOSEPH STH#00-67-58-85

01/10/2001

CHIEF COMPLAINT: Followup surgery of left elbow.

HISTORY OF PRESENT ILLNESS: Mr. Osmanski is well known to our service. He is now approximately three-and-a-half months after a complex left total arthroplasty. He also had a previous radial ulnar synostosis. He has been wearing his Hledsoe brace and working on motion. He does complain of occasional popping noises coming from that elbow, and lack of strength.

PHYSICAL EXAMINATION: The surgical wounds are well healed. There are no signs of infection. Range of motion actually is fairly good considering what he has been through. It is from approximately 40 degrees to 110 degrees. He can fully flex extend his fingers and his wrist, and abduct and extend his thumb. Light touch sensation is intact to his fingers, however, he complains of numbness on the dorsal side of his hand and forearm. He is able to actively flex and extend his elbow but with minimal strength, compared to the other side.

X-RAYS: X-rays, radiographs obtained again today show the prosthesis in position with tension band construct on the lateral condyle. A line is seen around the cement area which may or may not be related to loosening of the cement, but rather the technique.

IMPRESSION: Status post complex left salvage total hip arthroplasty.

PLAN: The patient was seen and evaluated today with Dr. Chidgey. We again reiterated no more narcotics and will continue the Ultram and Neurontin. He does feel a difference with both of these medications. We again stressed the importance of limited use of his left arm to increase the longevity of this prosthesis. He can work on gentle exercises and motion, and a lot of that popping he is feeling is suspected to be scar tissue which will loosen over time. He will always have a 15 pound weight limit restriction for the left upper extremity. He should also avoid situations where he might fall or excessively stress his left arm. We stressed this multiple times today, and the patient stated he understands. Overall, his wife stated that she feels he has made significant improvements, and is much better than he was prior to this last surgery. All questions were answered. We will see him again in three months with pre-clinic x-rays of the left elbow.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery

Requested by WHIDDS on 01/07/09 at 10:07 From MD09 Page 1

NL138630

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR	DOB: 02/24/74	M	EAD SEN:	30	SHANDS-UF
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Clinic N 02/11/02
 SHANDS at UF CLINIC
 02/11/2002

OSMANSKI, JOSEPH STH#00-67-58-85

Joseph returns today for evaluation status post ulnar nerve neurolysis on 11/01/01. On exam, his incision is well-healed. Sensation is unchanged. X-rays are not obtained. His elbow range of motion is approximately 0 to 120 degrees of flexion, minimal pronation and supination.

Assessment: Status post left ulnar nerve neurolysis following transposition.

Plan: The plan will be to obtain a functional capacity evaluation. This was written today to set permanent impairment. We have indicated, however, that he will be at a 10-pound lifting restriction indefinitely for his left upper extremity due to this total elbow arthroplasty on that side. We will see him back after functional capacity evaluation again to set his permanent impairment grading. Work restrictions were given (again, a 10-pound lifting restriction). The patient was seen and examined by Dr. Chidgey.

Larry K. Chidgey, M.D.
 Associate Professor, Hand Surgery
 Dept. of Orthopaedics and Rehabilitation

Dictated by: Thomas F. Saylor, MD
 /357 02/11/2002:02/11/2002 9:58 P
 Job ID# 001188532

cc:

Requested by WHIDDS on 01/07/09 at 10:07 From MD09 Page 1

N11E8640

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Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

DOB:

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EAD ESN:

PIDX MRN:

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SHANDS-UF

Clinic N 03/22/02

SHANDS at UF CLINIC

03/22/2002

OSMANSKI, JOSEPH STH#00-67-58-85

DIAGNOSIS: Status post left total elbow arthroplasty and left ulnar nerve neurolysis and transposition

INTERVAL HISTORY: The patient returns today for repeat evaluation following his functional capacity evaluation. We agree with the findings and work recommendations which include a conditioning program as well as teaching techniques to promote good biomechanics. We also agree with them limiting his workload and emphasized that he cannot lift more than 10 or 15 pounds with his left arm due to his total elbow arthroplasty. We will place him at MMI today for his left elbow with a PPI of 14%. This combined with his 6% for his right shoulder gives him a total PPI of 20%.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Daniel A. Worrel, M.D.
DAW/329 03/22/2002 03/26/2002 2:17 P
Job ID# 001232836

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Requested by WHIDDS on 01/07/09 at 10:08 From M009 Page 1

NL1E8641



SHANDS HOSPITAL AND CLINICS
at the University of Florida
OPERATIVE REPORT

OSMANSKI, JOSEPH
#67-58-85

08-23-88

SERVICE: ORTHOPAEDICS DAYS: VOUCHER # 1892 I.P.x O.P.
SURGEON: Dr. Chidgey ASSISTANT: Dr. McCormick
ANESTHESIOLOGIST: Dr. DePadua ASSISTANT: Dr. Winston/Raessler/Fontanot

PREOPERATIVE DIAGNOSIS: Essex-Lopresti fracture
status post radial head excision plus Darrach procedure

POSTOPERATIVE DIAGNOSIS: Same

OPERATION PERFORMED: Fusion left distal radial-ulna joint and fusion of
proximal radial-ulna joint and creation of synostosis
with iliac bone graft left radius and ulna

1. SCRUB: G. Braman, CST 2. SCRUB: M. Holsbeke RELIEF:
1. CIRCULATOR: S. Bingham, RN 2. CIRCULATOR: Donovan, RN RELIEF:
BLOOD LOST: BLOOD REPLACED:
FLUID LOST: FLUID REPLACED:

SPECIMEN: yes _____
no: _____
SPONGE COUNT yes _____
no: _____
CORRECT: _____

SUMMARY OF PROCEDURE: The patient was taken to the Operating Room and after adequate general anesthesia was established, the tourniquet was placed on the upper left arm and the limb prepped and sterily draped. The right hip area was also prepped and sterily draped for an iliac bone graft. The left arm was then exsanguinated with an Esmarch bandage and the tourniquet inflated to 250 mm. of Mercury. The patient had an previous ulnar longitudinal incision over the distal ulna for the previous Darrach procedure. This incision was incorporated into an S-type incision over the dorsal distal forearm. Blunt dissection was carried through the subcutaneous tissue and all superficial veins that could be protected, were retracted out of the way. Blunt dissection was continued down to deep fascia which was split longitudinally. The fourth compartment muscles were retracted radialward and the ulna was identified just on the radial side of the extensor carpi ulnaris. The ulna was also identified between the flexor carpi ulnaris and the extensor carpi ulnaris thus mobilizing the extensor carpi ulnaris such that full access to the excised distal radius was achieved. The fourth and fifth compartment muscles were then retracted radialward and the distal portion of the radius dorsally was exposed subperiosteally along its ulnar border. A small drill was used to make multiple drill holes and an osteotome connecting the drill holes used to create a window in the ulnar side of the radius. The cortical margins of the ulna were then rongeuared to reveal cancellous bone and the ulna transposed radialward into the slot in the radius. Two 40 mm. length 3.5 screws were then used to fix the distal ulna to the radius. Attention had been turned slightly more proximally where the dorsal portions of the radius and ulna were exposed. 2 1/2 cm. wide slot was then cut in both the dorsal one-third of the distal ulna and the dorsal one-third of the distal radius to accept an iliac bone cortical cancellous graft.



