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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

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SC Court of Appeals

Appellate Case No.: 2014-002354

Hector G. Fragosa, Claimant,

Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Insurance Company of S.C., Carrier, Defendants,

Respondents.

RECORD ON APPEAL

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-17-2007 19:04	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-17-2007 18:10	GLUCOSE PCX, WHOLE BLOOD	Finished	132	70 - 100	H	POCT	
11-17-2007 17:12	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
11-17-2007 15:08	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
11-17-2007 13:14	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
11-17-2007 12:08	GLUCOSE PCX, WHOLE BLOOD	Finished	135	70 - 100	H	POCT	
11-17-2007 11:07	GLUCOSE PCX, WHOLE BLOOD	Finished	136	70 - 100	H	POCT	
11-17-2007 09:30	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		37 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		93 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.5 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.8 MMOL/L	22.0 - 26.0		OR LAB	
11-17-2007 09:01	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-17-2007 08:01	GLUCOSE PCX, WHOLE BLOOD	Finished	119	70 - 100	H	POCT	
11-17-2007 06:28	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-17-2007 05:23	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-17-2007 03:43	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-17-2007 03:40	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		135.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		107.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		23 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		5 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		110.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		12.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.6 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.2 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.1 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.2 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.720 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.14 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.9 GM/DL	14.0 - 18.0	L	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	HEMATOCRIT		27.90 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.9 FL	80.0 - 94.0		GEN LAB	
	MCH		28.3 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		31.9 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.8 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		335 K/CUMM	140 - 440		GEN LAB	
	MPV		11.80 FL	9.15 - 12.31		GEN LAB	
11-17-2007 02:30	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-17-2007 01:25	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-16-2007 22:13	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
11-16-2007 21:04	GLUCOSE PCX, WHOLE BLOOD	Finished	98	70 - 100		POCT	
11-16-2007 18:54	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-16-2007 17:15	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-16-2007 16:28	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-16-2007 15:02	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-16-2007 14:07	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-16-2007 13:13	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-16-2007 12:20	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-16-2007 10:58	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-16-2007 10:08	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-16-2007 08:54	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-16-2007 08:03	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-16-2007 07:02	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-16-2007 06:11	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-16-2007 05:07	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-16-2007 04:04	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-16-2007 02:48	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
11-16-2007 02:07	ARTERIAL POINT OF CARE PANEL	Finished					
	FIO2		40 %			POCT	
	PATIENT'S TEMPERATURE		37.0 DEG C			POCT	
	PH		7.43	7.35 - 7.45		POCT	
	PCO2		38 MM HG	35 - 45		POCT	
	PO2		100 MM HG	80 - 100		POCT	
	O2 SATURATION		98 %	96 - 97	H	POCT	
	BICARBONATE		25 MMOL/L	22 - 26		POCT	
	TOTAL CO2		26 MMOL/L	23 - 27		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BASE EXC/DEF		1 MMOL/L	-2 - 3		POCT	
	HEMOGLOBIN		8.8 GM/DL	14.0 - 18.0	L	POCT	
	HEMATOCRIT		26 %	42 - 52	L	POCT	
	SODIUM		141 MMOL/L	135 - 145		POCT	
	POTASSIUM		3.8 MMOL/L	3.6 - 5.0		POCT	
	GLUCOSE		99 MG/DL	70 - 100		POCT	
	IONIZED CALCIUM		1.37 MMOL/L	1.14 - 1.29	H	POCT	
11-16-2007 02:00	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		144.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.90 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		113.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		98.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		19.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.7 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.2 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.5 MG/DL	2.4 - 4.7		GEN LAB	
	TRIGLYCERIDES	Finished	202.0 MG/DL	<=150.0	H	GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.300 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.16 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.1 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		28.00 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.6 FL	80.0 - 94.0		GEN LAB	
	MCH		28.8 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.5 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.3 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		329 K/CUMM	140 - 440		GEN LAB	
	MPV		11.90 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		16.2 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.25			GEN LAB	
	APTT	Finished	34.5 SEC	23.3 - 35.7		GEN LAB	*
11-16-2007 00:49	GLUCOSE PCX, WHOLE BLOOD	Finished	93	70 - 100		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-15-2007 23:04	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-15-2007 22:14	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-15-2007 21:10	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-15-2007 19:09	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-15-2007 18:46	GLUCOSE PCX, WHOLE BLOOD	Finished	69	70 - 100	L	POCT	
11-15-2007 16:57	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-15-2007 15:59	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-15-2007 15:06	GLUCOSE PCX, WHOLE BLOOD	Finished	93	70 - 100		POCT	
11-15-2007 13:53	GLUCOSE PCX, WHOLE BLOOD	Finished	93	70 - 100		POCT	
11-15-2007 12:53	GLUCOSE PCX, WHOLE BLOOD	Finished	98	70 - 100		POCT	
11-15-2007 11:48	GLUCOSE PCX, WHOLE BLOOD	Finished	127	70 - 100	H	POCT	
11-15-2007 11:07	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-15-2007 09:54	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-15-2007 09:15	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-15-2007 07:56	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-15-2007 07:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		37 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		96 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.9 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.4 MMOL/L	22.0 - 26.0		OR LAB	
11-15-2007 06:56	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
11-15-2007 05:49	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-15-2007 05:00	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-15-2007 03:51	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
11-15-2007 03:04	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-15-2007 02:17	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		144.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.50 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		115.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		109.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		26.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.6 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.4 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.9 MG/DL	2.4 - 4.7		GEN LAB	
	TRIGLYCERIDES	Finished	131.0 MG/DL	<=150.0		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.790 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.18 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.4 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		28.30 %	42.00 - 52.00	L	GEN LAB	
	MCV		89.0 FL	80.0 - 94.0		GEN LAB	
	MCH		29.6 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.2 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.6 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		317 K/CUMM	140 - 440		GEN LAB	
	MPV		12.00 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		16.6 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.29			GEN LAB	
	APTT	Finished	34.1 SEC	23.3 - 35.7		GEN LAB	*
11-15-2007 02:11	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-15-2007 02:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.0 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.47	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		86 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.1 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.8 MMOL/L	22.0 - 26.0		OR LAB	
11-15-2007 01:17	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-15-2007 00:00	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-14-2007 23:16	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-14-2007 22:10	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PCO2 AT PATIENT TEMP		37 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.5 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.9 MMOL/L	22.0 - 26.0		OR LAB	
11-14-2007 22:07	GLUCOSE PCX, WHOLE BLOOD	Finished	123	70 - 100	H	POCT	
11-14-2007 19:32	GLUCOSE PCX, WHOLE BLOOD	Finished	119	70 - 100	H	POCT	
11-14-2007 18:49	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-14-2007 18:08	GLUCOSE PCX, WHOLE BLOOD	Finished	126	70 - 100	H	POCT	
11-14-2007 17:06	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.6 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.5 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.5 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 17:05	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-14-2007 16:12	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-14-2007 15:22	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-14-2007 15:17	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.6 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		3.2 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		26.9 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 14:16	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-14-2007 13:30	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.41	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		45 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		79 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.5 %	96.0 - 97.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BASE EXC/D		3.2 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		27.6 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 12:58	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-14-2007 12:51	TRIGLYCERIDES	Finished	188.0 MG/DL	<=150.0	H	GEN LAB	*
	PROTHROMBIN TIME (PT)	Finished					
	PT		16.5 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.28			GEN LAB	
	APTT	Finished	32.9 SEC	23.3 - 35.7		GEN LAB	*
11-14-2007 11:50	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-14-2007 11:00	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-14-2007 10:30	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.6 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.45	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		41 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		88 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.5 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		4.1 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		27.7 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 10:05	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-14-2007 08:59	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-14-2007 08:01	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-14-2007 07:55	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.2 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		4.1 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		27.7 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 06:45	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-14-2007 06:07	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-14-2007 04:55	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-14-2007 04:51	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-14-2007 04:03	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
11-14-2007 03:15	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.3 DEG C			OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PH AT PATIENT TEMP		7.49	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		77 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.8 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		4.4 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		27.3 MMOL/L	22.0 - 26.0	H	OR LAB	
11-14-2007 02:43	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-14-2007 02:13	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-14-2007 02:00	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.48	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		91 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.3 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		3.2 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		26.2 MMOL/L	22.0 - 26.0	H	OR LAB	
	METABOLIC PANEL, BASIC - BMP	Started					
	SODIUM (NA)		142.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		108.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		9 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		113.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		29.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		0.8 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.1 MG/DL	8.4 - 10.2		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.8 MG/DL	2.4 - 4.7		GEN LAB	
	MAGNESIUM (MG)	Finished	2.7 MG/DL	1.6 - 2.3	H	GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.980 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.88 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.4 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		34.40 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.7 FL	80.0 - 94.0		GEN LAB	
	MCH		29.4 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.1 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.6 %	11.5 - 14.5	H	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PLATELET COUNT	Finished					
	PLATELET COUNT		359 K/CUMM	140 - 440		GEN LAB	
	MPV		12.40 FL	9.15 - 12.31	H	GEN LAB	
11-14-2007 00:48	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-13-2007 23:47	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-13-2007 22:55	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-13-2007 21:53	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-13-2007 20:52	GLUCOSE PCX, WHOLE BLOOD	Finished	84	70 - 100		POCT	
11-13-2007 20:05	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		37 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		72 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.2 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.8 MMOL/L	22.0 - 26.0		OR LAB	
11-13-2007 20:02	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-13-2007 19:08	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-13-2007 18:15	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.52	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		31 MM HG	35 - 45	L	OR LAB	
	PO2 AT PATIENT TEMP		77 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		96.1 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		3.3 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		25.4 MMOL/L	22.0 - 26.0		OR LAB	
11-13-2007 17:58	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-13-2007 17:09	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-13-2007 16:49	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		65 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		92.3 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.6 MMOL/L	-2.0 - 3.0		OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BICARBONATE		26.3 MMOL/L	22.0 - 26.0	H	OR LAB	
11-13-2007 16:33	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		100 %			OR LAB	
	BODY TEMPERATURE		37.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.41	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		59 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		87.8 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		1.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.7 MMOL/L	22.0 - 26.0		OR LAB	
11-13-2007 16:16	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-13-2007 15:32	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		5L %			OR LAB	
	BODY TEMPERATURE		38.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.21	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		73 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		95 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		94.5 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-0.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		27.8 MMOL/L	22.0 - 26.0	H	OR LAB	
11-13-2007 15:12	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-13-2007 13:51	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-13-2007 13:08	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-13-2007 11:19	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-13-2007 09:50	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-13-2007 09:47	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		5 L %			OR LAB	
	BODY TEMPERATURE		37.7 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.45	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		77 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.4 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		1.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.8 MMOL/L	22.0 - 26.0		OR LAB	
11-13-2007 09:11	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-13-2007 07:55	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-13-2007 06:52	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-13-2007 05:55	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-13-2007 04:55	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-13-2007 03:57	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-13-2007 02:56	GLUCOSE PCX, WHOLE BLOOD	Finished	81	70 - 100		POCT	
11-13-2007 02:30	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.6 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		71 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		93.9 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.3 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.3 MMOL/L	22.0 - 26.0		OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		148.0 MMOL/L	135.0 - 145.0	H	GEN LAB	
	POTASSIUM (K)		4.00 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		112.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		28 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		8 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		80.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		18.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.6 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.4 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.1 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		11.900 K/CUMM	4.800 - 10.800	H	GEN LAB	
	RED BLOOD CELL COUNT		3.92 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.3 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		35.00 %	42.00 - 52.00	L	GEN LAB	
	MCV		89.3 FL	80.0 - 94.0		GEN LAB	
	MCH		28.8 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.3 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.0 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		297 K/CUMM	140 - 440		GEN LAB	
	MPV		11.60 FL	9.15 - 12.31		GEN LAB	
11-13-2007 01:56	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
11-13-2007 01:03	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-13-2007 00:04	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-12-2007 22:58	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-12-2007 21:55	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-12-2007 20:56	GLUCOSE PCX, WHOLE BLOOD	Finished	80	70 - 100		POCT	
11-12-2007 19:53	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-12-2007 18:53	GLUCOSE PCX, WHOLE BLOOD	Finished	76	70 - 100		POCT	
11-12-2007 18:07	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-12-2007 16:11	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-12-2007 14:58	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-12-2007 14:06	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-12-2007 12:11	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-12-2007 10:54	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-12-2007 10:17	GLUCOSE PCX, WHOLE BLOOD	Finished	76	70 - 100		POCT	
11-12-2007 09:05	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-12-2007 06:51	GLUCOSE PCX, WHOLE BLOOD	Finished	93	70 - 100		POCT	
11-12-2007 06:45	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.40	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		134 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.1 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.1 MMOL/L	22.0 - 26.0		OR LAB	
11-12-2007 06:23	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-12-2007 05:30	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-12-2007 04:05	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-12-2007 03:36	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-12-2007 03:30	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		144.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.80 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		111.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		26 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		82.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		27.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		0.8 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.6 MG/DL	8.4 - 10.2		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	MAGNESIUM (MG)	Finished	2.2 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.7 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		9.760 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.53 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		10.5 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		31.20 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.4 FL	80.0 - 94.0		GEN LAB	
	MCH		29.7 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.7 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.1 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		267 K/CUMM	140 - 440		GEN LAB	
	MPV		11.30 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.6 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.20			GEN LAB	
	APTT	Finished	30.6 SEC	23.3 - 35.7		GEN LAB	*
	PREALBUMIN	Finished	28.1 MG/DL	18.0 - 38.0		GEN LAB	
11-12-2007 02:09	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-12-2007 01:18	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
11-12-2007 00:18	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-11-2007 23:21	GLUCOSE PCX, WHOLE BLOOD	Finished	75	70 - 100		POCT	
11-11-2007 22:05	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-11-2007 22:00	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		97 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		98.1 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.9 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.5 MMOL/L	22.0 - 26.0		OR LAB	
11-11-2007 21:25	GLUCOSE PCX, WHOLE BLOOD	Finished	140	70 - 100	H	POCT	
11-11-2007 20:45	GLUCOSE PCX, WHOLE BLOOD	Finished	57	70 - 100	L	POCT	
11-11-2007 19:04	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-11-2007 18:17	GLUCOSE PCX, WHOLE BLOOD	Finished	71	70 - 100		POCT	
11-11-2007 17:16	GLUCOSE PCX, WHOLE BLOOD	Finished	79	70 - 100		POCT	
11-11-2007 15:57	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-11-2007 15:03	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-11-2007 15:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.6 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.45	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		100 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		98.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.3 MMOL/L	22.0 - 26.0		OR LAB	
11-11-2007 14:14	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-11-2007 11:59	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
11-11-2007 11:06	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-11-2007 09:25	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		38.0 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		35 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		105 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.2 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.4 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.2 MMOL/L	22.0 - 26.0		OR LAB	
11-11-2007 09:17	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-11-2007 07:43	GLUCOSE PCX, WHOLE BLOOD	Finished	138	70 - 100	H	POCT	
11-11-2007 05:37	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-11-2007 04:26	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-11-2007 03:11	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-11-2007 02:35	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		111.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		100.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		28.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		0.9 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.1 MG/DL	8.4 - 10.2		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	MAGNESIUM (MG)	Finished	2.4 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.7 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		10.770 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.88 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.3 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		34.20 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.1 FL	80.0 - 94.0		GEN LAB	
	MCH		29.1 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.0 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.8 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		317 K/CUMM	140 - 440		GEN LAB	
	MPV		11.00 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		14.8 SEC	12.6 - 15.2		GEN LAB	*
	INR		1.12			GEN LAB	
	APTT	Finished	28.9 SEC	23.3 - 35.7		GEN LAB	*
11-11-2007 02:30	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.43	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		36 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		77 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.7 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		0.6 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.6 MMOL/L	22.0 - 26.0		OR LAB	
11-11-2007 02:26	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-11-2007 01:33	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-11-2007 00:03	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-10-2007 23:03	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-10-2007 22:15	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
11-10-2007 20:57	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
11-10-2007 19:36	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-10-2007 18:57	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-10-2007 17:54	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-10-2007 16:11	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-10-2007 15:05	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-10-2007 14:18	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-10-2007 13:06	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-10-2007 12:07	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-10-2007 10:35	GLUCOSE PCX, WHOLE BLOOD	Finished	131	70 - 100	H	POCT	
11-10-2007 07:58	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-10-2007 06:57	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-10-2007 05:58	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-10-2007 04:58	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
11-10-2007 03:48	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-10-2007 02:57	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-10-2007 02:55	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.70 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		108.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		20 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		10 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		82.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		22.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		0.9 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.1 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.5 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.8 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		10.990 K/CUMM	4.800 - 10.800	H	GEN LAB	
	RED BLOOD CELL COUNT		4.11 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		35.60 %	42.00 - 52.00	L	GEN LAB	
	MCV		86.6 FL	80.0 - 94.0		GEN LAB	
	MCH		29.0 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.4 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.9 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		313 K/CUMM	140 - 440		GEN LAB	
	MPV		10.40 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.1 SEC	12.6 - 15.2		GEN LAB	*
	INR		1.15			GEN LAB	
	APTT	Finished	30.9 SEC	23.3 - 35.7		GEN LAB	*

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.0 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		30 MM HG	35 - 45	L	OR LAB	
	PO2 AT PATIENT TEMP		148 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.3 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-1.9 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		20.6 MMOL/L	22.0 - 26.0	L	OR LAB	
11-10-2007 01:57	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-10-2007 01:55	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	
11-10-2007 01:05	GLUCOSE PCX, WHOLE BLOOD	Finished	139	70 - 100	H	POCT	
11-09-2007 23:48	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-09-2007 22:19	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-09-2007 21:59	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-09-2007 20:58	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-09-2007 19:49	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-09-2007 19:02	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
11-09-2007 18:12	GLUCOSE PCX, WHOLE BLOOD	Finished	81	70 - 100		POCT	
11-09-2007 18:08	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.41	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		35 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		88 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.4 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-2.2 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		21.2 MMOL/L	22.0 - 26.0	L	OR LAB	
11-09-2007 17:17	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-09-2007 16:13	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-09-2007 15:04	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-09-2007 14:59	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		38.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.37	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		89 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.4 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		-2.7 MMOL/L	-2.0 - 3.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BICARBONATE		21.2 MMOL/L	22.0 - 26.0	L	OR LAB	
11-09-2007 14:02	GLUCOSE PCX, WHOLE BLOOD	Finished	142	70 - 100	H	POCT	
11-09-2007 13:06	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-09-2007 12:03	PATHOLOGIST INTERPRETATION	Cancelled					
	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-09-2007 11:04	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-09-2007 09:42	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-09-2007 09:35	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		38.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		85 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		95.3 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-1.2 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		22.6 MMOL/L	22.0 - 26.0		OR LAB	
11-09-2007 09:01	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-09-2007 07:54	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-09-2007 06:51	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-09-2007 05:36	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
11-09-2007 05:02	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-09-2007 04:11	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-09-2007 03:12	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-09-2007 02:10	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		38.7 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.36	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		41 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		84 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		95.9 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-1.6 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		22.5 MMOL/L	22.0 - 26.0		OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		137.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.90 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		105.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		23 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		9 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		100.0 MG/DL	70.0 - 100.0		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	UREA NITROGEN, BLOOD (BUN)		22.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		1.0 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.2 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.5 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.4 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		10.480 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.99 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.7 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		35.70 %	42.00 - 52.00	L	GEN LAB	
	MCV		89.5 FL	80.0 - 94.0		GEN LAB	
	MCH		29.3 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.8 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.2 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		293 K/CUMM	140 - 440		GEN LAB	
	MPV		10.40 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.3 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.17			GEN LAB	
	APTT	Finished	30.2 SEC	23.3 - 35.7		GEN LAB	*
11-09-2007 01:45	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-09-2007 01:06	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
11-09-2007 00:22	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-08-2007 23:11	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
11-08-2007 21:54	GLUCOSE PCX, WHOLE BLOOD	Finished	137	70 - 100	H	POCT	
11-08-2007 21:09	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-08-2007 20:15	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-08-2007 19:06	GLUCOSE PCX, WHOLE BLOOD	Finished	126	70 - 100	H	POCT	
11-08-2007 17:48	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-08-2007 17:45	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.39	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		92 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		95.7 %	96.0 - 97.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BASE EXC/D		-1.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		22.6 MMOL/L	22.0 - 26.0		OR LAB	
11-08-2007 17:07	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
11-08-2007 16:06	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-08-2007 15:13	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-08-2007 14:27	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		38.6 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.41	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		128 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.5 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.1 MMOL/L	22.0 - 26.0		OR LAB	
11-08-2007 13:59	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-08-2007 13:14	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-08-2007 13:10	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		39.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		94 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.1 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		2.9 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.6 MMOL/L	22.0 - 26.0		OR LAB	
11-08-2007 12:05	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
11-08-2007 10:57	GLUCOSE PCX, WHOLE BLOOD	Finished	123	70 - 100	H	POCT	
11-08-2007 10:11	GLUCOSE PCX, WHOLE BLOOD	Finished	137	70 - 100	H	POCT	
11-08-2007 08:57	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
11-08-2007 07:54	GLUCOSE PCX, WHOLE BLOOD	Finished	122	70 - 100	H	POCT	
11-08-2007 06:40	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-08-2007 05:56	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-08-2007 05:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		38.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		46 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		73 MM HG	80 - 100	L	OR LAB	*

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	% O2 SATURATION		93.0 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		5.7 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		29.7 MMOL/L	22.0 - 26.0	H	OR LAB	
11-08-2007 04:56	GLUCOSE PCX, WHOLE BLOOD	Finished	137	70 - 100	H	POCT	
11-08-2007 04:00	GLUCOSE PCX, WHOLE BLOOD	Finished	129	70 - 100	H	POCT	
11-08-2007 03:15	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-08-2007 02:01	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-08-2007 02:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		38.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		44 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		71 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		92.8 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		5.3 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		29.1 MMOL/L	22.0 - 26.0	H	OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		146.0 MMOL/L	135.0 - 145.0	H	GEN LAB	
	POTASSIUM (K)		3.50 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		109.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		30 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		98.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		21.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		1.0 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.6 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.3 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.8 MG/DL	2.4 - 4.7	H	GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		10.150 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.81 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.1 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		33.60 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.2 FL	80.0 - 94.0		GEN LAB	
	MCH		29.1 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.0 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.5 %	11.5 - 14.5	H	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PLATELET COUNT	Finished					
	PLATELET COUNT		279 K/CUMM	140 - 440		GEN LAB	
	MPV		10.30 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		16.8 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.31			GEN LAB	
	APTT	Finished	28.3 SEC	23.3 - 35.7		GEN LAB	*
11-08-2007 00:41	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-07-2007 23:57	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
11-07-2007 23:39	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
11-07-2007 22:25	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-07-2007 21:29	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-07-2007 20:45	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-07-2007 20:00	TOBRAMYCIN, PEAK	Finished					
	DATE OF LAST DOSE		not given			GEN LAB	
	TIME OF LAST DOSE		not given			GEN LAB	
	TOBRAMYCIN, PEAK		8.1 MCG/ML	5.0 - 10.0		GEN LAB	*
11-07-2007 19:57	GLUCOSE PCX, WHOLE BLOOD	Finished	80	70 - 100		POCT	
11-07-2007 18:07	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-07-2007 18:05	TOBRAMYCIN, TROUGH	Finished					
	DATE OF LAST DOSE		not given			GEN LAB	
	TIME OF LAST DOSE		not given			GEN LAB	
	TOBRAMYCIN, TROUGH		0.6 MCG/ML	<=2.0		GEN LAB	*
11-07-2007 17:10	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-07-2007 16:01	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
11-07-2007 16:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		70 %			OR LAB	
	BODY TEMPERATURE		39.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.36	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		50 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		102 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		97.2 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.8 MMOL/L	22.0 - 26.0	H	OR LAB	
11-07-2007 14:15	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-07-2007 13:17	GLUCOSE PCX, WHOLE BLOOD	Finished	93	70 - 100		POCT	
11-07-2007 13:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	

ID: PA1500-11
USER: col9
MUSC Medical Center
Revenue Code Summary
DATE: 02/15/08
TIME: 10:07:35
MRN: 002581962-ADT
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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BODY TEMPERATURE		37.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		66 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		92.8 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.2 MMOL/L	22.0 - 26.0	H	OR LAB	
11-07-2007 11:54	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
11-07-2007 10:49	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
11-07-2007 09:54	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	
11-07-2007 08:59	GLUCOSE PCX, WHOLE BLOOD	Finished	79	70 - 100		POCT	
11-07-2007 07:53	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-07-2007 07:40	VANCOMYCIN, TROUGH	Finished					
	DATE OF LAST DOSE		unknown			GEN LAB	
	TIME OF LAST DOSE		unknown			GEN LAB	
	VANCOMYCIN, TROUGH		26.2 MCG/ML	5.0 - 10.0	H	GEN LAB	*
11-07-2007 06:48	GLUCOSE PCX, WHOLE BLOOD	Finished	147	70 - 100	H	POCT	
11-07-2007 06:08	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
11-07-2007 04:55	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-07-2007 04:20	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-07-2007 04:12	GLUCOSE PCX, WHOLE BLOOD	Finished	294	70 - 100	H	POCT	
11-07-2007 03:15	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.770 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		2.37 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.8 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		20.90 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.2 FL	80.0 - 94.0		GEN LAB	
	MCH		28.7 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.5 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.2 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		223 K/CUMM	140 - 440		GEN LAB	
	MPV		10.70 FL	9.15 - 12.31		GEN LAB	
11-07-2007 03:08	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
11-07-2007 03:06	GLUCOSE PCX, WHOLE BLOOD	Finished	473	70 - 100	C	POCT	
11-07-2007 02:50	PROTHROMBIN TIME (PT)	Finished					
	PT		17.0 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.33			GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	APTT	Finished	25.8 SEC	23.3 - 35.7		GEN LAB	*
11-07-2007 02:25	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		9.200 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		2.42 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.30 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.0 FL	80.0 - 94.0		GEN LAB	
	MCH		28.5 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.4 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.1 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		228 K/CUMM	140 - 440		GEN LAB	
	MPV		10.30 FL	9.15 - 12.31		GEN LAB	
11-07-2007 02:00	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		149.0 MMOL/L	135.0 - 145.0	H	GEN LAB	
	POTASSIUM (K)		3.10 MMOL/L	3.50 - 5.00	L	GEN LAB	
	CHLORIDE		119.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		27 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		3 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		68.0 MG/DL	70.0 - 100.0	L	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		19.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.0 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.6 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.5 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Corrected					*
	WHITE BLOOD CELL COUNT		* K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		* M/CUMM	4.70 - 6.10		GEN LAB	
	HEMOGLOBIN		* GM/DL	14.0 - 18.0		GEN LAB	
	HEMATOCRIT		* %	42.00 - 52.00		GEN LAB	
	MCV		* FL	80.0 - 94.0		GEN LAB	
	MCH		* UUGM	27.0 - 31.0		GEN LAB	
	MCHC		* GM/DL	30.7 - 34.4		GEN LAB	
	RDW		* %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Corrected					
	PLATELET COUNT		* K/CUMM	140 - 440		GEN LAB	
	MPV		* FL	9.15 - 12.31		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PROTHROMBIN TIME (PT)	Corrected					*
	PT		* SEC	12.6 - 15.2		GEN LAB	*
	INR		*			GEN LAB	
	APTT	Cancelled	SEC				
	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		55 %			OR LAB	
	BODY TEMPERATURE		37.0 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		37 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		146 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.2 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.9 MMOL/L	22.0 - 26.0		OR LAB	
11-07-2007 01:59	GLUCOSE PCX, WHOLE BLOOD	Finished	72	70 - 100		POCT	
11-07-2007 01:08	GLUCOSE PCX, WHOLE BLOOD	Finished	198	70 - 100	H	POCT	
11-07-2007 00:02	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-06-2007 23:58	GLUCOSE PCX, WHOLE BLOOD	Finished	206	70 - 100	H	POCT	
11-06-2007 23:00	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-06-2007 21:57	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
11-06-2007 20:57	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-06-2007 20:07	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-06-2007 19:27	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-06-2007 18:06	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-06-2007 16:59	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
11-06-2007 16:09	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
11-06-2007 15:13	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-06-2007 14:08	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-06-2007 13:30	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		55 %			OR LAB	
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.45	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		92 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.5 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.4 MMOL/L	22.0 - 26.0	H	OR LAB	
	TOTAL CO2 CONTENT		27.6 MMOL/L	23.0 - 27.0	H	OR LAB	
	HEMOGLOBIN		9.5 GM/DL	14.0 - 18.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN,,COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	HEMATOCRIT - BLOOD GAS		29 %	42 - 52	L	OR LAB	
	SODIUM (NA)		148 MMOL/L	135 - 145	H	OR LAB	
	POTASSIUM (K)		3.1 MMOL/L	3.5 - 5.0	L	OR LAB	
	CHLORIDE		114 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		87 MG/DL	70 - 100		OR LAB	
	CA++ MEASURED		1.22 MMOL/L	1.14 - 1.29		OR LAB	
11-06-2007 13:17	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
11-06-2007 12:06	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-06-2007 11:18	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	
11-06-2007 11:00	CELL COUNT, BODY FLUID	Finished					*
	COLOR		Colrless			GEN LAB	
	CLARITY		Hazy		A	GEN LAB	
	TOTAL RBC COUNT		185 /CUMM			GEN LAB	
	TOTAL NUCLEATED CELL COUNT		769 /CUMM			GEN LAB	
	ABSOLUTE WBC		654 /CUMM			GEN LAB	
	NEUTROPHILS		85 %			GEN LAB	
	ANC		654 /CUMM			GEN LAB	
	MACROPHAGES		15 %			GEN LAB	
	COMMENT		See Comment			GEN LAB	
11-06-2007 10:16	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-06-2007 09:26	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	
11-06-2007 08:15	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-06-2007 06:48	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-06-2007 05:42	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-06-2007 04:17	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-06-2007 03:33	ABO AND RH BLOOD TYPE	Finished					
	ABO RH INTERPRETATION		B POS			GEN LAB	
	ANTIBODY SCREEN (INDIRECT COOMBS)	Finished					
	ANTIBODY SCREEN INTERP					GEN LAB	*
11-06-2007 03:03	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-06-2007 03:00	VANCOMYCIN, RANDOM	Finished					
	DATE OF LAST DOSE		11-5-07			GEN LAB	
	TIME OF LAST DOSE		2000			GEN LAB	
	VANCOMYCIN, RANDOM		13.0 MCG/ML			GEN LAB	*
11-06-2007 02:03	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-06-2007 00:59	METABOLIC PANEL, BASIC - BMP	Started					
	SODIUM (NA)		150.0 MMOL/L	135.0 - 145.0	H	GEN LAB	
	POTASSIUM (K)		2.90 MMOL/L	3.50 - 5.00	L	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	CHLORIDE		116.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		30 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		99.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		15.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.8 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.3 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.7 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.8 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.010 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		2.48 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.2 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.50 %	42.00 - 52.00	L	GEN LAB	
	MCV		86.7 FL	80.0 - 94.0		GEN LAB	
	MCH		29.0 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.5 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.7 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		205 K/CUMM	140 - 440		GEN LAB	
	MPV		10.40 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.4 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.18			GEN LAB	
	APTT	Finished	27.1 SEC	23.3 - 35.7		GEN LAB	*
11-06-2007 00:55	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		55 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.45	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		73 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.8 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		2.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.2 MMOL/L	22.0 - 26.0	H	OR LAB	
11-06-2007 00:46	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-05-2007 23:48	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-05-2007 23:11	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-05-2007 21:56	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
11-05-2007 21:07	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-05-2007 19:27	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-05-2007 18:50	GLUCOSE PCX, WHOLE BLOOD	Finished	148	70 - 100	H	POCT	
11-05-2007 18:22	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-05-2007 17:11	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-05-2007 16:09	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
11-05-2007 15:03	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-05-2007 14:01	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-05-2007 12:56	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-05-2007 12:08	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-05-2007 11:20	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		55 %			OR LAB	
	BODY TEMPERATURE		36.9 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.43	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		90 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.4 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.7 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.5 MMOL/L	22.0 - 26.0		OR LAB	
11-05-2007 11:04	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-05-2007 10:05	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-05-2007 09:13	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-05-2007 09:10	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		36.9 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		93 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.8 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.7 MMOL/L	22.0 - 26.0		OR LAB	
11-05-2007 07:58	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-05-2007 06:44	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-05-2007 05:54	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.2 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		1.2 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.2 MMOL/L	22.0 - 26.0		OR LAB	
11-05-2007 05:50	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-05-2007 05:35	VANCOMYCIN, TROUGH	Finished					
	DATE OF LAST DOSE		11-4-07			GEN LAB	
	TIME OF LAST DOSE		1800			GEN LAB	
	VANCOMYCIN, TROUGH		4.4 MCG/ML	5.0 - 10.0	L	GEN LAB	*
11-05-2007 05:09	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-05-2007 04:20	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		36.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.39	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		66 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		93.0 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-0.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.4 MMOL/L	22.0 - 26.0		OR LAB	
11-05-2007 04:19	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
11-05-2007 03:05	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.30 MMOL/L	3.50 - 5.00	L	GEN LAB	
	CHLORIDE		108.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		90.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.5 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.3 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.3 MG/DL	2.4 - 4.7	L	GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.230 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		2.89 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.2 GM/DL	14.0 - 18.0	L	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	HEMATOCRIT		24.50 %	42.00 - 52.00	L	GEN LAB	
	MCV		84.8 FL	80.0 - 94.0		GEN LAB	
	MCH		28.4 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.5 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.5 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		173 K/CUMM	140 - 440		GEN LAB	
	MPV		11.10 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.2 SEC	12.6 - 15.2		GEN LAB	*
	INR		1.16			GEN LAB	
	APTT	Finished	30.7 SEC	23.3 - 35.7		GEN LAB	*
11-05-2007 03:03	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-05-2007 02:22	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-05-2007 00:51	GLUCOSE PCX, WHOLE BLOOD	Finished	141	70 - 100	H	POCT	
11-05-2007 00:05	GLUCOSE PCX, WHOLE BLOOD	Finished	130	70 - 100	H	POCT	
11-04-2007 23:03	GLUCOSE PCX, WHOLE BLOOD	Finished	134	70 - 100	H	POCT	
11-04-2007 22:22	GLUCOSE PCX, WHOLE BLOOD	Finished	139	70 - 100	H	POCT	
11-04-2007 21:04	GLUCOSE PCX, WHOLE BLOOD	Finished	131	70 - 100	H	POCT	
11-04-2007 20:01	GLUCOSE PCX, WHOLE BLOOD	Finished	149	70 - 100	H	POCT	
11-04-2007 19:08	GLUCOSE PCX, WHOLE BLOOD	Finished	131	70 - 100	H	POCT	
11-04-2007 17:58	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-04-2007 17:01	GLUCOSE PCX, WHOLE BLOOD	Finished	132	70 - 100	H	POCT	
11-04-2007 15:48	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
11-04-2007 14:52	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-04-2007 14:45	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		142.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		26 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		106.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		4.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		0.8 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.5 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.1 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.3 MG/DL	2.4 - 4.7		GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-04-2007 14:07	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-04-2007 12:49	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-04-2007 12:05	GLUCOSE PCX, WHOLE BLOOD	Finished	137	70 - 100	H	POCT	
11-04-2007 10:45	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-04-2007 10:04	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-04-2007 09:05	GLUCOSE PCX, WHOLE BLOOD	Finished	84	70 - 100		POCT	
11-04-2007 07:50	GLUCOSE PCX, WHOLE BLOOD	Finished	213	70 - 100	H	POCT	
	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-04-2007 06:50	GLUCOSE PCX, WHOLE BLOOD	Finished	130	70 - 100	H	POCT	
11-04-2007 06:00	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
11-04-2007 05:04	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-04-2007 04:02	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-04-2007 02:35	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		139.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.40 MMOL/L	3.50 - 5.00	L	GEN LAB	
	CHLORIDE		112.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		3 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		90.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		4.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		0.8 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	
	CALCIUM		8.3 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.2 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	1.9 MG/DL	2.4 - 4.7	L	GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.070 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.00 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.6 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		25.40 %	42.00 - 52.00	L	GEN LAB	
	MCV		84.7 FL	80.0 - 94.0		GEN LAB	
	MCH		28.7 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.9 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.3 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		110 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.00 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PT		16.5 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.28			GEN LAB	
	APTT	Finished	31.5 SEC	23.3 - 35.7		GEN LAB	*
	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.39	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		112 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.4 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-1.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.1 MMOL/L	22.0 - 26.0		OR LAB	
11-04-2007 01:50	GLUCOSE PCX, WHOLE BLOOD	Finished	119	70 - 100	H	POCT	
11-04-2007 00:54	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-03-2007 23:54	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-03-2007 23:00	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-03-2007 21:59	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-03-2007 21:11	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-03-2007 19:41	GLUCOSE PCX, WHOLE BLOOD	Finished	142	70 - 100	H	POCT	
11-03-2007 15:46	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
11-03-2007 11:55	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		37.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.34	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		163 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.9 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-2.5 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		22.2 MMOL/L	22.0 - 26.0		OR LAB	
11-03-2007 11:51	GLUCOSE PCX, WHOLE BLOOD	Finished	188	70 - 100	H	POCT	
11-03-2007 07:44	GLUCOSE PCX, WHOLE BLOOD	Finished	151	70 - 100	H	POCT	
11-03-2007 06:58	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.30	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		48 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		84 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.0 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		-2.8 MMOL/L	-2.0 - 3.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	BICARBONATE		23.0 MMOL/L	22.0 - 26.0		OR LAB	
11-03-2007 03:20	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.36	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		109 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		97.9 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-2.7 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		21.8 MMOL/L	22.0 - 26.0	L	OR LAB	
	CA++ MEASURED	Finished	1.25 MMOL/L	1.14 - 1.29		OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.50 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		109.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		23 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		110.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		4.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		1.0 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.3 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.1 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.1 MG/DL	2.4 - 4.7	L	GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.060 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.06 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		26.40 %	42.00 - 52.00	L	GEN LAB	
	MCV		86.3 FL	80.0 - 94.0		GEN LAB	
	MCH		29.1 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.7 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.5 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		88 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.60 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		17.2 SEC	12.6 - 15.2	H	GEN LAB	*

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	INR		1.35			GEN LAB	
	APTT	Finished	26.6 SEC	23.3 - 35.7		GEN LAB	*
11-02-2007 23:47	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-02-2007 19:52	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-02-2007 18:35	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		136.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.70 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		109.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		22 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		5 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		162.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		5.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		1.0 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.1 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.0 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	2.5 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.800 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.02 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		26.10 %	42.00 - 52.00	L	GEN LAB	
	MCV		86.4 FL	80.0 - 94.0		GEN LAB	
	MCH		29.5 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		34.1 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.9 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		97 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.40 FL	9.15 - 12.31		GEN LAB	
11-02-2007 18:30	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.5 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.32	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		44 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		114 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-3.8 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		21.5 MMOL/L	22.0 - 26.0	L	OR LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-02-2007 12:10	CA++ MEASURED	Finished	1.29 MMOL/L	1.14 - 1.29		OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.70 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		112.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		114.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		8.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.9 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.4 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.0 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.3 MG/DL	2.4 - 4.7		GEN LAB	
11-02-2007 09:05	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		37.1 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.31	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		46 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		126 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.9 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-3.0 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		22.5 MMOL/L	22.0 - 26.0		OR LAB	
11-02-2007 07:20	POTASSIUM (K)	Finished	3.90 MMOL/L	3.50 - 5.00		GEN LAB	
11-02-2007 02:50	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		38.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		98 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.6 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-0.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.9 MMOL/L	22.0 - 26.0		OR LAB	
	CA++ MEASURED	Finished	1.15 MMOL/L	1.14 - 1.29		OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		144.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		2.90 MMOL/L	3.50 - 5.00	L	GEN LAB	
	CHLORIDE		113.0 MMOL/L	98.0 - 107.0	H	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		102.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		9.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.1 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		7.8 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	1.5 MG/DL	1.6 - 2.3	L	GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.2 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		4.340 K/CUMM	4.800 - 10.800	L	GEN LAB	
	RED BLOOD CELL COUNT		3.03 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		25.90 %	42.00 - 52.00	L	GEN LAB	
	MCV		85.5 FL	80.0 - 94.0		GEN LAB	
	MCH		29.4 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		34.4 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.7 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		82 K/CUMM	140 - 440	L	GEN LAB	
	MPV		12.10 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		16.4 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.27			GEN LAB	
	APTT	Finished	30.1 SEC	23.3 - 35.7		GEN LAB	*
	HEMOGLOBIN A1C	Finished	5.5 %			GEN LAB	*
11-02-2007 02:48	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-02-2007 01:17	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-01-2007 23:38	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		3.880 K/CUMM	4.800 - 10.800	L	GEN LAB	
	RED BLOOD CELL COUNT		3.10 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.0 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		26.80 %	42.00 - 52.00	L	GEN LAB	
	MCV		86.5 FL	80.0 - 94.0		GEN LAB	
	MCH		29.0 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.6 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.4 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PLATELET COUNT		77 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.10 FL	9.15 - 12.31		GEN LAB	
	ARTERIAL BLOOD GAS	Finished					
	BODY TEMPERATURE		38.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		41 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		78 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		95.1 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-0.9 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.2 MMOL/L	22.0 - 26.0		OR LAB	
	CA++ MEASURED	Finished	1.09 MMOL/L	1.14 - 1.29	L	OR LAB	
11-01-2007 21:00	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		4.320 K/CUMM	4.800 - 10.800	L	GEN LAB	
	RED BLOOD CELL COUNT		2.06 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.0 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		17.90 %	42.00 - 52.00	C	GEN LAB	*
	MCV		86.9 FL	80.0 - 94.0		GEN LAB	
	MCH		29.1 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.5 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		12.8 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		88 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.60 FL	9.15 - 12.31		GEN LAB	
	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		60 %			OR LAB	
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		221 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.2 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-1.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		23.2 MMOL/L	22.0 - 26.0		OR LAB	
	CA++ MEASURED	Finished	1.01 MMOL/L	1.14 - 1.29	L	OR LAB	
11-01-2007 20:10	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		5.550 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		2.21 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.6 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		19.20 %	42.00 - 52.00	L	GEN LAB	

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	MCV		86.9 FL	80.0 - 94.0		GEN LAB	
	MCH		29.9 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		34.4 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		13.1 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		100 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.30 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					*
	SODIUM (NA)		146.0 MMOL/L	135.0 - 145.0	H	GEN LAB	
	POTASSIUM (K)		3.80 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		117.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		5 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		97.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		10.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.1 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		6.4 MG/DL	8.4 - 10.2	C	GEN LAB	
	MAGNESIUM (MG)	Finished	1.5 MG/DL	1.6 - 2.3	L	GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.0 MG/DL	2.4 - 4.7		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		18.4 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.47			GEN LAB	
	APTT	Finished	28.1 SEC	23.3 - 35.7		GEN LAB	*
11-01-2007 17:18	PROTHROMBIN TIME (PT)	Finished					*
	PT		17.7 SEC	12.6 - 15.2	H	GEN LAB	*
	INR		1.40			GEN LAB	
	APTT	Finished	27.0 SEC	23.3 - 35.7		GEN LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		143.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.90 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		113.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		23 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		171.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		13.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.2 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		56			GEN LAB	*

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Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	CALCIUM		7.2 MG/DL	8.4 - 10.2	L	GEN LAB	
	OSMOLALITY, SERUM	Finished	437 MOSM/K	280 - 300	C	GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		15.130 K/CUMM	4.800 - 10.800	H	GEN LAB	
	RED BLOOD CELL COUNT		3.48 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		10.3 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		30.70 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.2 FL	80.0 - 94.0		GEN LAB	
	MCH		29.6 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		33.6 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		12.8 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		207 K/CUMM	140 - 440		GEN LAB	
	MPV		12.40 FL	9.15 - 12.31	H	GEN LAB	
11-01-2007 17:10	ABO AND RH BLOOD TYPE	Finished					
	ABO RH INTERPRETATION		B POS			GEN LAB	
	ANTIBODY SCREEN (INDIRECT COOMBS)	Finished					
	ANTIBODY SCREEN INTERP					GEN LAB	*

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GOMEZ, HECTOR
MUSC
Interdisciplinary Plan Of Care Adult
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 1

FLOWSHEET	11/02	11/21	11/22		11/23
Cardiovascular	15:55	21:30	11:00	20:00	08:15
Cardiovascular		initiated	met	met	met
Comfort	15:55	21:30	11:00	20:00	08:15
Comfort		initiated	met	met	met
Disch Planning	15:55	21:30	11:00	20:00	08:15
Disch Planning	initiated	met	met	met	met
OthDischPln intv	&				

11/02/07 15:55 OthDischPln intv(FS): pt in ICU - currently in OR s/p being hit in head with crane - on vent - case discussed during ICU IDT meeting, NCM, NM, & MSW in attendance. will follow clinical course to determine needs.

Func/Muscuoskel	15:55	21:30	11:00	20:00	08:15
Func/Muscuoskel		initiated	met	met	met
Gastrointestinal	15:55	21:30	11:00	20:00	08:15
Gastrointestinal		initiated	met	met	met
Genitourinary	15:55	21:30	11:00	20:00	08:15
Genitourinary		initiated	met	met	met
Neuro/EENT	15:55	21:30	11:00	20:00	08:15
Neuro/EENT		initiated	met	met	met
Nutrition	15:55	21:30	11:00	20:00	08:15
Nutrition		initiated	met	met	met
Psy/Spirit/Ed	15:55	21:30	11:00	20:00	08:15
PsySpiritEd Eval		initiated	met	met	met
Respiratory	15:55	21:30	11:00	20:00	08:15
Respiratory		initiated	met	met	met
Safety	15:55	21:30	11:00	20:00	08:15
Safety		initiated	met	met	met
CARE PROVIDERS	FS	CAST	AW3	CAST	KMAD

MADDALENA, KRISTINE(KMAD)RN SIMMONS, FLORENCE(FS)NCM STORM, CARRIE A(CAST)RN
WILLIAMS, AUDREY(AW3)RN

CONTINUED

GOMEZ, HECTOR
MUSC
Interdisciplinary Plan Of Care Adult
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 2

FLOWSHEET	11/23	11/24	11/25		
Cardiovascular	20:35	08:00	01:44	08:00	23:58
Cardiovascular	met	met	met	met	met
Comfort	20:35	08:00	01:44	08:00	23:58
Comfort	met	met	met	met	met
Disch Planning	20:35	08:00	01:44	08:00	23:58
Disch Planning	met	met	met	met	met
Func/Muscuoskel	20:35	08:00	01:44	08:00	23:58
Func/Muscuoskel	met	met	met	met	met
Gastrointestinal	20:35	08:00	01:44	08:00	23:58
Gastrointestinal	met	met	met	met	met
Genitourinary	20:35	08:00	01:44	08:00	23:58
Genitourinary	met	met	met	met	met
Neuro/EENT	20:35	08:00	01:44	08:00	23:58
Neuro/EENT	met	met	met	met	met
Nutrition	20:35	08:00	01:44	08:00	23:58
Nutrition	met	met	met	met	met
Psy/Spirit/Ed	20:35	08:00	01:44	08:00	23:58
PsySpiritEd Eval	met	met	met	met	met
Respiratory	20:35	08:00	01:44	08:00	23:58
Respiratory	met	met	met	met	met
Safety	20:35	08:00	01:44	08:00	23:58
Safety	met	met	met	met	met
CARE PROVIDERS	CAST	KMAD	SHUT	KMAD	SHUT

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
Interdisciplinary Plan Of Care Adult
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 3

FLOWSHEET	11/26		11/27		11/28
Cardiovascular	10:39	13:11	01:10	11:29	03:02
Cardiovascular	met		met	met	met
Comfort	10:39	13:11	01:10	11:29	03:02
Comfort	met		met	met	met
Disch Planning	10:39	13:11	01:10	11:29	03:02
Disch Planning	met	initiated &	met	met	met
Inadeq finances		active			
11/26/07 13:11 Disch Planning(FS): Pt transferred to floor - case discussed during attending Rounds - plan decannulation regular diet, continue therapy					
Func/Muscuoskel	10:39	13:11	01:10	11:29	03:02
Func/Muscuoskel	met		met	met	met
Gastrointestinal	10:39	13:11	01:10	11:29	03:02
Gastrointestinal	initiated		met	met	met
Genitourinary	10:39	13:11	01:10	11:29	03:02
Genitourinary	met		met	met	met
Neuro/EENT	10:39	13:11	01:10	11:29	03:02
Neuro/EENT	met		met	met	met
Nutrition	10:39	13:11	01:10	11:29	03:02
Nutrition	met		met	met	met
Psy/Spirit/Ed	10:39	13:11	01:10	11:29	03:02
PsySpiritEd Eval	met		met	resolved/dc'ed	met
Respiratory	10:39	13:11	01:10	11:29	03:02
Respiratory	met		met	met	met
Safety	10:39	13:11	01:10	11:29	03:02
Safety	met		met	met	met
CARE PROVIDERS	SBRO	FS	SHUT	SBRO	LGBR

BROWN, SUZANNE(SBRO)RN BRYAN, LINDA G(LGBR)RN HUTCHINSON, STEPHANIE(SHUT)RN
SIMMONS, FLORENCE(FS)NCM

CONTINUED

GOMEZ, HECTOR
MUSC
Interdisciplinary Plan Of Care Adult
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28	11/29		11/30
Cardiovascular	09:08	13:16	14:23	09:05
Cardiovascular	met		met	met
Comfort	09:08	13:16	14:23	09:05
Comfort	met		met	met
Disch Planning	09:08	13:16	14:23	09:05
Disch Planning	met	met &	met	met
11/29/07 13:16 Disch Planning(FS): Discussed in IDT rounds with chg nurse- awaiting amputation of toes- DME order placed/and referral for PT.				
Func/Muscuoskel	09:08	13:16	14:23	09:05
Func/Muscuoskel	met		met	met
Gastrointestinal	09:08	13:16	14:23	09:05
Gastrointestinal	met		met	met
Genitourinary	09:08	13:16	14:23	09:05
Genitourinary	met		met	met
Neuro/EENT	09:08	13:16	14:23	09:05
Neuro/EENT	resolved/dc'ed		met	met
Nutrition	09:08	13:16	14:23	09:05
Nutrition	met		met	met
Psy/Spirit/Ed	09:08	13:16	14:23	09:05
PsySpiritEd Eval	resolved/dc'ed		met	met
Respiratory	09:08	13:16	14:23	09:05
Respiratory	met		met	met
Safety	09:08	13:16	14:23	09:05
Safety	met		met	met
CARE PROVIDERS	SBRO	FS	SGUL	JDW1

BROWN, SUZANNE(SBRO)RN GULLEDGE, SHARON(SGUL)RN SIMMONS, FLORENCE(FS)NCM
WILKINS, JANE D(JDW1)RN

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/21		11/22				
Vital Signs	21:54	23:30	00:09	03:00	04:21	06:54	07:45
TEMP #1 in F	99.7F Oral		99.3F Oral		99.6F Oral		100.1F Oral
PULSE	112 Brachl		114 Brachl		**124 Brachl**		119 Apical
RESPIRATIONS	20 Visual		22 Visual		20 Visual		24 Visual
O2 SAT %	93% O2		96% O2		95% O2		95% O2
O2 flow	40 Prcent		40 Prcent		40 Prcent		50 Prcent
BP (NIBP)	130/80 Rarm		137/74 Rarm		126/78 Rarm		122/78 Rarm
Glucose fs			104mg/dL		116mg/dL		101mg/dL
PAIN LEVEL							
I&O SUMMARY	21:54	23:30	00:09	03:00	04:21	06:54	07:45
Intake Total		70		240		240	
Output Total			550		650		350
NET		70	-550	240	-650	240	-350
INTAKE	21:54	23:30	00:09	03:00	04:21	06:54	07:45
Tube feeding		70		200		200	
NaCl 0.9%+KCl				40		40	
Intake Total		70		240		240	
OUTPUT	21:54	23:30	00:09	03:00	04:21	06:54	07:45
Foley cath			550		650		350
Output Total			550		650		350
CARE PROVIDERS	BPM	CAST	BPM	CAST	BPM	CAST	RKRE

MCGUINESS, BRYAN P(BPM)CA REESER, REBECCA K(RKRE)CA STORM, CARRIE A(CAST)RN

Apical apical Oral oral Rarm arm R
Brachl brachial Prcent percent Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/22					
Vital Signs	11:40	15:03	15:31	19:00	19:40	23:00
TEMP #1 in F	99.3F Axilry		99.2F Axilry		99.7F Oral	
PULSE	117 Radial		100 Radial		112 Radial	
RESPIRATIONS	22 Visual		20 Visual		**28 Visual**	
O2 SAT %	93% O2		93% O2		92% O2	
O2 flow	50 Prcent		50 Prcent		50 Prcent	
BP (NIBP)	123/68 Rarm		120/72 Rarm		120/72 Rarmly	
Glucose fs	112mg/dL		112mg/dL		90mg/dL	
PAIN LEVEL						
I&O SUMMARY	11:40	15:03	15:31	19:00	19:40	23:00
Intake Total		480		240		320
Output Total	400		75		340	
NET	-400	480	-75	240	-340	320
INTAKE	11:40	15:03	15:31	19:00	19:40	23:00
Tube feeding		400		200		200
NaCl 0.9%+KCl		80		40		120
Intake Total		480		240		320
OUTPUT	11:40	15:03	15:31	19:00	19:40	23:00
Foley cath	400		75		340	
Output Total	400		75		340	
CARE PROVIDERS	RKRE	AW3	RKRE	KMO	RSM	CAST

MACKENZIE, ROBERT S(RSM)CA
O'COIN, KARI M(KMO)RN
REESER, REBECCA K(RKRE)CA
STORM, CARRIE A(CAST)RN
WILLIAMS, AUDREY(AW3)RN

Axilry axillary
Oral oral
Prcent percent
Radial radial
Rarm arm R
Rarmly Rt arm lying
Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23					
Vital Signs	00:00	03:00	04:40	06:30	08:15	12:00
TEMP #1 in F	99F Oral		99.1F Oral		99.1F Axilry	99.7F Oral
PULSE	104 Radial		92 Radial		109 Brachl	112 Brachl
RESPIRATIONS	16 Visual		12 Visual		21 Visual	22 Visual
O2 SAT %	**90% O2**		96% O2		92% O2	92% O2
O2 flow	50 Prcent		50 Prcent		50 Prcent	50 Prcent
BP (NIBP)	121/78 Rarmly		113/71 Rarmly		128/82 Rarmly	126/76 Larm
Glucose fs	112mg/dL		106mg/dL		110mg/dL	104mg/dL
PAIN LEVEL						
I&O SUMMARY	00:00	03:00	04:40	06:30	08:15	12:00
Intake Total		280		220		
Output Total			100		850	
NET		280	-100	220	-850	
INTAKE	00:00	03:00	04:40	06:30	08:15	12:00
Tube feeding		200		150		
NaCl 0.9%+KCl		80		70		
Intake Total		280		220		
OUTPUT	00:00	03:00	04:40	06:30	08:15	12:00
Foley cath			100		850	
Output Total			100		850	
CARE PROVIDERS	RSM	CAST	RSM	CAST	BAC	BAC

CHANDLER, BETTY A(BAC)CA MACKENZIE, ROBERT S(RSM)CA STORM, CARRIE A(CAST)RN

Axilry axillary
Brachl brachial
Larm arm L
Oral oral
Prcent percent
Radial radial
Rarmly Rt arm lying
Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
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FLOWSHEET	11/23						11/24
Vital Signs	15:00	16:30	18:48	19:53	23:00	23:48	03:00
TEMP #1 in F		98.9F Oral		97.1F Oral		96.6F Oral	
PULSE		78 Brachl		101 Brachl		86 Brachl	
RESPIRATIONS		23 Visual		24 Visual		20 Visual	
O2 SAT %		99% O2		96% O2		92% O2	
O2 flow		50 Prcent		50 Prcent		50 Prcent	
BP (NIBP)		124/74 Larm		129/73 Rarmsi		117/72 Rarmly	
Glucose fs		110mg/dL		120mg/dL		116mg/dL	
PAIN LEVEL				5 Numvlu		10 Numvlu	
I&O SUMMARY	15:00	16:30	18:48	19:53	23:00	23:48	03:00
Intake Total	280		280		280		280
Output Total		75					
NET	280	-75	280		280		280
INTAKE	15:00	16:30	18:48	19:53	23:00	23:48	03:00
Tube feeding	200		200		200		200
NaCl 0.9%+KCl	80		80		80		80
Intake Total	280		280		280		280
OUTPUT	15:00	16:30	18:48	19:53	23:00	23:48	03:00
Urine (O)						2	
Foley cath		75&					
Output Total		75					

11/23/07 16:30 Foley cath(BAC): wet brief

CARE PROVIDERS	KMAD	BAC	KMAD	HCF	CAST	HCF	CAST

CHANDLER, BETTY A(BAC)CA FOSTER, HYPATIA C(HCF)CA MADDALENA, KRISTINE(KMAD)RN
STORM, CARRIE A(CAST)RN

Brachl	brachial	Numvlu	Numeric Value	Prcent	percent	Rarmsi	Rt arm sitting
Larm	arm L	Oral	oral	Rarmly	Rt arm lying	Visual	visual

CONTINUED

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/24						
Vital Signs	03:43	06:00	08:10	11:00	12:40	12:50	15:00
TEMP #1 in F	98.6F Oral		97.7F Oral		97.8F Oral		
PULSE	82 Brachl		96 Brachl		96 Brachl		
RESPIRATIONS	18 Visual		20 Visual		20 Visual		
O2 SAT %	93% O2		94% O2		92% O2		
O2 flow	50 Prcent		70 Prcent		50 Prcent		
BP (NIBP)	116/74 Rarmly		132/78 Rarmly		127/77 Rarmly		
Glucose fs	82mg/dL		84mg/dL		84mg/dL		
PAIN LEVEL	8 Numvlu				0 Numvlu		
I&O SUMMARY	03:43	06:00	08:10	11:00	12:40	12:50	15:00
Intake Total		150		280			280
Output Total	300						
NET	-300	150		280			280
INTAKE	03:43	06:00	08:10	11:00	12:40	12:50	15:00
Tube feeding		150		200			200
NaCl 0.9%+KCl				80			80
Intake Total		150		280			280
OUTPUT	03:43	06:00	08:10	11:00	12:40	12:50	15:00
Urine (O)			0		75&	1&	
Foley cath	300						
Output Total	300						
11/24/07 12:40 Urine	(O)(BAC): urinal						
11/24/07 12:50 Urine	(O)(BAC): miss urinal pead in bed.						
CARE PROVIDERS	HCF	CAST	BAC	KMAD	BAC	BAC	KMAD

CHANDLER, BETTY A(BAC)CA FOSTER, HYPATIA C(HCF)CA MADDALENA, KRISTINE(KMAD)RN
STORM, CARRIE A(CAST)RN

Brachl brachial Oral oral Rarmly Rt arm lying
Numvlu Numeric Value Prcent percent Visual visual

CONTINUED

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/24					11/25	
Vital Signs	16:20	18:00	18:21	21:15	23:00	00:33	03:42
TEMP #1 in F	98.2F Oral			99.8F Oral		98.7F Oral	
PULSE	88 Brachl			112 Brachl		105 Radial	
RESPIRATIONS	18 Visual			18 Visual		18 Visual	
O2 SAT %	95% O2			92% O2		96% O2	
O2 flow	50 Prcent			50 Prcent		50 Prcent	
BP (NIBP)	119/65 Rarmly			116/71 Rarmly		111/68 Rarmly	
Glucose fs	89mg/dL			102mg/dL		97mg/dL	
PAIN LEVEL				6 Numvlu		0 Numvlu	
I&O SUMMARY	16:20	18:00	18:21	21:15	23:00	00:33	03:42
Intake Total			280		400		120
NET			280		400		120
INTAKE	16:20	18:00	18:21	21:15	23:00	00:33	03:42
Oral		&					
Tube feeding			200		250		
NaCl 0.9%+KCl			80		150		120
Intake Total			280		400		120
11/24/07 18:00 Oral(BAC): very little ice chip.							
OUTPUT	16:20	18:00	18:21	21:15	23:00	00:33	03:42
Urine (O)	350			300		225	
CARE PROVIDERS	BAC	BAC	KMAD	HCF	SHUT	HCF	SHUT

CHANDLER, BETTY A(BAC)CA FOSTER, HYPATIA C(HCF)CA HUTCHINSON, STEPHANIE(SHUT)RN
MADDALENA, KRISTINE(KMAD)RN

Brachl brachial Oral oral Radial radial Visual visual
Numvlu Numeric Value Prcent percent Rarmly Rt arm lying

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25						
Vital Signs	03:54	03:55	04:48	05:11	08:15	09:30	10:39
TEMP #1 in F			98.4F Oral		98.7F Oral		
PULSE			81 Brachl		87 Brachl		
RESPIRATIONS			16 Visual		20 Visual		
O2 SAT %			93% O2		97% O2		
O2 flow			50 Prcent		40 Prcent		
BP (NIBP)			116/67 Rarmly		116/71 Rarmly		
Glucose fs			**69mg/dL&**	127mg/dL	148mg/dL&		
PAIN LEVEL			8 Numvlu				
11/25/07 04:48 Glucose fs(HCF): RN informed							
11/25/07 08:15 Glucose fs(BAC): RN notified							
I&O SUMMARY	03:54	03:55	04:48	05:11	08:15	09:30	10:39
Intake Total	200	90			60	75	
Output Total			125		0		250
NET	200	90	-125		60	75	-250
INTAKE	03:54	03:55	04:48	05:11	08:15	09:30	10:39
Oral					60&		
Tube feeding	200					75&	
Tube feed flush		90					
Intake Total	200	90			60	75	
11/25/07 08:15 Oral(BAC): doctor gave him.							
11/25/07 09:30 Tube feeding(KMAD): continuous TF dc'd per MD							
OUTPUT	03:54	03:55	04:48	05:11	08:15	09:30	10:39
Urine			125		0		250
Output Total			125		0		250
CARE PROVIDERS	SHUT	SHUT	HCF	HCF	BAC	KMAD	BAC

CHANDLER, BETTY A(BAC)CA FOSTER, HYPATIA C(HCF)CA HUTCHINSON, STEPHANIE(SHUT)RN
MADDALENA, KRISTINE(KMAD)RN

Brachl brachial Oral oral Rarmly Rt arm lying
Numvlu Numeric Value Prcent percent Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25							
Vital Signs	12:25	12:30	13:00	13:30	15:23	16:00	16:25	16:30
TEMP #1 in F	98.2F Oral						98.6F Oral	
PULSE	82 Brachl						102 Brachl	
RESPIRATIONS	18 Visual						21 Visual	
O2 SAT %	95% O2						93% O2	
O2 flow	40 Prcent						2 Liters	
BP (NIBP)	113/60						126/71 Rarmly	
Glucose fs	**62mg/dL&**	&	132mg/dL&				122mg/dL	
PAIN LEVEL								
11/25/07 12:25 Glucose fs(BAC): RN NOTIFIED								
11/25/07 12:30 Glucose fs(KMAD): bolus feeding given. BS corrected								
11/25/07 13:00 Glucose fs(BAC): RECHECK FSBS								
I&O SUMMARY	12:25	12:30	13:00	13:30	15:23	16:00	16:25	16:30
Intake Total		267		240	240	267		120
Output Total	0						0	
NET	0	267		240	240	267	0	120
INTAKE	12:25	12:30	13:00	13:30	15:23	16:00	16:25	16:30
Oral				240&	(240&)			120&
Tube feeding		237&				237		
Tube feed flush		30				30		
Intake Total		267		240	240	267		120
11/25/07 12:30 Tube feeding(KMAD): bolus feed								
11/25/07 13:30 Oral(KMAD): thickened liquid								
11/25/07 15:23 Oral(KMAD): thickened liquid								
11/25/07 16:30 Oral(KMAD): thickened liquid								
OUTPUT	12:25	12:30	13:00	13:30	15:23	16:00	16:25	16:30
Urine	0						0	
Urine (O)			1&			1		
Stool (O)						1&		
Output Total	0						0	
11/25/07 13:00 Urine	(O)(KMAD): voided in toilet. tried to explain to pt to use urinal							
11/25/07 16:00 Stool	(O)(KMAD): pt reported one small stool. flushed toilet							
CARE PROVIDERS	BAC	KMAD	BAC*	KMAD	KMAD	KMAD	BAC	KMAD

CHANDLER, BETTY A(BAC)CA MADDALENA, KRISTINE(KMAD)RN

Brachl brachial Oral oral Rarmly Rt arm lying
Liters liter(s) Prcent percent Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
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FLOWSHEET	11/25			11/26			
Vital Signs	20:30	21:00	21:06	00:00	00:10	04:00	04:04
TEMP #1 in F			98.7F Oral		98.4F Axilry		97.6F Oral
PULSE			97 Radial		89 Radial		70 Brachl
RESPIRATIONS			20 Visual		18 Steth		16 Visual
O2 SAT %			**91% O2**		96% O2		95% O2
O2 flow			2 Liters		2 Liters		2 Liters
O2 equipment			Naslcn		Naslcn		Naslcn
BP (NIBP)			115/66		108/67 Rarmly		118/75 Rarmly
Glucose fs			102mg/dL		81mg/dL		**61mg/dL**
PAIN LEVEL			0 Numvlu		7 Numvlu		0 Numvlu
I&O SUMMARY	20:30	21:00	21:06	00:00	00:10	04:00	04:04
Intake Total	267	240		267			
Output Total					250	200	
NET	267	240		267	-250	-200	
INTAKE	20:30	21:00	21:06	00:00	00:10	04:00	04:04
Oral		240					
Tube feeding	237			237			
Tube feed flush	30			30			
Intake Total	267	240		267			
OUTPUT	20:30	21:00	21:06	00:00	00:10	04:00	04:04
Urine					250	200	
Output Total					250	200	
CARE PROVIDERS	SHUT	SHUT	SHUT	SHUT	HCF	SHUT	HCF

FOSTER, HYPATIA C(HCF)CA HUTCHINSON, STEPHANIE(SHUT)RN

Axilry	axillary	Naslcn	nasal cannula	Radial	radial	Visual	visual
Brachl	brachial	Numvlu	Numeric Value	Rarmly	Rt arm lying		
Liters	liter(s)	Oral	oral	Steth	stethoscope		

CONTINUED

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26						
Vital Signs	05:08	07:52	10:25	11:47	14:07	15:49	18:01
TEMP #1 in F		97.9F Oral		96.7F Oral		98.6F Oral	
PULSE		77 Radial		83 Radial		94 Radial	
RESPIRATIONS		14 Visual		18 Visual		20 Visual	
O2 SAT %		92% O2		92% O2		92% O2	
O2 flow		2 Liters		2 Liters		2 Liters	
O2 equipment		Naslcn		Naslcn		Naslcn	
BP (NIBP)		115/76 Rarm		107/62 Larm		140/75 Rarm	
Glucose fs	141mg/dL	117mg/dL		156mg/dL		106mg/dL	
PAIN LEVEL		0 Numvlu		0 Numvlu			
I&O SUMMARY	05:08	07:52	10:25	11:47	14:07	15:49	18:01
Intake Total			440		360		
Output Total							500
NET			440		360		-500
INTAKE	05:08	07:52	10:25	11:47	14:07	15:49	18:01
Oral			100		360		
Tube feeding			240				
Tube feed flush			100				
Intake Total			440		360		
OUTPUT	05:08	07:52	10:25	11:47	14:07	15:49	18:01
Urine							500
Urine (O)							
Stool (O)							
Output Total							500
CARE PROVIDERS	HCF	KLMI	SBRO	KLMI	SBRO	KLMI	KLMI

BROWN, SUZANNE(SBRO)RN FOSTER, HYPATIA C(HCF)CA MIN, KATHERINE L(KLMI)CA

Larm arm L
Liters liter(s)
Naslcn nasal cannula
Numvlu Numeric Value
Oral oral
Radial radial
Rarm arm R
Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26				11/27	
Vital Signs	18:38	19:25	20:26	21:30	00:22	04:04
TEMP #1 in F			97.2F Oral		98.1F Oral	98.2F Oral
PULSE			110 Brachl		75 Brachl	74 Brachl
RESPIRATIONS			14 Visual		16 Visual	16 Visual
O2 SAT %			93% O2		97% O2	94% O2
O2 flow			2 Liters		2 Liters	2 Liters
O2 equipment			Naslcn		Naslcn	Naslcn
BP (NIBP)			122/79 Rarmly		113/73 Rarmly	120/77 Rarmly
Glucose fs			111mg/dL		113mg/dL	85mg/dL
PAIN LEVEL			0 Numvlu		0 Numvlu	0 Numvlu
I&O SUMMARY	18:38	19:25	20:26	21:30	00:22	04:04
Intake Total	120	240		120		
Output Total			300		0	500
NET	120	240	-300	120	0	-500
INTAKE	18:38	19:25	20:26	21:30	00:22	04:04
Oral	120	240		120		
Intake Total	120	240		120		
OUTPUT	18:38	19:25	20:26	21:30	00:22	04:04
Urine			300		0	500
Urine (O)	1					
Stool (O)	1					
Output Total			300		0	500
CARE PROVIDERS	SBRO	KLMI	HCF	SHUT	HCF	HCF

BROWN, SUZANNE(SBRO)RN FOSTER, HYPATIA C(HCF)CA HUTCHINSON, STEPHANIE(SHUT)RN
MIN, KATHERINE L(KLMI)CA

Brachl brachial Naslcn nasal cannula Oral oral Visual visual
Liters liter(s) Numvlu Numeric Value Rarmly Rt arm lying

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27						
Vital Signs	07:50	08:35	11:30	12:45	14:10	14:57	15:50
TEMP #1 in F	97.6F Oral			96F Oral			98.6F Oral
PULSE	77 Radial			102 Radial			101 Radial
RESPIRATIONS	15 Visual			13 Visual			20 Visual
O2 SAT %	95% O2			92% Rmair			92% Rmair
O2 flow	2 Liters						
O2 equipment	Naslcn						
BP (NIBP)	111/69 Rarm			113/78 Rarmsi			119/70 Rarm
Glucose fs		96mg/dL		113mg/dL			
PAIN LEVEL	0 Numvlu			0 Numvlu			&
11/27/07 15:50 PAIN LEVEL(SMAY): headache							
I&O SUMMARY	07:50	08:35	11:30	12:45	14:10	14:57	15:50
Intake Total			360		300	240	
Output Total	0			0			
NET	0		360	0	300	240	
INTAKE	07:50	08:35	11:30	12:45	14:10	14:57	15:50
Oral			360		300	240	
Intake Total			360		300	240	
OUTPUT	07:50	08:35	11:30	12:45	14:10	14:57	15:50
Urine	0			0			
Urine (O)			1&				1&
Output Total	0			0			
11/27/07 11:30 Urine	(O)(SBRO): incontinent, large amount urine						
11/27/07 15:50 Urine	(O)(SMAY): when asked if pt had used restroom, response was "yes"						
CARE PROVIDERS	SMAY	SMAY	SMAY*	SMAY	SMAY	SBRO	SMAY

BROWN, SUZANNE(SBRO)RN MAY, SARAH(SMAY)CA

Liters	liter(s)	Oral	oral	Rarmsi	Rt arm sitting
Naslcn	nasal cannula	Radial	radial	Rmair	room air
Numvlu	Numeric Value	Rarm	arm R	Visual	visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27					11/28		
Vital Signs	17:25	18:19	18:20	20:07	21:25	00:05	00:07	01:00
TEMP #1 in F				97.9F Oral		98.3F Oral		
PULSE				101 Radial		82 Radial		
RESPIRATIONS				18 Visual		18 Visual		
O2 SAT %				95% Rmair		**91% Rmair**	95% O2	
O2 flow							2 Liters	
O2 equipment							Naslcn	
BP (NIBP)				126/78 Rarm		123/71 Rarm		
Glucose fs	114mg/dL				111mg/dL			
PAIN LEVEL				&		0 Numvlu		
11/27/07 20:07 PAIN LEVEL(KWIL): yes								
I&O SUMMARY	17:25	18:19	18:20	20:07	21:25	00:05	00:07	01:00
Intake Total		480	500					125
Output Total						200		
NET		480	500			-200		125
INTAKE	17:25	18:19	18:20	20:07	21:25	00:05	00:07	01:00
Oral		480	500					
NaCl 0.45%								125
Intake Total		480	500					125
OUTPUT	17:25	18:19	18:20	20:07	21:25	00:05	00:07	01:00
Urine						200		
Output Total						200		
CARE PROVIDERS	SMAY	SBRO	SMAY	KWIL	KWIL	KWIL	KWIL	LGBR

BROWN, SUZANNE(SBRO)RN BRYAN, LINDA G(LGBR)RN MAY, SARAH(SMAY)CA
WILLINGHAM, KASSANDRA(KWIL)CA

Liters	liter(s)	Numvlu	Numeric Value	Radial	radial	Rmair	room air
Naslcn	nasal cannula	Oral	oral	Rarm	arm R	Visual	visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28							
Vital Signs	04:00	04:25	06:35	07:43	07:52	10:44	11:00	11:36
TEMP #1 in F		97.9F Oral			97.8F Oral			98.2F Oral
PULSE		66 Radial			78 Radial			78 Radial
RESPIRATIONS		18 Visual			22 Visual			14 Visual
O2 SAT %		97% O2			92% Rmair			95% Rmair
O2 flow		2 Liters						
O2 equipment		Naslcn						
BP (NIBP)		111/75 Larm			124/74 Larm			123/74 Larm
Glucose fs					89mg/dL			92mg/dL
PAIN LEVEL		8 Numvlu			7 Numvlu			7 Numvlu
WEIGHT in Kg		69.72kg						
I&O SUMMARY	04:00	04:25	06:35	07:43	07:52	10:44	11:00	11:36
Intake Total	375		375				500	
Output Total		250		650		450		
NET	375	-250	375	-650		-450	500	
INTAKE	04:00	04:25	06:35	07:43	07:52	10:44	11:00	11:36
NaCl 0.45%	375		375				500	
Intake Total	375		375				500	
OUTPUT	04:00	04:25	06:35	07:43	07:52	10:44	11:00	11:36
Urine		250		650		450		
Output Total		250		650		450		
CARE PROVIDERS	LGBR	KWIL	LGBR	SBRO	KLMI	KLMI	SBRO	KLMI

BROWN, SUZANNE(SBRO)RN BRYAN, LINDA G(LGBR)RN MIN, KATHERINE L(KLMI)CA
WILLINGHAM, KASSANDRA(KWIL)CA

Larm arm L
Liters liter(s)
Naslcn nasal cannula
Numvlu Numeric Value
Oral oral
Radial radial
Rmair room air
Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28						
Vital Signs	12:19	14:12	14:16	15:13	18:59	19:25	20:54
TEMP #1 in F				98.3F Oral		96.5F Axilry	
PULSE				87 Radial		95 Radial	
RESPIRATIONS				16 Visual		18 Visual	
O2 SAT %				95% Rmair		94% Rmair	
BP (NIBP)				133/77 Larm		119/79 Larm	
Glucose fs				95mg/dL			105mg/dL
PAIN LEVEL				0 Numvlu		0 Numvlu	
I&O SUMMARY	12:19	14:12	14:16	15:13	18:59	19:25	20:54
Intake Total		700			480		
Output Total	450		350			0	
NET	-450	700	-350		480	0	
INTAKE	12:19	14:12	14:16	15:13	18:59	19:25	20:54
Oral		200&			480		
NaCl 0.45%		500					
Intake Total		700			480		
11/28/07 14:12 Oral(SBRO): Pt drank 1 glucerna, pt knew he was supposed to be NPO							
OUTPUT	12:19	14:12	14:16	15:13	18:59	19:25	20:54
Urine	450		350			0	
Urine (O)							1
Output Total	450		350			0	
CARE PROVIDERS	KLMI	SBRO	KLMI	KLMI	SBRO	KWIL	KWIL

BROWN, SUZANNE(SBRO)RN MIN, KATHERINE L(KLMI)CA WILLINGHAM, KASSANDRA(KWIL)CA

Axilry axillary Numvlu Numeric Value Radial radial Visual visual
Larm arm L Oral oral Rmair room air

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/29					
Vital Signs	00:10	03:20	07:45	12:20	13:24	17:05
TEMP #1 in F	98.4F Oral	98.2F Oral	97F Oral	96.6F Oral		97.4F Oral
PULSE	92 Radial	94 Radial	74 Brachl	93 Brachl		92 Brachl
RESPIRATIONS	16 Visual	16 Visual	18 Visual	16 Visual		16 Visual
O2 SAT %	94% Rmair	92% Rmair	94% Rmair	94% Rmair		95% Rmair
BP (NIBP)	118/72 Larm	126/75 Larm	119/68 Larm	121/70 Rarm		124/79 Larm
Glucose fs			86mg/dL	103mg/dL		
PAIN LEVEL	5 Numvlu	7 Numvlu	8 Numvlu	7 Numvlu		8 Numvlu
I&O SUMMARY	00:10	03:20	07:45	12:20	13:24	17:05
Intake Total					480	
Output Total	0	400	400	200		0
NET	0	-400	-400	-200	480	0
INTAKE	00:10	03:20	07:45	12:20	13:24	17:05
Oral					480	
Intake Total					480	
OUTPUT	00:10	03:20	07:45	12:20	13:24	17:05
Urine	0	400	400	200		0
Urine (O)			0	0		1
Stool (O)			0	0		0
Output Total	0	400	400	200		0
CARE PROVIDERS	KWIL	KWIL	JWO	JWO	JWO	JWO

OKELLO, JEANETTE W(JWO)CA WILLINGHAM, KASSANDRA(KWIL)CA

Brachl brachial Numvlu Numeric Value Radial radial Rmair room air
Larm arm L Oral oral Rarm arm R Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/29				11/30		
Vital Signs	18:13	19:09	19:50	23:46	04:18	06:18	08:01
TEMP #1 in F			96.3F Oral	98.1F Oral	98.5F Oral		98F Oral
PULSE			89 Brachl	78 Brachl	91 Brachl		73 Brachl
RESPIRATIONS			20 Visual	19 Visual	20 Visual		18 Visual
O2 SAT %			95% Rmair	97% Rmair	95% Rmair		94% Rmair
BP (NIBP)			115/77 Larm	124/76 Larm	140/82 Larm		132/75 Larm
PAIN LEVEL			7 Numvlu	0 Numvlu	8 Numvlu		9 Numvlu
I&O SUMMARY	18:13	19:09	19:50	23:46	04:18	06:18	08:01
Intake Total	120					1000	
Output Total		250	0	0	850		
NET	120	-250	0	0	-850	1000	
INTAKE	18:13	19:09	19:50	23:46	04:18	06:18	08:01
Oral	120						
D5W/NaCl 0.45%						1000	
Intake Total	120					1000	
OUTPUT	18:13	19:09	19:50	23:46	04:18	06:18	08:01
Urine		250	0	0&	850		
Urine (O)		0					
Stool (O)		1					
Output Total		250	0	0	850		
11/29/07 23:46 Urine(TC): rn notify pt has not void							
CARE PROVIDERS	SGUL	JWO	TC	TC	TC	LLHU	KLMI

CAMPBELL, TRACY(TC)CA
GULLEDGE, SHARON(SGUL)RN
HURLEY, LORRI L(LLHU)RN
MIN, KATHERINE L(KLMI)CA
OKELLO, JEANETTE W(JWO)CA

Brachl brachial
Larm arm L
Numvlu Numeric Value
Oral oral
Rmair room air
Visual visual