Page 2 OPERATIVE REPORT
SHANDS HOSPITAL AND CLINICS
at the University of Florida

OSMANSKI, JOSEPH
#67-58-05

08-23-88

Attention was then turned to the iliac crest on the right side which had been previously draped sterilely and through an oblique incision overlying the iliac crest, blunt dissection continued down to the deep fascia which was incised and the external musculature from the iliac wing dissected from the iliac wing and a 2 1/2 cm. x 4 cm. corticocancellous graft was harvested from the external table of the iliac wing. A generous supply of cancellous bone was also harvested. A Gelfoam was then placed over the defect in the iliac wing and the deep fascia was closed with interrupted 0-Vicryl, followed by closure of the subcutaneous tissue with 2-0 Vicryl and closure of the skin with staples. A Jackson-Pratt drain had been placed down through a separate stab wound at the hip. Attention was then turned to the forearm and the cortical cancellous bone "plate" was inserted into the slot prepared in the distal radius and ulna. 3.5 mm. screws were then used to secure the dome plate across the radius and ulna. Two were placed into the radius and two into the ulna through the bone graft. A generous supply of cancellous bone was then packed on the cortical cancellous bone "plate" and the distal ulna and radius synostosis site. It should be noted that prior to securing the radius to the ulna, the rotation of the forearm was set at neutral. The tourniquet was then deflated during the harvesting of the bone graft and had been reinflated prior to completing the procedure on the forearm. After the distal forearm procedure had been performed, attention was turned to the proximal forearm. A previous radial incision over the radial head region had been used for the previous radial head excision. This incision was re-entered and blunt dissection carried through the subcutaneous tissue. This incision was re-entered and blunt dissection carried through the subcutaneous tissue. The scar overlying the interval between the inconeus and extensor carpi ulnaris was then entered and the proximal radial region identified. The radial head region was exposed subperiosteally revealing the proximal 1-2 cm. of the proximal radius. The interval between the radius and ulna was cleaned out with a rongeur and cancellous bone exposed on both the ulna notch region as well as the proximal radius. A 3.5 mm. screw was then inserted across the proximal radial and ulna joint and cancellous bone was packed around this synostosis region. Drains had been placed down through separate stab wounds in both proximal and distal forearm wounds and the interval between the inconeus and extensor carpi ulnaris closed with interrupted 4-0 Vicryl followed by closure of the subcutaneous tissue with 4-0 Vicryl and closure of the skin with staples. Attention was then turned to the distal wound which was closed with interrupted subcu 4-0 Vicryl followed by closure of the skin with staples. Sterile dressings were then applied both to the hip and arms and a long arm bulky hand dressing incorporating long arm splints was applied to the arm. The tourniquet was inflated with good vascular status returning to the hand. The patient tolerated the procedure well, was taken to the Recovery Room in stable condition.

LCH
Larry Chidgey, M.D.
Assistant Professor.
Department of Orthopaedics

LC/ss 08-23-88/08-25-88

**SHANDS HOSPITAL**

at the University of Florida
Gainesville, Florida 32610

August 31, 1988

OSMANSKI, JOSEPH

67-58-85

ADMISSION: 08-23-88

DISCHARGE: 08-29-88

DIAGNOSIS:

1. Left Essex-Lopresti fracture.

OPERATIONS/MAJOR PROCEDURES WITH DATES:

1. Left one bone forearm with right iliac crest bone grafting,
08-23-88.

CONSULTATIONS: Physical Therapy.

BRIEF HISTORY: Mr. Osmanski is a 23 year old, right hand dominant white male, presently unemployed (previously a carpenter) who, on December 18, 1987 fell from a ladder approximately 22 feet landing on outstretched both arms. At that time he suffered a right radial head fracture and an Essex-Lopresti fracture on the left. The patient was treated on December 18 with open reduction and internal fixation of the humerus fracture and a radial head excision of the left elbow.

Subsequently the patient developed a ulnar positive wrist on the left which was painful, largely symptomatic and for this the patient underwent Darrach procedure with ipsilateral radial head excision and Darrach procedure. The patient developed an unstable above forearm with proximal migration of the carpus and progressive pain and decreased range of motion. He was admitted for elective radial ulnar synostosis/one bone forearm.

PAST MEDICAL HISTORY: Essentially unremarkable. The patient denies any history of cardiopulmonary, gastrointestinal, renal, endocrine, or hemopoetic diseases. He denies taking any medications at the time of admission.

THE PATIENT IS ALLERGIC TO PENICILLIN.

PHYSICAL EXAMINATION: Examination at the time of admission is essentially within normal limits with the exception of the right forearm. There are well healed scars of the left elbow and wrist, has decreased grip and pinch strength. Range of motion of the elbow is 30-115°, with 45° supination and 60° pronation with marked pain at the extremes of motion. He is significantly swollen over wrist and elbow. There is no evidence of inflammation or infection.

DISCHARGE SUMMARY

at the University of Florida
Gainesville, Florida 32610

OMANSKI, JOSEPH
67-58-85

LABORATORY: Routine preoperative evaluation revealed no contraindications for surgery.

HOSPITAL COURSE: Therefore on 8-23-88 he was taken to the major Operating Room where under general endotracheal anesthesia he underwent ~~the formation of a~~ one bone forearm to the left upper extremity. Iliac crest bone grafting was utilized. The patient tolerated the procedure well. Estimated blood loss was 300 cc. Total tourniquet time was 151/130. The patient received 1,900 cc of crystalloid intraoperatively.

After routine stabilization in the Recovery Room the patient as returned to the orthopedic ward. There a Physical Therpay consultation was obtained and the patient was instructed in partial weight bearing ambulation. Postoperative drainage was moderate and his wound drain was removed on the second postoperative day. All perioperative antibiotics were discontinued subsequent to this. The patient's only complaint postoperatively was of persistent pain. His neurovascular exams were normal.

Current medications include Tylox 3 p.o. q 3 hours p.r.n. pain.

- 92 -

**SHANDS HOSPITAL**at the University of Florida
Gainesville, Florida 32610

Page 3.

OMANSKI, JOSEPH
67-58-85

08-31-88

We will see the patient back in the Clinic on 09-02-88 at which time x-rays should be obtained of the forearm. At that time he will be changed from his coaptation splint to a long arm cast.

LARRY CHIDGEY, M.D.
Assistant Professor
Department of Orthopaedics

Dictated by: Michael McCormick, M.D.
MTS110 #1456 08-22/08-31-88

REFERRING PHYSICIAN

George Haaf, M.D.
309 S. E. Riverside Avenue
Stuart, FL 34994

DISCHARGE SUMMARY

Osmanski, Joseph Arthur

Sex: M

BD: 09/24/1964

MR#: 00675885

Print this Page.
PT#: 603809323

Nov 09, 1999

Oper Note Orthopedic Hand P

DATE OF SURGERY: 11/09/1999

PREOPERATIVE DIAGNOSIS: Left shoulder pain, possible instability.

POSTOPERATIVE DIAGNOSIS: Left shoulder arthritis.

OPERATION PERFORMED: 1) Left shoulder arthroscopy and synovectomy. 2)
Left shoulder complete bursectomy.

SURGEON: Wright

ASSISTANT: Kiernan

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: Joseph Osmanski is a gentleman who has had significant problems with his left shoulder consistent with instability. He previously had an arthroscopic shrinkage and Bankart repair. He still has significant pain and feels that he is unstable. It was therefore, felt that evaluation under anesthesia and arthroscopy was indicated. Repair of appropriately disrupted structures would be performed at the same time. The risks, benefits, alternatives and rehab course were fully discussed preoperatively.

PROCEDURE: The patient was placed on the operating room table in a supine position. General endotracheal anesthesia was induced. The patient was then placed in a full beach-chair position. Examination of his left arm under anesthesia showed that he had 45 degrees of external rotation with his arm by his side, 160 degrees of passive elevation. The arm was not dislocatable anteriorly or posteriorly. There was a negative sulcus sign. There was no significant increase in translation of the humeral head on the glenoid. The arm was then sterilely prepped and draped. The 4.5 30 degree arthroscope was introduced posteriorly. Using a Waisinger rod, a second portal was then placed above the subscapularis and rotator cuff interval, lateral to the conjoint tendon. Through this, a 4.5 Aggressor meniscal shaver was introduced. Evaluation of the joint showed a large amount of fibrillated and fibrinous material. Using the shaver, this was debrided. There was a moderate to significant synovitis throughout. A synovectomy was performed of the anterior capsule, undersurface of rotator cuff and along the labrum. The biceps anchor was palpated with the shaver and was noted to be stable with no evidence of a SLAP lesion. The anterior labrum was well-attached on the glenoid rim; although it was hypoplastic, it was definitely well-attached and the anterior inferior glenohumeral ligament which, again was hypoplastic, was attached appropriately. There was no real significant large middle glenohumeral ligament. Evaluation of the humeral head showed there was no Hill-Sachs lesion posteriorly. Anteriorly and superiorly, however, there was a 1 cm by 5 mm osteochondral defect at the way down to cortical cancellous bone. The rest of the humeral head - at least the anterior two-thirds of it, was covered with grade II and possibly grade III chondromalacia. The glenoid likewise had chondromalacia grade II at least throughout. There was a negative drive-through sign. Under direct arthroscopic visualization, the humeral head was not dislocatable anteriorly or posteriorly. There was some tendency to it - just slightly inferiorly and anteriorly subluxate, but this would not be considered pathologic. With even significant pressure, I could not get the head to come outside of the labrum. It was, therefore, our feeling that the patient's problem was not instability but was likely secondary to arthritis. The rotator cuff was nicely funneled through its insertion. There was no evidence of undersurface cuff tear after debridement of the synovitis. In the area, the cuff appeared to be totally normal and its