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/30							
Vital Signs	08:03	09:00	10:00	15:58	18:00	19:00	20:20	22:58
TEMP #1 in F				97F Axilry			96.5F Oral	
PULSE				86 Radial			108 Brachl	
RESPIRATIONS				20 Visual			20 Visual	
O2 SAT %				92% O2			96% Rmair	
O2 flow				2 Liters				
O2 equipment				Naslcn				
BP (NIBP)				120/73 Rarm			138/89 Larm	
PAIN LEVEL				2 Numvlu			9 Numvlu	
I&O SUMMARY	08:03	09:00	10:00	15:58	18:00	19:00	20:20	22:58
Intake Total		250	125		50	250		500
Output Total	375						200	
NET	-375	250	125		50	250	-200	500
INTAKE	08:03	09:00	10:00	15:58	18:00	19:00	20:20	22:58
IVPB					50&			
D5W/NaCl 0.45%		250	125			250		500
Intake Total		250	125		50	250		500
11/30/07 18:00 IVPB(IDP): Ancef IV								
OUTPUT	08:03	09:00	10:00	15:58	18:00	19:00	20:20	22:58
Urine	375						200	
Output Total	375						200	
CARE PROVIDERS	KLMI	JDW1	JDW1	KLMI	IDP	IDP	TC	LLHU

CAMPBELL, TRACY(TC)CA
HURLEY, LORRI L(LLHU)RN
MIN, KATHERINE L(KLMI)CA
PINEDA, IGNACIO D(IDP)RN
WILKINS, JANE D(JDW1)RN

Axilry	axillary	Liters	liter(s)	Oral	oral	Rmair	room air
Brachl	brachial	Naslcn	nasal cannula	Radial	radial	Visual	visual
Larm	arm L	Numvlu	Numeric Value	Rarm	arm R		

GOMEZ, HECTOR
MUSC
Vital Signs, I&O
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	12/01						
Vital Signs	00:45	03:00	03:27	03:55	08:55	09:56	11:35
TEMP #1 in F	99.3F Oral			99.2F Oral	99.3F Oral		99.4F Oral
PULSE	114 Brachl			**125 Brachl&**	**132 Radial&**		118 Brachl
RESPIRATIONS	19 Visual			18 Visual	20 Visual		20 Visual
O2 SAT %	99% Rmair			93% Rmair	98% Rmair		97% Rmair
BP (NIBP)	118/81			138/86 Rarm	137/77 Rarm		118/73 Rarm
PAIN LEVEL	9 Numvlu			9 Numvlu	10 Numvlu		8 Numvlu
12/01/07 03:55 PULSE(TC): rn notify							
12/01/07 08:55 PULSE(EOC): rn notify							
I&O SUMMARY	00:45	03:00	03:27	03:55	08:55	09:56	11:35
Intake Total			500		600	400	
Output Total	0	1000		300	450		
NET	0	-1000	500	-300	150	400	
INTAKE	00:45	03:00	03:27	03:55	08:55	09:56	11:35
Oral					600		
IVPB						100	
D5W/NaCl 0.45%			500			300	
Intake Total			500		600	400	
OUTPUT	00:45	03:00	03:27	03:55	08:55	09:56	11:35
Urine	0	1000		300	450		
Output Total	0	1000		300	450		
CARE PROVIDERS	TC	TC	LLHU	TC	EOC	KWIX	EOC

CAMPBELL, TRACY(TC)CA CUENCA, EVA O(EOC)CA HURLEY, LORRI L(LLHU)RN
WIX, KRISTA(KWIX)RN

Brachl brachial Oral oral Rarm arm R Visual visual
Numvlu Numeric Value Radial radial Rmair room air

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/21	11/22			
Neuro/EENT	21:30	00:15	02:50	04:26	05:49
Follows commands	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Behavior/neuro	agitated restless &				
Orientation	unable to assess				
Cervical collar	Miami j				
CollarAssessIntv	in place				
Both pupilsShape Both pupilsReact	round brisk				
Both pupils size	2mm				
11/21/07 21:30 Behavior/neuro(CAST): at times restraints in place					
Special Neuro	21:30	00:15	02:50	04:26	05:49
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 1=tube/trach 6=obeysVbCommand 11				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
Cardiovascular	21:30	00:15	02:50	04:26	05:49
Reg rate, rhythm	&				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	WNL &				
Thigh/CalfTender	none				
Absence of edema	WNL				
11/21/07 21:30 Reg rate, rhythm(CAST): tachy at times					
11/21/07 21:30 Cap refill<3 sec(CAST): all but right toes d/t nercrotic					
CARE PROVIDERS	CAST				

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 *MR: 002581962
REQUESTED 12/02/07 05:50
OPT OUT:
Page: 2

FLOWSHEET	11/21	11/22			
Respiratory	21:30	00:15	02:50	04:26	05:49
Spont respers	WNL				
NonLaboredEffort	WNL				
RegClrBreathSnds	all lobes				
BS all lobes	present				
Cough	productive				
Sputum/Secretion	tan				
Consistency	thick				
Trachea	midline				
Airway	tracheostomy				
Trach size	8				
Peristoma appear	pink				
Oxygen %	40% trach collar				
Gastrointestinal	21:30	00:15	02:50	04:26	05:49
Norm bowelSounds	WNL				
AbdSoftNontender	WNL				
BMpattrnConsistn	normal				
No c/o N/V.	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	11/16				
Tube feeding	see MAR				
Tube type	g-tube				
Genitourinary	21:30	00:15	02:50	04:26	05:49
Continent	WNL				
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Catheter	foley				
Func/Musculoskel	21:30	00:15	02:50	04:26	05:49
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
Weakness	generalized				
SCD site	leg L leg R				
SCD type	short leg				
SCD assess	on operational				
CARE PROVIDERS	CAST				

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 3

FLOWSHEET	11/21	11/22			
Skin	21:30	00:15	02:50	04:26	05:49
Skin warm	WNL				
Skin dry& intact	WNL				
Color approp	to ethnicity				
Sens perception	3=slight limited				
Moisture	3=occasnly moist				
Activity	1=bedfast				
Mobility	3=slight limited				
Nutrition	2=prob adequate				
Friction & shear	2=poten.problm				
Total score	14				
Psychological	21:30	00:15	02:50	04:26	05:49
Approp affect	to situation				
Nutrition	21:30	00:15	02:50	04:26	05:49
Meal type	NPO				
Act Daily Living	21:30	00:15	02:50	04:26	05:49
Bath					
Mouth care					
Bedrest/BRP					dependent
ROM joints					independent
Catheter care					dependent
Peri care					dependent
Deep breathe					independent
Cough					independent
Vascular Access	21:30	00:15	02:50	04:26	05:49
Site#1 location	hand L				
Insertion date	11/21/2007				
Gauge	#20				
Site#1 appear	secure				
Site#1 dressing	dry and intact				
Interventions	saline lock				
Safety	21:30	00:15	02:50	04:26	05:49
Hospital ID band	on				
CallSystm access	done				
Bed in low posit	done				
Bed brakes on	done				
Bed alarms on	done				
Bed press relief	on				
Imple SafetyPOC	done				
CARE PROVIDERS	CAST				BPM

MCGUINESS, BRYAN P(BPM)CA STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/21	11/22			
Morse Fall Risk	21:30	00:15	02:50	04:26	05:49
HxFall(w/in 3mo)	no=0				
Secondary Dx	no=0				
Ambulatory Aid	None Bedrest=0				
IV or IV Access	yes=20				
Gait	Norm BR w/c=0				
Mental Status	OvrestFrgtLmt=15				
Total Score	35 25 - 44 mod r isk				
Imple SafetyPOC	done				
Restraints	21:30	00:15	02:50	04:26	05:49
Pt DevicesImpact					
Alt/Intervention					
Restraint type					
Restraint site					
No.hrs to be res					
Skin checks q1h					
Circ checks q1h					
Restraint rel q2					
ROM q2h					
Position chg q2h					
Orient behav q2h					
Hydra needs q2h					
Feed needs q2h					
Call bell q2					
Behavior q2h					
Misc Events	21:30	00:15	02:50	04:26	05:49
Evaluated POC	done				
Misc events	&	&	&	&	

11/21/07 21:30 Misc events(CAST): pt on floor from STICU. assessment done. restraints applied. pt resting without S&S of distress. will cont to monitor.

11/22/07 00:15 Misc events(CAST): MD Leppard paged for new tube feeding orders. pt suctioned. IV fluid started. pt resting without S&S of distress. will cont to monitor.

11/22/07 02:50 Misc events(CAST): pt suctioned and trach care done. resting without S&S of distress. will cont to monitor.

11/22/07 04:26 Misc events(CAST): RT in working with pt.

CARE PROVIDERS	CAST	CAST	CAST	CAST	

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 5

FLOWSHEET	11/22				
Neuro/EENT	08:15	09:00	10:00	10:01	11:00
Follows commands	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Behavior/neuro	calm				
Orientation	unable to assess				
Cervical collar	Miami j				
CollarAssessIntv	in place				
Both pupilsShape Both pupilsReact	round brisk				
Both pupils size	2mm				
Special Neuro	08:15	09:00	10:00	10:01	11:00
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 1=tube/trach 6=obeysVbCommand 11				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
Cardiovascular	08:15	09:00	10:00	10:01	11:00
Reg rate, rhythm	WNL				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	&				
Thigh/CalfTender	none				
Absence of edema	WNL				
11/22/07 08:15 Cap refill<3 sec(AW3): right toes necrotic					
Respiratory	08:15	09:00	10:00	10:01	11:00
Spont respers	WNL				
NonLaboredEffort	WNL				
RegClrBreathSnds	all lobes				
BS all lobes	present				
Cough	productive				
Sputum/Secretion	clear white				
CARE PROVIDERS	AW3				

WILLIAMS, AUDREY(AW3)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 6

FLOWSHEET	11/22				
Respiratory-Cont.	08:15	09:00	10:00	10:01	11:00
Consistency	thick				
Trachea	midline				
Airway	tracheostomy				
Trach size	8				
Peristoma appear	pink				
Oxygen %	40% trach collar				
Gastrointestinal	08:15	09:00	10:00	10:01	11:00
Norm bowelSounds	WNL				
AbdSoftNontender	WNL				
BMpattrnConsistn	normal				
No c/o N/V	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	11/16				
Tube feeding	see MAR				
Tube type	g-tube				
Genitourinary	08:15	09:00	10:00	10:01	11:00
Continent	WNL				
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Catheter	foley				
Func/Musculoskel	08:15	09:00	10:00	10:01	11:00
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
Weakness	generalized				
SCD site	leg L leg R				
SCD type	short leg				
SCD assess	on operational				
Skin	08:15	09:00	10:00	10:01	11:00
Skin warm	WNL				
Skin dry& intact	WNL				
Color approp	to ethnicity				
Sens perception	3=slight limited				
Moisture	3=occasnly moist				
CARE PROVIDERS	AW3				

WILLIAMS, AUDREY(AW3)RN

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 7

FLOWSHEET	11/22				
Skin Cont.	08:15	09:00	10:00	10:01	11:00
Activity	1=bedfast				
Mobility	3=slight limited				
Nutrition	2=prob adequate				
Friction & shear	2=poten.problm				
Total score	14				
Nutrition	08:15	09:00	10:00	10:01	11:00
Meal type	NPO				
Act Daily Living	08:15	09:00	10:00	10:01	11:00
Bath	assist			dependent &	
Mouth care	assist			dependent	
Bedrest/BRP	assist			dependent	
ROM joints	independent			independent	
Catheter care	assist			dependent	
Peri care	assist			dependent	
Deep breathe	independent			assist	
Cough	independent			independent	

11/22/07 10:01 Bath(RKRE): linens changed

Vascular Access	08:15	09:00	10:00	10:01	11:00
Site#1 location	hand L &				
Insertion date	11/21/2007				
Gauge	#20				
Site#1 appear	secure				
Site#1 dressing	dry and intact				

11/22/07 08:15 Site#1 location(AW3): NS@10cc/hr

Safety	08:15	09:00	10:00	10:01	11:00
Hospital ID band	on				
CallSystm access	done	&			
Bed in low posit	done				
Bed brakes on	done				
Bed alarms on	done				
Bed press relief	on				
Imple SafetyPOC	done				

11/22/07 09:00 CallSystm access(AW3): Haldol 2 mg IVP

Morse Fall Risk	08:15	09:00	10:00	10:01	11:00
HxFall(w/in 3mo)	no=0				
Secondary Dx	no=0				
Ambulatory Aid	None Bedrest=0				
CARE PROVIDERS	AW3	AW3		RKRE	

REESER, REBECCA K(RKRE)CA WILLIAMS, AUDREY(AW3)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
Page: 8

FLOWSHEET	11/22				
Morse Fall Risk Cont.	08:15	09:00	10:00	10:01	11:00
IV or IV Access	yes=20				
Gait	WeakUsesTouch=10				
Mental Status	Knows limits=0				
Total Score	30 25 - 44 mod risk				
Imple SafetyPOC	done				
Restraints	08:15	09:00	10:00	10:01	11:00
Why restrained		noUndrstndDirect			
Pt DevicesImpact	tracheostomy	tracheostomy			
Alt/Intervention	addrssdNutrition addressed pain addrssdHydration addrssdToileting addrssd CallBell clarify pt needs reach belongings use siderails				
Restraint type	wrist				
Restraint site	two wrists				
No.hrs to be res	6hr(s)				
Skin checks q1h	done	done	done		done
Circ checks q1h	done	done	done		done
Restraint rel q2	done	done	done		
ROM q2h	done	done	done		
Position chg q2h	done		done		
Orient behav q2h	done		done		
Hydra needs q2h	done		done		
Feed needs q2h	done		done		
Call bell q2	done		done		
Behavior q2h	terminated	continues	continues		
Misc Events	08:15	09:00	10:00	10:01	11:00
Evaluated POC	done				
Misc events	&				
11/22/07 08:15 Misc events(AW3): Report received. Assume care of pt.Assessment c/o and documented. HOB 30 degrees. Will monitor frequently. Assessment c/o and documented.					
CARE PROVIDERS	AW3	AW3	AW3		AW3

WILLIAMS, AUDREY(AW3)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 12

FLOWSHEET	11/22				
Restraints-Cont.	12:00	13:00	14:00	15:04	17:00
Circ checks q1h	done	done	done	done	
Restraint rel q2	done		done		
ROM q2h	done		done		
Position chg q2h	done		done		
Orient behav q2h	done		done		
Hydra needs q2h	done		done		
Feed needs q2h	done		done		
Call bell q2	done		done		
Behavior q2h			continues		
Misc Events	12:00	13:00	14:00	15:04	17:00
Evaluated POC					
Misc events					&
11/22/07 17:00 Misc events(KMO): meds given via peg. no residual noted. denies pain. resting in bed.					
CARE PROVIDERS	AW3	AW3	AW3	AW3	KMO

O'COIN, KARI M(KMO)RN WILLIAMS, AUDREY(AW3)RN

GOMEZ, HECTOR
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ROOM: *D657-A* ADM: 11/01/07 18:40
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REQUESTED:12/02/07 05:50
OPT OUT:
Page: 13

FLOWSHEET	11/22				11/23
Neuro/EENT	20:00	21:00	22:00	23:00	00:00
Follows commands	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Behavior/neuro	calm				
Orientation	unable to assess				
Cervical collar	Miami j				
CollarAssessIntv	in place				
Both pupilsShape Both pupilsReact	round brisk				
Both pupils size	2mm				
Special Neuro	20:00	21:00	22:00	23:00	00:00
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 1=tube/trach 6=obeysVbCommand 11				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
Cardiovascular	20:00	21:00	22:00	23:00	00:00
Reg rate, rhythm	&				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	&				
Thigh/CalfTender	none				
Absence of edema	WNL				

11/22/07 20:00 Reg rate, rhythm(CAST): tachy

11/22/07 20:00 Cap refill<3 sec(CAST): rt. toes necrotic

Respiratory	20:00	21:00	22:00	23:00	00:00
Spont respers	WNL				
NonLaboredEffort	WNL				
RUL	rhonchi				
RML	diminished				
RLL	diminished				
CARE PROVIDERS	CAST				

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
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REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/22				11/23
Respiratory-Cont.	20:00	21:00	22:00	23:00	00:00
LUL	rhonchi				
LLL	diminished				
Cough	productive				
Sputum/Secretion	tan				
Consistency	thick				
Trachea	midline				
Airway	tracheostomy				
Trach size	8				
Peristoma appear	pink				
Oxygen %	40% trach collar				
Trach suction	done				
Trach secretions	tan				
Trach-consistncy	thick				
Gastrointestinal	20:00	21:00	22:00	23:00	00:00
AbdSoftNontender	WNL				
BMpattrnConsistn	normal				
No c/o N/V	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	11/16				
BowelSndsAllQuad	hypoactive				
Tube feeding	see MAR				
Tube type	g-tube				
Genitourinary	20:00	21:00	22:00	23:00	00:00
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Catheter	condom				
Func/Musculoskel	20:00	21:00	22:00	23:00	00:00
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
Weakness	generalized				
SCD site	leg L leg R				
SCD type	short leg				
SCD assess	on operational				
CARE PROVIDERS	CAST				

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
Page: 15

FLOWSHEET	11/22				11/23
Skin	20:00	21:00	22:00	23:00	00:00
Skin warm	WNL				
Skin dry& intact	WNL				
Color approp	to ethnicity				
Sens perception	3=slight limited				
Moisture	3=occasnly moist				
Activity	1=bedfast				
Mobility	3=slight limited				
Nutrition	2=prob adequate				
Friction & shear	2=poten.problm				
Total score	14				
Psychological	20:00	21:00	22:00	23:00	00:00
Approp affect	to situation				
Nutrition	20:00	21:00	22:00	23:00	00:00
Meal type	NPO				
Safety	20:00	21:00	22:00	23:00	00:00
Hospital ID band	on				
CallSystm access	done				
Bed in low posit	done				
Bed brakes on	done				
Bed alarms on	done				
Bed press relief	on				
Imple SafetyPOC	done				
Morse Fall Risk	20:00	21:00	22:00	23:00	00:00
HxFall(w/in 3mo)	no=0				
Secondary Dx	yes=15				
Ambulatory Aid	None Bedrest=0				
IV or IV Access	yes=20				
Gait	Norm BR w/c=0				
Mental Status	Knows limits=0				
Total Score	35 25 - 44 mod r isk				
Imple SafetyPOC	done				
Restraints	20:00	21:00	22:00	23:00	00:00
Why restrained	noUndrstndDirect				
Pt DevicesImpact	peripheral IV tracheostomy				
Alt/Intervention	addressed pain addrssdToileting addrssdPosition addrssd CallBell				
CARE PROVIDERS	CAST				

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
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OPT OUT:
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FLOWSHEET	11/22				11/23
Restraints-Cont.	20:00	21:00	22:00	23:00	00:00
Restraint type	wrist				
Restraint site	two hands				
No.hrs to be res	24hr(s)				
Skin checks q1h	done	done	done	done	done
Circ checks q1h	done	done	done	done	done
Restraint rel q2	done		done		done
ROM q2h	done		done		done
Position chg q2h	done		done		done
Orient behav q2h	done		done		done
Hydra needs q2h	done		done		done
Feed needs q2h	done		done		done
Call bell q2	done		done		done
Behavior q2h	continues		continues		continues
Misc Events	20:00	21:00	22:00	23:00	00:00
Evaluated POC	done				
Misc events	&				
11/22/07 20:00 Misc events(CAST): pt assessment done. pt suctioned and given pain med. per mar. pt resting without S&S of distress. will cont. to monitor.					
CARE PROVIDERS	CAST	CAST	CAST	CAST	CAST

STORM, CARRIE A(CAST)RN

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23				
Restraints	00:45	01:00	02:00	03:00	04:00
Skin checks q1h		done	done	done	done
Circ checks q1h		done	done	done	done
Restraint rel q2			done		done
ROM q2h			done		done
Position chg q2h			done		done
Orient behav q2h			done		done
Hydra needs q2h			done		done
Feed needs q2h			done		done
Call bell q2			done		done
Behavior q2h			continues		continues
Misc Events	00:45	01:00	02:00	03:00	04:00
Misc events	&				&
11/23/07 00:45 Misc events(CAST): pt suctioned. given pain med and repositioned in bed.					
11/23/07 04:00 Misc events(CAST): pt trying to get out off bed. reoriented. pain meds. given. pt suctioned. will cont to monitor					
CARE PROVIDERS	CAST	CAST	CAST	CAST	CAST

STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 18

FLOWSHEET	11/23				
Neuro/EENT	05:00	06:00	08:15	09:00	10:00
Follows commands			WNL		
NormHear&/orAid			WNL		
Abs of drainage			WNL		
Norm closure			WNL		
Abs of swelling			WNL		
No visual impair			WNL		
PERRLA			WNL		
Behavior/neuro			restless		
Orientation			unable to assess		
Cervical collar			Miami j		
CollarAssessIntv			in place		
Both pupilsShape Both pupilsReact			round brisk		
Both pupils size			3mm		
Special Neuro	05:00	06:00	08:15	09:00	10:00
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 1=tube/trach 6=obeysVbCommand 11		
Motor exam LUE			6=obeys commands		
Motor exam LLE			6=obeys commands		
Motor exam RUE			6=obeys commands		
Motor exam RLE			6=obeys commands		
Cardiovascular	05:00	06:00	08:15	09:00	10:00
S1S2			WNL		
Angina/chestPain			none		
PalpPerhipPulses			WNL		
Cap refill<3 sec			- &		
Thigh/CalfTender			none		
Absence of edema			WNL		
11/23/07 08:15 Cap refill<3 sec(KMAD): rt toes necrotic					
Respiratory	05:00	06:00	08:15	09:00	10:00
Spont respers			WNL		
NonLaboredEffort			WNL		
BS all lobes			present		
RUL			rhonchi		
RML			rhonchi		
RLL			diminished		
LUL			rhonchi		
CARE PROVIDERS			KMAD		

MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 19

FLOWSHEET	11/23				
Respiratory Cont	05:00	06:00	08:15	09:00	10:00
LLL			diminished		
Cough			productive		
Sputum/Secretion			tan		
Consistency			thick		
Trachea			midline		
Airway			tracheostomy		
Trach size			8		
Peristoma appear			pink		
Oxygen %			40% trach collar		
Trach suction			done		
Trach secretions			tan		
Trach-consistncy			thick		
GastroIntestinal	05:00	06:00	08:15	09:00	10:00
AbdSoftNontender			WNL		
No c/o N/V			WNL		
Normal dentition			WNL		
MucousMembIntact			WNL		
Last BM			11/16		
BowelSndsAllQuad			hypoactive		
Tube feeding			see MAR		
Tube type			g-tube		
Genitourinary	05:00	06:00	08:15	09:00	10:00
Adequate UOP			WNL		
ClearYellowUrine			WNL		
NoChgPattrn/Char			WNL		
NoAbn penile bld			WNL		
NoAbnPenileDisch			WNL		
Catheter			condom		
Func/Musculoskel	05:00	06:00	08:15	09:00	10:00
ActiveROM x4 ext			WNL		
Symmetry all ext			WNL		
Weakness			generalized		
SCD site			leg L leg R		
SCD type			short leg		
SCD assess			on operational		
CARE PROVIDERS			KMAD		

MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23				
Skin	05:00	06:00	08:15	09:00	10:00
Skin warm			WNL		
Skin dry& intact			WNL		
Color approp			to ethnicity		
Sens perception			3=slight limited		
Moisture			3=occasnly moist		
Activity			1=bedfast		
Mobility			3=slight limited		
Nutrition			2=prob adequate		
Friction & shear			3=no app.probl		
Total score			15		
Nutrition	05:00	06:00	08:15	09:00	10:00
Meal type			NPO		
Act Daily Living	05:00	06:00	08:15	09:00	10:00
Bath			dependent		
Mouth care			dependent		
Bedrest/BRP			dependent		
ROM joints			independent		
Catheter care			dependent		
Peri care			dependent		
Deep breathe			independent		
Cough			independent		
Vascular Access	05:00	06:00	08:15	09:00	10:00
Site#1 location			hand L		
Insertion date			11/22/2007		
Gauge			#22		
Site#1 appear			secure		
Site#1 dressing			dry and intact		
Safety	05:00	06:00	08:15	09:00	10:00
Hospital ID band			on		
CallSystm access			done		
Bed in low posit			done		
Bed brakes on			done		
Bed press relief			on		
Imple SafetyPOC			done		
Morse Fall Risk	05:00	06:00	08:15	09:00	10:00
HxFall(w/in 3mo)			no=0		
Secondary Dx			yes=15		
Ambulatory Aid			w/c NrsAssist=0		
IV or IV Access			yes=20		
CARE PROVIDERS			KMAD		

MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23				
Morse Fall Risk-Cont.	05:00	06:00	08:15	09:00	10:00
Gait			Norm BR w/c=0		
Mental Status			Knows limits=0		
Total Score			35 25 - 44 mod r isk		
Imple SafetyPOC			done		
Restraints	05:00	06:00	08:15	09:00	10:00
Why restrained			intf w/tubes noUndrstndDirect		
Pt DevicesImpact			peripheral IV tracheostomy		
Alt/Intervention			addrssdNutrition addressed pain addrssdHydration addrssdToileting addrssdPosition addrssd CallBell clarify pt needs address medCause reach belongings decrease stimuli reality orient adeq lighting use siderails diversion		
Restraint type			wrist		
Restraint site			two wrists		
No.hrs to be res			24hr(s)		
Skin checks q1h	done	done	done	done	done
Circ checks q1h	done	done	done	done	done
Restraint rel q2		done	done		done
ROM q2h		done	done		done
Position chg q2h		done	done		done
Orient behav q2h		done	done		done
Hydra needs q2h		done	done		done
Feed needs q2h		done	done		done
Call bell q2		done	done		done
Behavior q2h		continues	continues		continues
Misc Events	05:00	06:00	08:15	09:00	10:00
Evaluated POC			done		
Misc events			&		

11/23/07 08:15 Misc events(KMAD): NAD noted. trauma team here rounding on pt. no new orders. VSS, O2 sats 95%. pt lying in bed, appears comfortable. cont to monitor.

CARE PROVIDERS	CAST	CAST	KMAD	KMAD	KMAD

MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 22

FLOWSHEET	11/23			11/24	
Neuro/EENT	11:00	11:50	20:35	00:21	08:00
Follows commands			WNL		WNL
NormHear&/orAid			WNL		WNL
Abs of drainage			WNL		WNL
Norm closure			WNL		WNL
Abs of swelling			WNL		WNL
No visual impair			WNL		WNL
PERRLA			WNL		WNL
Behavior/neuro			calm		calm
Orientation			unable to assess		unable to assess
Cervical collar			Miami j		Miami j
CollarAssessIntv			in place		in place
Both pupilsShape Both pupilsReact			round brisk		round brisk
Both pupils size			3mm		3mm
Special Neuro	11:00	11:50	20:35	00:21	08:00
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 1=tube/trach 6=obeysVbCommand 11		4=spontaneously 1=tube/trach 6=obeysVbCommand 11
Motor exam LUE			6=obeys commands		6=obeys commands
Motor exam LLE			6=obeys commands		6=obeys commands
Motor exam RUE			6=obeys commands		6=obeys commands
Motor exam RLE			6=obeys commands		6=obeys commands
Cardiovascular	11:00	11:50	20:35	00:21	08:00
Reg rate, rhythm			&		
S1S2			WNL		WNL
Angina/chestPain			none		none
PalpPerhipPulses			WNL		WNL
Cap refill<3 sec			&		&
Thigh/CalfTender			none		none
Absence of edema			WNL		WNL
11/23/07 20:35 Reg rate, rhythm(CAST): tachy at times					
11/23/07 20:35 Cap refill<3 sec(CAST): rt toes necrotic					
11/24/07 08:00 Cap refill<3 sec(KMAD): right toes necrotic					
Respiratory	11:00	11:50	20:35	00:21	08:00
Spont respers			WNL		WNL
NonLaboredEffort			WNL		WNL
BS all lobes			present		present
RUL			rhonchi		rhonchi
CARE PROVIDERS			CAST		KMAD

MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 23

FLOWSHEET	11/23			11/24	
Respiratory-Cont.	11:00	11:50	20:35	00:21	08:00
RML			rhonchi		rhonchi
RLL			diminished		diminished
LUL			rhonchi		rhonchi
LLL			diminished		diminished
Cough			productive		productive
Sputum/Secretion			tan		tan
Consistency			thick		thick
Trachea			midline		
Airway			tracheostomy		tracheostomy
Trach size			8		8
Peristoma appear			pink		pink
Oxygen %			40% trach collar		40% trach collar
Trach suction					done
Trach secretions					tan
Trach-consistncy					thick
Gastrointestinal	11:00	11:50	20:35	00:21	08:00
AbdSoftNontender			WNL		WNL
No c/o N/V			WNL		WNL
Normal dentition			WNL		WNL
MucousMembIntact			WNL		WNL
Last BM			11/16		11/16/2007
BowelSndsAllQuad			hypoactive		hypoactive
Tube feeding			see MAR		see MAR
Tube type			g-tube		g-tube
Genitourinary	11:00	11:50	20:35	00:21	08:00
Continent					&
Adequate UOP			WNL		WNL
ClearYellowUrine			WNL		WNL
NoAbn penile bld			WNL		WNL
NoAbnPenileDisch			WNL		WNL
11/24/07 08:00 Continent(KMAD): pt using urinal at times					
Func/Musculoskel	11:00	11:50	20:35	00:21	08:00
ActiveROM x4 ext			WNL		WNL
Symmetry all ext			WNL		WNL
Weakness			generalized		generalized
SCD site			leg L leg R		leg L leg R
SCD type			short leg		short leg
CARE PROVIDERS			CAST		KMAD

MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23			11/24	
Func/Musculoskel-Cont.	11:00	11:50	20:35	00:21	08:00
SCD assess			on operational		on operational
Skin	11:00	11:50	20:35	00:21	08:00
Skin warm			WNL		WNL
Skin dry& intact			WNL		WNL
Color approp			to ethnicity		to ethnicity
Sens perception			4=no impairmnt		4=no impairmnt
Moisture			3=occasnly moist		4=rarely moist
Activity			2=chairfast		2=chairfast
Mobility			3=slight limited		3=slight limited
Nutrition			2=prob adequate		2=prob adequate
Friction & shear			3=no app.probl		3=no app.probl
Total score			17		17
Psychological	11:00	11:50	20:35	00:21	08:00
Approp affect			to situation		to situation
Nutrition	11:00	11:50	20:35	00:21	08:00
Meal type			NPO		NPO
Act Daily Living	11:00	11:50	20:35	00:21	08:00
Bath					dependent
Mouth care					assist
Bedrest/BRP					assist
ROM joints					independent
Peri care					assist
Deep breathe					assist
Cough					independent
Vascular Access	11:00	11:50	20:35	00:21	08:00
Site#1 location			hand L		hand L
Insertion date			11/22/2007		11/22/2007
Gauge			#22		#22
Site#1 appear			secure		secure
Site#1 dressing			dry and intact		dry and intact
Interventions			&		
11/23/07 20:35 Interventions(CAST): iv fluid infusing					
Safety	11:00	11:50	20:35	00:21	08:00
Hospital ID band			on		on
CallSystm access			done		done
Bed in low posit			done		done
Bed brakes on			done		done
Bed press relief			on		on
CARE PROVIDERS			CAST		KMAD

MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/23			11/24	
Safety-Cont.	11:00	11:50	20:35	00:21	08:00
Imple SafetyPOC			done		done
Morse Fall Risk	11:00	11:50	20:35	00:21	08:00
HxFall(w/in 3mo)			no=0		no=0
Secondary Dx			yes=15		yes=15
Ambulatory Aid			w/c NrsAssist=0		w/c NrsAssist=0
IV or IV Access			yes=20		yes=20
Gait			Norm BR w/c=0		Norm BR w/c=0
Mental Status			Knows limits=0		Knows limits=0
Total Score			35 25 - 44 mod risk		35 25 - 44 mod risk
Imple SafetyPOC			done		done
Restraints	11:00	11:50	20:35	00:21	08:00
Skin checks q1h	done	done			
Circ checks q1h	done	done			
Restraint rel q2		done			
ROM q2h		done			
Position chg q2h		done			
Orient behav q2h		done			
Hydra needs q2h		done			
Feed needs q2h		done			
Call bell q2		done			
Behavior q2h		continues			
Misc Events	11:00	11:50	20:35	00:21	08:00
Evaluated POC			done		done
Misc events			&	&	&

11/23/07 20:35 Misc events(CAST): pt assesment done. removed restraints. pt. medicated for pain per mar. resting without S&S of distress. will cont to monitor.

11/24/07 00:21 Misc events(CAST): pt cleaned up. instructed on how to use urinal. trach care done. medicated for pain per mar. will cont to monitor

11/24/07 08:00 Misc events(KMAD): NAD noted. VSS. O2 sats 95%. good cough with pt mobilizing secretions well. Pt unrestrained, participating in care. appears comfortable, cooperative. cont to monitor.

CARE PROVIDERS	KMAD	KMAD	CAST	CAST	KMAD

MADDALENA, KRISTINE(KMAD)RN STORM, CARRIE A(CAST)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED 12/02/07 05:50
OPT OUT:
Page: 26

FLOWSHEET	11/24			11/25	
Neuro/EENT	10:00	11:53	20:00	08:00	08:45
Follows commands			WNL	WNL	
NormHear&/orAid			WNL	WNL	
Abs of drainage			WNL	WNL	
Norm closure			WNL	WNL	
Abs of swelling			WNL	WNL	
No visual impair			WNL	WNL	
PERRLA			WNL	WNL	
Behavior/neuro			calm	calm	
Orientation			unable to assess	unable to assess	
Cervical collar			Miami j	Miami j	
CollarAssessIntv			in place	in place	
Both pupilsShape Both pupilsReact			round brisk	round brisk	
Both pupils size			3mm	3mm	
Special Neuro	10:00	11:53	20:00	08:00	08:45
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 1=no response 6=obeysVbComma 11	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15	
Motor exam LUE			6=obeys commands	6=obeys commands	
Motor exam LLE			6=obeys commands	6=obeys commands	
Motor exam RUE			6=obeys commands	6=obeys commands	
Motor exam RLE			6=obeys commands	6=obeys commands	
Cardiovascular	10:00	11:53	20:00	08:00	08:45
Reg rate, rhythm			WNL		
S1S2			WNL	WNL	
Angina/chestPain			none	none	
PalpPerhipPulses			WNL	WNL	
Cap refill<3 sec			&	&	
Thigh/CalfTender			none	none	
Absence of edema			WNL	WNL	
11/24/07 20:00 Cap refill<3 sec(SHUT): right toes necrotic					
11/25/07 08:00 Cap refill<3 sec(KMAD): right toes necrotic					
Respiratory	10:00	11:53	20:00	08:00	08:45
Spont respers			WNL	WNL	
NonLaboredEffort			WNL	WNL	
BS all lobes			present	present	
RUL			rhonchi	rhonchi	
RML			rhonchi	present	
CARE PROVIDERS			SHUT	KMAD	

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24 Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: "D657-A" ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
Page: 27

FLOWSHEET	11/24			11/25	
Respiratory-Cont	10:00	11:53	20:00	08:00	08:45
RLL			diminished	present	
LUL			rhonchi	rhonchi	
LLL			diminished	present	
Cough			productive	productive	
Sputum/Secretion			tan	tan	
Consistency			thick	thin	
Trachea			midline		
Airway	tracheostomy		tracheostomy	tracheostomy	
Trach size	6 &		6	6	
Peristoma appear	pink		pink	pink	
Oxygen %	40% trach collar		40% trach collar	40% trach collar	
Trach secretions			tan		
Trach-consistncy			thick		
11/24/07 10:00 Trach size(KMAD): Dr. Minshall in to see pt. Trach downsized to #6. pt tolerated well. sats remain above 93%					
Gastrointestinal	10:00	11:53	20:00	08:00	08:45
AbdSoftNontender			WNL	WNL	
No c/o N/V			WNL	WNL	
Normal dentition			WNL	WNL	
MucousMembIntact			WNL	WNL	
Last BM			11/16/52007	11/16/2007	
BowelSndsAllQuad			hypoactive		
Tube feeding			see MAR	see MAR	
Tube type			g-tube	g-tube	
Genitourinary	10:00	11:53	20:00	08:00	08:45
Continent			&	WNL	
Adequate UOP			WNL	WNL	
ClearYellowUrine			WNL	WNL	
NoAbn penile bld			WNL	WNL	
NoAbnPenileDisch			WNL	WNL	
11/24/07 20:00 Continent(SHUT): pt uses urinal					
Func/Musculoskel	10:00	11:53	20:00	08:00	08:45
ActiveROM x4 ext			WNL	WNL	
Symmetry all ext			WNL	WNL	
Weakness			generalized	generalized	
SCD site			leg L leg R	leg L leg R	
SCD type			short leg	short leg	
CARE PROVIDERS	KMAD		SHUT	KMAD	

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 28

FLOWSHEET	11/24			11/25	
Func/Musculoskel-Cont.	10:00	11:53	20:00	08:00	08:45
SCD assess			on operational	on operational	
Skin	10:00	11:53	20:00	08:00	08:45
Skin warm			WNL	WNL	
Skin dry& intact			WNL	WNL	
Color approp			to ethnicity	to ethnicity	
Sens perception			4=no impairmnt	4=no impairmnt	
Moisture			4=rarely moist	4=rarely moist	
Activity			2=chairfast	3=walks occasion	
Mobility			3=slight limited	3=slight limited	
Nutrition			2=prob adequate	2=prob adequate	
Friction & shear			3=no app.probl	3=no app.probl	
Total score			18	19	
Psychological	10:00	11:53	20:00	08:00	08:45
Approp affect			to situation	to situation	
Nutrition	10:00	11:53	20:00	08:00	08:45
Meal type				NPO &	
11/25/07 08:00 Meal type(KMAD): may have thickened liquids					
Act Daily Living	10:00	11:53	20:00	08:00	08:45
Bath				assist	
Mouth care				assist	
Amb w/assistance				assist	
OOB-chair				assist	
ROM joints				independent	
Peri care				assist	
Deep breathe				independent	
Cough				independent	
Vascular Access	10:00	11:53	20:00	08:00	08:45
Site#1 location			hand L	hand L	
Insertion date			11/22/2007	11/22/2007	
Gauge			#22	#22	
Site#1 appear			secure	secure	
Site#1 dressing			dry and intact	dry and intact	
Safety	10:00	11:53	20:00	08:00	08:45
Hospital ID band			on	on	
CallSystm access			done	done	
Bed in low posit			done	done	
Bed brakes on			done	done	
CARE PROVIDERS			SHUT	KMAD	

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 29

FLOWSHEET	11/24			11/25	
Safety-Cont.	10:00	11:53	20:00	08:00	08:45
Bed press relief			on	on	
Imple SafetyPOC			done	done	
Morse Fall Risk	10:00	11:53	20:00	08:00	08:45
HxFall(w/in 3mo)			no=0	no=0	
Secondary Dx			yes=15	yes=15	
Ambulatory Aid			None Bedrest=0	w/c NrsAssist=0	
IV or IV Access			yes=20	yes=20	
Gait			Norm BR w/c=0	Norm BR w/c=0	
Mental Status			Knows limits=0	Knows limits=0	
Total Score			35 25 - 44 mod risk	35 25 - 44 mod risk	
Imple SafetyPOC				done	
Misc Events	10:00	11:53	20:00	08:00	08:45
Evaluated POC			done	done	
Misc events	&	&	&	&	&

11/24/07 10:00 Misc events(KMAD): Dr. Minshall assessed pt and downsized trach to #6. pt tolerated well with sats remaining above 93%. Pt pointed to yankeur and then himself. Demonstrated how pt may use yankeur himself. Pt smiled and returned demo of suction to trach and mouth.

11/24/07 11:53 Misc events(KMAD): pt remains unrestrained. using yankeur and urinal appropriately. speech to eval. pt appears to understand POC.

11/24/07 20:00 Misc events(SHUT): at this time pt was all twisted up in lines stated he wanted pain medication

11/25/07 08:00 Misc events(KMAD): NAD noted. O2 sats 95%. no complaints at this time. appears comfortable.