Page 1 of 2

attachment appeared to be totally normal. Therefore, the arthroscope was then placed into the subacromial space. A third portal was then placed laterally through which the shaver was placed. A significant burr was noted with very hypertrophic globules of synovium. The synovium was removed. The acromial undersurface was palpated. The anterior lateral cord could easily be palpated with the shaver and there was absolutely no hook consistent with having a previous acromioplasty. There was no reason to denude bone again from our standpoint. A complete bursectomy was performed and rotator cuff appeared normal from this superior side. It was our conclusion at the end of the operative procedure that 90% of the patient's pathology could be attributed to glenohumeral arthritis. The arthroscope was then removed from the joint. The wounds were closed with 4-0 nylon. The wound was dressed with a sterile compressive dressing. The patient had a saline block postoperatively. The patient was placed in a sling and transferred to the recovery room in stable condition.

Thomas Wright, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Thomas Wright, M.D.
TW/385 11/09/1999 11/09/1999 10:45 A

Top of Page

Page created: Monday, January 12, 2009 1:06 PM For: DUDDYB

Page 2 of 2

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PTDX MRN:

DOB:

A M

EAD BSN:

0

SHANDS-ITF

Oper Not 02/17/00

DATE OF SURGERY: 02/17/2000

PREOPERATIVE DIAGNOSIS: Post-traumatic end-stage degenerative joint disease, left elbow.

POSTOPERATIVE DIAGNOSIS: Post-traumatic end-stage degenerative joint disease, left elbow.

OPERATION PERFORMED: Fascia lata interposition arthroplasty, left elbow.

SURGEON: Chidgey
ASSISTANT: Stone

ANESTHESIA: General endotracheal anesthesia.
ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR SURGERY: Briefly, Joseph Ozmanski is a 35-year-old, right-hand dominant gentleman, who sustained an injury of his left forearm and wrist after a fall approximately 30 ft. from a scaffolding. He underwent multiple procedures, including distal ulnar resection and one-bone forearm fusion, and he has continued to progress to severe degenerative joint disease of the left elbow. His pain and stiffness have been severely limiting to his activities of daily living. Upon discussion of risks, benefits, and alternatives to the above procedure, the patient provided informed consent.

DESCRIPTION OF OPERATION: The patient was properly identified and brought into the operating room and placed in the supine position on the operating table, at which time he underwent administration of general endotracheal anesthesia. Following successful administration of general endotracheal anesthesia, the patient's left leg and left upper extremity were prepped with Hibiclens x 3 and then draped in a usual sterile fashion. A sterile tourniquet was then placed on the upper extremity. The left arm was then exsanguinated with an Esmarch graft and tourniquet was inflated to 350 mmHg. A straight posterior incision that was curved medially so as not to cross the posterior aspect of the olecranon, hip was outlined and made with a 10-blade knife, again curving somewhat medially around the tip of the olecranon and then brought back to straight posterior midline. Incision was made approximately 15 to 20 cm in length. Subcutaneous tissue was then bluntly dissected in line with the incision with scissors. Electrocautery was used to obtain hemostasis where necessary. The triceps muscle was identified and the subcutaneous tissue was elevated off of the triceps fascia to its medial border. At the medial aspect of the triceps and the proximal aspect of the wound, the ulnar nerve was identified where it pierces the lateral intermuscular septum and traced distally. Because the

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 1

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Shands HealthCare

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OSMANSKI	THUR	PTDX MFW,
DOB:	M	RAD SSN:
		SHANDS-UP

ulnar nerve had been previously transposed, it was embedded in a fair amount of scar tissue, but it had already been transposed anteriorly. Therefore, having taken great care to dissect free the ulnar nerve far enough past the elbow to ensure that it would be elevated safely with the subcutaneous and then periosteal flap, the humerus was approached through the posteromedial interval by elevating the triceps off of the posterior aspect of the humerus and reflecting it laterally. Again, the ulnar nerve and medial tissues were taken medially and protected. Dissection was then carried down to subperiosteal plane, down to the posterior capsule, and the capsule was incised and elevated off of the distal humerus. The dissection was carried down across the posterior aspect of the elbow joint, again by elevating the medial structures off in a subperiosteal plane, including the significantly scarred ligamentous tissues as well. An osteotome was used to remove a sliver of the tip of the olecranon so that the triceps fascia could be taken with this piece of bone laterally. This dissection was aided by extending the incision along the ulna with the knife down through periosteum and the proximal ulna was also exposed in a subperiosteal plane with blunt and sharp dissection using elevators and a 15-blade knife, reflecting the majority of the periosteum with the triceps fascia laterally and the medial periosteum and medial structures medial.

Following exposure of the elbow joints, on its posterior aspect there was evidence there was severe osteophyte formation and loose bodies within the joint, as well as near complete loss of articular cartilage and severe eburnation of bone. Having elevated the ligaments as well in the subperiosteal plane off the lateral side, as well as the scarred ligaments on the medial side, The elbow could not be easily subluxed. A bur was then used to bur down through the eburnated subchondral bone of the distal humerus, creating a barrel-shaped contour of the distal humerus. The severely enlarged portion of the radial head, which had been fused to the ulna due to reactive bone as well as was resected sharply with rongeur and osteotomes. Then, osteotomes and a bur were used to remove the severely eburnated bone from the olecranon articular surface as well.

Following this, the two joint surfaces were evaluated for smoothness of contouring and congruency of fit now that subchondral bone was exposed with bleeding bone via the bur. The size of the distal humerus and olecranon were then measured, and it was felt that a 9 x 25 cm piece of fascia lata was needed for the fascia lata autograft to be used for interposition.

At this time approximately a 20 to 25 cm lateral incision was made on the thigh with a 15-blade knife. Subcutaneous tissue was sharply dissected in line with the incision with a knife down to the fascia lata. A key elevator was used to elevate the subcutaneous tissue, both medially and laterally and anteriorly and posteriorly off of the fascia lata. A 9 x 25 cm rectangular portion of the fascia lata was outlined and then heavy Mayo scissors were used to sharply excise the fascia lata carefully elevating it

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 2

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Shands HealthCare

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Not an Original

OBMANSKI, JORDAN ARTHUR	PIDX MRN:
DOB: 064 M	EAD SSN: 30 SHANDS-UF

off of the underlying vastus lateralis musculature and fascia. The fascia lata was then removed from the leg after sharp dissection and tagged with sutures for orientation and placed in a saline-soaked gauze on the back table.

This wound was then irrigated. A medium Hemovac drain was placed and the wound was closed in layers with 2-0 Vicryl sutures followed by staples. Attention was now turned back to the left elbow and a drill was used to make three holes from posterior to anterior on both the medial and lateral sides of the distal humerus and these were stepwise brought down along the distal humerus. They were also taken cleanly from posterior to anterior.

0 Ethibond sutures were then used to secure the fascia lata autograft with its mucosal surface facing toward the joint space, and this was wrapped around the distal humerus and secured with the 0 Ethibond sutures, both medially and laterally utilizing three sutures on each side with inverted horizontal mattress sutures, which were placed so that the knots would be buried beneath the fascia.

Following successful suturing of the fascia lata autograft to the distal humerus, the fascia lata was then carried down to the olecranon and laid out such that it would fit appropriately onto the olecranon. A drill bit was then used to create multiple holes in both the anterior portion where the coronoid had been resected of osteophytes. Drill holes were also placed through the posterior aspect of the olecranon as well in the region where it had been debrided of osteophytes also. Three holes were placed anteriorly and three holes were placed posteriorly and the fascia lata was secured with inverted horizontal mattress sutures, burying the knots away from the joint space. Then, 0 Vicryl sutures were used to suture the loose ends of the fascia lata on both the medial and lateral sides, thus further fine-tuning the contouring and fit of the fascia lata autograft.

Following this, the elbow joint was reduced and was taken through full extension to 0 degrees and flexion to 145 degrees with smooth motion. Suture drill holes were then placed through both the lateral aspect of the ulna and the medial aspect of the humeral medial epicondyle and 0 Ethibond sutures were then used to repair the collateral ligaments back down to bone through these bone holes from where they had been elevated in the subperiosteal plane. Again, the elbow was noted to be with satisfactory reduction and taken through full extension to 145 degrees of flexion without any evidence of subluxation or medial lateral instability. 0 Vicryl sutures were then used to close the remainder of the periosteal full-thickness medial and lateral flaps along the olecranon and this was carried up completely closing the interval. Again, the ulnar nerve was observed throughout this time to take great care not to create any tethering of the nerve. The nerve was released more proximally of adherent tissue and a portion of the intermuscular septum was sharply excised to

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 3

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OSMANSKI, JOSEPH ARTHUR

DOB: 01/01/1950

DOB:

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EAD SSN:

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SHANDS-ITF

remove any possible impingement upon the nerve more proximally as well. A drain had been inserted into the elbow joint prior to closure of the periosteal flaps and capsule.

The wound was then irrigated with antibiotic irrigation solution and the skin was closed in layers with 2-0 Vicryl sutures followed by staples. Sterile dressing was applied to both wounds. A long-arm splint was placed posteriorly on the elbow and upper extremity and was appropriately padded. Prior to application of the splint, the tourniquet was deflated and removed and patient had palpable radial and ulnar pulses with capillary refill less than 2 seconds in all digits.

Patient was extubated in the operating room and taken to the surgical recovery room in good condition.

The plan for this patient was to admit him for pain control and observation of his drains and IV antibiotics postoperatively.

Dr. Larry Chidgey, the attending surgeon, was present and scrubbed throughout all key portions of the surgical procedure and immediately available for opening and closing.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jeffrey D. Stone, M.D.
JDS/417 02/19/2000:02/20/2000 7:56 P

cc:

Requested by WHIDDS on 01/07/09 at 10:06 From M009 Page 4

NL1E8518

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

DISCHARGE SUMMARY

SHANDS at UF

ADMISSION DATE: 02/17/2000
DISCHARGE DATE: 02/19/2000

ADMISSION DIAGNOSIS: (1) Degenerative joint disease, left elbow.

DISCHARGE DIAGNOSIS: (1) Degenerative joint disease, left elbow.

PROCEDURES: (1) Left elbow fascia lata interpositional graft on 2/17/00. CONSULTATIONS: (1) Physical Therapy.

HISTORY AND PHYSICAL: Please see the chart for the complete H&P.

HOSPITAL COURSE: The patient is a 35-year-old white male with a history of left elbow DJD. He was admitted on 2/17/00 following the aforementioned procedure which was performed at Florida Surgical Center on 2/17/00. The patient tolerated the procedure well and was placed on a morphine PCA for pain control until postop day two. He was switched over to oral pain medication at that time and tolerated that well. His Hemovac drain was discontinued with minimal drainage on the day of discharge on postop day two. He had no fevers and was tolerating a regular diet.

DISCHARGE CONDITION: Stable.

DISPOSITION: Home.

DISCHARGE MEDICATIONS: (1) Tylox one to two PO q.4-6h. PRN pain. (2) Oxycodone 5-10 mg PO q.4-6h. PRN breakthrough pain. (3) Clindamycin 600 mg one PO t.i.d. x 1 day.

DISCHARGE INSTRUCTIONS: The patient should notify us for a temperature greater than 35, increased drainage from his wound, pain uncontrolled with pain medication, numbness, tingling or weakness in his extremity. He was given physical therapy for a walking device as directed by PT.

FOLLOW-UP: Follow-up will be with Dr. Chidgey at Hampton Oaks and the Surgery Clinic in two weeks.


Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Jason W. Thackeray, M.D.
JWT/344 02/19/2000;02/20/2000 5:17 P

DISCHARGE SUMMARY

Page 1

Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSHUA THUR	MRN:
DOB: M	EAD SEN: 130 SHANDS-UF

Oper Not 09/14/00

DATE OF SURGERY: 09/14/2000

PREOPERATIVE DIAGNOSIS: Left elbow arthritis.

POSTOPERATIVE DIAGNOSIS: Left elbow arthritis.

OPERATION PERFORMED: Left total elbow arthroplasty.

SURGEON: Chidgey.

ASSISTANT:

ANESTHESIOLOGIST:

ASSISTANT:

ANESTHESIA: General.

DESCRIPTION OF PROCEDURE: The patient was taken to the Operating Room. After adequate general anesthesia was established, the arm was prepped and sterilely draped. The limb was exsanguinated and a tourniquet around the upper arm inflated to 250 mmHg. A posterior incision was utilized. The triceps was dissected off of the ulna and kept intact with the forearm fascia. It was dissected subperiosteally off of the tip of the olecranon. The patient had a previous anterior transposition of the ulnar nerve. Therefore, the nerve did not have to be dissected out. The patient had no articular cartilage left on either side of the joint as he had a previous fascial arthroplasty which had failed. There was no sign of any infection. The patient had also had a previous one bone forearm with a radial head excision so the radial head did not have to be dealt with. The ulna was prepared with a power saw and a combination of the reamers to prepare the canal. The trial was then fitted. The saw was then utilized to prepare the distal humerus and the canal reamed; and a trial reduction with the trial implant was carried out and found to be good, lacking only the last 20 degrees from full extension. The ulnar component was then cemented into place. The humeral component was then cemented into place. During the cementing process, there was trouble with the articulating pin. In an effort to try and get the pin articulated properly, the cement hardened sufficiently that it could not be fully seated. Therefore, the humeral component was taken back out and the canal cleaned of the cement. Another attempt was then made filling the humeral canal with cement. At this time, the humeral component seated well with the ulnar component and the pin articulated appropriately. The humeral component was then fully seated in the humerus. Once the cement hardened, the triceps was reattached to the ulna through drill holes utilizing #2 Ethibond suture. It should also be mentioned that the lateral epicondylar area fractured off and had to be secured back down with two K-wires and a figure-of-eight tension band wire. A drain was then placed through a separate stab wound and the wound closed.

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 1

NL1E8627

Shands HealthCare

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Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDX MRN:

SHANDS-UP

DOB:

M

FAD SSN:

in layers. A sterile dressing was then applied followed by a splint. The

patient tolerated the procedure well and was taken to the Recovery Room in stable condition. Good vascular status returned to the hand after tourniquet deflation.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Larry K. Chidgey, M.D.
LKC/344 09/14/2000:09/14/2000 6:10 P

Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 2

NL1E8627

SHANDE HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

DATE OF SURGERY: 11/01/2001

PREOPERATIVE DIAGNOSIS:

Left ulnar nerve compression at the elbow with excessive scar formation

POSTOPERATIVE DIAGNOSIS:
excessive scar formation

Left ulnar nerve compression at the elbow with

OPERATION PERFORMED:

Left ulnar nerve transposition and neurolysis

SURGEON: Chidgey
ASSISTANT: Gilmore

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: The patient initially had a cubital tunnel syndrome of the left ulnar nerve. He sustained paresthesias and sensation difficulties in the ulnar distribution of his hand. The initial procedure was a left ulnar nerve transposition. He did return complaining of continued pain and paresthesias about his arm. He had developed a significant amount of scar tissue after multiple surgical procedures to his left elbow. It was deemed he would need a revision of the transposition and likely neurolysis.