11/25/07 08:45 Misc events(KMAD): Dr. Minshall on floor to assess pt, performed swallow eval on pt, new orders for thickened liquid diet. pt in no resp distress, sats remain above 93%.

CARE PROVIDERS	KMAD	KMAD	SHUT	KMAD	KMAD

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25				
Neuro/EENT	09:30	12:15	16:00	17:33	20:30
Follows commands					WNL
NormHear&/orAid					WNL
Abs of drainage					WNL
Norm closure					WNL
Abs of swelling					WNL
No visual impair					WNL
PERRLA					WNL
Behavior/neuro					calm
Orientation					unable to assess
Cervical collar					Miami j
CollarAssessIntv					in place
Both pupilsShape Both pupilsReact					round brisk
Both pupils size					3mm
Special Neuro	09:30	12:15	16:00	17:33	20:30
GCS eyes open GCS best verbal Best upper motor GCS total score					4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15
Motor exam LUE					6=obeys commands
Motor exam LLE					6=obeys commands
Motor exam RUE					6=obeys commands
Motor exam RLE					6=obeys commands
Cardiovascular	09:30	12:15	16:00	17:33	20:30
S1S2					WNL
Angina/chestPain					none
PalpPerhipPulses					WNL
Cap refill<3 sec					&
Thigh/CalfTender					none
Absence of edema					WNL
11/25/07 20:30 Cap refill<3 sec(SHUT): right toes necrotic					
Respiratory	09:30	12:15	16:00	17:33	20:30
Spont respers					WNL
NonLaboredEffort					WNL
BS all lobes					present
RUL					rhonchi
RML					rhonchi
RLL					present
LUL					rhonchi
CARE PROVIDERS					SHUT

HUTCHINSON, STEPHANIE(SHUT)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25				
Respiratory-Cont.	09:30	12:15	16:00	17:33	20:30
LLL					present
Cough					productive
Sputum/Secretion					tan
Consistency					thin
Trachea					midline
Airway					tracheostomy
Trach size					6
Peristoma appear					pink
Gastrointestinal	09:30	12:15	16:00	17:33	20:30
AbdSoftNontender					WNL
No c/o N/V					WNL
Normal dentition					WNL
MucousMembIntact					WNL
Last BM				11/25/2007 &	11/25/2007
BowelSndsAllQuad					hypoactive
Tube feeding					see MAR
Tube type					g-tube
11/25/07 17:33 Last BM(KMAD): pt reports he flushed small stool					
Genitourinary	09:30	12:15	16:00	17:33	20:30
Continent					WNL
Adequate UOP					WNL
ClearYellowUrine					WNL
NoAbn penile bld					WNL
NoAbnPenileDisch					WNL
Func/Musculoskel	09:30	12:15	16:00	17:33	20:30
ActiveROM x4 ext					WNL
Symmetry all ext					WNL
Weakness					generalized
SCD site					leg L leg R
SCD type					short leg
SCD assess					on &
11/25/07 20:30 SCD assess(SHUT): pt does not want to wear them					
Skin	09:30	12:15	16:00	17:33	20:30
Skin warm					WNL
Skin dry& intact					WNL
Color approp					to ethnicity
CARE PROVIDERS				KMAD	SHUT

HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25				
Skin-Cont.	09:30	12:15	16:00	17:33	20:30
Sens perception					4=no impairmnt
Moisture					4=rarely moist
Activity					3=walks occasion
Mobility					3=slight limited
Nutrition					2=prob adequate
Friction & shear					3=no app.probl
Total score					19
Psychological	09:30	12:15	16:00	17:33	20:30
Approp affect					to situation
Nutrition	09:30	12:15	16:00	17:33	20:30
Meal type			clear liquid		&
11/25/07 20:30 Meal type(SHUT): thickened liquids					
Vascular Access	09:30	12:15	16:00	17:33	20:30
Site#1 location					hand L
Insertion date					11/22/2007
Gauge					#22
Site#1 appear					secure
Site#1 dressing					dry and intact
Safety	09:30	12:15	16:00	17:33	20:30
Hospital ID band					on
CallSystm access					done
Bed in low posit					done
Bed brakes on					done
Bed press relief					on
Imple SafetyPOC					done
Morse Fall Risk	09:30	12:15	16:00	17:33	20:30
HxFall(w/in 3mo)					no=0
Secondary Dx					no=0
Ambulatory Aid					None Bedrest=0
IV or IV Access					yes=20
Gait					Norm BR w/c=0
Mental Status					Knows limits=0
Total Score					20 0 - 24 low risk
Misc Events	09:30	12:15	16:00	17:33	20:30
Evaluated POC					done
Misc events	&	&			&
11/25/07 09:30 Misc events(KMAD): pt decannulated trach. no resp distress, sats 93%. Dr. Manskar notified and replaced trach w/o difficulty. pt OOB in chair.					
CARE PROVIDERS	KMAD	KMAD	BAC		SHUT

CHANDLER, BETTY A(BAC)CA HUTCHINSON, STEPHANIE(SHUT)RN MADDALENA, KRISTINE(KMAD)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: "D657-A" ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/25				
Misc Events Cont.	09:30	12:15	16:00	17:33	20:30
11/25/07 12:15 Misc events(KMAD): spanish interpreter on floor with Dr. Leppard to discuss pt's foot and pending surgery with pt. all questions answered. per interpreter, pt has no complaints.					
11/25/07 20:30 Misc events(SHUT): pt having pain @ this time but does not want any pain meds tolerated bolus tube feeds and pt seems a little depressed and Hypatia was going in to talk to pt					

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26				
Neuro/EENT	03:25	04:05	08:30	09:30	10:26
Follows commands					WNL
NormHear&/orAid					WNL
Abs of drainage					WNL
Norm closure					WNL
Abs of swelling					WNL
No visual impair					WNL
PERRLA					WNL
Behavior/neuro					calm
Orientation					unable to assess
Cervical collar					Miami j
CollarAssessIntv					cleand/reapplied
Both pupilsShape Both pupilsReact					round brisk
Both pupils size					4mm
Special Neuro	03:25	04:05	08:30	09:30	10:26
GCS eyes open GCS best verbal Best upper motor GCS total score					4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15
Motor exam LUE					6=obeys commands
Motor exam LLE					6=obeys commands
Motor exam RUE					6=obeys commands
Motor exam RLE					6=obeys commands
Cardiovascular	03:25	04:05	08:30	09:30	10:26
Reg rate, rhythm					WNL
S1S2					WNL
Angina/chestPain					none
PalpPerhipPulses					WNL
Cap refill<3 sec					&
Thigh/CalfTender					none
Absence of edema					WNL
11/26/07 10:26 Cap refill<3 sec(SBRO): necrotic toes rt					
Respiratory	03:25	04:05	08:30	09:30	10:26
Spont respers					WNL
NonLaboredEffort					WNL
BS all lobes					present
RUL					coarse
RML					coarse
RLL					present
CARE PROVIDERS					SBRO

BROWN, SUZANNE(SBRO)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 16:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26				
Respiratory-Cont.	03:25	04:05	08:30	09:30	10:26
LUL					present
LLL					present
Cough					productive
Sputum/Secretion					creamy tan yellow
Trachea					midline
Airway					tracheostomy
Trach size					6
Peristoma appear					pink
Oxygen L					2LPM nasal cannula
Gastrointestinal	03:25	04:05	08:30	09:30	10:26
AbdSoftNontender					WNL
No c/o N/V					WNL
Normal dentition					WNL
MucousMembIntact					WNL
Last BM					11/25/2007
BowelSndsAllQuad					&
Tube feeding					see MAR
Tube type					g-tube
11/26/07 10:26 BowelSndsAllQuad(SBRO): present					
Genitourinary	03:25	04:05	08:30	09:30	10:26
Continent					WNL
Adequate UOP					WNL
ClearYellowUrine					WNL
NoChgPattrn/Char					WNL
NoAbn penile bld					WNL
NoAbnPenileDisch					WNL
Func/Musculoskel	03:25	04:05	08:30	09:30	10:26
ActiveROM x4 ext					WNL
Symmetry all ext					WNL
Weakness					generalized
SCD site					leg L leg R
SCD type					short leg
SCD assess					on
CARE PROVIDERS					SBRO

BROWN, SUZANNE(SBRO)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
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FLOWSHEET	11/26				
Skin	03:25	04:05	08:30	09:30	10:26
Skin warm					WNL
Skin dry& intact					WNL
Color approp					to ethnicity
Sens perception					4=no impairmnt
Moisture					4=rarely moist
Activity					3=walks occasion
Mobility					3=slight limited
Nutrition					3=adequate
Friction & shear					3=no app.probl
Total score					20
Psychological	03:25	04:05	08:30	09:30	10:26
Memory intact					WNL
Approp affect					to situation
Approp behavior					to situation
Approp verbaliz					to situation
Abnorm findings					&
11/26/07 10:26 Abnorm findings(SBRO): seems depressed about toe amputation					
Nutrition	03:25	04:05	08:30	09:30	10:26
Meal type					
Breakfast amt					
Act Daily Living	03:25	04:05	08:30	09:30	10:26
Bath				&	
11/26/07 09:30 Bath(KLMI): patient refused bath					
Vascular Access	03:25	04:05	08:30	09:30	10:26
Site#1 location					hand L
Insertion date					11/22/2007
Gauge					#22
Site#1 appear					secure
Site#1 dressing					dry and intact
Interventions					saline lock
Safety	03:25	04:05	08:30	09:30	10:26
Hospital ID band					on
CallSystm access					done
Bed in low posit					done
Bed brakes on					done
Bed press relief					on
Imple SafetyPOC					done
CARE PROVIDERS				KLMI	SBRO

BROWN, SUZANNE(SBRO)RN MIN, KATHERINE L(KLMI)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
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FLOWSHEET	11/26				
Morse Fall Risk	03:25	04:05	08:30	09:30	10:26
HxFall(w/in 3mo)					no=0
Secondary Dx					no=0
Ambulatory Aid					None Bedrest=0
IV or IV Access					yes=20
Gait					Norm BR w/c=0
Mental Status					Knows limits=0
Total Score					20 0 - 24 low risk
Misc Events	03:25	04:05	08:30	09:30	10:26
Evaluated POC					done
Misc events	&	&	&		&

11/26/07 03:25 Misc events(SHUT): c/o R shoulder hurting couldn't get comfortable Dilaudid 2mg IV given.

11/26/07 04:05 Misc events(SHUT): FSBS 61 TF's given @ this time.

11/26/07 08:30 Misc events(SBRO): Pt medicated for pain(points to left side neck), tube feed given, will cont to monitor.

11/26/07 10:26 Misc events(SBRO): Pt resting in bed, doing fine with thickened liquids, pain meds working, pt sleeping

CARE PROVIDERS	SHUT	SHUT	SBRO		SBRO

BROWN, SUZANNE(SBRO)RN HUTCHINSON, STEPHANIE(SHUT)RN

CONTINUED

GOMEZ, HECTOR
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24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26				
Skin-Cont.	11:04	11:17	15:52	18:10	19:25
Friction & shear					
Total score					
Psychological	11:04	11:17	15:52	18:10	19:25
Memory intact					
Approp affect					
Approp behavior					
Approp verbaliz					
Abnorm findings					
Nutrition	11:04	11:17	15:52	18:10	19:25
Meal type	&				regular
Breakfast amt	100%				
Dinner amt					75%
11/26/07 11:04 Meal type(KLMI): thickened liquids					
Act Daily Living	11:04	11:17	15:52	18:10	19:25
Bath				&	
Mouth care		independent			
Amb w/assistance				assist	
OOB-chair		independent &			
ROM joints		independent			
Bathroom/BSC		independent &			
Peri care				independent	
Deep breathe		independent			
Cough		independent			
11/26/07 11:17 OOB-chair(KLMI): patient oob to chair, linens changed					
11/26/07 11:17 Bathroom/BSC(KLMI): urinal					
11/26/07 18:10 Bath(KLMI): patient refused bath					
Vascular Access	11:04	11:17	15:52	18:10	19:25
Site#1 location					
Insertion date					
Gauge					
Site#1 appear					
Site#1 dressing					
Safety	11:04	11:17	15:52	18:10	19:25
Hospital ID band					
CallSystm access					
Bed in low posit					
Bed brakes on					
CARE PROVIDERS	KLMI	KLMI		KLMI	KLMI

MIN, KATHERINE L(KLMI)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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FLOWSHEET	11/26				
Safety Cont.	11:04	11:17	15:52	18:10	19:25
Bed press relief					
Morse Fall Risk	11:04	11:17	15:52	18:10	19:25
HxFall(w/in 3mo)					
Secondary Dx					
Ambulatory Aid					
IV or IV Access					
Gait					
Mental Status					
Total Score					
Misc Events	11:04	11:17	15:52	18:10	19:25
Misc events			&		
11/26/07 15:52 Misc events(SBRO): Pt ate most of lunch, tube feeds held, pt assisted to bathroom, will cont to monitor.					
CARE PROVIDERS			SBRO		

BROWN, SUZANNE(SBRO)RN

GOMEZ, HECTOR
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24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
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FLOWSHEET	11/26	11/27			
Neuro/EENT	21:30	08:09	11:08	11:10	11:30
Follows commands	WNL			WNL	
NormHear&/orAid	WNL			WNL	
Abs of drainage	WNL			WNL	
Norm closure	WNL			WNL	
Abs of swelling	WNL			WNL	
No visual impair	WNL			WNL	
PERRLA	WNL			WNL	
Behavior/neuro	calm			calm	
Orientation	unable to assess			unable to assess	
Cervical collar	Miami j			Miami j	
CollarAssessIntv	in place			in place	
Both pupilsShape Both pupilsReact	round brisk			round brisk	
Both pupils size	4mm			4mm	
Special Neuro	21:30	08:09	11:08	11:10	11:30
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15	
Motor exam LUE	6=obeys commands			6=obeys commands	
Motor exam LLE	6=obeys commands			6=obeys commands	
Motor exam RUE	6=obeys commands			6=obeys commands	
Motor exam RLE	6=obeys commands			6=obeys commands	
Cardiovascular	21:30	08:09	11:08	11:10	11:30
Reg rate, rhythm	WNL			WNL	
S1S2	WNL			WNL	
Angina/chestPain	none			none	
PalpPerhipPulses	WNL			WNL	
Cap refill<3 sec	&			&	
Thigh/CalfTender	none			none	
Absence of edema	WNL			WNL	
11/26/07 21:30 Cap refill<3 sec(SHUT): necrotic toes on right					
11/27/07 11:10 Cap refill<3 sec(SBRO): rt toes necrotic					
Respiratory	21:30	08:09	11:08	11:10	11:30
Spont respers	WNL			WNL	
NonLaboredEffort	WNL			WNL	
BS all lobes	present			present	
RUL	coarse			coarse	
RML	coarse			coarse	
CARE PROVIDERS	SHUT			SBRO	

BROWN, SUZANNE(SBRO)RN HUTCHINSON, STEPHANIE(SHUT)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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OPT OUT:
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FLOWSHEET	11/26	11/27			
Respiratory-Cont.	21:30	08:09	11:08	11:10	11:30
RLL	present			present	
LUL	present			present	
LLL	present			present	
Cough	productive			productive	
Sputum/Secretion	tan &			creamy	
Consistency	thin			thick	
Trachea	midline				
Airway	tracheostomy			oral	
Trach size	6				
Peristoma appear	pink				
Oxygen L	2LPM nasal cannula				
Trach secretions	tan				
Trach-consistncy	thin				

11/26/07 21:30 Sputum/Secretion(SHUT): not a strong cough

Gastrointestinal	21:30	08:09	11:08	11:10	11:30
AbdSoftNontender	WNL			WNL	
No c/o N/V	WNL			WNL	
Normal dentition	WNL			WNL	
MucousMembIntact	WNL			WNL	
Last BM	11/26/2007			11/26/2007	
BowelSndsAllQuad	&			hypoactive	
Tube type	g-tube			g-tube &	

11/26/07 21:30 BowelSndsAllQuad(SHUT): normoactive BS

11/27/07 11:10 Tube type(SBRO): promote tube feeds dc'd

Genitourinary	21:30	08:09	11:08	11:10	11:30
Continent	WNL				
Adequate UOP	WNL			WNL	
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL			WNL	
NoAbnPenileDisch	WNL				
Func/Musculoskel	21:30	08:09	11:08	11:10	11:30
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
Limited ROM				leg R &	
CARE PROVIDERS	SHUT			SBRO	

BROWN, SUZANNE(SBRO)RN HUTCHINSON, STEPHANIE(SHUT)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
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FLOWSHEET	11/26	11/27			
Func/Musculoskel-Cont.	21:30	08:09	11:08	11:10	11:30
Weakness	generalized			leg R	
SCD site	leg L leg R			leg L leg R	
SCD type	short leg			short leg	
SCD assess	on operational			on operational	
11/27/07 11:10 Limited ROM(SBRO): toes					
Skin	21:30	08:09	11:08	11:10	11:30
Skin warm	WNL			WNL	
Skin dry& intact	WNL				
Color approp	to ethnicity			to ethnicity	
Sens perception	4=no impairmnt			4=no impairmnt	
Moisture	4=rarely moist			4=rarely moist	
Activity	3=walks occasion			3=walks occasion	
Mobility	3=slight limited			3=slight limited	
Nutrition	3=adequate			2=prob adequate	
Friction & shear	3=no app.probl			3=no app.probl	
Total score	20			19	
Psychological	21:30	08:09	11:08	11:10	11:30
Memory intact	WNL			WNL	
Approp affect	to situation			to situation	
Approp behavior	to situation			to situation	
Approp verbaliz	to situation			to situation	
Abnorm findings	maladj illness				
Nutrition	21:30	08:09	11:08	11:10	11:30
Meal type	regular &				regular
Breakfast amt					50%
Lunch amt					
11/26/07 21:30 Meal type(SHUT): thickened liquids					
Act Daily Living	21:30	08:09	11:08	11:10	11:30
Bath					(modified) &
Mouth care					independent
Amb w/assistance					assist
OOB-chair					independent
ROM joints					independent
Bathroom/BSC					independent &
Peri care					independent
CARE PROVIDERS	SHUT			SBRO	SMAY

BROWN, SUZANNE(SBRO)RN HUTCHINSON, STEPHANIE(SHUT)RN MAY, SARAH(SMAY)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/26	11/27			
Act Daily Living-Cont.	21:30	08:09	11:08	11:10	11:30
Deep breathe					independent
Cough					independent

11/27/07 11:30 Bath(SMAY): linens changed; brought towels for bath and told him to call if he needed help

11/27/07 11:30 Bathroom/BSC(SMAY): urinal

Vascular Access	21:30	08:09	11:08	11:10	11:30
Site#1 location	hand L			hand L	
Insertion date	11/22/2007			11/27/2007	
Gauge	#22			#22	
Site#1 appear	secure			secure	
Site#1 dressing	dry and intact			dry and intact	
Safety	21:30	08:09	11:08	11:10	11:30
Hospital ID band	on			on	
CallSystm access	done			done	
Bed in low posit	done			done	
Bed brakes on	done			done	
Bed press relief	on			on	
Imple SafetyPOC				done	
Morse Fall Risk	21:30	08:09	11:08	11:10	11:30
HxFall(w/in 3mo)	no=0			no=0	
Secondary Dx	no=0			no=0	
Ambulatory Aid	None Bedrest=0			CrtchCaneWlkr=15	
IV or IV Access	yes=20			yes=20	
Gait	Norm BR w/c=0			WeakUsesTouch=10	
Mental Status	Knows limits=0			Knows limits=0	
Total Score	20			45 45 or> high risk	
Imple SafetyPOC				done	
Misc Events	21:30	08:09	11:08	11:10	11:30
Evaluated POC				done	
Misc events	&	&	&	&	

11/26/07 21:30 Misc events(SHUT): pt could not reach urinal and wet bed linens were changed and Dilaudid 2mg was given for pain

11/27/07 08:09 Misc events(SBRO): Pt resting in bed, assisted with AM meal tray, vitals stable, will cont to monitor.

11/27/07 11:08 Misc events(SBRO): Pt oob to chair this am, trach removed by PA, pt c/o headache pain, medicated with dilaudid and order for tylenol obtained, pt ambulate in halls with assist and use of walker, will cont to monitor.

11/27/07 11:10 Misc events(SBRO): Pt to xray for flex ext films.

CARE PROVIDERS	SHUT	SBRO	SBRO	SBRO	SMAY

BROWN, SUZANNE(SBRO)RN HUTCHINSON, STEPHANIE(SHUT)RN MAY, SARAH(SMAY)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27		11/28		
Neuro/EENT	14:10	18:20	00:00	07:43	08:30
Follows commands			WNL		
NormHear&/orAid			WNL		
Abs of drainage			WNL		
Norm closure			WNL		
Abs of swelling			WNL		
No visual impair			WNL		
PERRLA					
Behavior/neuro			calm		
Orientation			unable to assess		
Cervical collar			Miami j		
CollarAssessIntv			in place		
Special Neuro	14:10	18:20	00:00	07:43	08:30
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15		
Motor exam LUE			6=obeys commands		
Motor exam LLE			6=obeys commands		
Motor exam RUE			6=obeys commands		
Motor exam RLE			6=obeys commands		
Cardiovascular	14:10	18:20	00:00	07:43	08:30
Reg rate, rhythm			WNL		
S1S2			WNL		
Angina/chestPain			none		
PalpPerhipPulses			WNL		
Cap refill<3 sec					
Thigh/CalfTender			none		
Absence of edema			WNL		
Respiratory	14:10	18:20	00:00	07:43	08:30
Spont respers			WNL		
NonLaboredEffort			WNL		
BS all lobes			present		
RLL					
Cough					
Sputum/Secretion					
Consistency					
Trachea			midline		
Airway			oral		
CARE PROVIDERS			LGBR		

BRYAN, LINDA G(LGBR)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M :MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED.12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27		11/28		
Gastrointestinal	14:10	18:20	00:00	07:43	08:30
AbdSoftNontender			WNL		
No c/o N/V			WNL		
Normal dentition			WNL		
MucousMembIntact			WNL		
Last BM			11/26/2007		
BowelSndsAllQuad			hyperactive		
Tube type			g-tube		
Genitourinary	14:10	18:20	00:00	07:43	08:30
Continent					
Adequate UOP			WNL		
ClearYellowUrine			WNL		
NoChgPattrn/Char			WNL		
NoAbn penile bld					
NoAbnPenileDisch					
Func/Musculoskel	14:10	18:20	00:00	07:43	08:30
ActiveROM x4 ext			WNL		
Symmetry all ext			WNL		
Limited ROM					
SCD site					
SCD type					
SCD assess					
Skin	14:10	18:20	00:00	07:43	08:30
Skin warm			WNL		
Skin dry& intact			WNL		
Color approp			to ethnicity		
Sens perception			4=no impairmnt		
Moisture			4=rarely moist		
Activity			3=walks occasion		
Mobility			3=slight limited		
Nutrition			2=prob adequate		
Friction & shear			3=no app.probl		
Total score			19		
Psychological	14:10	18:20	00:00	07:43	08:30
Memory intact			WNL		
Approp affect			to situation		
Approp behavior			to situation		
Approp verbaliz			to situation		
CARE PROVIDERS			LGBR		

BRYAN, LINDA G(LGBR)RN

GOMEZ, HECTOR
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FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27		11/28		
Nutrition	14:10	18:20	00:00	07:43	08:30
Lunch amt	80%				
Dinner amt		80%			
Act Daily Living	14:10	18:20	00:00	07:43	08:30
Bath			assist		
Mouth care			independent		
Amb w/assistance			assist		
OOB-chair			independent		
ROM joints			independent		
Bathroom/BSC			independent		
Peri care			independent		
Deep breathe			independent		
Cough			independent		
Vascular Access	14:10	18:20	00:00	07:43	08:30
Site#1 location			hand L		
Insertion date			11/27/2007		
Gauge			#22		
Site#1 appear			secure		
Site#1 dressing			dry and intact		
Interventions					
Safety	14:10	18:20	00:00	07:43	08:30
Hospital ID band			on		
CallSystm access			done		
Bed in low posit			done		
Bed brakes on			done		
Bed press relief			on		
Imple SafetyPOC			done		
Morse Fall Risk	14:10	18:20	00:00	07:43	08:30
HxFall(w/in 3mo)			no=0		
Secondary Dx			no=0		
Ambulatory Aid			CrtchCaneWlkr=15		
IV or IV Access			yes=20		
Gait			WeakUsesTouch=10		
Mental Status			Knows limits=0		
Total Score			45 45 or> high risk		
Imple SafetyPOC			done		
CARE PROVIDERS	SMAY	SMAY	LGBR		

BRYAN, LINDA G(LGBR)RN MAY, SARAH(SMAY)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/27		11/28		
Misc Events	14:10	18:20	00:00	07:43	08:30
Evaluated POC			done		
Misc events			&	&	&
11/28/07 00:00 Misc events(LGBR): Translator in pt's room to ask preop questions. Pt reminded not to eat or drink anything after midnight.					
11/28/07 07:43 Misc events(SBRO): Assumed pt care, pt resting in bed, waiting to go to OR.					
11/28/07 08:30 Misc events(SBRO): Pt medicated for pain.					
CARE PROVIDERS			LGBR	SBRO	SBRO

BROWN, SUZANNE(SBRO)RN BRYAN, LINDA G(LGBR)RN

GOMEZ, HECTOR
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FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28				
Neuro/EENT	09:01	09:07	09:45	11:03	14:37
Follows commands	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Behavior/neuro	calm				
Orientation	unable to assess				
Cervical collar	Miami j				
CollarAssessIntv	in place				
Special Neuro	09:01	09:07	09:45	11:03	14:37
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
Cardiovascular	09:01	09:07	09:45	11:03	14:37
Reg rate, rhythm	WNL				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	WNL				
Thigh/CalfTender	none				
Absence of edema	WNL				
Respiratory	09:01	09:07	09:45	11:03	14:37
Spont respers	WNL				
NonLaboredEffort	WNL				
BS all lobes	present				
RLL	rhonchi				
Cough	productive				
Sputum/Secretion	creamy				
Consistency	thick				
Trachea	midline				
Airway	oral				
CARE PROVIDERS	SBRO				

BROWN, SUZANNE(SBRO)RN

CONTINUED

GOMEZ, HECTOR
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FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28				
Gastrointestinal	09:01	09:07	09:45	11:03	14:37
Norm bowelSounds					
AbdSoftNontender	WNL				
No c/o N/V	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	11/26/2007				
BowelSndsAllQuad	hyperactive				
Tube type	g-tube &				
11/28/07 09:01 Tube type(SBRO): clamped, po meds given thru tube					
Genitourinary	09:01	09:07	09:45	11:03	14:37
Continent	&				
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
11/28/07 09:01 Continent(SBRO): incont at times					
Func/Musculoskel	09:01	09:07	09:45	11:03	14:37
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
Limited ROM	leg R &				
SCD site	leg L leg R				
SCD type	short leg				
SCD assess	operational				
11/28/07 09:01 Limited ROM(SBRO): toes					
Skin	09:01	09:07	09:45	11:03	14:37
Skin warm	WNL				
Skin dry& intact	WNL				
Color approp	to ethnicity				
Sens perception	4=no impairmnt				
Moisture	4=rarely moist				
Activity	3=walks occasion				
Mobility	3=slight limited				
Nutrition	3=adequate				
Friction & shear	3=no app.probl				
Total score	20				
CARE PROVIDERS	SBRO				

BROWN, SUZANNE(SBRO)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
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DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28				
Psychological	09:01	09:07	09:45	11:03	14:37
Memory intact	WNL				
Approp affect	to situation				
Approp behavior	to situation				
Approp verbaliz	to situation				
Nutrition	09:01	09:07	09:45	11:03	14:37
Meal type			NPO		
Act Daily Living	09:01	09:07	09:45	11:03	14:37
Bath					assist
Mouth care					assist
Ambulate self					independent
OOB-chair					independent
ROM joints					independent
Bathroom/BSC					independent
Peri care					independent
Deep breathe					independent
Cough					independent
Vascular Access	09:01	09:07	09:45	11:03	14:37
Site#1 location	hand R				
Insertion date	11/27/2007				
Gauge	#22				
Site#1 appear	secure				
Site#1 dressing	dry and intact				
Interventions	IV fluid started				
Safety	09:01	09:07	09:45	11:03	14:37
Hospital ID band	on				
CallSystm access	done				
Bed in low posit	done				
Bed brakes on	done				
Bed press relief	on				
Imple SafetyPOC	done				
Morse Fall Risk	09:01	09:07	09:45	11:03	14:37
HxFall(w/in 3mo)	no=0				
Secondary Dx	no=0				
Ambulatory Aid	CrtchCaneWlkr=15				
IV or IV Access	yes=20				
Gait	WeakUsesTouch=10				
Mental Status	Knows limits=0				
Total Score	45 45 or> high risk				
CARE PROVIDERS	SBRO		KLMI		KLMI

BROWN, SUZANNE(SBRO)RN MIN, KATHERINE L(KLMI)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
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OPT OUT:
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FLOWSHEET	11/28				
Morse Fall Risk-Cont.	09:01	09:07	09:45	11:03	14:37
Imple SafetyPOC	done				
Wound	09:01	09:07	09:45	11:03	14:37
Wound #1 site		other (specify) &			
Wound #1 type		other (specify) &			
WndAssess% Black		90%			
Periwound#1 skin		intact			
11/28/07 09:07 Wound #1 site(SBRO): toes rt					
11/28/07 09:07 Wound #1 type(SBRO): trauma					
Misc Events	09:01	09:07	09:45	11:03	14:37
Evaluated POC	done				
Misc events	&			&	
11/28/07 09:01 Misc events(SBRO): Pt waiting to go to OR for toe amputation					
11/28/07 11:03 Misc events(SBRO): Pt resting in bed pain better.					
CARE PROVIDERS	SBRO	SBRO		SBRO	

BROWN, SUZANNE(SBRO)RN

GOMEZ, HECTOR
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24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
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REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28	11/29			
Neuro/EENT	21:30	13:24	13:26	15:23	15:35
Follows commands	WNL			WNL	
NormHear&/orAid	WNL			WNL	
Abs of drainage	WNL			WNL	
Norm closure	WNL			WNL	
Abs of swelling	WNL			WNL	
No visual impair	WNL			WNL	
PERRLA	WNL			WNL	
Behavior/neuro	calm			calm	
Orientation	&				
11/28/07 21:30 Orientation(LLHU): pt speaks limited English, act appropriate.					
Special Neuro	21:30	13:24	13:26	15:23	15:35
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
Cardiovascular	21:30	13:24	13:26	15:23	15:35
Reg rate, rhythm	WNL			WNL	
S1S2	WNL			WNL	
Angina/chestPain	none			none	
PalpPerhipPulses	WNL			WNL	
Cap refill<3 sec	WNL			WNL	
Thigh/CalfTender	none			none	
Absence of edema	WNL			WNL	
Respiratory	21:30	13:24	13:26	15:23	15:35
Spont respers	WNL			WNL	
NonLaboredEffort	WNL			WNL	
Natural airway				WNL	
No O2 requiremnt				WNL	
BS all lobes	coarse present			coarse	
Cough	none			nonproductive	
Trachea	midline				
Airway	oral &				
11/28/07 21:30 Airway(LLHU): Pt's trach removed 11/27, drsg over old trach site. O2sats 94% on RA					
CARE PROVIDERS	LLHU			SGUL	

GULLEDGE, SHARON(SGUL)RN HURLEY, LORRI L(LLHU)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28	11/29			
Gastrointestinal	21:30	13:24	13:26	15:23	15:35
Norm bowelSounds	WNL			WNL	
AbdSoftNontender	WNL			WNL	
No c/o N/V	WNL			WNL	
Normal dentition	WNL			WNL	
MucousMembIntact	WNL			WNL	
Last BM	11/26/2007			11/26/2007	
Tube type	g-tube				
Genitourinary	21:30	13:24	13:26	15:23	15:35
Continent	WNL			WNL	
Adequate UOP	WNL			WNL	
ClearYellowUrine	WNL			WNL	
NoChgPattrn/Char	WNL			WNL	
NoAbn penile bld	WNL			WNL	
NoAbnPenileDisch	WNL			WNL	
Func/Musculoskel	21:30	13:24	13:26	15:23	15:35
ActiveROM x4 ext	WNL			WNL	
Symmetry all ext	WNL			WNL	
Strength all ext				WNL	
Speech clear				WNL	
Limited ROM	leg R &				
SCD site	leg L leg R				
SCD type	short leg				
SCD assess	on operational				

11/28/07 21:30 Limited ROM(LLHU): toes

Skin	21:30	13:24	13:26	15:23	15:35
Skin warm	WNL			WNL	
Skin dry& intact	WNL			WNL	
Color approp	to ethnicity			to ethnicity	
Sens perception	4=no impairmnt			4=no impairmnt	
Moisture	4=rarely moist			4=rarely moist	
Activity	3=walks occasion			3=walks occasion	
Mobility	3=slight limited			3=slight limited	
Nutrition	3=adequate			3=adequate	
Friction & shear	3=no app.probl			3=no app.probl	
Total score	20			20	
CARE PROVIDERS	LLHU			SGUL	

GULLEDGE, SHARON(SGUL)RN HURLEY, LORRI L(LLHU)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28	11/29			
Psychological	21:30	13:24	13:26	15:23	15:35
Memory intact	WNL			WNL	
Approp affect	to situation			to situation	
Approp behavior	to situation			to situation	
Approp verbaliz	to situation			to situation	
Nutrition	21:30	13:24	13:26	15:23	15:35
Meal type	regular &		regular	NPOafter midnite regular	
Breakfast amt			90%		
11/28/07 21:30 Meal type(LLHU): with thickened liquids					
Act Daily Living	21:30	13:24	13:26	15:23	15:35
Bath		independent &			
Mouth care		independent			
Ambulate self		independent			
OOB-chair		independent			
ROM joints		independent			
Bathroom/BSC		independent			
Peri care		independent			
Deep breathe		independent			
Cough		independent			
11/29/07 13:24 Bath(JWO): Pt Had a shower bed linen changed					
Vascular Access	21:30	13:24	13:26	15:23	15:35
Site#1 location	hand R				
Insertion date	11/28/2007				
Gauge	#22				
Site#1 appear	secure				
Site#1 dressing	dry and intact				
Safety	21:30	13:24	13:26	15:23	15:35
Hospital ID band	on			on	
CallSystm access	done			done	
Bed in low posit	done			done	
Bed brakes on	done			done	
Bed press relief	on			on	
Imple SafetyPOC	done				
Morse Fall Risk	21:30	13:24	13:26	15:23	15:35
HxFall(w/in 3mo)	no=0			no=0	
Secondary Dx	no=0			yes=15	
Ambulatory Aid	CrtchCaneWlkr=15			None Bedrest=0	
IV or IV Access	yes=20			no=0	
CARE PROVIDERS	LLHU	JWO	JWO	SGUL	

GULLEDGE, SHARON(SGUL)RN HURLEY, LORRI L(LLHU)RN OKELLO, JEANETTE W(JWO)CA

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/28	11/29			
Morse Fall Risk-Cont.	21:30	13:24	13:26	15:23	15:35
Gait	WeakUsesTouch=10			Norm BR w/c=0	
Mental Status	Knows limits=0			Knows limits=0	
Total Score	45 25 - 44 mod risk			15	
Wound	21:30	13:24	13:26	15:23	15:35
Wound #1 site	foot R &				foot R
Wound #1 type					other (specify) &
Periwound#1 skin					other (specify) &
11/28/07 21:30 Wound #1 site(LLHU): toes necrotic, paint with betadine q day					
11/29/07 15:35 Wound #1 type(SGUL): crushing injury					
11/29/07 15:35 Periwound#1 skin(SGUL): all toes except great toe on the r foot are black					
Misc Events	21:30	13:24	13:26	15:23	15:35
Evaluated POC	done				
Misc events	&				&
11/28/07 21:30 Misc events(LLHU): Assessment completed as charted. Pt displays no s/s distress. WIll cont to mon.					
11/29/07 15:35 Misc events(SGUL): recieved pt at 0700 this am sleeping at that time at 0915 eating breakfast without assist pt knows enough english to communicate some. 1030 pt brushed his teeth then ambulated and took shower, during this time his I brcame dislodged cath tip intact..					
CARE PROVIDERS	LLHU			SGUL	SGUL

GULLEDGE, SHARON(SGUL) RN HURLEY, LORRI L(LLHU) RN

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 58

FLOWSHEET	11/29			11/30	
Neuro/EENT	15:40	18:56	21:00	06:58	08:58
Follows commands			WNL		WNL
NormHear&/orAid			WNL		WNL
Abs of drainage			WNL		WNL
Norm closure			WNL		WNL
Abs of swelling			WNL		WNL
No visual impair			WNL		WNL
PERRLA			WNL		WNL
Behavior/neuro			calm		calm
Orientation			&		situation to person &
11/29/07 21:00 Orientation(LLHU): Pt acts appropriate, speaks little english.					
11/30/07 08:58 Orientation(JDW1): spanish speaking					
Special Neuro	15:40	18:56	21:00	06:58	08:58
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 5=orient/verbalz 6=obeysVbComma 11	nd	4=spontaneously 5=orient/verbalz 6=obeysVbComma 11
Cardiovascular	15:40	18:56	21:00	06:58	08:58
Reg rate, rhythm			WNL		WNL
S1S2			WNL		WNL
Angina/chestPain			none		none
PalpPerhipPulses			WNL		WNL
Cap refill<3 sec			WNL &		WNL
Thigh/CalfTender			none		none
Absence of edema			WNL		WNL
11/29/07 21:00 Cap refill<3 sec(LLHU): Except in R toes.					
Respiratory	15:40	18:56	21:00	06:58	08:58
Spont respers			WNL		WNL
NonLaboredEffort			WNL		WNL
Natural airway			WNL		WNL
No O2 requiremnt			WNL		WNL
BS all lobes			coarse present		present
Cough			none		
Trachea			midline		midline
Airway			&		
11/29/07 21:00 Airway(LLHU): Pt had trach removed 11/27, O2 sats 95% on RA, dry drsg over trach site.					
CARE PROVIDERS			LLHU		JDW1

HURLEY, LORRI L(LLHU)RN WILKINS, JANE D(JDW1)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 59

FLOWSHEET	11/29			11/30	
Gastrointestinal	15:40	18:56	21:00	06:58	08:58
Norm bowelSounds			WNL		WNL
AbdSoftNontender			WNL		WNL
No c/o N/V			WNL		WNL
Normal dentition			WNL		WNL
MucousMembIntact			WNL		WNL
Last BM			11/26/2007		11262007
Tube type			g-tube		g-tube
Genitourinary	15:40	18:56	21:00	06:58	08:58
Continent			WNL		WNL
Adequate UOP			WNL		WNL
ClearYellowUrine			WNL		WNL
NoChgPattrn/Char			WNL		WNL
NoAbn penile bld			WNL		WNL
NoAbnPenileDisch			WNL		WNL
Func/Musculoskel	15:40	18:56	21:00	06:58	08:58
ActiveROM x4 ext			WNL		WNL
Symmetry all ext			WNL		WNL
Strength all ext			WNL		WNL
Speech clear			WNL		WNL
Skin	15:40	18:56	21:00	06:58	08:58
Skin warm			WNL		WNL
Skin dry& intact			WNL		WNL
Color approp			to ethnicity		to ethnicity
Sens perception			4=no impairmnt		4=no impairmnt
Moisture			4=rarely moist		4=rarely moist
Activity			3=walks occasion		3=walks occasion
Mobility			3=slight limited		4=no limitation
Nutrition			3=adequate		3=adequate
Friction & shear			3=no app.probl		3=no app.probl
Total score			20		20
Psychological	15:40	18:56	21:00	06:58	08:58
Memory intact			WNL		WNL
Approp affect			to situation		to situation
Approp behavior			to situation		to situation
Approp verbaliz			to situation		to situation
CARE PROVIDERS			LLHU		JDW1

HURLEY, LORRI L(LLHU)RN WILKINS, JANE D(JDW1)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 60

FLOWSHEET	11/29			11/30	
Nutrition	15:40	18:56	21:00	06:58	08:58
Meal type			NPOafter midnite		NPO
Lunch amt		100%			
Dinner amt		100%			
Act Daily Living	15:40	18:56	21:00	06:58	08:58
Bath				independent	independent
Mouth care				independent	independent
Ambulate self				independent	independent
ROM joints				independent	independent
Bathroom/BSC				independent	independent
Peri care				independent	independent
Deep breathe				independent	independent
Cough				independent	independent
Vascular Access	15:40	18:56	21:00	06:58	08:58
Site#1 location			hand L		hand L
Insertion date			11/29/2007		11/29/2007
Gauge			#22		#22
Site#1 appear			secure		secure
Site#1 dressing			dry and intact		dry and intact
Safety	15:40	18:56	21:00	06:58	08:58
Hospital ID band			on		on
CallSystm access			done		done
Bed in low posit			done		done
Bed brakes on			done		done
Bed press relief			on		on
Imple SafetyPOC					done
Morse Fall Risk	15:40	18:56	21:00	06:58	08:58
HxFall(w/in 3mo)			no=0		no=0
Secondary Dx			no=0		no=0
Ambulatory Aid			CrtchCaneWlkr=15		w/c NrsAssist=0
IV or IV Access			yes=20		yes=20
Gait			WeakUsesTouch=10		WeakUsesTouch=10
Mental Status			Knows limits=0		Knows limits=0
Total Score			45 45 or> high risk		45
Wound	15:40	18:56	21:00	06:58	08:58
Wound #1 site			other (specify) &		other (specify) &
CARE PROVIDERS		JWO	LLHU	TC	JDW1

CAMPBELL, TRACY(TC)CA HURLEY, LORRI L(LLHU)RN OKELLO, JEANETTE W(JWO)CA
WILKINS, JANE D(JDW1)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED: 12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/29			11/30	
Wound Cont	15:40	18:56	21:00	06:58	08:58
Wound #1 type			other (specify) &		
WndAssess% Black			85%		90%
11/29/07 21:00 Wound #1 site(LLHU): R toes					
11/29/07 21:00 Wound #1 type(LLHU): crush injury, toes necrotic					
11/30/07 08:58 Wound #1 site(JDW1): rt toes necrotic					
Misc Events	15:40	18:56	21:00	06:58	08:58
Evaluated POC					done
Misc events	&		&		&
11/29/07 15:40 Misc events(SGUL): tolerated diet well today FSBS hae all been WNL dc'd per MD. spanish interpretor called for DrKosnik to discuss with pt about surgery options for foot					
11/29/07 21:00 Misc events(LLHU): Assessment completed as charted. Pt sitting up in chair with no complaints and no s/s distress at this time. Reviewed with pt that he was not to have anything to eat or drink past 12PM. pt stated understanding. Will reinforce. Will cont to mon.					
11/30/07 08:58 Misc events(JDW1): assessment completed pt has no distress/pain at this time pt sitting in bed awake					
CARE PROVIDERS	SGUL		LLHU		JDW1

GULLEDGE, SHARON(SGUL)RN HURLEY, LORRI L(LLHU)RN WILKINS, JANE D(JDW1)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 16:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 62

FLOWSHEET	11/30			12/01	
Neuro/EENT	10:08	17:00	21:38	07:57	09:00
Follows commands		WNL	WNL	WNL	
NormHear&/orAid		WNL	WNL	WNL	
Abs of drainage		WNL	WNL	WNL	
Norm closure		WNL	WNL	WNL	
Abs of swelling		WNL	WNL	WNL	
No visual impair		WNL	WNL	WNL	
PERRLA		WNL	WNL	WNL	
Behavior/neuro		calm	calm	calm	
Orientation		situation to person to place to time	situation to person &	situation to person	
11/30/07 21:38 Orientation(LLHU): pt acts appropriate, speaks little English					
Special Neuro	10:08	17:00	21:38	07:57	09:00
GCS eyes open GCS best verbal Best upper motor GCS total score		4=spontaneously 5=orient/verbalz 6=obeysVbComma 15	4=spontaneously 5=orient/verbalz 6=obeysVbComma 15	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15	
Motor exam LUE		6=obeys commands	6=obeys commands	6=obeys commands	
Motor exam LLE		6=obeys commands	6=obeys commands	6=obeys commands	
Motor exam RUE		6=obeys commands	6=obeys commands	6=obeys commands	
Motor exam RLE		6=obeys commands	6=obeys commands	6=obeys commands	
Cardiovascular	10:08	17:00	21:38	07:57	09:00
Reg rate, rhythm		WNL		WNL	
S1S2		WNL	WNL		
Angina/chestPain		none	none	none	
PalpPerhipPulses		WNL	WNL	WNL	
Cap refill<3 sec		WNL	WNL	WNL	
Thigh/CalfTender		none	none	none	
Absence of edema		WNL	WNL	WNL	
Rhythm			sinus tach	sinus tach	
Respiratory	10:08	17:00	21:38	07:57	09:00
Spont respers		WNL	WNL	WNL	
NonLaboredEffort		WNL	WNL	WNL	
Natural airway		WNL	WNL	WNL	
No O2 requiremnt		WNL	WNL	WNL	
BS all lobes		present	coarse present	coarse present	
Cough			nonproductive	nonproductive	
CARE PROVIDERS		IDP	LLHU	KWIX	

HURLEY, LORRI L(LLHU)RN PINEDA, IGNACIO D(IDP)RN WIX, KRISTA(KWIX)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED 12/02/07 05:50
OPT OUT:
Page: 63

FLOWSHEET	11/30			12/01	
Respiratory-Cont.	10:08	17:00	21:38	07:57	09:00
Trachea		midline	midline &		
11/30/07 21:38 Trachea(LLHU): pt with dry drsg over old trach site. O2 sats 96%					
Gastrointestinal	10:08	17:00	21:38	07:57	09:00
Norm bowelSounds		WNL	WNL	WNL	
AbdSoftNontender		WNL	WNL	WNL	
No c/o N/V		WNL	WNL	WNL	
Normal dentition		WNL	WNL	WNL	
MucousMembIntact		WNL	WNL	WNL	
Last BM		11/26/2007	11/26/2007	11262007	
Tube type		g-tube	g-tube		
Genitourinary	10:08	17:00	21:38	07:57	09:00
Continent		WNL	WNL	WNL	
Adequate UOP		WNL	WNL	WNL	
ClearYellowUrine		WNL	WNL	WNL	
NoChgPattrn/Char		WNL	WNL	WNL	
NoAbn penile bld		WNL	WNL	WNL	
NoAbnPenileDisch		WNL	WNL	WNL	
Func/Musculoskel	10:08	17:00	21:38	07:57	09:00
ActiveROM x4 ext		WNL		WNL	
Symmetry all ext		WNL	WNL	WNL	
Strength all ext		WNL	WNL	WNL	
Speech clear		WNL	WNL	WNL	
Limited ROM		leg R	leg R	leg R	
Weakness		leg R	leg R generalized	leg R generalized &	
12/01/07 07:57 Weakness(KWIX): ace bandage and boot					
Skin	10:08	17:00	21:38	07:57	09:00
Skin warm		WNL	WNL	WNL	
Skin dry& intact		WNL		WNL	
Color approp		to ethnicity	to ethnicity	to ethnicity	
Sens perception		4=no impairmnt	4=no impairmnt	4=no impairmnt	
Moisture		3=occasnly moist	4=rarely moist	4=rarely moist	
Activity		3=walks occasion	3=walks occasion	3=walks occasion	
Mobility		3=slight limited	3=slight limited	3=slight limited	
Nutrition		3=adequate	3=adequate	3=adequate	
Friction & shear		3=no app.probl	3=no app.probl	3=no app.probl	
Total score		19	20	20	
CARE PROVIDERS		IDP	LLHU	KWIX	

HURLEY, LQRRI L(LLHU)RN PINEDA, IGNACIO D(IDP)RN WIX, KRISTA(KWIX)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
Page: 64

FLOWSHEET	11/30			12/01	
Psychological	10:08	17:00	21:38	07:57	09:00
Memory intact		WNL	WNL	WNL	
Approp affect		to situation	to situation	to situation	
Approp behavior		to situation	to situation	to situation	
Approp verbaliz		to situation	to situation	to situation	
Nutrition	10:08	17:00	21:38	07:57	09:00
Meal type		clear liquid	clear liquid		clear liquid
Breakfast amt					100%
Vascular Access	10:08	17:00	21:38	07:57	09:00
Site#1 location		hand L	hand L	hand L	
Insertion date		11/30/2007	11/29/2007	11/29/2007	
Gauge		#18	#22	#22	
Site#1 appear		secure	secure	secure	
Site#1 dressing		dry and intact	dry and intact	dry and intact	
Interventions		IV fluid started			
Safety	10:08	17:00	21:38	07:57	09:00
Hospital ID band		on	on	on	
CallSystm access		done	done	done	
Bed in low posit		done	done	done	
Bed brakes on		done	done	done	
Bed press relief		on	on	on	
Imple SafetyPOC		done	done	done	
Morse Fall Risk	10:08	17:00	21:38	07:57	09:00
HxFall(w/in 3mo)		no=0	no=0	no=0	
Secondary Dx		no=0	no=0	no=0	
Ambulatory Aid		w/c NrsAssist=0	CrtchCaneWlkr=15	CrtchCaneWlkr=15	
IV or IV Access		yes=20	yes=20	yes=20	
Gait		WeakUsesTouch=10	WeakUsesTouch=10	WeakUsesTouch=10	
Mental Status		Knows limits=0	Knows limits=0	Knows limits=0	
Total Score		30 25 - 44 mod risk	45 45 or> high risk	45	
Imple SafetyPOC		done	done	-	
Wound	10:08	17:00	21:38	07:57	09:00
Wound #1 site			foot R &	foot R &	

11/30/07 21:38 Wound #1 site(LLHU): Pt to OR this AM for amputation of R 2nd to 5th toe, pt now with ace bandage and support boot on foot. Positive pulses all four extremities.

12/01/07 07:57 Wound #1 site(KWIX): ace bandage and boot

CARE PROVIDERS		IDP	LLHU	KWIX	EOC

CUENCA, EVA O(EOC)CA
HURLEY, LORRI L(LLHU)RN
PINEDA, IGNACIO D(IDP)RN
WIX, KRISTA(KWIX)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	11/30			12/01	
Intact Incision	10:08	17:00	21:38	07:57	09:00
Incision#1 site		other (specify) &			
Incision#1 type		other (specify) &			

11/30/07 17:00 Incision#1 site(IDP): R 2nd -5th toe amputated with OR drssing and ACE bandage CDI, Neurovascular checks WNL X3 q 1 hr.

11/30/07 17:00 Incision#1 type(IDP): OR dressing CDI

Misc Events	10:08	17:00	21:38	07:57	09:00
Evaluated POC			done	done	
Misc events	&	&	&	&	

11/30/07 10:08 Misc events(JDW1): off the floor to surgery to amputate toes on r foot

11/30/07 17:00 Misc events(IDP): pt. arrived on the floor from OR , AOX3, R foo with OR dressing intact with shoe

11/30/07 21:38 Misc events(LLHU): Assessment completed as charted, tylenol given as ordered for pain. Will cont to mon.

12/01/07 07:57 Misc events(KWIX): Assessment done.

CARE PROVIDERS	JDW1	IDP	LLHU	KWIX	

HURLEY, LORRI L(LLHU)RN
PINEDA, IGNACIO D(IDP)RN
WILKINS, JANE D(JDW1)RN
WIX, KRISTA(KWIX)RN

CONTINUED

GOMEZ, HECTOR
MUSC
24Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	12/01				
Nutrition	09:31	10:04	10:30	12:41	14:58
Meal type					
Lunch amt					
Act Daily Living	09:31	10:04	10:30	12:41	14:58
Bath			assist &		
Mouth care			independent		
OOB-chair			assist		
ROM joints			independent		
Bathroom/BSC			assist		
Peri care			independent		
Deep breathe			independent		
Cough			independent		
12/01/07 10:30 Bath(EOC): pt. linen changed					
Misc Events	09:31	10:04	10:30	12:41	14:58
Misc events	&	&		&	&
12/01/07 09:31 Misc events(KWIX): Oxycodone and tylenol given po for pain.					
12/01/07 10:04 Misc events(KWIX): Pt may be still in slight pain as evidenced by increased heartrate . Will observe.					
12/01/07 12:41 Misc events(KWIX): Pain meds given as per order. Dry gauze applied to old trach site. No reddness, drainage or swelling noted.					
12/01/07 14:58 Misc events(KWIX): Asked Dr re leaving in peg tube. He states it is to stay until pts appt with traum MD.					
CARE PROVIDERS	KWIX	KWIX	EOC	KWIX	KWIX

CUENCA, EVA O(EOC)CA WIX, KRISTA(KWIX) RN

CONTINUED

GOMEZ, HECTOR
MUSC
24 Hour Adult Patient Record
FROM: 11/01/07 18:40 TO: 12/03/07 05:00
ROOM: *D657-A* ADM: 11/01/07 18:40
AGE: 56Y SEX: M : MINSHALL, CHRISTIAN T
DOB: 01/01/1951 ID: 490943644 MR: 002581962
REQUESTED:12/02/07 05:50
OPT OUT:
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FLOWSHEET	12/01		
Nutrition	15:05	16:00	16:45
Meal type	regular		
Lunch amt	80%		
Misc Events	15:05	16:00	16:45
Misc events		&	&

12/01/07 16:00 Misc events(KWIX): Discharge instructions given to pt and family via interpretor. Apria here with walker for pt. to take home. IV dc'd. Peg tube left, Dr aware until appt in 2 weeks. Peg taped to avoid dangling. Instructed pt on cleaning peg tube site. Understands.

12/01/07 16:45 Misc events(KWIX): Pain meds given prior to 2hr ride home. Discharged home with family via W/C to family car. No home health services ordered at this time. Pt voices no concerns with discharge.

CARE PROVIDERS	EOC	KWIX	KWIX
CUENCA, EVA O(EOC)CA		WIX, KRISTA(KWIX)RN	

LAST PAGE

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123

CONSULTATION REPORT

Patient: GOMEZ-FRAGOSO, HECTOR **MRN: 002581962**

Date: 11/1/2007
Status: FINAL

JSC Medical Center
CONSULTATION REPORT
ient Name: GOMEZ, HECTOR
N: 002581962
Patcom: 490943644
e: 11/01/2007
vice: Orthopedic
Attending: Shane K. Woolf, MD
TORY OF PRESENT ILLNESS: The patient is a 56-year-old patient, at
nstruction site was hit in the head with a crane. Apparently he
omited prior to the ED arrival, with unsuccessful intubation at an
ide hospital. Past medical history none. No known drug
gies. No known previous surgeries, no current medical
onditions. Apparently could smell alcohol on the patient's breath.
stionable tobacco use.
MILY HISTORY: Noncontributory.
EVIEW OF SYSTEMS: Unable to obtain.
patient incurred a large fracture through his skull, apparently
open, with subdural and epidural fluid collections.
rthopedics was consulted for a right clavicle fracture as well as
ures of the proximal phalanges of the right foot, 2-12, with
natic arthrotomies of the 4th and 5th toes as well as a
ondisplaced oblique fracture of the right great toe.
SICAL EXAMINATION: The patient is a Hispanic male, intubated,
ed. Apparently he was moving all extremities upon admission.
is right upper extremity is noted to have some bruising and swelling
t the right hand, but no crepitus is noted about the hand, wrist,
v, arm, or shoulder. There is gross crepitus at the right
avicle. The left upper extremity is unremarkable. Again it was
ag, apparently, on admission. There is no crepitus or step-off
His left lower extremity also has no obvious injuries,
elling, step-offs, crepitus noted about the hip, thigh, knee, leg,
de or foot. The right foot is significant for traumatic
tomies of the 4th and 5th digits, and gross swelling about the
t The ankle appears to be intact without any swelling or bony
ffs or crepitus, as well as the leg, knee, and thigh, and there
ange of motion in his hip without crepitus. His pelvis is stable
AP and lateral compression. Abdomen is soft, nontender,
stended.

ASSESSMENT: Hispanic male with the aforementioned injuries with traumatic arthrotomies at the 4th and 5th toes of the right foot as well as right clavicle fracture. Will apply a splint to the clavicle fracture. The arthrotomies will be washed out and assessed. Antibiotics q. 8h will be recommended, and patient apparently is not a surgical candidate at the moment per neurosurgery. Will possibly take him to the OR for more definitive washout and closure and possible pinning of the fractures at a future date.
The plan has been discussed with the attending and he is in agreement.

Dictated by: Bennett Grimm, MD

_____
Bennett Grimm, MD

_____
Shane K. Woolf, MD
Attending
902536 / 35634 /
JOB: 367701
DD: 11/01/07 08:40 PM
DT: 11/02/07 12:19 PM
Additional CC:_____

DOCID: 18231902536

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:22:19 AM

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

11/01/07 : 10:53pm
PORTABLE CHEST 1 VIEW
Accession number: 5075505

EXAMINATION: CHEST 11/01/07 22:53:00

ACCESSION NUMBER: 5075505

INDICATION: 28 yo hit by a crane with LOC and foot fractures and rib fractures

COMPARISON: 11/01/07.

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomedistinal silhouette. There has been interval withdrawal of endotracheal tube, with its distal tip now 2 cm from the carina. Enteric catheter is unchanged. Again noted are bilateral apical air space opacities, contusions versus atelectasis or aspiration. There is no evidence of pneumothorax. Right clavicular fracture is also noted.

IMPRESSION:

1. Status-post repositioning of endotracheal tube

2. Bilateral apical opacities, contusions versus atelectasis or aspiration

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: PHILIP COSTELLO

4STN4STN04 brown 15310
28 yo hit by a crane with LOC and foot fractures and rib fractures

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

01/16/08 : 10:08am
DIAG T SPINE 2
Accession number: 5142260

EXAMINATION: THORACIC SPINE 01/16/08 10:08:00

ACCESSION NUMBER: 5142260

INDICATION: C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

COMPARISON: CT cervical spine and CT chest 11/01/07

FINDINGS: AP and lateral views of the thoracic spine were obtained. Vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. There is normal curvature. Disc spaces are well-maintained. Visualized portions of the chest are unremarkable.

IMPRESSION:

Normal thoracic spine.

VOICE DICTATED BY: Dr. W Taylor Rowlett
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

27 YO MALE WITH C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

11/04/07 : 3:55pm
DIAG FOOT,COMP/MIN 3 VIEWS
Accession number: 5077073

EXAMINATION: FOOT 11/04/07 15:55:00

ACCESSION NUMBER: 5077073

INDICATION: s/p MVC, multiple fractures of right foot phalanges, s/p pinning, please evaluate alignment

COMPARISON: 11/1/07.

FINDINGS: Frontal, lateral, and oblique views of right foot demonstrate interval K wire fixation of first distal phalanx fracture, second proximal/distal phalanges fractures, third and proximal/distal phalanges fractures, fourth proximal phalanx fracture, and fifth middle/proximal phalanges. Bony detail is obscured by overlying casting material. There is no evidence of hardware failure or complication.

IMPRESSION:

K-wire fixation of multiple right phalanges fractures with no evidence of hardware complication.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

4STN4STN04 Requesting Clinician: selander ReqPager: 15668
s/p MVC

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

11/06/07 : 10:24pm
DIAG CERV SPINE AP/LAT
Accession number: 5080007

EXAMINATION: CERVICAL SPINE 11/06/07 22:24:00

ACCESSION NUMBER: 5080007

INDICATION: c spine clearance, altered mental status

COMPARISON: None.

FINDINGS: Lateral flexion/extension views of the cervical spine were obtained. The craniocervical junction is unremarkable. The vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. Disc spaces are well maintained. There is a normal cervical curvature. There is no abnormal cervical motion with flexion/extension. The paraspinal soft tissues are normal. Left parietal/temporal/frontal bone fracture. Endotracheal tube with distal tip not visualized.

IMPRESSION:

No cervical instability.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

4STN4STN04 krishna 15388 please page 15388 to schedule for c spine clerance

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

11/27/07 : 12:05pm
DIAG CERV SPINE AP/LAT
Accession number: 5098405

EXAMINATION: CERVICAL SPINE X-RAY 11/27/07 12:05:00

ACCESSION NUMBER: 5098405

INDICATION: Male sp accident of crane falling on patient while at work.

COMPARISON: Cervical spine radiograph 11/6/07

FINDINGS: Two lateral views of the cervical spine in flexion and extension, two swimmer's lateral views of the cervical spine with incomplete visualization of the upper thoracic vertebral bodies reveal inferior and posteriorly displaced fractures of the spinous processes of C7 and T1. No evidence of cervical instability from C7 and above. No prevertebral soft tissue swelling.

IMPRESSION:

1. Incomplete visualization below C7, no evidence of cervical instability.

2. Inferiorly and posteriorly displaced spinous process fractures at C7 and T1.

VOICE DICTATED BY: Dr. Daniel Zapton
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: TIMOTHY ALDER

: flex/ex films of the cervical spine 006WD657A Morgan 15568
Male sp accident of crane falling on patient while at work.

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

11/30/07 : 12:10pm
DIAG FOOT,COMP/MIN 3 VIEWS
Accession number: 5102660

EXAMINATION: FOOT XRAY 11/30/07 12:10:00

ACCESSION NUMBER: 5102660

INDICATION: CHECK SCREW PLACEMENT RIGHT FOOT

COMPARISON: 11/04/07

FINDINGS: AP, lateral, and oblique views of the right foot demonstrate interval removal of the multiple K wires seen on the prior examination. The previously described fractures within the foot remain present without evidence of healing. There appears to be no operative correction of these fractures.

IMPRESSION:
Removal of prior K wires without evidence of operative fixation of multiple fractures within the right foot.

VOICE DICTATED BY: Dr. RICHARD COURSEY
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

PRE-OP
CHECK SCREW PLACEMENT RIGHT FOOT

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR 2581962 Sex: M Age: 27 DOB:

ISCHEMIC RIGHT FOOT

Recent Lab Results:
HEMATOCRIT: 37.20 on 12/01/2007
HEMOGLOBIN: 12.0 on 12/01/2007
PLATELET COUNT: 519
TRIGLYCERIDES: 202.0 on 11/16/2007
SODIUM: 137.0 on 12/01/2007
POTASSIUM: 3.30 on 12/01/2007
CO2: 24 on 12/01/2007
BUN: 3.0 on 12/01/2007
CREATININE: 0.7 on 12/01/2007
CALCIUM: 9.4 on 12/01/2007
12/12/07
HGBA1C: 5.5 on 11/02/2007
PT: 15.2 on 11/21/2007
INR: 1.16 on 11/21/2007

Past Medical History -

Social History -

Family History -

Routine Health Maintenance Status:

REPORT GIVEN TO: Time:
CODE STATUS: Resuscitate

Transfer time: TO ADMITTING OFFICE 1630
Transfer condition at time of admission: STABLE, AMBULATORY
Mode of transport: ambulatory
Accompanied by: Family / friend

RECEIVING NURSE SIGNATURE:_____
Date/Time: _____

RN GIVING REPORT (see Electronic Signature below)

SIGNED BY CHRISTINE M STRANGE, RN (W50) 12/12/2007 04:11PM

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Patient Chart

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

12/12/07 : 03:25pm
OUTPATIENT TO INPATIENT TRANSFER FORM
MEDICAL UNIVERSITY OF SOUTH CAROLINA

MUSC

AMBULATORY CARE SERVICES
OUTPATIENT TO INPATIENT
TRANSFER FORM REPORT

This is a report of patient condition at time of transfer and does not represent a complete patient assessment
(Not to be used for transfers outside MUSC)

TRANSFER

HECTOR GOMEZ
MRN: 2581962

DOB: 01/01/51
AGE: 56 year
SEX: male

Clinic: ORTHOPAEDICS - Phone number: 6-8988

PT TO ADMITTING OFFICE TO WAIT FOR AVAILABLE BED WITH FAMILY/FRIENDS PER DR KEITH MERRILL

ADMITTING DIAGNOSIS: RT FOOT INFECTION, S/P AMPUTATION 2ND THRU 5TH TOES
Service: ORTHO
Resident/fellow: ZILKOSKI
Admitting physician: MERRILL

Vital Signs:
Weight: 33.1 kg **Isolation**: no **Allergy band on: YES**

ALLERGIES:
PENICILLIN

ADDITIONAL VITAL SIGNS:

TIME	TEMP	PULSE	R	SYS	DIA	INITIALS
	98.8	117		138	83	

Labs drawn/Cultures sent: no
Procedure/Diagnostic tests completed at time of clinic 588 no

Printed using Practice Partner®

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

12/12/07 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
A7S
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
CHIEF COMPLAINT: Right foot amputation.

SUBJECTIVE: Mr. Gomez is a 26-year-old male who had a crush injury to his foot and developed an ischemic right foot requiring a transmetatarsal amputation of the second through fifth toes on the right foot. He underwent surgery on 11/30/2007 and returned to clinic today for his first postoperative appointment. He has had some pain and swelling to the foot. He has not done any dressing changes as of yet.

PHYSICAL EXAMINATION: The patient's dressings were taken down. He was noted to have essentially complete dehiscence of this wound with fairly significant fibrinous exudate as well as some necrotic tissue. The propylene stitches used on the deep tissues were exposed. There was a foul odor to the wound and his foot was somewhat swollen.

IMAGING STUDIES: No new x-rays were obtained.

IMPRESSION AND PLAN: This is a 26-year-old male who underwent amputation in the second through fifth toes. He has significant wound breakdown and concern for infection at this point. The patient is to be admitted to the hospital and plans to revise his amputation with irrigation and debridement and possible placement of a wound VAC. The patient agrees to this and has signed a consent form for surgery. We will post the case for an add-on for Friday with Dr. Merrill.

Monica Zilkoski, MD
MZ/am:600
DD: 12/12/2007 DT: 12/13/2007
131760

Keith Merrill, M.D., Attending

SIGNED BY MONICA A ZILKOSKI, MD (A7S) 01/18/2008 09:14PM

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

12/12/07 : 03:25pm
OUTPATIENT TO INPATIENT TRANSFER FORM
MEDICAL UNIVERSITY OF SOUTH CAROLINA

MUSC

AMBULATORY CARE SERVICES
OUTPATIENT TO INPATIENT
TRANSFER FORM REPORT

This is a report of patient condition at time of transfer and does not represent a complete patient assessment
(Not to be used for transfers outside MUSC)

TRANSFER

HECTOR GOMEZ
MRN: 2581962

DOB: 01/01/51
AGE: 56 year
SEX: male

Clinic: ORTHOPAEDICS - Phone number: 6-8988

PT TO ADMITTING OFFICE TO WAIT FOR AVAILABLE BED WITH FAMILY/FRIENDS PER DR KEITH MERRILL

ADMITTING DIAGNOSIS: RT FOOT INFECTION, S/P AMPUTATION 2ND THRU 5TH TOES
Service: ORTHO
Resident/fellow: ZILKOSKI
Admitting physician: MERRILL

Vital Signs:
Weight: 33.1 kg **Isolation**: no **Allergy band on: YES**

ALLERGIES:
PENICILLIN

ADDITIONAL VITAL SIGNS:

TIME	TEMP	PULSE	R	SYS	DIA	INITIALS
	98.8	117		138	83	

Labs drawn/Cultures sent: no
Procedure/Diagnostic tests completed at time of clinic visit: no
Cardiac monitor: no
Respiratory treatment: no

PAIN SCORE TODAY: 4 on 12/12/2007
Location of pain: RT FOOT
Pain intensity on a scale of 0 to 10 (visual analogue scale):
Quality:
What, if any, medication does patient take for pain?
Is pain satisfactorily controlled now? no

INTAKE: none	**OUTPUT**: none

Printed using Practice Partner®

Tubes, drains, catheters: none
Dressings: WOUNDS/DRAINS/TUBES/IV SITES:

RN assessment of wound: OPEN WOUND RT FOOT. TISSUE PINK WITH LITTLE DRAINAGE. INTERNAL SUTURES VISIBLE.

Damp to Dry

MEDICATION (given during clinic visit):

Was medication given for pain? no

CURRENT MEDICATIONS:at start of visit:
Rx: OXYCODONE 5 mg 1-2 every 4-6 hours PRN

Medication Reconciliation: *reconciled per patient report.*

Mental status: alert oriented
Fall Risk: no
Fall risk band on: no **ID band on**: yes
Primary language: Spanish **Sensory barriers:**
Valuables:

NARRATIVE NOTES/OTHER RELEVANT ISSUES: 11/01/2007 CONCTRUCTION ACCIDENT, HIT IN HEAD BY CRANE. SUBDURAL & EPIDURAL HEMATOMA, SKULL FRACTURE, BILAT FRONTAL CONTUSIONS, RESP FAILURE, MULT RIB FX'S.. ORTHO TO OR 11/30 FOR ISCHEMIC RT FOOT, AMPUTATION 2-5TH TOES.
PATIENT HISTORY:
Active Problems:
ISCHEMIC RIGHT FOOT

Recent Lab Results:
HEMATOCRIT: 37.20 on 12/01/2007
HEMOGLOBIN: 12.0 on 12/01/2007
PLATELET COUNT: 519
TRIGLYCERIDES: 202.0 on 11/16/2007
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CREATININE: 0.7 on 12/01/2007
CALCIUM: 9.4 on 12/01/2007
12/12/07
HGBA1C: 5.5 on 11/02/2007
PT: 15.2 on 11/21/2007
INR: 1.16 on 11/21/2007

Past Medical History -

Social History -

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

Family History -

Routine Health Maintenance Status:

REPORT GIVEN TO: Time:
CODE STATUS: Resuscitate

Transfer time: TO ADMITTING OFFICE 1630
Transfer condition at time of admission: STABLE, AMBULATORY
Mode of transport: ambulatory
Accompanied by: Family / friend

RECEIVING NURSE SIGNATURE:_____
Date/Time: _____

RN GIVING REPORT (see Electronic Signature below)

SIGNED BY CHRISTINE M STRANGE, RN (W50) 12/12/2007 04:11PM

Progress Notes

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 04/24/08
ID: 2581962 SEX:M AGE:27

12/17/07:GOMEZ-FRAGOSO,HECTOR:2581962
TRAUMA/CRITICAL CARE SURGERY F/U VISIT
MEDICAL UNIVERSITY OF SOUTH CAROLINA
H52

Hector Gomez-Fragoso returns for follow-up for injuries sustained in an accident in which a crane apparently fell on him. His injuries included an injury to his foot, as well as a closed-head injury with a skull fracture and epidural hematoma. He underwent a trach and a PEG-tube while in the Intensive Care Unit, but made an actually remarkable neurologic recovery. He was ultimately discharged to home.

At this point, he complains of some ongoing headaches and some dizziness to changing positions, but no nausea or vomiting. He is eating well. His bowel and bladder function is normal. He is having no chest pain or shortness of breath. He has had no hematuria, and he is eating well. He has pain only in the right foot, and this is minimal. He is taking very few Oxycodone.

PHYSICAL EXAMINATION: On physical examination, the patient is awake, alert, and oriented. Heart is regular in rate and rhythm. His lungs are clear. His cranial nerves appear to be intact. His extraocular motions are intact. His facial bony structure appears to be intact, and his dental occlusion is normal. His abdomen is benign. He has full range of motion in all extremities, with the exception of the right foot and ankle. His tympanic membranes are clear bilaterally.

Of note, the patient is following up with Orthopaedic Surgery, and has seen them, and continues to follow-up with them. However, no appointment was made with Neurosurgery at the time of discharge. Given the severity of his injuries, I think this should be appropriate, and a consultation was filled out with Dr. Takacs, who saw the patient in-house. Hopefully, they will see him in follow-up.

Orthopaedic Surgery did pull out the PEG-tube on Friday. That site looks good, and it is nearly completely healed. There is no further drainage. I will change that dressing. He will change the dressing daily, with a shower, and remove the dressing once it is not leaking any further. I gave the patient a prescription for Lortab and my card, and told him to call me with any questions or concerns. However, at this point, I have very little more to offer. He should continue to follow-up with Neurosurgery and Orthopaedic Surgery.

E. Douglas Norcross, MD
Associate Professor of Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite 420
PO Box 250613
Charleston, SC 29425
Telephone: (843) 792-4638
Facsimile: (843) 792-3315

EDN/mm

SIGNED BY E DOUGLAS NORCROSS, MD (H52) 01/30/2008 03:02PM

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

12/19/07 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
KS2
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
HISTORY OF PRESENT ILLNESS: Mr. Gomez returns to clinic today. He previously had a right transmetatarsal amputation of second through fifth toes on 11/03/2007 by Dr. Wolff. He had part dehiscence of his wound and underwent irrigation and debridement last Friday by Dr. Merrill and subsequently has had a wet-to-dry dressing change. The patient states he has not changed the dressing since the surgery. He thought he was instructed by that time not to change the dressing. He states he only a small amount of pain. No excessive amount of drainage was noted. The patient states he might have had some low-grade fevers at home. This was all through the Spanish interpreter.

PHYSICAL EXAMINATION: His wound shows no evidence of purulent drainage. There is no erythema surrounding the wound. There is very little granulation at this time. The rest of his wound is clean, dry, and intact. His sutures are still in.

ASSESSMENT AND PLAN: I showed the patient how to do a wet-to-dry dressing change using the interpreter's help. We discussed that this is important to continue to do once a day. He will finish his antibiotics, which he only has few more days' doses worth. I decided to leave the sutures in at this point just to prevent dehiscence of the rest of the wound, thus we will remove this at follow up appointment, which is going to be in two weeks. I gave him some dressing supplies to help out with his first couple of dressing changes. He understands he needs to get to the pharmacy to obtain 2 x 2's, normal saline, and Kerlix gauze using a Spanish interpreter's help. We feel that the patient understands how to do the dressing changes. He will continue to be weightbearing as tolerated using a hard sole shoe and we will see Mr. Gomez back in two weeks.

Shaun Traub, MD
ST/am:599
DD: 12/19/2007 DT: 12/23/2007
140579

Keith Merrill, MD, Attending

SIGNED BY SHAUN TRAUB, MD (KS2) 01/16/2008 02:04PM

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

12/12/07 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
A7S
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
CHIEF COMPLAINT: Right foot amputation.

SUBJECTIVE: Mr. Gomez is a 26-year-old male who had a crush injury to his foot and developed an ischemic right foot requiring a transmetatarsal amputation of the second through fifth toes on the right foot. He underwent surgery on 11/30/2007 and returned to clinic today for his first postoperative appointment. He has had some pain and swelling to the foot. He has not done any dressing changes as of yet.

PHYSICAL EXAMINATION: The patient's dressings were taken down. He was noted to have essentially complete dehiscence of this wound with fairly significant fibrinous exudate as well as some necrotic tissue. The propylene stitches used on the deep tissues were exposed. There was a foul odor to the wound and his foot was somewhat swollen.

IMAGING STUDIES: No new x-rays were obtained.

IMPRESSION AND PLAN: This is a 26-year-old male who underwent amputation in the second through fifth toes. He has significant wound breakdown and concern for infection at this point. The patient is to be admitted to the hospital and plans to revise his amputation with irrigation and debridement and possible placement of a wound VAC. The patient agrees to this and has signed a consent form for surgery. We will post the case for an add-on for Friday with Dr. Merrill.

Monica Zilkoski, MD
MZ/am:600
DD: 12/12/2007 DT: 12/13/2007
131760

Keith Merrill, M.D., Attending

SIGNED BY MONICA A ZILKOSKI, MD (A7S) 01/18/2008 09:14PM

Cardiac monitor: no
Respiratory treatment: no

PAIN SCORE TODAY: 4 on 12/12/2007
Location of pain: RT FOOT
Pain intensity on a scale of 0 to 10 (visual analogue scale):
Quality:
What, if any, medication does patient take for pain?
Is pain satisfactorily controlled now? no

INTAKE: none	**OUTPUT**: none

Tubes, drains, catheters: none
Dressings: WOUNDS/DRAINS/TUBES/IV SITES:

RN assessment of wound: OPEN WOUND RT FOOT. TISSUE PINK WITH LITTLE DRAINAGE. INTERNAL SUTURES VISIBLE.

Damp to Dry

MEDICATION (given during clinic visit):

Was medication given for pain? no

CURRENT MEDICATIONS:at start of visit:
Rx: OXYCODONE 5 mg 1-2 every 4-6 hours PRN

Medication Reconciliation: reconciled per patient report.

Mental status: alert oriented
Fall Risk: no
Fall risk band on: no
ID band on: yes
Primary language: Spanish
Sensory barriers:
Valuables:

NARRATIVE NOTES/OTHER RELEVANT ISSUES: 11/01/2007 CONCTRUCTION ACCIDENT, HIT IN HEAD BY CRANE. SUBDURAL & EPIDURAL HEMATOMA, SKULL FRACTURE, BILAT FRONTAL CONTUSIONS, RESP FAILURE, MULT RIB FX'S.. ORTHO TO OR 11/30 FOR ISCHEMIC RT FOOT, AMPUTATION 2-5TH TOES.
PATIENT HISTORY:
Active Problems:

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Patient Chart

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

12/17/07:GOMEZ-FRAGOSO,HECTOR:2581962
TRAUMA/CRITICAL CARE SURGERY F/U VISIT
MEDICAL UNIVERSITY OF SOUTH CAROLINA
H52

Hector Gomez-Fragoso returns for follow-up for injuries sustained in an accident in which a crane apparently fell on him. His injuries included an injury to his foot, as well as a closed-head injury with a skull fracture and epidural hematoma. He underwent a trach and a PEG-tube while in the Intensive Care Unit, but made an actually remarkable neurologic recovery. He was ultimately discharged to home.

At this point, he complains of some ongoing headaches and some dizziness to changing positions, but no nausea or vomiting. He is eating well. His bowel and bladder function is normal. He is having no chest pain or shortness of breath. He has had no hematuria, and he is eating well. He has pain only in the right foot, and this is minimal. He is taking very few Oxycodone.

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Of note, the patient is following up with Orthopaedic Surgery, and has seen them, and continues to follow-up with them. However, no appointment was made with Neurosurgery at the time of discharge. Given the severity of his injuries, I think this should be appropriate, and a consultation was filled out with Dr. Takacs, who saw the patient in-house. Hopefully, they will see him in follow-up.

Orthopaedic Surgery did pull out the PEG-tube on Friday. That site looks good, and it is nearly completely healed. There is no further drainage. I will change that dressing. He will change the dressing daily, with a shower, and remove the dressing once it is not leaking any further. I gave the patient a prescription for Lortab and my card, and told him to call me with any questions or concerns. However, at this point, I have very little more to offer. He should continue to follow-up with Neurosurgery and Orthopaedic Surgery.

E. Douglas Norcross, MD
Associate Professor of Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite 420
PO Box 250613
Charleston, SC 29425
Telephone: (843) 792-4638
Facsimile: (843) 792-3315

EDN/mm

Patient Chart

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

SIGNED BY E DOUGLAS NORCROSS, MD (H52) 01/30/2008 03:02PM

Patient Chart

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

12/19/07 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
KS2
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
HISTORY OF PRESENT ILLNESS: Mr. Gomez returns to clinic today. He previously had a right transmetatarsal amputation of second through fifth toes on 11/03/2007 by Dr. Wolff. He had part dehiscence of his wound and underwent irrigation and debridement last Friday by Dr. Merrill and subsequently has had a wet-to-dry dressing change. The patient states he has not changed the dressing since the surgery. He thought he was instructed by that time not to change the dressing. He states he only a small amount of pain. No excessive amount of drainage was noted. The patient states he might have had some low-grade fevers at home. This was all through the Spanish interpreter.

PHYSICAL EXAMINATION: His wound shows no evidence of purulent drainage. There is no erythema surrounding the wound. There is very little granulation at this time. The rest of his wound is clean, dry, and intact. His sutures are still in.