DESCRIPTION OF PROCEDURE: The patient was appropriately identified, as well as the extremity was identified. He was taken to the operative suite, and general anesthesia was obtained. Next sterile dressings were applied, along with a sterile tourniquet. The total tourniquet time was approximately 1 hour and 6 minutes. Before the tourniquet was inflated the arm was exsanguinated.

Next the previous scar was identified on the medial ulnar aspect of his left elbow. The incision was made over the previous scar site. It was extended approximately 3 cm proximal and distal from that site. Dissection was then performed down through the skin with a knife in the subcutaneous tissue. Next tenotomies were used to clear some of the scar tissue, and the ulnar nerve was identified distally just underneath the subcutaneous tissue. It was mobilized both distally and proximally across the elbow.

It was noted there was a significant amount of scar tissue on the floor of the nerve, and the nerve was released from the scar tissue with neurolysis. It was determined that instead of dissecting through the abundance and thickness of the scar tissue that it would best serve the ulnar nerve to lie above this tissue with an overlying subcutaneous tissue for cushion. As this layer was sutured over top of the ulnar nerve, it was determined that the ulnar nerve was mobile and free. The rest of the suture line was drawn with 2-

FSC OPERATIVE REPORT

Page 1

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

FSC OPERATIVE REPORT

0 Polysorb. This was done in inverted interrupted fashion. Next skin was stapled. The patient then had sterile dressings applied.

Next the patient was awakened. The tourniquet was deflated, and the patient was taken to the Recovery Room without difficulty. He remained neurovascularly intact postoperatively. He will be admitted to the hospital postoperatively for observation overnight. His pain is under good control with the use of Tylox and morphine.

Dr. Chidgey was present for the entire procedure and participated in the case.



Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/448 11/01/2001 11/01/2001 10:33 P
Job ID# 001087363

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FSC OPERATIVE REPORT

Shands HealthCare

Confidential

Not an Original

OSMANSKI	RTHUR	PIDK MRN:
DOB:	4 M	EAD SSN:
		SHANDS-UP

Oper Not 11/01/01

DATE OF SURGERY: 11/01/2001

OSMANSKI, JOSEPH STH#00-67-58-85

PREOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

POSTOPERATIVE DIAGNOSIS: Left ulnar nerve compression at the elbow with excessive scar formation

OPERATION PERFORMED: Left ulnar nerve transposition and neurolysis

SURGEON: Chidgey
ASSISTANT: Gilmore

ANESTHESIOLOGIST:
ASSISTANT:

INDICATIONS FOR PROCEDURE: The patient initially had a cubital tunnel syndrome of the left ulnar nerve. He sustained paresthesias and sensation difficulties in the ulnar distribution of his hand. The initial procedure was a left ulnar nerve transposition. He did return complaining of continued pain and paresthesias about his arm. He had developed a significant amount of scar tissue after multiple surgical procedures to his left elbow. It was deemed he would need a revision of the transposition and likely neurolysis.

DESCRIPTION OF PROCEDURE: The patient was appropriately identified, as well as the extremity was identified. He was taken to the operative suite, and general anesthesia was obtained. Next sterile dressings were applied, along with a sterile tourniquet. The total tourniquet time was approximately 1 hour and 6 minutes. Before the tourniquet was inflated the arm was exsanguinated.

Next the previous scar was identified on the medial ulnar aspect of his left elbow. The incision was made over the previous scar site. It was extended approximately 3 cm proximal and distal from that site. Dissection was then performed down through the skin with a knife in the subcutaneous tissue. Next tenotomies were used to clear some of the scar tissue, and the ulnar nerve was identified distally just underneath the subcutaneous tissue. It was mobilized both distally and proximally across the elbow.

It was noted there was a significant amount of scar tissue on the floor of the nerve, and the nerve was released from the scar tissue with neurolysis. It was determined that instead of dissecting through the abundance and thickness of the scar tissue that it would best serve the ulnar nerve to lie above this tissue with an overlying subcutaneous tissue for cushion. As this layer was sutured over top of the ulnar nerve, it was determined

Requested by WHEDDS on 01/07/09 at 10:07 From M009 Page 1

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Shands HealthCare

Confidential

Not an Original

OSMANSKI, JOSEPH ARTHUR

PIDX MRN:

DOB:

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M

EAD SSN:

730

SHANDS-UP

that the ulnar nerve was mobile and free. The st of the suture line was drawn with 2-0 Polysorb. This was done in inverted interrupted fashion. Next skin was stapled. The patient then had sterile dressings applied.

Next the patient was awakened. The tourniquet was deflated, and the patient was taken to the Recovery Room without difficulty. He remained neurovascularly intact postoperatively. He will be admitted to the hospital postoperatively for observation overnight. His pain is under good control with the use of Tylox and morphine.

Dr. Chidgey was present for the entire procedure and participated in the case.

Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/44811/01/2001-11/01/2001-10:33 P
Job ID# 001087363

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Requested by WHIDDS on 01/07/09 at 10:07 From M009 Page 2

NL1B8636

SHANDS HOSPITAL
at the University of Florida

OSMANSKI, JOSEPH
00-67-58-85

DISCHARGE SUMMARY

SHANDS at UF

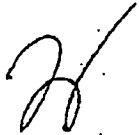
ADMISSION DATE: 11/01/2001
DISCHARGE DATE: 11/02/2001

PRINCIPAL DIAGNOSIS: Ulnar nerve neuritis and neuropathy.

DISCHARGE DIAGNOSIS: Status post revision of an ulnar nerve transposition and neurolysis.

HOSPITAL COURSE: The patient was admitted to the hospital postop for pain control. He was placed on Tylox and OxyContin. He tolerated this well. His pain has been under good control. His arm has remained elevated. He is eating a regular diet without any difficulties.

DISCHARGE INSTRUCTIONS: He will follow up with Dr. Chidgey on 11/09/01. An appointment has already been scheduled. He should call for confirmation. He will also be discharged on Lortab and OxyContin along with clindamycin p.o. for 7 days.



Larry K. Chidgey, M.D.
Associate Professor, Hand Surgery
Dept. of Orthopaedics and Rehabilitation

Dictated by: Michael D. Gilmore, M.D.
MDG/426 11/02/2001:11/02/2001 11:04 A
Job ID# 001088525

cc:

DISCHARGE SUMMARY

Page 1



Affirmative Action Program Information

Full Name: Joseph Arthur OsmauskSocial Security Number: 3

DATE: _____

As an Equal Opportunity/Affirmative Action employer, government regulations require us to obtain the following information about every employee and applicant for employment. Your completion of this form is voluntary.

This information will not be used in making any hiring or employment decision, and it will be used solely for equal employment opportunity reporting purposes. If you choose not to complete this form, or if you indicate clearly inappropriate information, the form will be completed based on visual or other factors. The information will be kept confidential if it is supplied, except that government officials investigating compliance shall be informed. You will not be adversely affected if you refuse to supply the information.

SEX: MALE ☒ FEMALE ☐BIRTHDATE: 9/24/1964

RACE/ETHNIC CATEGORY

- ☒ 1. WHITE (Not of Hispanic Origin) - All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- ☐ 2. BLACK (Not of Hispanic Origin) - All persons having origins in any of the Black racial groups of Africa.
- ☐ 3. HISPANIC - All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- ☐ 4. ASIAN OR PACIFIC ISLANDER - All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, Samoa, India, Pakistan, Bhutan and Bangladesh.
- ☐ 5. AMERICAN INDIAN/ALASKAN NATIVE - All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.
- ☐ 6. OTHER _____

DISABLED

- ☐ YES: 1. You have an impairment (physical or mental) that substantially limits one or more of your major life activities (i.e. any mental or physical function which, if impaired, creates a substantial barrier to employment); or
2. You have a record of such an impairment; or
3. Society regards you as having such an impairment.
- ☒ NO

VIETNAM ERA VETERAN

- ☐ YES: 1. You served on active duty for more than 180 days, any part of which occurred between August 5, 1964 and May 7, 1975, and you were discharged or released from duty with other than a dishonorable discharge; or
2. You were discharged or released from active duty for a service-connected disability and any part of that duty was performed between August 5, 1964 and May 7, 1975.
- ☒ NO

SPECIAL DISABLED VETERAN

- ☐ YES: 1. You are entitled to disability compensation under laws administered by the Veterans Administration for a disability rated at 30% or more, or rated at 10 or 20% for veterans with a serious employment handicap; or
2. You were discharged or released from active duty because of a service-connected disability.
- ☒ NO

- Driver's license or CDL suspension or revocation.
- Arrest or conviction of a DUI/DWI in either a commercial vehicle or private vehicle as set forth in Article I, Section T, "Driver Disqualification."
- Arrest or conviction of any offense involving the use, possession or distribution of a controlled substance (drugs).
- Citation or conviction of hit and run, leaving the scene of an accident or failure to report an accident while in a commercial motor vehicle or a private vehicle.
- A citation or conviction of reckless, negligent or careless driving or other more serious driving offense whether in a commercial motor vehicle or private vehicle.
- Receiving more than 2 moving violation convictions (including DOT log book convictions) in a 1 year period.
- Receiving more than 3 moving violation convictions (including DOT log book convictions) in a 5 year period.

In accordance with Federal Regulations, the Company runs a motor vehicle report on every driver at least once per year. Motor vehicle records are also often run when a driver is involved in a preventable collision and the Executive Safety Committee is considering disciplinary action against the driver.

K. Guidelines for Appropriate Conduct

As an employee driver of Watkins and Shepard, you are expected to accept certain responsibilities and exhibit a high degree of personal integrity at all times.

Certain types of behavior are so serious they may warrant disciplinary action up to and including termination of employment. Behavior and conduct that Watkins and Shepard Trucking, Inc. considers inappropriate include, but are not limited to, the following:

- Major preventable accident as determined by the Executive Safety Committee after a full investigation.
- Tampering with the on-board computer, electronic

equipment, speedograph, service records, governors, and/or fuel pump.

- Unauthorized carrying of passengers. If you pick up a passenger during an emergency, make a notation on your log and notify the Driver Supervisor or Safety Director immediately.
- Failure to comply with controlled substance and alcohol regulations of the FMCSR, including use, impairment, or possession of a controlled substance as defined in the Statement of Procedure and Policy on Controlled Substances and Alcohol Use.
- Failure to report a collision or cargo claim immediately.
- Reporting to work under the influence of alcoholic beverages and/or non-prescribed drugs (while engaged in company business on or off the Company's premises).
- Use of Company assets for personal benefit.
- Unauthorized access to Company records.
- Disregarding safety or security regulations.
- The use of profanity or abusive language.
- The personal possession of firearms, weapons, or explosives on Company property.
- Insubordination or the refusal by a driver to follow management's instructions concerning a job-related matter.
- Fighting or assault on a co-worker or customer.
- Theft, destruction, defacement, or misuse of Company property or of another employee's or customer's property.
- Falsifying or altering any Company record or report, such as an application for employment, a medical report, a production record, a time record, an expense account, an absentee report, or shipping and receiving records.
- Threatening or intimidating co-workers or customers.
- Horseplay, pranks, or practical jokes.
- Engaging in any form of sexual or other harassment.
- Unsatisfactory work performance.
- Failing to maintain confidentiality of Company, staff or

2. C **Function:** Drives 3-axle tractor to hook up to and unhook from trailer and to transport general commodities not limited to furniture, carpet, mattresses, and box springs.
- Methods:** Sits (on air cushioned seat) with brief standing, walking, climbing, and/or stooping to access truck (first step is 16" from the ground; second step is 18"; final step is 13"). Uses reciprocal leg movements to operate foot controls. Uses unilateral lower extremities to operate clutch, brake, and gas pedal (requiring up to 60# exertional force). Bilaterally and/or unilaterally reaches (gear shift is 26" high), handles, fingers, pushes, and pulls controls, steering wheel, and truck doors (requiring negligible exertional force). Hears to monitor vehicular performance and warning signals. Uses visual near through far acuity, depth perception, accommodation for focal length changes, color vision, and field of vision.
- Note:** *See pictures 1-6: Drivers have 14 hours within a 24 hour period to drive 11 hours. Gripping the steering wheel for 11 hours has been noted to be hard on the drivers' hands. The trucks are equipped with power steering and require no more force to turn than a regular vehicle. Drivers get in and out of the cab approximately three to four times when hooking up to the trailer. The clutch is only fully depressed when starting and stopping and is only depressed approximately 3½" when driving. It takes approximately 10 clutch depressions to start. This is called "tapping the clutch". The gear shift takes the same amount of force to push/pull as a gear shift in a vehicle.*
3. O **Function:** Prepares to drive the truck (adjusts electric mirrors, releases parking brake, and adjusts steering wheel).
- Methods:** Sits (air-cushioned seat) while unilaterally and/or bilaterally reaching, handling, fingering, pushing, and/or pulling buttons and knobs (requiring weights and exertional force up to 5#). Uses visual near through far acuity, depth perception, and field of vision.
4. O **Function:** Utilizes Qualcomm to contact and correspond with dispatchers and other main office employees.
- Methods:** Sits (air-cushioned seat). Bilaterally and/or unilaterally reaches, handles, fingers, and lifts Qualcomm (requiring weights up to 3#). Uses visual near acuity.
- Note:** *See picture 5.*
5. O **Function:** Lowers and raises trailer support stands (landing gear) when hooking up and unhooking trailer.
- Methods:** Intermittently stands, walks, and stoops with brief crouching. Unilaterally and/or bilaterally reaches, handles, pushes, and/or pulls 38" high handle (requiring up to 57# exertional force). Hears for air bags to release. Uses visual near through far acuity and depth perception.
- Note:** *See picture 7.*
6. O **Function:** Hooks/unhooks electrical "glad hand connectors" between the cab and trailer
- Methods:** Stands with brief walking and climbing (steps to access glad hand connectors). Bilaterally reaches, handles, pushes, and/or pulls connectors (requiring weights and exertional force up to 5#). Uses visual near through far acuity and color vision.
- Note:** *See picture 8.*

7. O **Function:** Opens and closes trailer doors.
- Methods:** Walks with brief climbing (first step is 27" and the step up into the trailer is another 21"). Bilaterally reaches, handles, lifts, pushes, and/or pulls 62" high latch and doors (requiring weights and exertional force up to 3#). Uses visual far acuity and depth perception.
- Note:** See picture 11: Some trailers have handles on the back door and others do not.
8. O **Function:** Pulls fifth wheel pin.
- Methods:** Crouches with brief walking and stooping. Unilaterally reaches, handles, and pulls fifth wheel puller and/or fifth wheel pin (requiring exertional force up to 100#). Uses visual far acuity and depth perception.
- Note:** See picture 12: Pulling the fifth wheel pin is not difficult until it gets cold and grease gets stiff. This job analysis was completed in warm temperatures and, therefore, the exertional force required in cold weather could not be obtained.
9. O **Function:** Chains up as needed.
- Methods:** Intermittently stands, walks, stoops, kneels, and crouches (under trailer 43½" high). Bilaterally reaches, handles, lifts, carries, pushes, and/or pulls 3-railer or 1-railer chains (requiring weights and exertional force up to 45#). Uses visual near through far acuity, depth perception, and field of vision.
- Note:** See picture 13: Drivers typically only need to use three 1-railer chains weighing 25# each. Drivers are instructed to store the 1-railers on the outside of 3-railers for easy access and to avoid having to remove the 45# chains to get to the 1-railers. Drivers may be able to remove the mudflaps on some of the older trucks, which help the driver get better positioning behind the wheel to put the chains on.
10. O **Function:** Moves tandems on frame rail.
- Methods:** Stoops and crouches with brief kneeling. Bilaterally reaches, handles, pushes and/or pulls bar and pin (requiring exertional force up to 146#). Uses visual far acuity and depth perception.
- Note:** See picture 10: Some newer trucks are air-assisted and require the driver to only press a button.
11. O **Function:** Utilizes CB to communicate with other truck drivers and dispatchers.
- Methods:** Sits (air-cushioned seat). Unilaterally reaches (up to approximately 54" high to reach CB), handles, and fingers CB and controls (requiring negligible weights and exertional force). Talks and hears to exchange information by CB. Uses visual near acuity.
12. O **Function:** Pulls dock plate into place as needed.
- Methods:** Stands and walks. Unilaterally and/or bilaterally reaches, handles, lifts, and pulls bar and dock plate (requiring weights and exertional force up to 60#). Uses visual far acuity.
- Note:** The dock plates at the delivery sites in Missoula are on hydraulics and require 40# of force.