ASSESSMENT AND PLAN: I showed the patient how to do a wet-to-dry dressing change using the interpreter's help. We discussed that this is important to continue to do once a day. He will finish his antibiotics, which he only has few more days' doses worth. I decided to leave the sutures in at this point just to prevent dehiscence of the rest of the wound, thus we will remove this at follow up appointment, which is going to be in two weeks. I gave him some dressing supplies to help out with his first couple of dressing changes. He understands he needs to get to the pharmacy to obtain 2 x 2's, normal saline, and Kerlix gauze using a Spanish interpreter's help. We feel that the patient understands how to do the dressing changes. He will continue to be weightbearing as tolerated using a hard sole shoe and we will see Mr. Gomez back in two weeks.

Shaun Traub, MD
ST/am:599
DD: 12/19/2007 DT: 12/23/2007
140579

GOMEZ-FRAGOSO, HECTOR

Date Printed: 04/21/08
2581962 Sex: M Age: 27 DOB:

Keith Merrill, MD, Attending

SIGNED BY SHAUN TRAUB, MD (KS2) 01/16/2008 02:04PM

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

01/02/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
HISTORY OF PRESENT ILLNESS: Mr. Gomez is a 26-year-old gentleman who was seen for crush injury of his foot. He subsequently developed an ischemic right foot requiring a transmetatarsal amputation of second through fifth toes. When he returned for his first postoperative visit on the 12/12/2007, he was found to have had a wound dehiscence. He was admitted for irrigation and debridement, and delayed closure. He had his wound closed on 12/14/2007 and the middle part of it was left open and allowed to heal secondarily. The patient is currently doing wet-to-dry dressing changes once a day.

PHYSICAL EXAMINATION: On exam, his wounds are well healed. The suture line of his wounds is healing secondarily. It is filling in nicely with nice granulation tissue. His foot is perfused. I removed the stitches, replaced the wet-to-dry dressing, and he was told to continue that.

PLAN: We will see him back in two weeks for further wound check.

_____
Matthew Massey, MD
MM/am:617
DD: 01/30/2008 DT: 1/31/2008
184211

Langdon Hartsock, MD, Attending

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR

2581962 Sex: M Age: 27 DOB:

Progress Notes

01/16/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns to clinic today. He was previously seen on 01/02/2008, although the note from that day is not available. The patient had a transmetatarsal amputation of the second through fifth toes on 11/03/2007. He subsequently had a dehiscence and then underwent a repeat irrigation and debridement.

PHYSICAL EXAMINATION: Last time in the clinic, he had a central area of a small dehiscence, which has been treated with wet-to-dry dressing changes. The patient is doing well and this wound has healed completely. He is in his cast shoe. His big toe is neurovascularly intact with intact motor and sensory exams. He has good motion. There is no redness. There is no drainage.

PLAN: He is going to continue to do the wet-to-dry dressing changes for additional two weeks and come back and see us again at that time. If he has continued to do well as he is, we can probably discharge him from the clinic. The patient was seen in conjunction with the interpreter.

_____
Matthew Massey, MD
MM/am:625
DD: 01/16/2008 DT: 1/17/2008
170334

**, Attending

Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient:	GOMEZ-FRAGOSO, HECTOR	**MRN:**	002581962
Procedure:	5142260	Date Exam Completed:	2008/01/16
Accession#	5142260	Last Update:	2008/01/16

EXAMINATION: THORACIC SPINE 01/16/08 10:08:00

ACCESSION NUMBER: 5142260

INDICATION: C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

COMPARISON: CT cervical spine and CT chest 11/01/07

FINDINGS: AP and lateral views of the thoracic spine were obtained. Vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. There is normal curvature. Disc spaces are well-maintained. Visualized portions of the chest are unremarkable.

IMPRESSION:

Normal thoracic spine.

VOICE DICTATED BY: Dr. W Taylor Rowlett
I have reviewed the images and agree with the findings in this report.

History: 27 YO MALE WITH C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

Technologist:	BRIGETTE PIRRUNG	Date Dictated:	
Radiologist 1:	WILLIAM CONWAY	Proxy Signer:	
Radiologist 2:	TAYLOR ROWLETT	Authenticating Radiologist:	WILLIAM CONWAY M.D.
Radiologist 3:			
Transcribed By:	Tech IntTalk	Date Authenticated:	1/16/08 3:22 PM

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Printed by: POLLY, DEBORAH
Date Printed: 10/14/2008

Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient:	GOMEZ-FRAGOSO, HECTOR	**MRN:**	002581962
Procedure:	5142203	Date Exam Completed:	2008/01/16
Accession#	5142203	Last Update:	2008/01/16

History: 27 YO MALE WITH C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

Technologist:	BRIGETTE PIRRUNG	Date Dictated:	
Radiologist 1:	WILLIAM CONWAY	Proxy Signer:	
Radiologist 2:	TAYLOR ROWLETT	Authenticating Radiologist:	WILLIAM CONWAY M.D.
Radiologist 3:			
Transcribed By:	Tech IntTalk	Date Authenticated:	1/16/08 3:22 PM

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Printed by: POLLY, DEBORAH
Date Printed: 10/14/2008

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Patient Chart

Date Printed: 04/21/08

GOMEZ-FRAGOSO, HECTOR 2581962 Sex: M Age: 27 DOB:

Progress Notes

02/06/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
HISTORY OF PRESENT ILLNESS: Mr. Fragoso returns to clinic. He was previously seen on the 01/16/2008. He had a transmetatarsal amputation of the second through fifth toes status post traumatic injury on 11/03/2007. He had a wound dehiscence and required repeat irrigation and debridement.

PHYSICAL EXAMINATION: On exam today, his wound is completely healed. There is no drainage. He is neurovascularly intact. There is redness.

PLAN: He is going to be discharged from the clinic and I did write him a referral to Floyd's to see if there is any kind of prosthesis or shoe insert that could benefit him.

Matthew Massey, MD
MM/am:625
DD: 02/06/2008 DT: 2/7/2008
192424

**, Attending

RECEIVED
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Mt. Pleasant, SC 29464

GOMEZ-FRAGOSO.HECTOR
002581962 M H
02/06/08 02:15PM RET
MCB ORTHO1
V# 235182177 A# 4443395 Z99
MCB ORTHOPEDICS MOR

City: _____

Diagnosis: (R) FOOT AMPUTATION

Prognosis: _____

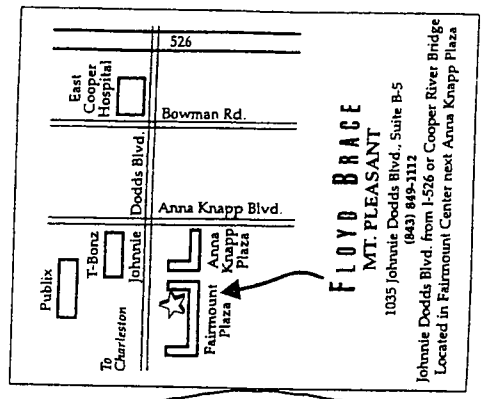
FIT FOR FOOT PROSTHESIS / SHOE INSERT

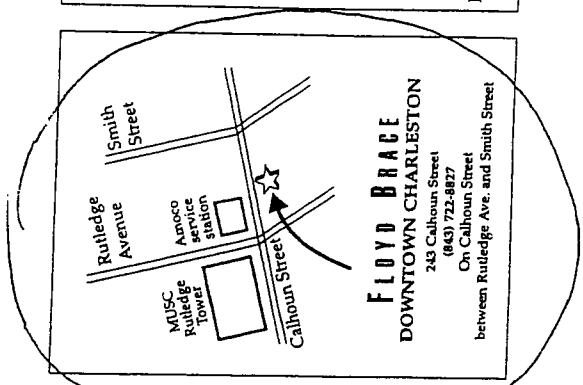
Signature: _____

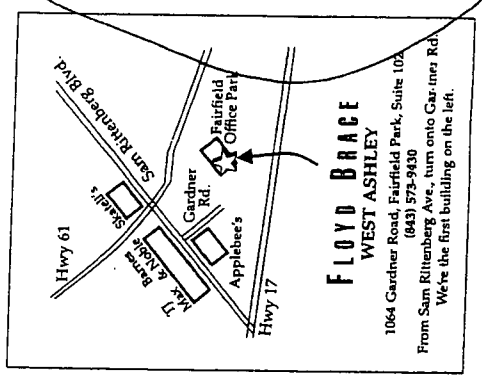
Print: MASS M.D.

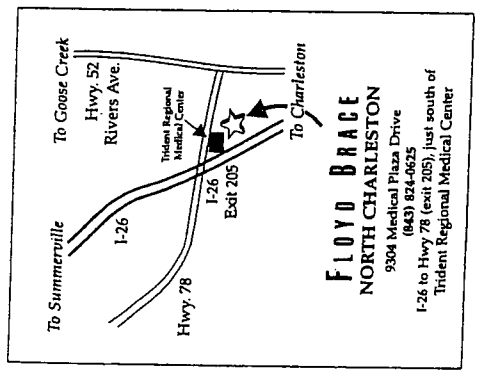
Address: _____

UPIN#: _____









MUSC Health
Medical University of South Carolina
Charleston, SC
843-792-2123

Practice Partner Note

Patient: GOMEZ-FRAGOSO, HECTOR **MRN: 002581962**
Attending: Date: 9/17/08 12:00 AM
Status: INITIAL

Date: 09/17/08 : 00:00am
Title: MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
Providers: 1A6
HISTORY OF PRESENT ILLNESS: Mr. Fragoso is a 27-year-old Hispanic male who was in clinic today. He was previously seen for the first time in clinic in April of 2008 after he underwent a transmetatarsal amputation of the second through fifth toes following a traumatic injury in November of 2007. He had a wound dehiscence, which required repeat irrigation and debridement. He was later seen in February 2008 for a follow up visit. At that time, his wounds were completely healed. There was no drainage. Now, he returns for approximately a nine-month followup from his surgery complaining of pain in his foot. Described it as a kind of shooting pain consistent with neuropathic or phantom pain. He also complains of swelling of the right foot.
PHYSICAL EXAMINATION: His wound is completely healed. There is no erythema. He has got 2+ DP pulses. Has sensation throughout his right lower extremity. He is mildly edematous, but not extremely edematous. He is slightly tender along the incision where it is healed, but there is induration or fluctuance.
PLAN: We stressed him the benefits of having some sort of prosthesis or inserts that he can utilize in his shoe to help him with gait and balance, and likely help with his gait and balance as mentioned before. In addition, Neurontin would likely help his phantom pain. The patient states that he has been on Neurontin before when he had associated head injury, he has taking 300 mg of Neurontin three times a day. It is suggested that increase of his dose might help him. However, that he would have to follow up with his primary care physician for this. Moreover, he said that Lyrica might be a better alternative in terms of phantom pain and shooting pains. So we told him to ask his primary care provider about that. In summary, we discussed with him how to getting on prosthesis or insert for shoes, as well as, Neurontin and Lyrica for phantom pain. We will discharge him form clinic today and he can follow up p.r.n. for any questions or concerns.

Kyle Kokko, MD
KK/am:625
DD: 09/17/2008 DT: 9/19/2008
651126
SIGNED BY KYLE KOKKO, MD, PhD (RESIDENT) (1A6) 10/15/2008 09:29AM

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Printed by: HAZEL, PENSOLA
Date Printed: 10/17/2008 Page1

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Georgetown, SC 29440
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GOMEZ-FRAGOSO,HECTOR
002581962 M H
09/17/08 02:30PM RET
MCB ORTHO1
V# 242741320 A# 5466099 Z99
MCB ORTHOPEDICS MOI

Diagnosis: Right transmetatarsal Amputation

Prognosis: Good

Prosthesis or Foot insert for Right Foot to improve balance & gait

Signature: [signature]

Print: Kyle P. Kokka M.D.

Address: _____

UPIN#: _____

12/01/08 : 00:00am
MUSC ORTHOPAEDICS INITIAL NOTE - MT PLEASANT
D99
CHIEF COMPLAINT: Left shoulder pain, neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old Hispanic gentleman whom I treated about a year ago following a work-related injury where a construction crane landed, striking him on the head, causing a small, subdural hematoma as well as cervical spinous process and transverse process fractures, also in the thoracolumbar area and a crush injury to the right foot which required amputation of dysvascular toes ultimately. He has done well from the standpoint of his foot and is actually planning to have an insert made for his shoe this week and is basically having no pain or issues with the wound. The shoulder continues to be painful for him as does his neck and lower back. He has not had formal treatment to date. He has radiation of pain down the forearm to his hand as well as some numbness compared to the contralateral side and all of his digits. He has had weakness about the shoulder and pain at nighttime. He has not had injections, therapy or any specific medications to treat his pain symptoms.

Past Medical History, Past Surgical History, Allergies, Medications, Social History, Family History and Review of Systems are all documented on the New Patient Encounter form and reviewed by me today.

ALLERGIES: Penicillin, which apparently causes some respiratory issues.

PHYSICAL EXAMINATION: He is a young, healthy appearing, Hispanic male in no acute distress. He is cooperative during the exam. He does not speak English and is accompanied by an interpreter. His cervical spine is tender at around C6, 7 and has slight increase in motion with lateral bend and flexion, extension, secondary to discomfort. His shoulder is tender anterolaterally and at the AC joint on the right. He has mild coracoid tenderness and no atrophy. Neer, Hawkins, crossover are negative. Drop-arm, liftoff, belly press, apprehension, sulcus, crepitation and O'Brien's negative. He does have pain at the AC joint as well as deep with O'Brien's but it is equal with supination, pronation. Lumbar spine is tender at around L4-5. He has reasonable motion of his lumbar spine and his DTRs in the upper and lower extremities are equal bilaterally. He is subjectively slightly hypesthetic on the right compared to the left, but his strength and grip, abduction, flexion, extension of the wrist and hand are all equal with elbow, flexion, extension and strength is equal bilaterally. Negative straight leg raise in the lower extremities. Palpable radial and dorsalis pedis pulses bilaterally. Active total elevation of the shoulder is about 160. ER is 35 and IR is to the midlumbar spine with negative liftoff. Passive supine forward flexion is about 165. ER 90 is 55. IR 90 is 35 on the right.

IMAGING: Plain radiographs show a Type II acromion, minimal degenerative spurring of the AC joint but no significant abnormality and no glenohumeral arthrosis. Cervical spine films show persistent, unhealed spinous process fracture at C7.

IMPRESSION:
1. Left AC joint arthritis.
2. Left shoulder posttraumatic stiffness.
3. Rotator cuff strain.
4. C7 spinous process nonunion with paracervical pain.
5. Low back pain.

PLAN: He agreed to a diagnostic and therapeutic left shoulder AC joint and subacromial injection performed through an ____ approach

PROCEDURE: With the patient's consent, using sterile technique, the left shoulder was injected with 80 mg of Depo-Medrol plus 8 cc lidocaine/Marcaine mix without complication. This was well tolerated, and the patient will notify us if problems develop.

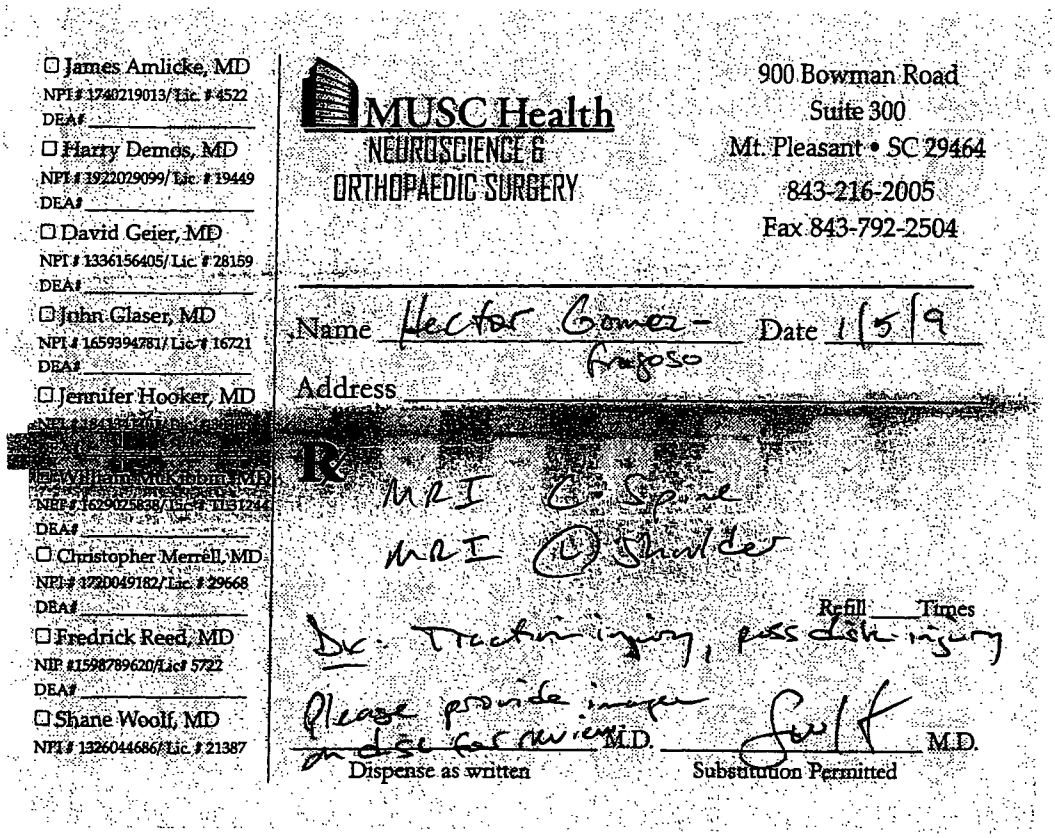
He is referred to physical therapy to work on motion and strengthening of his left shoulder as well as paraspinal strengthening of the neck and lumbar stabilization program. Follow up with me in 2-1/2 months to measure his progress. He has been unable to work since this incident, mostly because of shoulder and neck pain. If he continues to have symptoms, particularly the radicular type complaints, we may consider MRI of the cervical spine to specifically evaluate

C6, 7 and C7,8 for right sided nerve root injury or compression. His lumbar symptoms appear to be more mechanical in nature rather than radicular so no
further imaging at this point. He is comfortable with our plan.

Shane Woolf, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843 792-0404
Facsimile: 843 792-3843

SW/AM:1251
838384

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 12/03/2008 12:40PM



☐ James Amlicke, MD
NPI # 1740219013/ Lic. # 4522
DEA# _____

☐ Harry Demos, MD
NPI # 1922029099/ Lic. # 19449
DEA# _____

☐ David Geier, MD
NPI # 1336156405/ Lic. # 28159
DEA# _____

☐ John Glaser, MD
NPI # 1659394781/ Lic. # 16721
DEA# _____

☐ Jennifer Hooker, MD
NPI # 1184615401/ Lic. # 27[illegible]
DEA# _____

☐ William McKibbin, MD
NPI # 1629025838/ Lic. # 11512[illegible]
DEA# _____

☐ Christopher Merrell, MD
NPI # 1720049182/ Lic. # 29668
DEA# _____

☐ Fredrick Reed, MD
NPI #1598789620/ Lic# 5722
DEA# _____

☐ Shane Woolf, MD
NPI # 1326044686/ Lic. # 21387

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900 Bowman Road
Suite 300
Mt. Pleasant • SC 29464
843-216-2005
Fax 843-792-2504

Name Hector Gomez-Fregoso Date 1/5/19

Address _____

℞ MRI C-Spine
MRI L Shoulder

Dx: Tracking injury, pass Lab injury

Refill ___ Times

Please provide images on disc for review

_____ M.D. _____ M.D.
Dispense as written Substitution Permitted

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

01/02/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
HISTORY OF PRESENT ILLNESS: Mr. Gomez is a 26-year-old gentleman who was seen for crush injury of his foot. He subsequently developed an ischemic right foot requiring a transmetatarsal amputation of second through fifth toes. When he returned for his first postoperative visit on the 12/12/2007, he was found to have had a wound dehiscence. He was admitted for irrigation and debridement, and delayed closure. He had his wound closed on 12/14/2007 and the middle part of it was left open and allowed to heal secondarily. The patient is currently doing wet-to-dry dressing changes once a day.

PHYSICAL EXAMINATION: On exam, his wounds are well healed. The suture line of his wounds is healing secondarily. It is filling in nicely with nice granulation tissue. His foot is perfused. I removed the stitches, replaced the wet-to-dry dressing, and he was told to continue that.

PLAN: We will see him back in two weeks for further wound check.

_____
Matthew Massey, MD
MM/am:617
DD: 01/30/2008 DT: 1/31/2008
184211

Langdon Hartsock, MD, Attending

Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962

Procedure: 5141659 Date Exam Completed: 2008/01/17

Accession# 5141659 Last Update: 2008/01/17

EXAMINATION: CT of the Brain 01/16/08 09:59:00

ACCESSION NUMBER: 5141659

INDICATION: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS, FRONTAL CONTUSION, SKULL FRACTURES, ASSESS STABILITY

COMPARISON: Head CT 11/7/07

TECHNIQUE: Multiple contiguous axial CT images of the head were performed without IV contrast.

FINDINGS: There is no evidence of new hemorrhage or extra-axial fluid collection. There are no signs of acute infarct. There has been interval resolution of previously visualized left parietal and right temporoparietal soft tissue swelling. Again seen are skull fractures with extension into the sutures as described on prior CT. The fracture do appear to have some healing, but the fracture lines are still present. There's been interval on clearing of the paranasal sinuses with no significant mucosal thickening or fluid levels identified. The orbits are unremarkable.

IMPRESSION:

1. No evidence of acute intracranial process.

2. Healing skull fractures.

DICTATED BY: Dr. CHRISTOPHER MOSES
I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed by: POLLY, DEBORAH
Date Printed: 10/14/2008

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

01/16/08: GOMEZ-FRAGOSO, HECTOR: 2581962
NEUROSURGERY CLINIC
MEDICAL UNIVERSITY OF SOUTH CAROLINA
N64

HPI: 27-year-old Hispanic male who on 11/01/07 was struck by a construction crane and sustained multi-trauma and was treated on the trauma service. The patient had a skull fracture with a small thin-rimmed subdural hematoma in the right frontoparietal region. He also sustained multiple spinous and transverse process fractures in the thoracolumbar area. He also sustained a crush injury to his right foot necessitating amputation of several toes. He is now here for a clinical follow-up. He was discharged from the hospital on 12/01/07.

PHYSICAL EXAMINATION: Vital signs: temperature 97.8, blood pressure 111/76, respirations 20, pulse 74. Weight 73.9 kilograms.

Constitutional: Stocky body build. In no apparent distress.

Neurological: GCS 15. Patient is interviewed through an interpreter. Oriented x3. Cranial nerves II-XII are intact. Strength is 5/5 x4. Reflexes are brisk and symmetrical. Patient has a right-sided limp due to his foot injury. He complains of numbness in the fingertips bilaterally. Unclear if this has gotten any better over time.

RADIOGRAPHIC STUDIES: I reviewed the patient's head CT as well as his T and L-spine films from today. There are no surgical relevant lesions in the spine. His hematoma is still visible as a thin rim without mass effect in the right frontoparietal region.

ASSESSMENT AND PLAN: 27-year-old Hispanic male status post closed head injury. No neurological sequela. His fingertip numbness could possibly be from a whiplash injury for which I do not have a surgical solution. Patient is not in need of neurosurgical at this time.

Istvan Takacs, MD
Assistant Professor
Department of Neurosciences
Medical University of South Carolina
IT/AM:205
JOB:169463

SIGNED BY ISTVAN TAKACS, MD (N64) 01/31/2008 02:07PM

Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

01/16/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns to clinic today. He was previously seen on 01/02/2008, although the note from that day is not available. The patient had a transmetatarsal amputation of the second through fifth toes on 11/03/2007. He subsequently had a dehiscence and then underwent a repeat irrigation and debridement.

PHYSICAL EXAMINATION: Last time in the clinic, he had a central area of a small dehiscence, which has been treated with wet-to-dry dressing changes. The patient is doing well and this wound has healed completely. He is in his cast shoe. His big toe is neurovascularly intact with intact motor and sensory exams. He has good motion. There is no redness. There is no drainage.

PLAN: He is going to continue to do the wet-to-dry dressing changes for additional two weeks and come back and see us again at that time. If he has continued to do well as he is, we can probably discharge him from the clinic. The patient was seen in conjunction with the interpreter.

_____
Matthew Massey, MD
MM/am:625
DD: 01/16/2008 DT: 1/17/2008
170334

**, Attending

01/16/08 : 10:06am
DIAG LS SPINE 4
Accession number: 5142203

EXAMINATION: LUMBAR SPINE 01/16/08 10:06:00

ACCESSION NUMBER: 5142203

INDICATION: lumbar spine fractures

COMPARISON: CT pelvis 11/01/07

FINDINGS: AP and lateral standing flexion and extension films of the lumbar spine and coned down lateral views of the L5-S1 demonstrate five non-rib bearing lumbar vertebral bodies. Vertebral bodies are of normal height and alignment. Previously noted transverse process fractures involve L1 through L3 are poorly visualized on plain film. There is normal lumbar lordosis. Disc spaces are well-maintained. There is no sign of spondylolysis or spondylolysthesis with change in positioning. Sacroiliac joints are normal.

IMPRESSION:

1. No evidence of lumbar spine instability.
2. Poorly visualized transverse process fractures of the upper lumbar spine.

VOICE DICTATED BY: Dr. W Taylor Rowlett
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

27 YO MALE WITH C7-T1 AND L1-2-3 FX AFTER CONSTRUCTION TRAUMA ACCIDENT

01/05/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
D99
CHIEF COMPLAINT:
1. Left shoulder pain.
2. Neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns with his interpreter today, still having pain about the neck and shoulder. His low back has been symptomatic without radicular symptoms. His upper extremity pain seems to radiate down into the hand globally. He has not had atrophy or weakness about the hand. He feels physical therapy seems to help the neck, particularly with improvement in pain around his treatments, but his pain does return. He has had a modest improvement in his motion. His low back pain seems to be worse since starting therapy, but he is not associating radicular symptoms.

PHYSICAL EXAMINATION: He has mild tenderness at C6, 7 and his motion remains slightly decreased in lateral bend flexion and rotation because of his discomfort. His shoulder remains tender at the coracoid and AC joint mildly. His strength and motion remain about 150 of total elevation, ER of 35 and IR to the mid-lumbar spine with negative liftoff. His strength remains 5- in abduction and ER. His low back is still somewhat tender around L4, 5 with good motion and negative provocative test.

IMPRESSION:
1. Left AC joint arthritis.
2. Left shoulder posttraumatic stiffness.
3. Rotator cuff strain.
4. C7 spinous process nonunion with paracervical pain.
5. Low back pain.

PLAN: Given the nature of his injury and his upper extremity symptoms, I recommend MRI of the cervical spine which has not yet been performed as well as MRI of the shoulder. I would expect him to not have a rotator cuff tear but that is a possibility which may be a confounding factor. I would also like to assess his cervical disks, particularly at C6 – C8 nerve roots which may explain his upper extremity symptoms altogether. Concerning his low back problem, I still think physical therapy and nonsurgical treatment will be his course. If he continues to have pain, we will consider referral to Dr. Christopher Merrell for further management. He is comfortable with our plan. Follow up with me after the study is completed.

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SW/AM:997
919567

cc:
Workman's Compensation

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 01/07/2009 04:01PM

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Gomez Fragoso, Hector
DOB:
MRN: 590338
PHYSICIAN: Shane Woolf, MD
DATE: 1/9/2009

EXAM: MR OF THE LEFT SHOULDER WITHOUT CONTRAST

HISTORY: Pain after injury.

TECHNIQUE: Oblique coronal T1 and fat sat T2, oblique sagittal T1 and fat sat proton density, and axial gradient echo of the left shoulder.

CONTRAST: None.

FINDINGS:
ROTATOR CUFF: The rotator cuff muscles and tendons are normal.

GLENOHUMERAL JOINT: The long head of the biceps is intact and normal in signal. The labrum is unremarkable. There is no joint effusion or a loose body.

BONES: The bones are normal.

EXTRAARTICULAR STRUCTURES: The remaining visualized muscles, supraspinous and spinoglenoid notches, quadrilateral space, and axillary neurovascular bundle are normal. There is no bursitis.

IMPRESSION: Normal MRI of the left shoulder.

Robb Hoehlein, MD
RH / lb

DD: 1/12/2009
DT: 1/12/2009
Job: 7467459

This document has been electronically reviewed and signed.

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Gomez Fragoso, Hector
DOB:
MRN: 590338
PHYSICIAN: Shane Woolf, MD
DATE: 1/9/2009

EXAM: MR OF THE CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Pain after injury radiating to left shoulder.

TECHNIQUE: Sagittal T1 and T2, coronal T1 and axial T2 and gradient echo of the cervical spine.

CONTRAST: None.

FINDINGS: The alignment, marrow, paraspinous soft tissues, visualized portions of the brain, and cervical cord are normal. The facets are normal throughout.

C2-C3 through C3-C4: Normal.

C4-C5: There are early discogenic endplate changes with a left paracentral/intraforaminal either 3 mm disc protrusion or osteophyte resulting in moderate left neural foraminal stenosis (image 10, series 105 and image 9, series 102). The level is otherwise normal. The disc remains normally hydrated.

C5-C6: Mild disc desiccation. Otherwise normal.

C6-C7 through T2-T3: Normal.

IMPRESSION: There is a small left paracentral/intraforaminal probable disc protrusion versus osteophyte.

Robb Hoehlein, MD
RH / lb

DD: 1/12/2009
DT: 1/12/2009
Job: 7467551

This document has been electronically reviewed and signed.

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

GOMEZ-FRAGOSO(TOR
002581962 M H
01/27/09 01:15PM RET
WOOLF MD,SHANE KELBY
V# 247299209 A# 60047 W0P0
WA ADULT ORTHO BJC

WORKERS COMP

Physical Therapy Prescription

MUSC
ORTHOPAEDIC SURGERY

☑ **Evaluate and Treat**

Diagnosis/Procedure(s):

- Neck pain
- Rotator Cuff Strain

Therapeutic Exercises:

__ PROM __ AAROM __ AROM
__ Progressive Resistance/strength
__ Flexibility/stretching __ Edema control
__ Home Program Education

Modalities:

__ Ice/Heat __ U/S __ E-stim __ Massage

Shoulder protocol:

__ Scapular Stabilization __ Rotator Cuff
__ Sleeper/posterior capsule __ SLAP repair
__ Parascapular Isometrics __ Instability
__ Biceps tenodesis/tenotomy __ TSA/HHR

Motion Limits: ____ ER ____ abdxn/ff ____ IR
___ Short arc/below horizontal
__ To tolerance/no limits

Knee protocol:

__ Meniscal repair Brace settings:
__ Accelerated ACL rehab
__ Quad rehab _____

Specific Instructions/Restrictions:

- Continue with therapy - C-Spine Strengthening, Eccentric Rotator Strengthening

1-2
~~3~~ days/week for 4 weeks ☐ Visits x ___

I hereby certify these services are medically necessary for the patient's plan of care.

_____ 620 _____ 1/27/9
Physician's Signature Date

P667

Charleston Area Physical Therapy Centers

MUSC Outpatient Physical Therapy Locations
Downtown – Ashley Ave (792-6366)
Downtown – Main Hospital (792-3481)
James Island (266-1540)
West Ashley (573-1513)

James/John's Island
MUSC James Island (266-1540)
James Island PT (406-9889)
Island PT (559-7889)
Personal Care PT (559-7599)

Mt. Pleasant
Olympic Physical Therapy (216-3534)
Coastal Therapeutics (884-4783)
Family Physical Therapy (881-8887)
Premier Physical Therapy (388-6464)
Progressive Physical Therapy (849-6889)
PT Pros, Inc. (216-6047)
RCC (884-7880)

Sullivan's Island
Sports Plus (883-0054)

West Ashley
MUSC West Ashley (573-1513)
Lowcountry Physical Therapy (266-9200)
RCC (402-1495)
Sports Plus (766-8282)

North Charleston
Charleston Physical Therapy (768-5455)
HealthSouth (797-1103)
Island PT (744-5527)
PHC Rehab (766-3888)
Premier Physical Therapy (797-5167)
Progressive Physical Therapy (824-9251)
RCC (824-2183)
Sports Plus (553-6343)

Tricounty Area
Progressive Physical Therapy (851-5820)
RCC (695-0326)
Sports Plus (875-4770)
Moncks Corner Physical Therapy (899-5374)
SSI (761-4622)
Coastal Therapy Services (818-0908)
Nova Care (569-2303)

Progress Notes **Page: 1**

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

01/27/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-BONE AND JOINT CENTER
D99
CHIEF COMPLAINT:
1. Left shoulder pain.
2. Neck pain.
3. Right foot pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns, again with his interpreter, to follow-up on his cervical spine and shoulder MRI. He continues to have the same pain, which he localizes to the base of the neck on the left side and in the upper portion of the trapezius. He has radiating symptoms sometimes down the hand and arm. In addition, he has also had pain on the dorsum of the right foot just proximal to his transmetatarsal amputation site which otherwise has done well. He has been in a new modified shoe for the past couple of weeks but it seems that the pain has developed prior to that.

PHYSICAL EXAMINATION: On exam of the foot, he is tender directly over the base of the fourth metatarsal. There is no skin damage, no ulceration, no evidence of compromise to his wound, which is nicely healed, and the overall contour of his amputation stump looks excellent. He is somewhat tender along the distal scar. His shoe is in good shape, the insert appears well molded and formed, made of a closed cell foam. The uppers are soft and I do not appreciate any potential area for impingement. The shoulder he can move reasonably well but notes pain at the base of the neck. This is the case also with impingement testing as well as strength testing. He has pain with rotation in the lateral bend as well. He is otherwise neurovascularly intact to exam today.

IMAGING: Cervical spine MRI shows multilevel central disc bulge and a small paracentral disc protrusion or possibly osteophyte at C4-5. He has a slight disc bulge at C-7/T-1 and at C4-5. Shoulder MRI is reported as normal but to my read shows a small upper infraspinatus partial undersurface tear with articular side bony evulsion of a portion of the tendon. This is small and does not appear to involve much of the cuff. The labrum appears healthy and subacromial space is healthy.

IMPRESSION:
1. Painful right transmetatarsal amputation stump, with metatarsalgia.
2. Small partial thickness infraspinatus tear of the left shoulder.
3. Possible C4-5 nerve root impingement.

PLAN: Concerning the shoulder, I do not think that is a major source of his pain. I am more concerned about his neck, given his symptoms at the base of the neck and trapezius as well as his radiating symptoms in the upper extremity. I would like him to see Dr. Merrell for his opinion on the MRI as well as consideration for a trigger point or nerve root injection guided by his MRI finding. Concerning his foot, he may have some neurogenic pain along the digital nerves and I think his dorsal foot pain may be related to the shoe. He can float the area with a corn pad and may need some adjustments made to the position of the spacer. He is prescribed Neurontin to treat neurogenic pain in both the foot as well as the neck and will follow-up with me in a couple months after his assessment by Dr. Merrell. He is comfortable with that plan.

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Progress Notes

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:27

02/06/08 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
6D9
HISTORY OF PRESENT ILLNESS: Mr. Fragoso returns to clinic. He was previously seen on the 01/16/2008. He had a transmetatarsal amputation of the second through fifth toes status post traumatic injury on 11/03/2007. He had a wound dehiscence and required repeat irrigation and debridement.

PHYSICAL EXAMINATION: On exam today, his wound is completely healed. There is no drainage. He is neurovascularly intact. There is redness.

PLAN: He is going to be discharged from the clinic and I did write him a referral to Floyd's to see if there is any kind of prosthesis or shoe insert that could benefit him.

Matthew Massey, MD
MM/am:625
DD: 02/06/2008 DT: 2/7/2008
192424

**, Attending

Progress Notes **Page: 1**

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

02/04/09 : 00:00am
MUSC ORTHOPAEDICS INITIAL NOTE - MT PLEASANT
2FG
D99

REFERRING PHYSICIAN: Dr. Shane Woolf.

CHIEF COMPLAINT: Left-sided neck pain and shoulder pain.

Dear Dr. Woolf:

Thank you for allowing me the opportunity to serve in consultation regarding Mr. Gomez-Fragoso.

HISTORY OF PRESENT ILLNESS: As you know, he is a 28-year-old man with a history of left-sided neck pain and shoulder pain since November 2007. He works in construction and a cable broke and struck his head and left shoulder. Since then, he has had difficulties with pain. His pain is worse with shoulder abduction as well as with general range of motion of the neck. It is present at all times of the day and does interfere somewhat with sleep. He has been using Neurontin 300 mg nightly which is helping minimally. He has had cortisone injection as well as physical therapy and that is not helping too significantly as yet. He endorses left-sided five-finger numbness and tingling and this extends into the forearm as well. This is present all the time. No bowel or bladder incontinence. No other trauma is endorsed.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: He is in construction, single. He smokes one cigarette daily. He does not drink alcohol.

FAMILY HISTORY: Heart problems, diabetes.

MEDICATIONS: Include a pain medication as well as Neurontin 300 mg nightly.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling, especially in his thumb and middle finger. He does have a history of balance problems, blurry vision, breathing difficulties, bladder problems, and problems with hearing. Systems are otherwise negative.

PHYSICAL EXAMINATION: Blood pressure 113/75, heart rate 70, respiratory rate 12. In no apparent distress. Alert and oriented x3. Bright affect, normal mood. He speaks Spanish and has a translator with him today. He is relatively comfortable in the chair. Shoulder range of motion is fairly well preserved. Hawkins is negative. Biceps tendon is nontender. AC joint is nontender. His most tenderness is located at the superior trapezius with a small well-circumscribed trigger point identified in this region. His cervical paraspinals are also somewhat tender. Cervical range of motion is minimally reduced with leftward rotation. Spurling's is positive on the left, negative on the right. Reflexes are normal at the biceps, brachioradialis, and the triceps. Light touch sensory loss is present with pinprick and light touch predominantly at C6 distribution on the left. No hand intrinsic wasting is noted. Wrist extension is somewhat weak on the left compared to the right, but ADM testing is 5/5. Elbow and wrist range of motion otherwise within normal limits. Radial pulses 2+ bilaterally. No digital cyanosis.

RADIOGRAPHIC REVIEW: MRI of the cervical spine was reviewed and this was from an outside facility. According to my reading, he has disc protrusion just left to midline at C5-C6 as well as C7-T1. MRI of the left shoulder not reviewed today.

ASSESSMENT: Cervicalgia with symptoms consistent with possible left-sided C6 radiculitis.

PLAN:

Progress Notes

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

1. Discussed the possibility of a trapezius trigger point injection, and he would like to defer at this time.
2. I did prescribe Neurontin at an increased dose of 300 mg three times per day for improving neurogenic pain relief.
3. Naproxen also prescribed at 500 mg twice daily for anti-inflammatory and analgesic effect.
4. Physical therapy is the best way to go at this point for range of motion and modalities as tolerated. Particular attention should be addressed at the left superior trapezius with manual massage techniques as tolerated. Modalities if needed.
5. If he does not improve in the next four weeks or so, we may reconsider trapezius trigger point injection with a possibility of selective nerve root block at C6 on the left side.

Thank you for allowing me to participate and plan in the care of Mr. Gomez-Fragoso. I look forward to seeing him back in the next four weeks.

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CM/AM:578
1020783

cc: Dr. Shane K. Woolf, 650 Ellis Oaks Drive, Charleston, SC 29412

SIGNED BY REBECCA BUFFUM (RB9) 02/05/2009 12:45PM
SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 02/05/2009 12:46PM
REVIEWED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 02/09/2009 08:52AM

Progress Notes

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

SW/AM:243
981170

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 02/11/2009 10:35AM

Progress Notes **Page: 1**

Date Printed: 03/12/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

03/04/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left sided neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man who returns for follow up today regarding his left sided neck pain and shoulder pain. It has been present since November 2007. He is a construction worker and a cable broke and struck his head and left shoulder and since then he has had these symptoms. He was previously seen by Dr. Woolf and is here now with more myofascial type complaints including left paraspinal tenderness as well as superior trapezius tenderness. He has had subacromial injections with some benefit and he has undergone physical therapy and continues at Atlantic Physical Therapy which he further reports today suggested he is continuing to have pain difficulties most notably at the upper trapezius area. With self massage, he can reproduce these symptoms. He feels that his neck range of motion is fairly well preserved.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: Construction worker, single, smokes occasionally, no alcohol use.