13. O **Function:** Delivers merchandise to customers as needed.

Methods: Intermittently stands, walks, climbs, stoops, and crouches. Bilaterally reaches, handles, lifts, carries, pushes, and/or pulls carpet, mattresses, box springs, desks, recliners, marble, and sofas (requiring weights and exertional force up to 180#). Briefly talks and hears to exchange information in person. Uses visual acuity, depth perception, and field of vision.

Note: 80 percent of the time a dock worker is present to assist the driver with unloading. Drivers can call ahead to inform the store they are on their way and will need assistance. However, there are instances when dock workers are not available due to being at lunch, on a delivery, or unloading another truck. When this occurs, the driver can deliver to other locations and return to that one when there is assistance. If assistance is still not available, drivers will occasionally decide to unload with no assistance in order to ensure productivity. Furthermore, there are, on occasion, smaller stores that do not have dock workers or employees available to assist with unloading. Hand carts are not always available at the delivery locations. Drivers can ensure they have a hand cart by bringing their own. Forklifts are only available approximately 1% of the time. Following is a list of weights a driver may encounter:

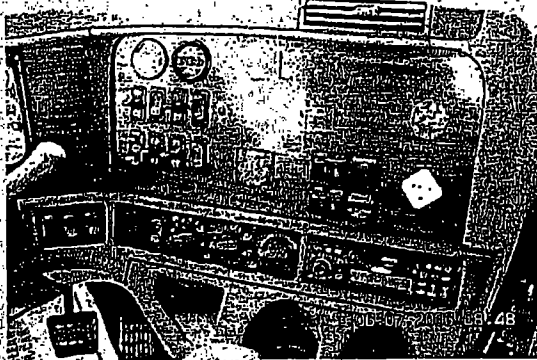
Regular Sofa:	20# of force with hand cart
Sleeper Sofa:	35# of force with hand cart
Love Seat:	40# of force with hand cart
2, 91# recliners:	45# of force with hand cart
Armoire (275#):	50# of force with hand cart
Queen Box Spring:	54#
Twin Mattress:	55#
Recliner:	60# of force with hand cart
Bench:	66#
Marble Top:	70#
Queen Mattress:	84#
Desk (404#) =	90# of force with hand cart
Roll of carpet =	90#
Recliner:	93# to 150#
Office Desk =	180# of force (two people lift the desk onto the hand cart)



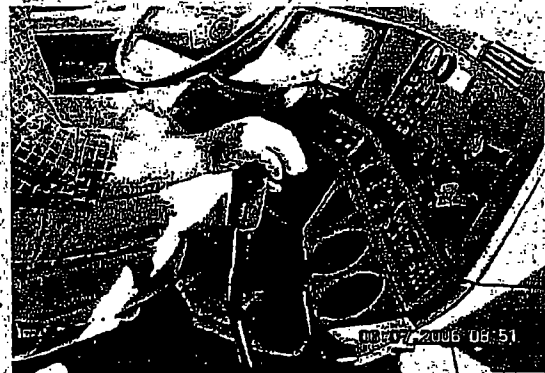
1. Trailer truck cab



2. Air-cushioned seat, height-adjustable steering wheel, and 26" high gear shift which is no more difficult to push/pull than a car's gear shift.



3. Cab controls



4. Demonstration of driver positioning when driving



5. Qualcomm used to communicate with the home office and dispatch



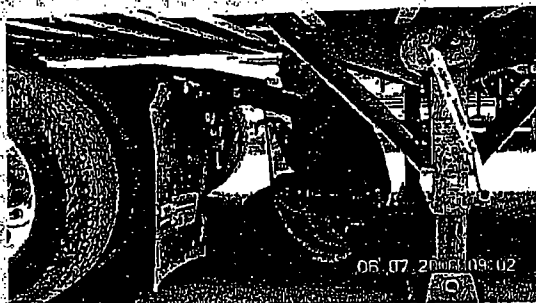
6. Clutch requiring 60# of force to depress to the floor. The clutch is only fully depressed when starting and stopping. Otherwise it is 'tapped', which requires pushing it down approximately 3 1/2"



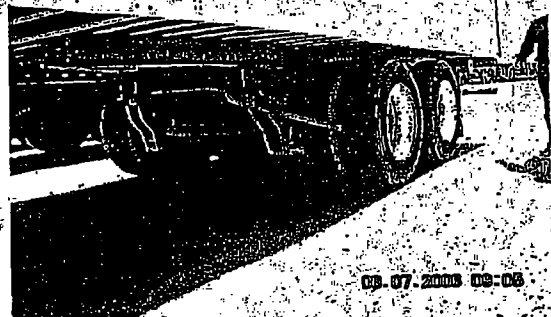
7. Raising trailer legs up and down requiring 40# to 57# of force



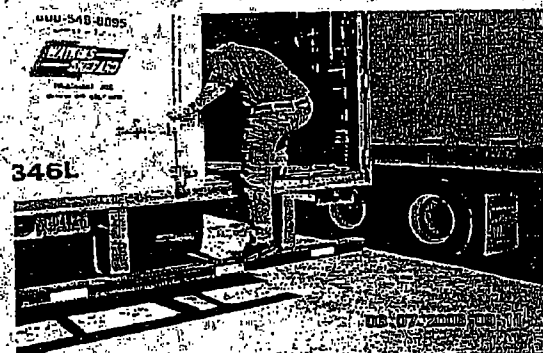
8. Connecting glad hands (electrical connections) between the cab and trailer



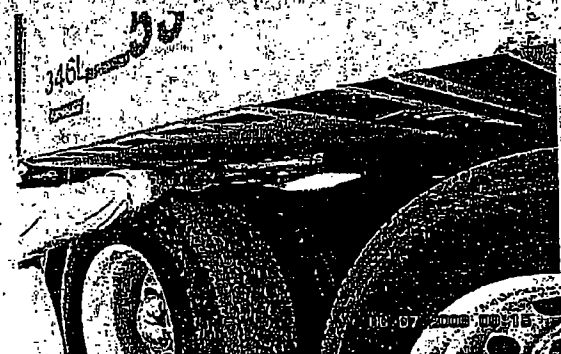
9. Ensuring fifth wheel hitch is connected properly



10. Moving tandems: pulls bar and pin located near the rear tires requiring 146# of exertional force



11. Driver climbing into the trailer. The first step is 27" and the second step into the trailer is another 21"



12. Pulling the fifth wheel pin -- up to 100# of force



13. 1-rail chains weighing 25# and 3-railers weighing 45#



14. Putting dock plate in place requiring 60# of force



15. Opening hood requiring 40# to 60# of force.

PHYSICAL DEMANDS SUMMARY

Sedentary	= Exert up to 10# occasionally or negligible force frequently
Light	= Exert up to 20# occasionally, up to 10# frequently or negligible force constantly
Medium	= Exert up to 50# occasionally, up to 25# frequently or up to 10# constantly
Heavy	= Exert up to 100# occasionally, up to 50# frequently or up to 20# constantly
Very Heavy	= Exert > 100# occasionally, > 50# frequently or > 20# constantly

Duration of Work Shift: N = none, O = occasionally - up to 33%, F = frequently - up to 66%, C = continuously - >67%

Frequency: Brief = occurs in short duration, Intermittent = occurs at varying intervals, Repetitive = performs tasks in regular cycles

STRENGTH REQUIREMENTS				
Position: Sits, Stands, Walks, Drives (only positions required for this specific job title are included in the following table)				
Activity	Duration	Frequency	Comments	
Sits	C	Repetitive	Air-cushioned seat	
Stands	O	Intermittent	Concrete, asphalt, dirt	
Walks	O	Intermittent	Concrete, asphalt, dirt	
Drives	C	Repetitive	Up to 11 hours	
Maximum Weight / Force: 0 - 10#, 11# - 20#, 21# - 50#, 51# - 100#, > 100#				
Lift	0 - 10#	O	Brief	Qualcomm, CB, glad hands, log book, writing materials
	11# - 20#	O	Brief	Merchandise
	21# - 50#	O	Brief	1-rail chains, 3-rail chains
	51# - 100#	O	Brief - Intermittent	Twin mattress, queen box spring, queen mattress, recliner, bench, carpet, bench, marble
	> 100#	O	Brief	Recliner, desk (up to 180# maximum)
Carry	0 - 10#	O	Brief	Log book, writing materials
	11# - 20#	O	Brief	Merchandise
	21# - 50#	O	Brief	1-rail chains, 3-rail chains
	51# - 100#	O	Brief - Intermittent	Twin mattress, queen box spring, queen mattress, recliner, bench, carpet (up to 90# maximum)
Push	0 - 10#	F	Intermittent	Truck knobs, buttons, controls, hand cart, sofa, and doors
	11# - 20#	O	Brief	Hand cart with merchandise (sofa)
	21# - 50#	O	Brief	Trailer leg crank, tandem bar, truck hood, loaded hand cart (sleeper sofa, love seat, 2- 91# recliners, armoire)
	51# - 100#	O	Brief	Sofa, truck hood, desk
	> 100#	O	Brief	Office desk (up to 180# maximum)

Pull	0 - 10#	F	Intermittent	Truck knobs, buttons, controls, hand cart, and doors
	11# - 20#	O	Brief	Hand cart with merchandise (sofa)
	21# - 50#	O	Brief	Trailer leg crank, tandem bar, truck hood, loaded hand cart (sleeper sofa, love seat, 2- 91# recliners, armoire)
	51# - 100#	O	Brief	Sofa, dock plate, truck hood, fifth wheel pin
	> 100#	O	Brief	Tandem bar (up to 146# maximum)
All Other Physical Demands: CLIMB, BALANCE, STOOP/BEND, KNEEL, CROUCH/SQUAT, CRAWL, REACHES, HANDLES, HAND - ARM CONTROLS, FOOT - LEG CONTROLS, FINGERS, FEELS, TALKS, HEARS, TASTE/SMELL, VISUAL - NEAR ACUITY, FAR ACUITY, DEPTH PERCEPTION, ACCOMMODATION, COLOR, FIELD OF VISION (ALL OTHER PHYSICAL DEMANDS REQUIRED FOR THIS SPECIFIC JOB TITLE ARE INCLUDED IN THE FOLLOWING TABLE)				
Activity	Duration	Frequency	Comments	
Climb	O	Intermittent	In/out of truck cab; In/out of back of trailer	
Stoop/Bend	O	Intermittent		
Kneels	O	Brief		
Crouch/Squat	O	Intermittent		
Crawl	O	Brief	Under trailer	
Reaches Vertically	Floor - 30"	O	Brief - Intermittent	Ensuring hitch is connected; unhitching hitch; moving tandems; retrieving chains; transporting merchandise (while handling weights and exertional force up to 180#)
	31" - 48"	O	Intermittent	Connecting glad hands, dollying trailer legs, opening/closing back door, putting dock plate in place, transporting merchandise (while handling weights and exertional force up to 180#)
	49" and Above	O	Brief	Opening/closing cab door; using CB in cab; opening hood; transporting merchandise (while handling weights and exertional force up to 90#)
Reaches Horizontally	Body - 20"	C	Repetitive	Driving; connecting trailer; moving tandems; transporting merchandise; using Qualcomm; putting dock plate in place; dollying trailer legs; opening/closing doors (while handling weights and exertional force up to 180#)
	21" or More	O	Intermittent	Operating truck cab controls; removing fifth wheel pin; chaining tires (while handling weights and exertional force up to 10#)
Handles	C	Repetitive		
Hand-Arm Controls	F	Intermittent		
Foot-Leg Controls	C	Intermittent - Repetitive		
Fingers	O	Intermittent		
Talks	O	Brief		
Hears	C	Repetitive		
Vision - Near Acuity	O	Brief - Intermittent		
	Far Acuity	C	Repetitive	
	Depth Perception	C	Repetitive	
	Accommodation	O	Intermittent	
	Color	O-F	Intermittent	
	Field of Vision	C	Repetitive	

Environmental Conditions: EXPOSURE TO WEATHER, ARTIFICIAL - EXTREME COLD, ARTIFICIAL - EXTREME HEAT, ARTIFICIAL - EXTREME HUMID, NOISE INTENSITY LEVEL (1 - 5), VIBRATION, ATMOSPHERIC IRRITANTS, MOVING PARTS, ELECTRICAL SHOCK/BURN, EXPOSED HEIGHTS, RADIANT ENERGY, EXPLOSIVES, TOXIC/CAUSTIC, OTHER HAZARDS/CONDITIONS CHEMICALS (ENVIRONMENTAL CONDITIONS ENCOUNTERED FOR THIS SPECIFIC JOB TITLE ARE INCLUDED IN THE FOLLOWING TABLE)			
Activity	Duration	Frequency	Comments
Exposure to Weather	O	Intermittent	Seasonal weather and temperature extremes
Noise Intensity Level (1 - 5)	C	(3-4)	Moderate - Loud
Atmospheric Irritants	O	Intermittent	Diesel fumes
Products, Materials, Machines, Tools, Equipment, and Work Aids Utilized			
1-rail tire chains (25#)	3-rail tire chains (45#)	Twin mattress (55#)	
Queen mattress (84#)	Queen box spring (54#)	Sofa sleeper (35# exertion)	
Recliners (93# to 150#)	Carpet (90#)	Tractor trailer	
Hood (40# - 60# exertion)	CB (negligible)	Qualcomm (3#)	
Trailer leg stand crank (56# exertion)	Glad hands (negligible)	Moving tandems (146# exertion)	
Regular sofa (20# exertion)	Love seat (40# exertion)	Armoire (50# exertion)	
Recliner (60# exertion)	Bench (66#)	Marble top (70#)	
Desk (90# exertion)	Office desk (180# exertion)		

General educational development, specific vocational preparation, aptitudes, temperaments, and/or other abilities necessary for average job performance:

Must have good driving record with no restrictions which would prevent transportation of specific types of freight. Must follow standard pre-trip inspection process. Mandatory drug testing. Must perform within the policies and performance expectations of the Company.

Required Licenses and/or Certifications:

Must have a current Class A, Type 1 Commercial Drivers' License, with air brakes endorsement. Van Drivers must have hazardous materials and combination endorsements. Minimum of one year proven Class 8 OTR driving experience; six months experience and driving school; truck driving school and Watkins Shepard training or successfully completed Watkins Shepard driving school.

General Comments:

Must be at least 21 years of age. Reasoning, problem solving, and organizational skills to plan routes and delivery sequences, load/unload freight quickly and safely; work independently; read directions, bills of lading, and road maps; follow directions; interact appropriately with customers; use radio to discuss routes with dispatchers and use cell phone to call customers in event of delivery time changes.

THE STATE OF SOUTH CAROLINA
In The Supreme Court

**APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION**

Avery B. Wilkerson, Appellate Panel Chairman, Commissioner

WCC File No.: 0818219
Ct. App. Case No.: 2011196087
Sup. Ct. Case No.: 2013001174

JOE OSMANSKI, EMPLOYEE,

PETITIONER,

V.

WATKINS & SHEPARD TRUCKING, INC.,
EMPLOYER, AND ZURICH NORTH AMERICAN
INSURANCE COMPANY, CARRIER,

RESPONDENTS,

PROOF OF SERVICE

I certify that I have served the Appendix by depositing a copy of it in the United States Mail, postage prepaid, on 5/31, 2013, addressed to the attorneys of record, Jason Lockhart, Esquire, McAngus, Goudelock & Courie, LLC, P.O. Box 12519, Columbia, SC 29211-2519.


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