FAMILY HISTORY: Heart disease and diabetes.

MEDICATIONS: Neurontin 300 mg three times per day as well as Naproxen 500 mg twice daily.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling in all five digits on the left side. He feels that his left hand is somewhat weak as well. Systems otherwise negative.

PHYSICAL EXAMINATION: No apparent distress. Alert and oriented x3. Bright affect, normal mood. Grip strength is 4/5 on the left side with fair effort. Superior trapezius is tender and a well circumscribed 1 cm diameter trigger point is identified at superior trapezius location. Cervical paraspinals on the left side is somewhat tender as well. However, cervical range of motion is well preserved. Spurling's positive on the left, negative on the right. Hawkins' test negative bilaterally. Yergason's negative bilaterally and Speed's test also negative. Upper extremity strength 5/5. Sensation to light touch is minimally reduced in glove distribution on the left side. Reflexes normal at the biceps, brachioradialis, and the triceps.

RADIOGRAPHIC IMAGING: MRI of the C-spine from an outside facility has been reviewed and revealed disc protrusion, left in midline at C5-C6 as well as C7-T1. There was an MRI of the left shoulder as well, however, I had not seen this.

ASSESSMENT:
1. Myofascial superior trapezius pain.
2. Cervicalgia with possible left sided C6 radiculitis versus C7 radiculitis.

PLAN:
1. As most of her symptoms are at the superior trapezius, discussed risks and benefits of a trigger point injection. He would like to proceed. Consent was obtained. Skin was cleansed with alcohol and anesthetized with ethyl chloride and utilizing 25-gauge 1.5-needle, 2 mL of 0.5% bupivacaine, 2 mL 1% lidocaine without epinephrine, 40 mg of Depo-Medrol was instilled in a sterile fashion and needling was pursed afterwards.
2 Continue with transition to home exercise program.
3. Continue Neurontin 300 mg three times per day and Naproxen 500 mg twice daily for anti-inflammatory and analgesic effect.
4. If the above is ineffective, I will have him follow up within the next one to two months and if no better, may consider SNRB of C6 versus C7 on the left side depending upon his symptoms.
5. May also consider nerve conduction studies depending upon his hand numbness. He does endorse it is worse

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Progress Notes

Date Printed: 03/12/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

nocturnally and this may be more of an ulnar neuropathy type picture.
6. He also complains of incidentally a right sided superior trapezius tenderness somewhat tender down to the left and may consider trigger point injection on the right side if the left side helps.

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CM/AM:576
1164741

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 03/05/2009 01:08PM

Progress Notes Pa

Date Printed: 0

Name GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M A

03/16/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
D89
CHIEF COMPLAINT:
1. Shoulder pain.
2. Neck pain.
3. Right foot pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns accompanied by his interpreter on follow up, rega his shoulder and cervical spine issues. He had seen Dr. Merrell, who performed a superior trapezius trigger point in and continued him on Neurontin plus Naprosyn. He also continues having pain on the dorsum of his foot. He never begin using corn pads to float the area.

PHYSICAL EXAMINATION: His shoulder remains tender with active motion but generally he can reach overhead, externally rotate equally bilaterally with less pain. He remains tender around the trapezius on the left side. The dors his foot is tender over the fourth ray, along the scar. He has negative Tinel's. Otherwise, this stump looks good and not appear infected.

IMPRESSION:
1. Painful right transmetatarsal amputation stump with metatarsalgia.
2. Small partial thickness infraspinatus tear, left shoulder.
3. C7 and T1 left sided disk protrusion with possible radiculitis.

PLAN: Concerning his foot, a prescription is provided for a pad which he can use at nighttime to manage dorsal foc caused by his shoe covers along the scar. He is again counseled to float the area with a corn pad as well and is pro prescription for such. I agree with Dr. Merrell's plan of considering a selective nerve root injection at the next visit sir did not respond to the trigger injection. Concerning his shoulder, his abduction and flexion have continued to improv the past three months in general, although his strength remains fairly weak. I would like to get his cervical issues fur clarified or resolved before considering any intervention for the rotator cuff issue, as I do not think that is a dominant source of his pain symptoms. Follow up with me in a month or two once he has had adequate follow up with Dr. Mer

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SW/AM:1197
1198475

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☐ James Amlicke, MD
NPI # 1740219013/ Lic. # 4522
DEA# _____
☐ Harry Demos, MD
NPI # 1922029099/ Lic. # 19449
DEA# _____
☐ David Geier, MD
NPI # 1336156405/ Lic. # 28159
DEA# _____
☐ John Glaser, MD
NPI # 1659394781/ Lic. # 16721
DEA# _____
☐ Jennifer Hooker, MD
NPI # 1841341401/ Lic. # 30308
DEA# _____
☐ William McKibbin, MD
NPI # 1629025838/ Lic. # TL31244
DEA# _____
☐ Christopher Merrell, MD
NPI # 1720049182/ Lic. # 29668
DEA# _____
☐ Fredrick Reed, MD
NPI #1598789620/Lic# 5722
DEA# _____
☐ Shane Woolf, MD
NPI # 1326044686/ Lic. # 21387

MUSC Health
NEUROSCIENCE & ORTHOPAEDIC SURGERY

900 Bowman Road
Suite 300
Mt. Pleasant • SC 29464
843-216-2005
Fax 843-792-2504

Name Hector Gomez Date 3/10/19
Address Fr. 650

℞ Please fabricate a pad to cover the (R) metatarsal apt in site to ↓ dorsal contact.

Refill ___ Times

_____ M.D. _____ M.D.
Dispense as written Substitution Permitted

Progress Notes **Page: 1**

Date Printed: 04/21/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

04/08/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left-sided neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man who returns for follow-up today regarding his neck and shoulder pain. He also endorses some numbness into the fingertips of all five digits on the left side. He feels that his left hand is weak and forearm is weak as well and it is worse with rotating his head. His pain is described as 8/10 in intensity and this is keeping her up at nighttime. He uses naproxen as well as Neurontin and feels that these both help somewhat. He is also seeing physical therapy for his symptoms and they are making some headway regarding his range of motion particularly at his shoulder. His strength is also somewhat improved with external rotation. He had a trigger point injection on the last visit, which reduced her symptoms but only for a day before her symptoms returned.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: Construction worker, single, smokes occasionally, no alcohol use.

FAMILY HISTORY: Family history of heart disease and diabetes.

MEDICATIONS: Neurontin 300 mg three times per day and naproxen 500 mg twice daily.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling again in to all five digits without particular finger preference. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Strength is 4/5 on the left again with questionable effort. ADM and FDI are also 4/5. Wrist extension is additionally 4/5. Upper limb involving the biceps and triceps is 5/5. No light touch sensory loss is apparent except at the fingertips, which is mostly at the index, thumb and middle finger. Tinel's is negative at the carpal tunnel. Hawkins test is negative bilaterally. Speed's test is negative. No muscular atrophy is noted. Spurling's is positive on the left. Cervical paraspinal is tender on the left from C4 to C7.

RADIOGRAPHIC REVIEW: MRI of the C-spine from outside facility revealed disc protrusion left of midline at C5-C6 and C7-T1.

ASSESSMENT:
1. Cervicalgia with left C6 versus C7 radiculitis symptoms.
2. Myofascial superior trapezius pain.

PLAN:
1. Discussed risks and benefits of epidural steroid injection. He would like to proceed. We will get him off his naproxen one week prior to scheduled epidural injection likely to be performed at the left paramidline at the C6-C7 versus C7-T1 junction.
2. Continue Neurontin 300 mg three times per day for neuropathic pain relief.
3. Hold off on naproxen as described above.
4. May consider nerve conduction studies if the epidural steroid injection does not give him any relief. This may give us more insight as to the actual level of the pathology and rule out any more peripheral nerve problems.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina

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Progress Notes

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

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Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:429
1260425

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 04/10/2009 09:50AM
REVISED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 04/16/2009 10:36AM

Progress Notes

Date Printed: 04/21/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

04/16/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
PROCEDURE NOTE

PROCEDURE DIAGNOSIS: Cervicalgia with C6 versus C6 radiculitis symptoms, and disc protrusion at C5-6 and C7-T1.

PROCEDURE: Risks and benefits were explained with the assistance of the interpreter and written consent was obtained. The patient escorted to fluoroscopy suite and placed in prone position. Skin was prepped with ChloraPrep and draped in sterile fashion. AP view identified the C6-7 interspace and the left paramidline approach was marked. Skin and subcutaneous tissues overlying the site was instilled with 1% lidocaine without epinephrine. Tip of a 20-gauge Tuohy needle was advanced under intermittent fluoroscopic guidance to this intended target site. Confirmation of proper needle placement was confirmed with lateral view, and after epidural space was identified on first pass with the loss of resistance technique, a small amount of nonionic contrast agent was injected and revealed the epidural space. Again after aspiration was negative, 15 mg dexamethasone along with 3 mL of normal saline without preservative was instilled. Needle was then restyletted and removed. Bandages were applied. He was re-examined at 30 minutes, found to have stable vital signs and no new neuromuscular findings, and was subsequently discharged to follow up with me in one to two months or sooner if needed.

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CM/AM:578
1281678

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 04/20/2009 09:47AM

Progress Notes

Date Printed: 06/23/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

05/17/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left-sided shoulder pain, neck pain and hand numbness.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old Hispanic male with a history of left-sided shoulder and neck pain present since a work-related injury. He says that his left hand continues to be weak and slightly clumsy. His right hand appears to be okay. Occasionally, he gets symptoms in his right shoulder, however, for the most part, his symptoms are on the left side. His forearm also feels to be weak on the left side. He has had physical therapy which did not seem to benefit him significantly. He has had an epidural steroid injection at the cervical spine, which also did not seem to give him any relief. The Neurontin seems to be helping some and this is giving him only minimal somnolence. His numbness involves all five fingers on the left side and can be present during the day, but particularly when he lies on his back at nighttime.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: He is a construction worker, single, smokes occasionally, no alcohol use.

FAMILY HISTORY: Family history of heart disease and diabetes.

MEDICATIONS: Neurontin 300 mg three times per day and naproxen 500 mg twice daily.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling in all five fingers on the left side. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Translator has been present. He has FDI and ADM weakness at 4/5 on the left side and wrist extension also 4/5. Full range of motion at the wrist is noted, however, and radial pulses are present and equal. No digital cyanosis or skin abnormalities are identified. Cervical range of motion is within normal limits and Spurling's is positive on the left. Reflexes are normal at the biceps, brachioradialis and the triceps. No thenar or hypothenar wasting is identified and no muscular atrophy is noted elsewhere. He does have some perceived numbness and sensory deficits particularly at the index finger. Tinel's is negative at the wrist. Phalen's is negative. Tinel's is negative at the elbows as well.

RADIOGRAPHIC REVIEW: MRI of the C-spine from outside facility revealed disc protrusion left of midline at C5-C6 and C7-T1.

ASSESSMENT:
1. Cervicalgia with possible radiculitis symptoms.
2. Hand numbness including differential of radiculitis of the cervical spine versus ulnar and median neuropathy.
3. Myofascial superior trapezius pain.

PLAN:
1. Increase Neurontin to 600 mg three times per day for neuropathic pain relief.
2. Continue naproxen for anti-inflammatory and analgesic effect.
3. Obtain nerve conduction studies and EMG to evaluate for ulnar neuropathy, median nerve neuropathy, or cervical radiculopathy.
4. Based upon the outcome of the EMG and nerve study, may consider possible cervical consultation depending upon the etiology.

Progress Notes

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

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CM/AM:579
1466749

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 06/19/2009 09:36AM

EMG on 6/30/09 @10AM
fu c Dr Merrell – 7/9/09 @2:15pm

CLIENT NOTIFIED?

____By Copy of this on:_____
and
X By Phone on: June 25th by Jaime
____Client's Appointment to Prepare
_____@_____

Printed using Practice Partner®

Hector Gomez-Fragoso 2581962 6/30/2009

MUSC

Neuroscience and Orthopaedics Associates

Patient: Hector Gomez-Fragoso
Patient ID: 2581962
Sex: Male
Date of Birth:
Age: 28 Years 8 Months
Referring Phys.: Dr. Chris Merrell
Examing Phys.: Dr. Chris Merrell

History / PE: 28 year old man with a history of work-related neck pain and left arm discomfort. It will refer to the hand and is associated with numbness and occasional dysesthesias. Cervical epidural injection previously performed without additional pain relief. He takes gabapentin for pain. Study is ordered to evaluate for cervical radiculopathy vs. median/ulnar neuropathy.

PMH: none

Exam: spurlings positive on left, reflexes wnl at bue, no muscular wasting identified, negative tinels at wrists and elbows. Light touch sensation reduced in nondermatomal distribution on left side at forearm and hand.

Summary:

1. Left median antidromic sensory study to the 3rd digit revealed normal latency and amplitude.
2. Left ulnar antidromic sensory study to the 5th digit revealed normal latency and amplitude.
3. Left radial sensory study revealed normal latency and amplitude.
4. Left median motor study to the APB revealed normal latency, amplitude, and CV.
5. Left ulnar motor study to the ADM revealed normal latency, amplitude, and CV. F-wave wnl.
6. Needle EMG at the LUE and left cervical paraspinals revealed no abnormal spontaneous activity. Normal recruitment and volitional activity was noted.

Conclusion:
Normal study. There is no electrophysiologic evidence of left cervical radiculopathy, left median neuropathy, or left ulnar neuropathy.

Christopher A. Merrell, M.D.

Hector Gomez-Fragoso 2581962 6/30/2009

Sensory NCS

Nerve / Sites	Rec. Site	Peak Lat ms	Pk-Pk Amp µV	Segments	Distance cm	Velocity m/s
L MEDIAN - Dig III Antidr						
Wrist	Dig III	2.85	103.0	Wrist - Dig III	14	68.3
Ref.		4.00	10.0	Ref.		
Palm	Dig III	1.65	51.9	Palm - Dig III	7	60.9
Ref.		2.40	10.0	Ref.		
L ULNAR - Dig V Antidr						
Wrist	Dig V	3.00	78.3	Wrist - Dig V	14	58.3
Ref.		4.00	6.0	Ref.		
L RADIAL - Wrist						
Forearm	Wrist	2.25	49.9	Forearm - Wrist	10	58.8
Ref.		2.80	7.0	Ref.		

Motor NCS

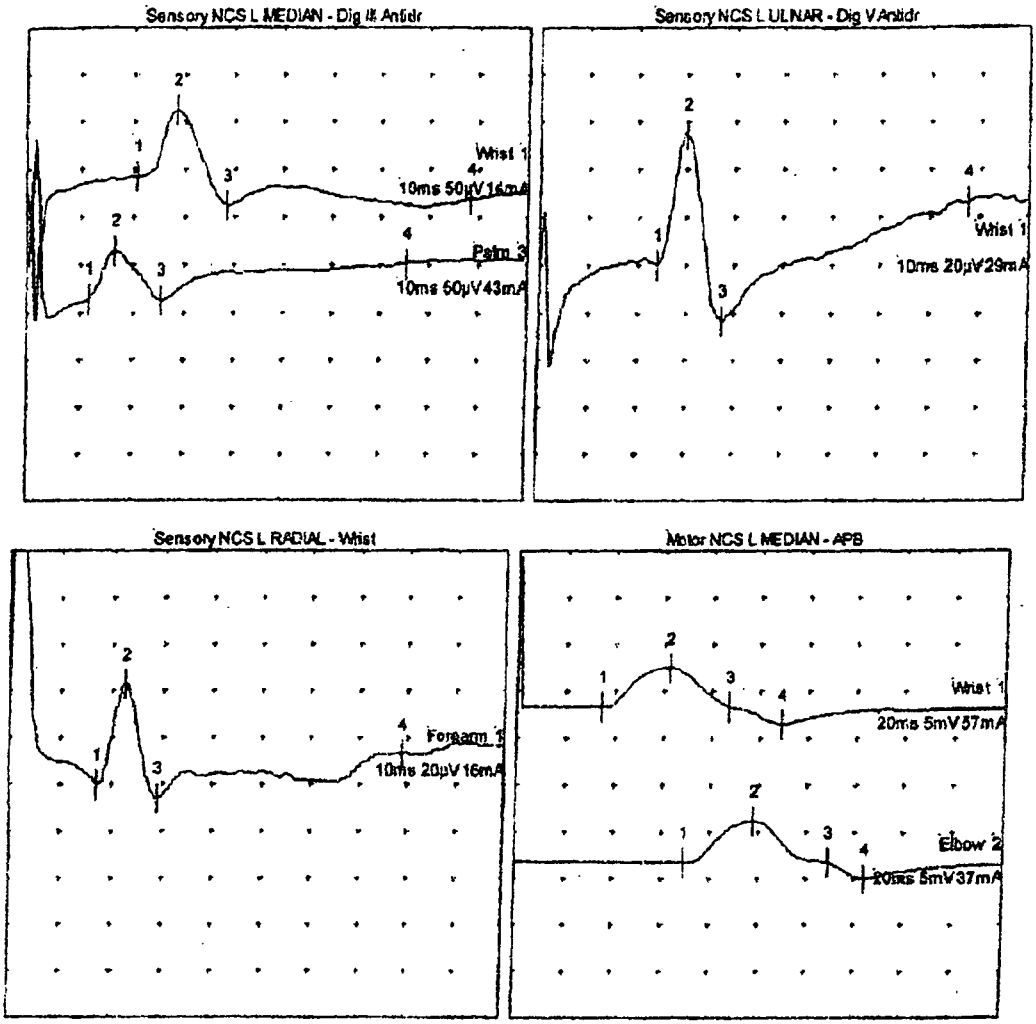
Nerve / Sites	Rec. Site	Lat ms	Amp mV	Rel Amp %	Segments	Dist cm	Velocity m/s
L MEDIAN - APB							
Wrist	APB	3.45	4.3	100	Wrist - APB	8	
Ref.		4.50	4.1		Ref.		
Elbow	APB	6.90	4.5	107	Elbow - Wrist	21	60.9
Ref.					Ref.		49.0
L ULNAR - ADM							
Wrist	ADM	2.85	10.6	100	Wrist - ADM	8	
Ref.		3.70	7.9		Ref.		
B.Elbow	ADM	5.95	8.6	80.8	B.Elbow - Wrist	20	64.5
Ref.					Ref.		52.0
A.Elbow	ADM	8.05	8.4	79.2	A.Elbow - B.Elbow	11	52.4
Ref.					Ref.		43.0

F Wave

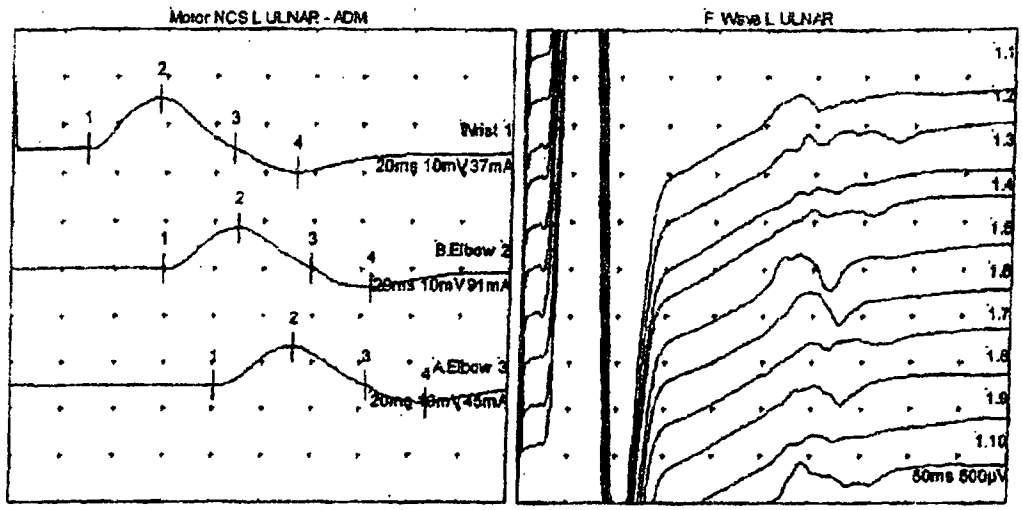
Nerve	Fmin ms
L ULNAR	24.15

EMG Summary Table									
	Spontaneous					MUAP			Recruitment
	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern
L. FIRST D INTEROSS	N	None	None	None	None	N	N	N	N
L. ABD POLL BREVIS	N	None	None	None	None	N	N	N	N
L. PRON TERES	N	None	None	None	None	N	N	N	N
L. FLEX CARPI ULN	N	None	None	None	None	N	N	N	N
L. TRICEPS	N	None	None	None	None	N	N	N	N
L. BICEPS	N	None	None	None	None	N	N	N	N
L. DELTOID	N	None	None	None	None	N	N	N	N
L. CERV PSPINAL	N	None	None	None	None	N	N	N	N

Hector Gomez-Fragoso 2581962 6/30/2009



Hector Gomez-Fragoso 2581962 6/30/2009



Progress Notes **Page: 1**

Date Printed: 07/09/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

06/29/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
D99
CHIEF COMPLAINT:
1. Left shoulder pain.
2. Neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is back with an interpreter on follow-up stating that his neck continues to be symptomatic. He mentioned shoulder pain, but actually localizes his pain to the supraspinatus fossa and adjacent to the SCM and trapezius junction. He has some pain with rotation of his neck and lateral bending. When he raises his arm overhead, he has no pain about the shoulder but has pain at the trapezius as well.

PHYSICAL EXAMINATION: Active total elevation of the shoulder is 168, ER is 42, and IR is about 45 degrees. Extension is 52 and adduction is 38. Forward flexion is 173. There is no instability. His strength is 5 in abduction and ER, IR, extension, and forward flexion about the shoulder. He is neurovascularly intact otherwise.

IMPRESSION:
1. Neck pain with radicular symptoms.
2. Small partial thickness infraspinatus tear, left shoulder.
2. Painful right transmetatarsal amputation stump with improved metatarsalgia.

PLAN: I do not think that his pain is accounted for by the shoulder. The reported rotator cuff tear was not even acknowledged by the radiologist. I do not think that this is a major source of pain, but rather is coming from the neck and base of the trapezius. He is followed by Dr. Christopher Merrell, who has done a trigger point injection in the trapezius as well as what appears to be a selective nerve root injection. He is planning on performing an EMG nerve conduction study of the left upper extremity, which I think is appropriate, to further assess his radicular symptoms. He did not have reproduction with Durkan's or Phalen's, but possibly mild increase with Tinel's which he reported radiated toward the shoulder and trapezius. We will not plan on formal follow-up with me until after he has been completely worked up by Dr. Merrell. Regarding the shoulder, he is permitted activity to his tolerance without any restrictions, as I think most of his issue is coming from the neck.

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SW/AM:243
1497390

cc: Workman's Compensation

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 07/01/2009 12:45PM

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GOMEZ-FRAGOSO,HECTOR
002581962 M H
06/30/09 10:00AM PRC
MERRELL EMG
V# 263207718 A# 6734743 W000
MT PLEASANT SPORTS MEDICINE MOP

Physical Therapy Prescription

MUSC

☒ Evaluate and Treat

Diagnosis/Procedure(s):

C4/C5 disc protrusion

Treatment Recommendations

- ☒ Evaluation and Treatment
- ☒ Therapeutic and Home Exercise Instruction
- ☐ Spine Rehabilitation
- ☐ Sports Rehabilitation
- ☐ Arthritis Program
- ☐ Aquatic Physical Therapy Program
- ☐ Fibromyalgia Program
- ☐ Lymphedema Management
- ☐ Neurological Rehabilitation
- ☐ Balance Rehabilitation
- ☐ Vestibular Rehabilitation
- ☐ Osteoporosis Management
- ☐ Pelvic Floor Rehabilitation
- ☐ Isokinetic Evaluation and Training
- ☐ Gait Training
- ☐ Pediatric Therapy Services (Main Hospital only)

Other Orders: _____

- ☐ Biofeedback / Neuromuscular Re-Education
- ☐ Ultrasound
- ☐ Phonophoresis with fluocinonide
- ☐ Iontophoresis with dexamethasone
- ☐ Electrical Stimulation / TENS / NMES
- ☐ Mechanical Traction
- ☐ Functional Capacity Evaluation
- ☐ Work Conditioning Program
- ☐ Work Site / Ergonomic Analysis
- ☐ ADL Re-training
- ☐ Pre-Operative Education
- ☐ Hand Rehabilitation
- ☐ Splint Type: Cervical traction, other modalities PRN

Charleston Area Physical Therapy Centers

MUSC Outpatient Physical Therapy Locations
Downtown – Ashley Ave (792-6366)
Downtown – Main Hospital (792-3481)
James Island (266-1540)
West Ashley (573-1513)

James John's Island
MUSC James Island (266-1540)
James Island PT (406-9849)
Island PT (559-7889)
Personal Care PT (559-7599)

Mt. Pleasant
Olympic Physical Therapy (216-3534)
Coastal Therapeutics (884-4783)
Family Physical Therapy (881-8887)
Premier Physical Therapy (388-6464)
Progressive Physical Therapy (849-6889)
PT Pros, Inc. (216-6047)
RCC (884-7980)

Sullivan's Island
Sports Plus (883-0054)

West Ashley
MUSC West Ashley (573-1513)
Lowcountry Physical Therapy (266-9200)
RCC (402-1495)
Sports Plus (766-8282)

North Charleston
Charleston Physical Therapy (768-5455)
HealthSouth (797-1103)
Island PT (744-5527)
PHC Rehab (766-3888)
Premier Physical Therapy (797-5167)
Progressive Physical Therapy (824-9251)
RCC (824-2183)
Sports Plus (553-6343)

Tricounty Area
Progressive Physical Therapy (851-5820)
RCC (695-0326)
Sports Plus (875-4770)
Moncks Corner Physical Therapy (899-5374)
551 (761-4622)
Coastal Therapy Services (818-0908)
Nova Care (569-2303)

2-3 days/week for 4-6 weeks = Visits x ___

I hereby certify these services are medically necessary for the patient's plan of care.

Christopher Merrell 6-30-09
Physician's Signature Date

Progress Notes

Date Printed: 09/01/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

08/26/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left-sided shoulder pain and arm pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man, who speaks Spanish, with interpreter who returns today for follow-up regarding his shoulder and neck pain. His pain is worsened with neck range of motion and extension and it is better at rest. He has seen Dr. Woolf as well for a small partial thickness infraspinatus tear of the left shoulder but most of the symptoms seem to be occurring at the neck. It is not giving any numbness or tingling, no focal weakness. The pain will refer into the trapezius as well as the scapular region on the left side. He feels that his left arm is somewhat weak, but no loss of hand dexterity or weakness. He does have some hand numbness which has for the most part been relieved with time. He uses gabapentin as well as Aleve and this has not been helping significantly.

PAST MEDICAL / SURGICAL HISTORY: Reviewed, unchanged.

SOCIAL HISTORY: Reviewed as per Practice Partner.

FAMILY HISTORY: Reviewed as per Practice Partner.

MEDICATIONS: Reviewed, unchanged.

REVIEW OF SYSTEMS: No hand numbness or tingling, no contralateral symptoms. Systems are otherwise negative.

PHYSICAL EXAMINATION: Mild distress, alert and oriented x3, bright affect, normal mood. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in the upper extremities, and no focal weakness or wasting are noted. Leftward and rightward rotation reproduces his symptoms. No scapular winging is identified. Hawkins test is positive. Speed's is negative. Bicipital tendon is nontender.

RADIOGRAPHIC REVIEW: MRI of the cervical spine from Long Bay Diagnostic Imaging from January 2009 revealed C4-C5 neuroforaminal narrowing on the left side, moderate in severity.

ASSESSMENT:
1. Left C5 radiculitis.
2. Neuroforaminal narrowing at C4-C5.

PLAN:
1. Discussed risks and benefits of left-sided C5 SNRB and he would like to proceed. Please see below note for details.
2. Continue gabapentin.
3. Continue Aleve for anti-inflammatory and analgesic effect.
4. Hold off from physical therapy for now.

PROCEDURE NOTE

PROCEDURE DIAGNOSIS: C4-C5 neuroforaminal narrowing and suspected C5 radiculitis.

PROCEDURE: Left-sided C5 selective nerve root block.

DESCRIPTION OF THE PROCEDURE: Risks and benefits were explained and consent was obtained. The patient was escorted to the fluoroscopic suite and placed in the right lateral position. The skin was prepped with ChloraPrep and draped in sterile fashion. Oblique view identified the neuroforamen between C4 and C5. The skin and the subcutaneous tissues overlying this site were instilled with 1% lidocaine without epinephrine. The tip of a 25-gauge spinal needle was advanced under intermittent fluoroscopic guidance to the C5 superior articular process. Periosteum was encountered and the needle was adjusted slightly and walked anteriorly about 2 mm from this point. Confirmation of proper needle

Progress Notes

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

placement was confirmed with the lateral and AP view. Aspiration was negative, and a small amount of nonionic contrast agent was injected and revealed the outline of the C5 spinal nerve with some proximal spread into the epidural space. Again after aspiration was negative, 2 mL of 0.25% bupivacaine and 10 mg of dexamethasone was instilled. The needle was restyletted and removed, bandages were applied. He was reexamined at 30 minutes, found to have stable vital signs and no new neuromuscular findings and was subsequently discharged with follow-up with me in two to three months or sooner if needed.

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CM/AM:578
1665325

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 08/27/2009 08:54AM

Progress Notes

Page: 1

Date Printed: 12/08/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/02/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Hector Gomez-Fragoso is a Spanish-speaking man who returns for follow-up today regarding his pain. It is again worse with neck rotation and better at rest. He was previously seen by Dr. Woolf and this was thought not to be shoulder related pain. For this reason, we had performed an EMG and nerve conduction study to evaluate for C5 radiculopathy which was negative. MRI previously performed at Long Bay Diagnostics was reviewed and report stated C4-C5 neuroforaminal narrowing in the left which is moderate in severity. For that reason, initially we did an epidural steroid injection which gave him about two weeks to three weeks of relief before symptoms recurred. Thereafter, we tried a C5 selective nerve root block with no significant benefit. He uses gabapentin and Aleve for symptoms and this is helping minimally.

PAST MEDICAL / SURGICAL HISTORY: Reviewed and unchanged.

SOCIAL HISTORY: Reviewed and unchanged.

FAMILY HISTORY: Reviewed and unchanged.

MEDICATIONS: As per Practice Partner.

REVIEW OF SYSTEMS: Occasional hand numbness into the fourth and fifth digits. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Hawkins is negative. Empty can test is negative. Shoulder range of motion is within normal limits. Cervical range of motion is reduced with end rotation bilaterally. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in all dermatomes at the upper limbs and no wasting is noted. AC joint is nontender. Paraspinal musculature is nontender. Facets are relatively nontender.

RADIOGRAPHIC REVIEW: MRI report of the cervical spine from Long Bay Diagnostics revealed C4-C5 neuroforaminal narrowing on the left, moderate in severity.

ASSESSMENT:
1. Presumed left C5 radiculitis.
2. Neuroforaminal narrowing at C4-C5.
3. History of mild rotator cuff pathology as well.
4. Symptoms consistent with ulnar neuropathy although EMG and nerve conduction study was negative. This is primarily a nocturnal phenomenon.

PLAN:
1. Continue gabapentin and Aleve for anti-inflammatory and analgesic effect and neuropathic pain relief.
2. Continue home exercise program.
3. Obtain a new MRI of the cervical spine as the last one was obtained almost a year ago. If symptoms are persistent, I would like to see these images for ongoing foraminal narrowing at C4-C5. This may be related to his symptoms.
4. I feel that the ulnar neuropathy symptoms that he experiences are predominantly positional in nature and has not given him any significant weakness or daytime symptoms.
5. Follow up with me after MRI and I would also at that point like to have Dr. Glaser review this patient as well as my treatments thus far have been particularly ineffective. If he does have foraminal narrowing, he may be a candidate for surgery.

Christopher Merrell, MD

Printed using Practice Partner®

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Gomez Fragoso, Hector
DOB:
MRN: 590338
PHYSICIAN: Christopher Merrell, MD
DATE: 12/8/2009

EXAM: CERVICAL MRI WITHOUT CONTRAST

HISTORY: Pain in the left side of the neck and shoulder.

COMPARISON STUDIES: None.

TECHNIQUE: Sagittal T2 FSE, sagittal T2 FSE with fat suppression, sagittal T1 FSE, coronal T1 FSE, axial T2 FSE, axial T2* gradient echo. No contrast.

FINDINGS:
OVERVIEW: No soft tissue mass or abnormal fluid collection is identified. Signal intensity in the musculature is normal and the muscles are symmetric. Lung apices are grossly clear. Central brachial plexus appears unremarkable.

CERVICAL SPINE: No acute fracture or subluxation. Vertebral body heights are preserved and the bone marrow signal intensity is normal. Asymmetric moderate to advanced hypertrophic facet arthropathy is seen on the left side at the levels of C3/4 and C4/5. Remaining facets appear unremarkable. Mild anterior osteophyte formation is seen at the level of C5.

DISC LEVELS: The intervertebral discs of the cervical spine and upper thoracic spine demonstrate normal signal intensity with the exception of C5/6 which is mildly desiccated. Heights of the intervertebral discs are normal. No focal or broad based disc protrusions identified.

On the left at the levels of C3/4 and C4/5 there is asymmetric uncovertebral joint hypertrophy. This combined with the degenerative facet changes results in neural foraminal stenosis at both levels which is mild to moderate. Remaining neural foramen and central canal are patent.

SPINAL CORD: The cord is normal in size, shape and signal intensity. No cord mass or edema.

IMPRESSION:
1. There is asymmetric degenerative facet arthropathy and uncovertebral joint of hypertrophic changes present on the left at C3/4 and C4/5 and degenerative facet changes present on the left. These changes result in a mild to moderate neural foraminal stenosis on the left at both levels.
2. Mild degenerative disc changes present C5/6.

Richard Clinton, MD
RC / ng

DD: 12/9/2009
DT: 12/9/2009
Job: 9394688

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

Patient: Gomez Fragoso, Hector
MRN: 590338
Exam: CERVICAL MRI WITHOUT CONTRAST

This document has been electronically reviewed and signed by Richard Clinton, MD.

Progress Notes

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/30/09 : 00:00am
MUSC ORTHOPAEDICS SPINE SURGERY CENTER NEW PATIENT-MT PLEASANT
D84
Patient: HECTOR GOMEZ-FRAGOSO Birth Date: 10/04/1980 MUH: 2581962 Physician: John A. Glaser, MD
Referral: ** Current Visit: 12/30/2009

New Patient Consultation

HISTORY OF PRESENT ILLNESS:
This is a pleasant 29-year-old gentleman that Dr. Merrell has asked us to see with a chief complaint of neck and left arm pain. He had an injury about two years ago. This was at work. He was hit in the head. He also had some injury to his right foot. He has been seeing Dr. Merrell for this. He has tried injections, medications, and physical therapy. He says he is a generally healthy gentleman. He says that he will have the pain in left greater than right paraspinal region, and he will have numbness diffusely down the arm into all five fingers. He feels the arm is somewhat weak. He denies any leg, bowel, bladder, or constitutional symptoms except where he had his right foot injury.

GENERAL ASSESSMENT - 12/30/2009
APPEARANCE: This is a pleasant, cooperative gentleman. He is alert and oriented. Affect is appropriate. He does not speak English. He is here with an interpreter.
MOBILITY: His gait is basically normal. He is unable to toe raise because of his right foot injury. He is able to heel raise and squat. He has no motor or reflex deficit in his upper extremities. He has decreased sensation to light touch throughout his entire left upper extremity, his neck, and his thorax anteriorly.

DIAGNOSTIC TEST INTERPRETATION:
I reviewed an MRI of his cervical spine which shows some mild degeneration with bulging at C4-5 and C5-6, but there is no neurologic compression.

TREATMENT PLAN 12/30/2009
I discussed this with him through his interpreter. I told him I really do not think I should be getting involved surgically. I think it is a very low likelihood that surgery is going to help. He asked about medication and I deferred this decision to Dr. Merrell. He is taking Cymbalta and Naprosyn already as well as some Neurontin. I will be happy to see him as needed.

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JG/AM:578
2051695

SIGNED BY JOHN GLASER, M.D. (ATTENDING) (D84) 12/31/2009 05:31PM

Progress Notes

Page: 1

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/30/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left neck pain and shoulder pain and arm numbness.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 29-year-old man who returns for follow-up today regarding his pain and numbness into his arm. Previously, his pain and numbness was in a C5 distribution, but we tried a C5 selective nerve root block with no significant benefit. Prior to this, we have done an interlaminar epidural steroid injection which gave him about two to three weeks of relief before his symptoms recurred. He has used gabapentin and Aleve with minimal significant relief. He is here for follow-up after repeat MRI which was obtained to evaluate for cervical nerve root pathology.

PAST MEDICAL / SURGICAL HISTORY: Reviewed and unchanged.

SOCIAL HISTORY: Reviewed and unchanged.

FAMILY HISTORY: Reviewed and unchanged.

MEDICATIONS: As per Practice Partner.

REVIEW OF SYSTEMS: Numbness will extend into all five digits today, which is a change from his previous description of his fourth and fifth digits. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Cervical range of motion is normal in all planes except for reduced end rotation. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in the upper extremities. No focal weakness or atrophy. Cervical paraspinal musculature is nontender. Facets are nontender. No cervical lymphadenopathy. No cutaneous changes of the upper limbs and no hand edema. Radial pulses are present and equal.

RADIOGRAPHIC REVIEW: MRI was reviewed by disc. This revealed mild neuroforaminal narrowing on the left side at C4-C5 and C3-C4. Mild degenerative changes at C5-C6.

ASSESSMENT:
1. Left-sided cervical radicular symptoms, but his symptoms changed and at this point it is difficult to identify the particular dermatome of involvement.
2. History of EMG and nerve conduction study which was negative for cervical radiculopathy and did not identify any evidence of ulnar or median neuropathy. This was performed on 06/30/2009.
3. History mild rotator cuff pathology, previously evaluated by Dr. Woolf.

PLAN:
1. Continue gabapentin and Aleve.
2. Continue home exercise program as instructed by physical therapy.
3. Hold off from further injections. I'm appreciative of Dr. Glaser's being able to see him today in consultation.
4. Follow up with me as needed or if symptoms change.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:578

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Progress Notes

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

2052227

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 12/31/2009 10:48AM

outh Carolina Workers' Compensation Com[illegible]on
333 Main Street, Suite 500 • Post Office B[illegible]/15
Columbia, South Carolina 29202-1715
303) 737-5723
ww.wcc.sc.gov

hysician's Statement

Claimant's Name Hector Gomez-Fragoso

Employer's Name: Kade Construction

Physician's Name: Dr. Shane Wolfe

Insurance Carrier: Key Risk Insurance Company

Practice/Clinic: MUSC Dept of Orthopaedic Surgery

SCWCC File No: 0717624

Preparer's Name: Dr. Shane Wolfe

Phone: ~~(843)792-0601~~ 843-792-1168

MRN: 2581962

he undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident ursuant to§§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: 12/1/08

Date of last visit: 6/29/9

agnosis or nature of injury or illness: Partial Thickness Left Rotator Cuff Tear

Body part(s) injured: Left shoulder Body part(s) affected: Left upper extremity

ate of **Maximum Medical Improvement:** _____

ased on the **AMA Guidelines,** the claimant has sustained a 1 **% medical impairment** to 1 injured body art(s) and a _____ **% medical impairment** to _____ other affected body part(s).

✓ The claimant is **able to return to work** without restriction. (Regarding the left shoulder. Please

___ The claimant is **able** to return to work **with the following restrictions:** refer to Dr. Merrell re: neck symptoms)

___ The claimant is **unable to return to work** at his or her current employment.

of the date I last saw this patient, it is **my professional medical opinion** the claimant:

✓ **will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of dical certainty (more likely than not). (for the left shoulder

____ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable legree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Salt

reating Physician

2/24/10

Date

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fragoso
Employer's Name: Kade Construction
Physician's Name: Dr. Kyle Shane Wolfe
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC Dept of Orthopaedic Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Shane Wolfe
Phone: (843)792-1168

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to§§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: _____ Date of last visit: 6/29/9

Diagnosis or nature of injury or illness: Transmetatarsal (R) amputation

Body part(s) injured: (R) foot Body part(s) affected: (R) LE

Date of **Maximum Medical Improvement:** 6/29/9

Based on the **AMA Guidelines,** the claimant has sustained a 40 **% medical impairment** to 1 (RLE) injured body part(s) and a 1 **% medical impairment** to Left Shoulder other affected body part(s).

16% wp + 1% wp = 17% combined value

_____The claimant is **able to return to work** without restriction.

__✓__The claimant is **able** to return to work **with the following restrictions:**

No climbing > 6 steps; use safety equipment.

17% = Combined rating for foot & Shoulder based on whole person %age for each + use of Combined Values Table.

_____The claimant is **unable to return to work** at his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

__✓__**will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

_____**will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician

4/8/10
Date

Apr 09 2010 2:23PM HP LASERJET P697 8435731577 p.2

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fragoso
Employer's Name: Kade Construction
Physician's Name: Dr. Christopher Merrell
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC Dept of Orthopaedic Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Christopher Merrell
Phone: (843)792-0601

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to§§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: 2-4-09 Date of last visit: _____

Diagnosis or nature of injury or illness: Cervical radiculitis, disc protrusion

Body part(s) injured: Cervical Spine Body part(s) affected: Cervical Spine

Date of **Maximum Medical Improvement:** 12-30-09

Based on the **AMA Guidelines**, the claimant has sustained a 11 **% medical impairment** to Whole Person injured body part(s) and a _____ **% medical impairment** to _____ other affected body part(s).

____The claimant is **able to return to work** without restriction.

X The claimant is **able** to return to work **with the following restrictions:**

Pain may limit overhead activities with the left arm.
He may perform overhead activities unless symptoms preclude

____The claimant is **unable to return to work** at his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

____**will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

X **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Occasional P.T., oral medications, possible injections.

CC Christopher Merrell M.D
Treating Physician

2-8-10
Date

Confidential **Page: 1**

Date Printed: 12/18/08

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

10/30/08 : 00:00am
MUSC NEUROLOGY-INDEPENDENT MEDICAL EVALUATION-RUTLEDGE TOWER
D69
MUSC Department of Neurology
96 Jonathan Lucas Street, Suite 309
PO Box 25060
Charleston, SC 29425

RE: GOMEZ-FRAGOSO, HECTOR
DOB:
DOS: 10/30/2008
CONFIDENTIAL

IDENTIFYING INFORMATION: Hector Gomez-Fragoso is a 28-year-old single Hispanic male that was involved in a work-related injury who presents for evaluation today. He was referred by Michael Burkett of the law firm Willson Carter Baxley who represent the employer's insurance company in this worker compensation claim. The claimant was accompanied to the evaluation by a translator Gladys Lapietra. The records that I had available for review include handwritten MUSC Trauma Admission notes, the discharge summary from MUSC during the hospitalization from 11/01/2007 through 12/01/2007 and all the associated records. These include notes from Orthopedics, Neurosurgery, Trauma Medicine with doctors, Dr. Hartsock, Dr. Langdon, Dr. Istvan Takacs, Dr. Keith Merrill, Dr. Norcross, and Dr. Minshall. There are serial CT studies. I had a couple of physical therapy notes and a speech evaluation progress note. Outpatient follow-up notes from the same services. I also had notes from George Santos, M.D. from Strand Regional Specialty Associates. The claimant was interviewed with the assistance of the interpreter. The claimant was examined with the assistance of the interpreter. Procedure code 990801. I felt that we had a very good communication between the claimant and myself with the assistance of the interpreter. At the conclusion of the evaluation, the interpreter confirmed my impression. Additionally, the claimant stating that he felt information was understood appropriately by me. He signed an informed consent. The caveat to this entire evaluation is the use of an interpreter and the use of tests that were not in Spanish. Both items can reduce the validity of the findings. In an ideal world, a Mexican born or educated neuropsychologist using urban test norms from Central Mexico City would be ideal. It is possible with the translator and non-standardized procedures that I employed, made the tasks more difficult and artificially lowered the claimants scores, suggesting more impairment than actually exists. Of course, the reverse is also possible. In an effort to reduce the confounding effects of the language barrier, I chose primarily nonverbal tests whenever possible and note the above caveat.

HISTORY: The claimant provided the following history. He stated that he was involved in a work-related accident that occurred on 11/01/2007. We were able to determine that this was a Thursday after the lunch hour. He was working for Kane Construction where he had been employed as a laborer/carpenter helper for approximately one year. He was making about $11 an hour. He was amnestic for the accident. He said the last thing that he remembered was that he was on top of a garage working on installing the gables for the roof of the one story garage. The next thing he remembers was waking up at MUSC as an inpatient. He said that he was told that a cable broke and he sustained a crush injury to his head and leg. He said that he was also knocked down one story falling to the ground. He stated that he was transported to MUSC via helicopter. He thought that he was in hospital for approximately one month and possibly woke up about midway into the course and estimated about 15 days after the accident. He said that he had injuries to his head and right foot. On his right foot, four toes were amputated. He said that he also injured his neck and left shoulder. He said that his seventh vertebra is "pointing out." He had a trach.

In terms of today's symptoms Mr. Gomez complains that it is hard for him to remember where he puts things. He complained of pain in his neck and left shoulder. He said that he has hearing loss especially on the left. He complains of occasional blurry vision. He described what sounded like phantom pain in his amputated toes. He also described pain in his left arm with occasional paresthesias in his hand. He complained of headaches. He described being anxious with mood swings. He complained of difficulty swallowing. He complained of a change in his gait because of the amputation. He rated his pain on average as an "8" on a VAS. He said that nothing triggers the pain and it seems to come out from nowhere. He gets relief by laying down. He said on some days he might not have pain and other days he might be in extreme pain. There has been no improvement in the pain symptoms over time.

In terms of treatment he has been on Neurontin and methocarbamol that he receives from Dr. Santos. He said the medicines help with the pain for a while, but then the pain returns. He said that he has been offered cortisone shots for his shoulder, but
has declined.

In terms of the mental confusion, he feels that his condition is getting worse over the time. He complains of forgetfulness. When I asked about the functional impact of his forgetfulness, he said that he has trouble remembering conversations and occasionally has difficulty pronounding words. I pushed him for other examples, but he had difficulty coming up with any specific complaints. Instead he talked about headache pain, other pains, and feelings of anxiety and depression that are getting worse over the time.

In terms of daily activities Mr. Gomez said that he mostly stays around the house and watches television. He does light housekeeping, socializes with friends and does some cooking. He is living on $266 a week and shares expenses with his house mates who are his cousins. He has not been back to work and has not made any attempts. He said that he feels that he is not capable of returning to work. When I asked about the barriers, he said that he speculated that he might forget measurements if he were asked and that he might do something wrong. He said his feet and back get tired when he is standing for a long time and this might interefere with his ability to do manual labor. He also said that he feels pain if he stands for too long, especially in his foot. When I asked, he alos admitted to having difficulty with balance and dizziness and thought this too might interfere with his ability to work. He did not know if he had any work-related restrictions from his doctor.

The daimant said that all of his followup has been with MUSC doctors and then with Dr. Santos. Now he only sees Dr. Santos perhaps on a monthly basis and is being prescribed the two medicines noted above.

In my review of the medical records, I have handwritten notes from initial Trauma Center evaluation. The above injury is described. Intubation was attempted by EMS, which was unsuccessful and then the aircrew was able to intubate the patient enroute on the helicopter. In the acute ER notes, there is a question of somebody smelling alcohol on his breath. I did not see any blood alcohol levels drawn. There is a reference to loss of consciousness at the scene and no Glasgow scores at admission.

I was unable to get the entire inpatient MUSC chart. The MUSC discharge record indicates an admission from the Trauma Service on 11/01/2007. the patient was hospitalized for one month from 11/01/2007 through 12/01/2007. Loss of consciousness and significant blood loss was noted at the scene. Marion County EMS was unsuccessful at intubation, but he was successfully intubated by Carolina LifeCare Helicopter Transport team. He is admitting diagnosis was skull fracture, open complex scalp wound with epidural and subdural hematoma, and bilateral frontal contusions. Acutely he had a CT scan of the abdomen that showed adrenal hemorrhage, bilateral L1 and L2 as well as right L3 transverse process fractures and multiple posterior rib fractures. A CT of the pelvis on 11/01/2007 showed a high density structure of uncertain significance. The CT of the head on 11/01/2007 showed comminuted fracture with small extra occipitoparietal hematoma at the midline at the vertex, worrisome for small epidural hematoma. CT of the chest showed bilateral lung contusions and/or aspiration. He had a fracture of his right clavicle and C7 and T1 spinal process fractures.

Neurosurgery and Orthopedics followed the patient during his protracted hospital stay. His final discharge diagnosis was subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypertension, scalp laceration status post repair, C7 and T1 spinous process fractures, right rib fractures at 7, 8, 9, and 10, bilateral transverse process fractures at L1 and L2 and right L3, right big toe fracture, right fifth toe fracture, fracture of the skull midline to sagittal through the frontal and parietal, placement of PEG tube, tracheostomy, and status post amputation of two through five toes.

Steve Takacs, M.D. saw him on 11/01/2007 and described him as combative at the scene with vomiting. He was traced at the time and Glasgow Coma Scale was 8/10. He had a number of procedures as noted above during his hospitalization. A CT on 11/07/2007 was indicated because of altered mental status and compared with prior studies. A collection of fluid adjacent to the vertex and extensive left-sided frontotemporal soft tissue swelling was noted. A fracture of the left frontal bone extending to the sagittal suture was noted as unchanged. Ultimately, he was discharged home on 12/01/2007.

Orthopedics had a follow-up on 12/12/2007 and there was significant wound breakdown and concern of infection, so he

was readmitted for irrigation and debridement. He had an outpatient follow-up on 12/17/2007 with Trauma/Critical Care and was described as having had made "remarkable neurologic recovery." In the exam he was described as awake, alert, and oriented. Because of the severity of his injuries he was told to follow-up with Neurosurgery. The PEG tube had been pulled. He was given Lortab by Dr. Norcross. Orthopedics saw him two days later for the initial follow-up and there was some confusion about changing the dressing. With the interpreter's help he was taught to change his dressing daily.

Mr. Gomez saw Dr. Takacs on 01/16/2008 and he was described as having a skull fracture with a small thin rimmed subdural hematoma in the right frontal parietal region. At this visit, his Glasgow Coma Scale was 15/15 and he was oriented times 3. The latest CT showed a thin rim without mass effect in the right frontal parietal region. Dr. Takacs felt that he had no basic neurologic sequelae and he was released.

The final follow-up visit at MUSC was with Orthopedics was on 09/17/2008 and Mr. Gomez was complaining of phantom limb pain, as well as difficulty with gait and balance because of the amputation. Prostheses or inserts were discussed and Neurontin was suggested for the pain.

There is a speech eval from 11/21/2007 as an inpatient. Pertinent information included possible mental confusion as he was only able to follow one step commands and could not adequately hold the pencil in the right or left hand in order to copy name or identify pictures scoring 1/3.

On 08/29/2008 the claimant had a follow-up with Dr. Santos. Complaints at that time had to do with severe and persistent headache, dizziness, neck pain, shortness of breath, difficulty swallowing, difficulty with attention and concentration, difficulty with complex tasks, irritability, and the amnesia that was described above. MMSE was 28/30. His neurologic exam was negative except he lurched forward with his gait. Tests were ordered. His MRI from 10/17/2008 was read as normal suggesting structural resolution of the the above acute CT findings. Nerve conduction and EMG studies were negative. Evoked potential was negative. His EEG was within normal limits. Cervical studies were significant for a disk protrusion at C4-5 and 5. A neuropsychological evaluation was ordered.

PAST MEDICAL HISTORY: Per the claimant largely unremarkable. He said that he had kidney stones in 2003. Before the accident he denied any history of a prior head trauma, pains, depression, and anxiety. He denied any significant alcohol or other substance abuse.

MEDICATIONS: Neurontin, methocarbamol.

FAMILY HISTORY: The father and mother were described as alive and well. He had two brothers that were described as alive and well.

SOCIAL HISTORY: The claimant stated he was born and raised in Mexico City. He said that he repeated the second grade. He finished the ninth grade and was unable to tell me if this was the US equivalent of high school. He joked that he did poorly in English, but excelled with typing. He reported that he had been in the US for five years and came to the Myrtle Beach Area because he had cousins that preceded him. In Mexico, he had worked as a clerk in a pharmacy and as a guard for private security. In the US, he worked in a construction industry as a carpenter assistant. His original plan was to come to the US "for a while" and then return to Mexico. His current plans are up in the air with the health and legal situation outstanding. His immediate family lives in Mexico and his extended family in Myrtle Beach and includes a cousin and uncle. Prior to the injury he played soccer. He has had to quit because of gait disturbance and I presume pain.

PHYSICAL EXAMINATION: Weight 191. Blood pressure 140/77. Pulse 77. The patient was ambulatory, spry, and had largely a flat affect. He was cooperative with evaluation and forthcoming with information. He showed me a scar on his forehead that was visible through his hairline. He passed the effort test on the second trial. His MMSE was 28/30, which is in the normal range and consistent with a prior study by Dr Takacs on 11/01/2007. On all of the nonverbal items from the WAIS-III his scores were impoverished and possibly consistent with his educational/vocational background. His estimated an overall index score was 68. On a arithmetic subtest from the WRAT, he had a similar score and did not know how to approach some of the more complicated arithmetic problems reflecting his academic achievement. He had psychomotor slowing on Trails A and C, but scored in weak-normal range for the more cognitively difficult Trails B test. On a visual memory test, he actually scored in the normal range. For simple vigilance he passed the test with a perfect score, but failed the more difficult task of distractibility. He endorsed moderate-to-severe pain in areas described in the history that included his head, neck, shoulder, and left foot. He reported that the pain is generally extreme, causing

functional limitations, and reported that the pain adversely affects his mood. He was unable to understand the Likert Scale and was given a true-false mood inventory to assess his mood. He scored in the extreme range with 27/30 positive and his is consistent with severe depression. He denied any suicidal ideation or attempt.

IMPRESSION:
1. Postconcussive syndrome, mild.
2. Chronic pain disorder.
3. Situational depression.

DISCUSSION: Mr. Gomez had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the the brain. Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury. He has persisting
cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive syndrome. The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. I do not think that the severity of his cognitive deficits represents a major barrier for return to work, especially manual labor. Additionally, he does have findings positive for situational depression and pain are also contributing to his functional disability.

In terms of recovery, Mr.Gomez is most likely at maximum medical improvement in terms of his neurologic/brain status. Fortunately, his cognitive deficits are relatively mild. Pain, dizziness, and balance will probably be the major limiting factor for his capacity to return to manual labor, but I would defer to his neurologist about work-related restrictions in this domain.

The most treatable aspect of the claimant's current syndrome is pain and depression, but unfortunately he has been variably noncompliant with his medications. Something like Cymbalta or another SSRI might double for treatment of both mood and pain related problems. Compliance with this type of treatment may reduce some of his functional disability.

Mark Wagner, PhD
Clinical Neuropsychologist
Associate Professor of Neurology

MW/am1251
dd: 10/31/2008
dt: 11/01/2008
JobID: 760927

cc:Mr. Michael Burkett, Willson Jones Carter Baxley LLC, 501 Wando Park Boulevard, Mount Pleasant, SC 29464

THIS NOTE IS CONFIDENTIAL

SIGNED BY MARK WAGNER, Ph. D. (ATTENDING) (D69) 11/04/2008 11:47AM

Progress Notes **Page: 1**

Date Printed: 01/20/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

01/12/09: GOMEZ-FRAGOSO, HECTOR: 2581962
OTOLARYNGOLOGY-HEAD AND NECK SURGERY
MEDICAL UNIVERSITY OF SOUTH CAROLINA
4EN

MEDICAL UNIVERSITY OF SOUTH CAROLINA
DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
135 Rutledge Avenue
MSC 550
Charleston, SC 29425-5500
(843) 792-8299

MUSC ENT Associates East Cooper Office

HISTORY:
Mr. Gomez-Fragoso is a 28-year-old Hispanic gentleman I saw for the first time on December 1, 2008 for evaluation of ear pain and dizziness following a work accident in November 2007. When I saw him in December, he was complaining of ear pain, hearing loss, ringing, disequilibrium, vertigo, and blurry vision. His examination at that time was unremarkable. He has since undergone an ENG that demonstrates a right-sided vestibulopathy. An audiogram obtained today was entirely normal. The patient continues to complain of left greater than right ear pain both around and behind the ear and persistent dizziness and disequilibrium.

PHYSICAL EXAM:
General: He is an overweight Hispanic male.
Oral Cavity: Benign.
Neck: Soft and supple with no masses.
Nose: Septum slightly deviated.
Ears: The ear canals are clear. The drums and middle ear spaces are essentially normal.

IMPRESSION:
1. Right vestibulopathy.
2. Normal hearing.
3. Complaints of otalgia.

RECOMMENDATIONS:
I reviewed the ENG results with the patient and have encouraged him to begin Cawthorne vestibular rehabilitation exercises at home. I have stressed the need for doing these several times a day for several months. I will have him return to the clinic in three months for reassessment.

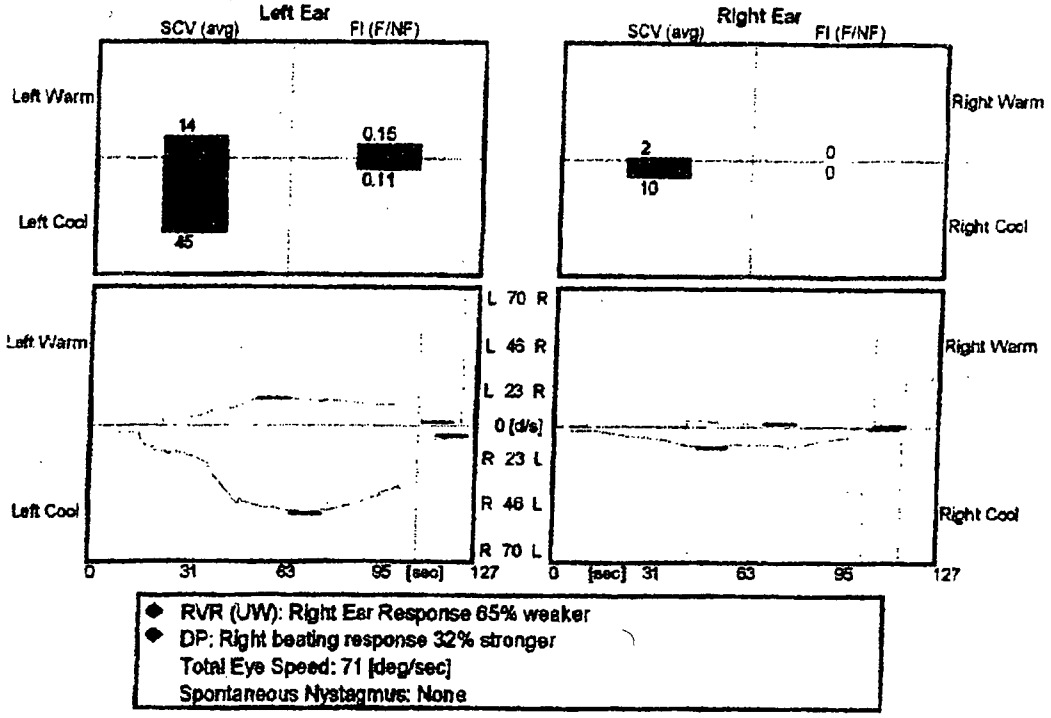
Mark J. Hoy, M.D.
MJH/NK1/VB

SIGNED BY MARK HOY, MD (ATTENDING) (4EN) 01/14/2009 08:34AM

Printed using Practice Partner®

Name:	Gomez-Fragoso, Hector	ID:	2581962
Age:	28	Visit Date:	01/12/2009

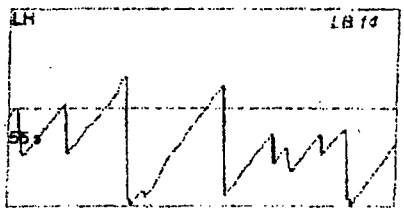
Caloric Summary



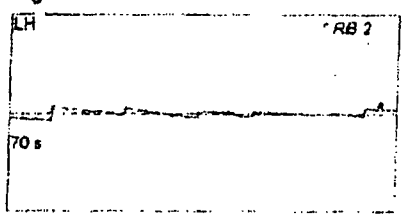
- RVR (UW): Right Ear Response 65% weaker
- DP: Right beating response 32% stronger

Total Eye Speed: 71 [deg/sec]
Spontaneous Nystagmus: None

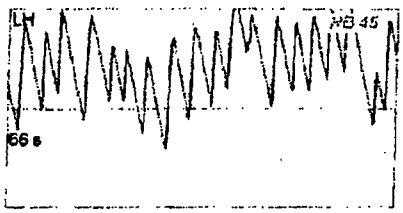
Left Warm



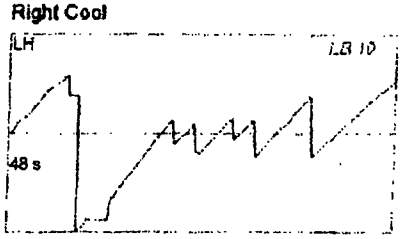
Right Warm



Left Cool



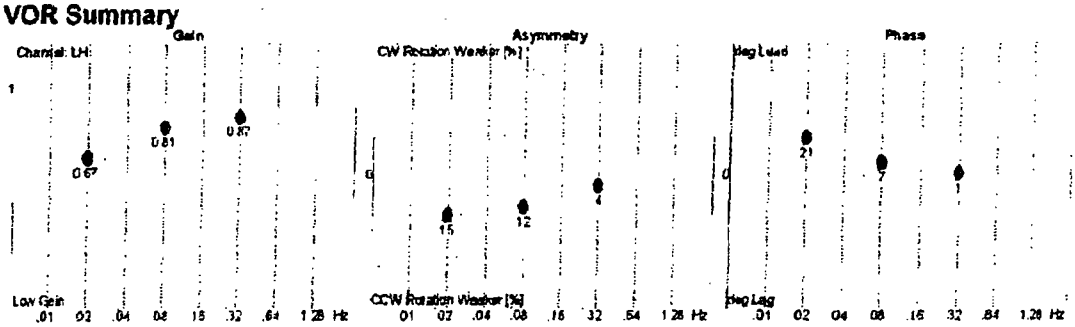
Right Cool



Name:	Gomez-Fragoso, Hector	ID:	2581962
Age:	28	Visit Date:	01/12/2009

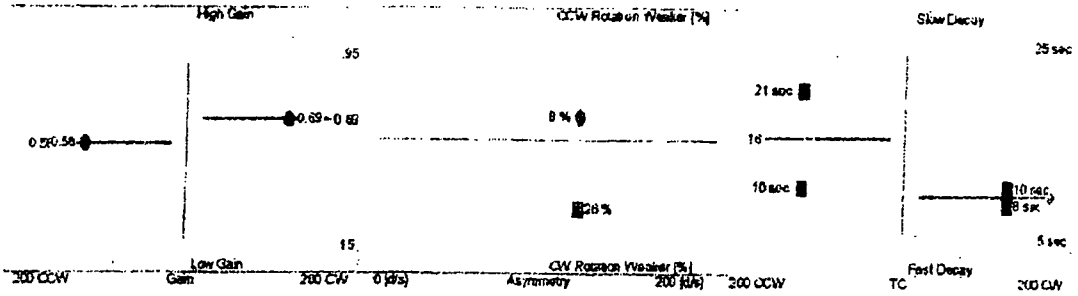
Rotational Chair Summary

VOR Summary



Name:	Gomez-Fragoso, Hector	ID:	2581962
Age:	28	Visit Date:	01/12/2009

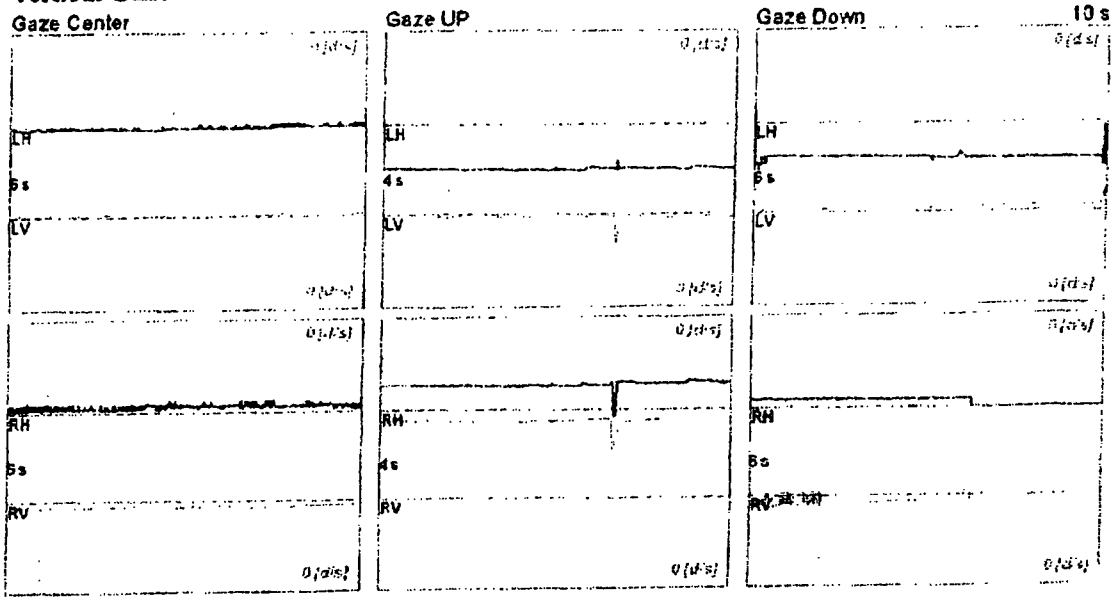
RVS Summary



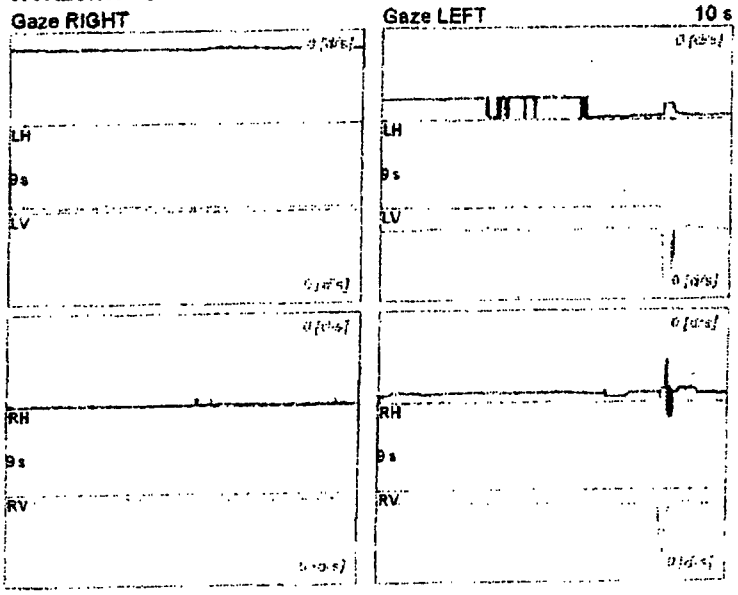
Name: Gomez-Fregoso, Hector ID: 2581962
Age: 28
Visit Date: 01/12/2009

Full Test H 10 deg V 10 deg 1 sec Close-up 10 deg H / V

Vertical Gaze Video

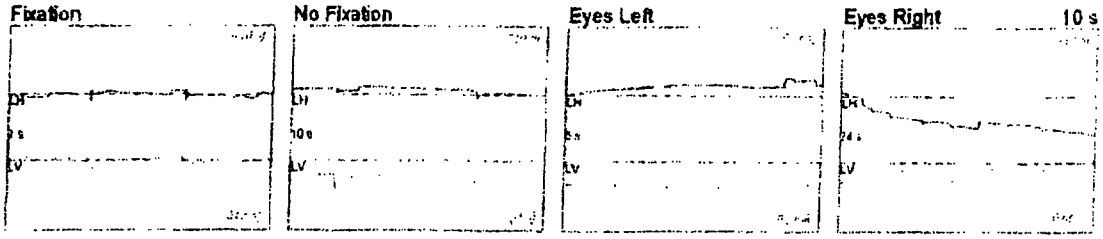


Horizontal Gaze Video

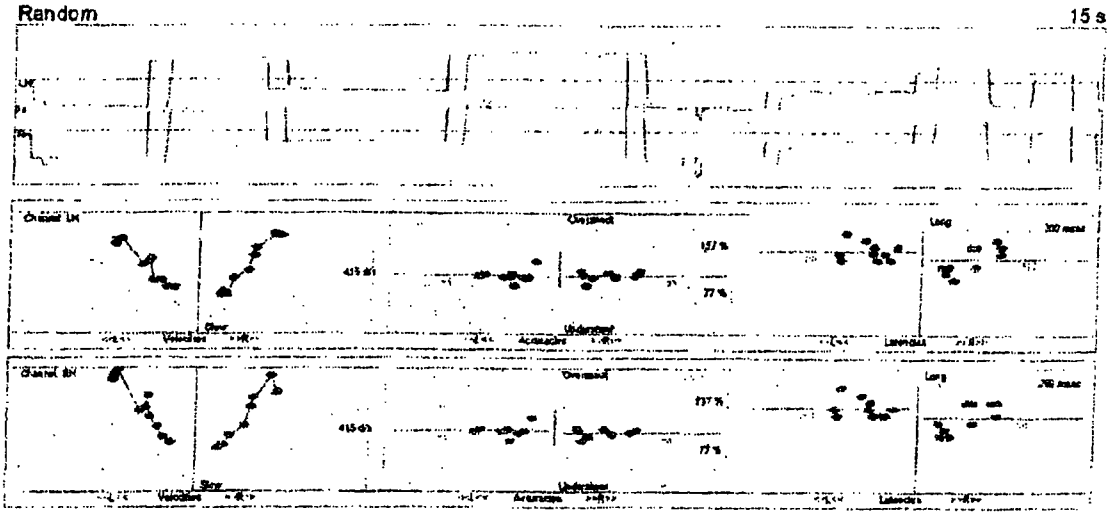


Name:	Gomez-Fragoso, Hector	ID:	2581962	Full Test H 10 deg V 10 deg / Close-up 10 deg H / V
Age:	28			
Visit Date:	01/12/2009			

Spontaneous Nystagmus Video

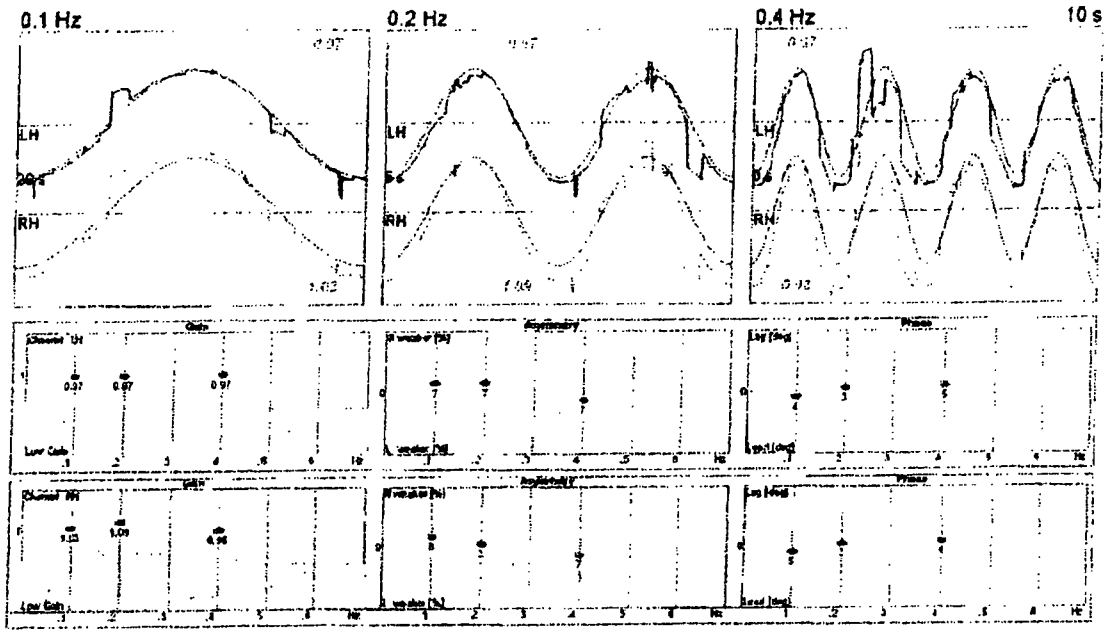


Saccade-Random Video



Name:	Gomez-Fragoso, Hector	ID:	2581962
Age:	28	Visit Date:	01/12/2009

Pursuit Video



Micromedical TECHNOLOGIES
Department of Otolaryngology
135 Rutledge Avenue
P.O. Box 250550
Charleston, SC 29464
(843) 792-8376

Name:	Gomez-Fragoso, Hector	ID:	2581962
Age:	28	Visit Date:	01/12/2009
Occupation:		Tester:	John King, Ph.D., CCC-A
Medication:	None reported.	Doctor:	Mark Hoy, M.D.

QT	Name	Test Comment
Summaries:		
◆	Caloric Summary	RVR (UW): R ear 65% weaker. DP: R btg 32% stronger
	VOR Summary	
	RVS Summary	
Nystagmus Tests:		
	Vertical Gaze	
	Horizontal Gaze	
	Spontaneous Nystagmus	Excessive eye blinks on eyes-right - no nystagmus in vertical channel.
Oculomotor Tests:		
	Saccade-Random	
	Pursuit	

◆ Finding(s) outside clinical threshold.

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Progress Notes **Page: 1**

Date Printed: 04/16/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

04/13/09: GOMEZ-FRAGOSO, HECTOR: 2581962
OTOLARYNGOLOGY-HEAD AND NECK SURGERY
MEDICAL UNIVERSITY OF SOUTH CAROLINA
4EN

MEDICAL UNIVERSITY OF SOUTH CAROLINA
DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
135 Rutledge Avenue
MSC 550
Charleston, SC 29425-5500
(843) 792-8299

MUSC ENT Associates East Cooper Office

HISTORY:
Mr. Gomez-Fragoso is a 28-year-old Hispanic male who I first saw in December 2008 for evaluation of ear pain and dizziness following a work accident that occurred in November 2007. I have seen him a couple of times since then. Last time was on January 12, 2009 following an ENG that demonstrated an incomplete right-sided vestibulopathy. He was started on Cawthorne vestibular exercise. He claims to be doing them several times a day. Overall, he has improved rather significantly. He is not having any significant dizziness. He does report, however, that on a couple of occasions when he is laughing very hard, he states that his vision gets blurry and he sees stars. He also complains of some intermittent left otalgia, which he has had since his injury. Of note is the fact that he had an audiogram in the past that showed normal hearing.

PHYSICAL EXAM:
General: Overweight Hispanic male in no distress.
Oral Cavity: Tongue, floor of mouth, and palate normal.
Neck: Soft and supple. No masses. No adenopathy.
Nose: Septum deviates slightly.
Ears: Canals clear. Drums and middle ear spaces normal. Tuning forks normal.

IMPRESSION:
1. History of right vestibulopathy, which has improved with vestibular exercises.
2. Complaints of otalgia with normal examination.
3. History of normal hearing by audiogram.

RECOMMENDATIONS:
It would appear that Mr. Gomez-Fragoso's vestibulopathy is improving. I have suggested he might want to continue the exercises for another couple of weeks and then can discontinue them. I feel he has probably reached the point of maximal medical improvement and at this point can follow up with me as needed. He was once again reassured that despite his complaints of ear pain his examination is entirely benign.

Mark J. Hoy, M.D.
MJH/VM/SK

SIGNED BY MARK HOY, MD (ATTENDING) (4EN) 04/15/2009 08:46AM

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Progress Notes

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:28

Printed using Practice Partner®

South Carolina Workers' Compensation Co[illegible]sion
1333 Main Street, Suite 500 • Post Office box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fragoso
Employer's Name: Kade Construction
Physician's Name: Dr. Mark Hoy
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC – Otolaryngology Head and Neck Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Mark Hoy
Phone: (843)792-8299

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: 12-1-08
Date of last visit: 4-13-09

Diagnosis or nature of injury or illness: HEAD INJURY / DIZZINESS / EAR PAIN

Body part(s) injured: EAR
Body part(s) affected: EAR

Date of **Maximum Medical Improvement:** 4-13-09

Based on the **AMA Guidelines**, the claimant has sustained a _____ **% medical impairment** to _____ injured body part(s) and a _____ **% medical impairment** to _____ other affected body part(s).

✓ The claimant is **able to return to work** without restriction.

_____ The claimant is **able** to return to work **with the following restrictions:**

_____ The claimant is **unable to return to work** at his or her current employment.

s of the date I last saw this patient, it is **my professional medical opinion** the claimant:

✓ **will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of edical certainty (more likely than not).

_____ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable gree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

[signature]

3-16-10

ating Physician **Date**

th Carolina Workers' Compensation C... sion
1333 Main Street, Suite 500 • Post Office box 1715
mbia, South Carolina 29202-1715
) 737-5723
www.wcc.sc.gov

Physician's Statement

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ing Physician

3-16-10
Date

Strand Regional Specialty Associates, LLC
Patient Data Base

Providing information about your personal and family medical history is one of the best ways to help your physician learn a great deal about your health in a short period of time. The questions in the Medical History Worksheet are designed to help you remember and communicate important details of your past and current health history. Complete as much of the worksheet as possible, answering as many of the questions as you can.

Name Hector G. Fragoso Date of Birth

Height 5'7 Weight 175 #'s ☒ Right-handed ☐ Left-handed

Please describe the problem you are experiencing:

How long have you been having this problem?

How often does this problem occur? 11/1/2007

How severe is the problem? ☒ Very severe ☐ Moderately severe ☐ Mild

Are there things that make this problem worse? Yes

Are there things that make this problem better? NO

What activities can you no longer do because of this problem?

Do you experience this problem with movement? ☐ Yes ☐ No

Do you experience this problem at rest? ☒ Yes ☐ No

Medical History

Prior Medical Problems (Include any Neurological and/or Orthopaedic related problems):

Prior Surgical History (List all operations and dates):

None N/A

Previous Hospitalizations other than Surgery (Include reason for hospitalization and dates):

None

Medications (List all present medications with dosages - include over-the-counter vitamins, Tylenol, etc.):

None

Allergic History to Medications (List medication and specific allergy and/or reaction):

NKDA

Family History (List age and medical problems of parents, siblings, and children - if any deaths have occurred in the family please list age and cause of death):

Mother: 44 HTN?

Father: 45 Not

Brother(s): 42 HTN

Sister(s): None

Children: None

Social History

Do you smoke? ☒ Yes ☐ No

How long have you smoked? 4 year

Did you ever quit? ☒ Yes ☐ No For How Long? 1 year

Do you drink alcohol? ☐ Yes ☒ No

If yes, indicate the number of drinks (and type) you take in an average week.

(Please include beer and wine) beer occ 6 pack

Do you use other drugs? ☐ Yes ☒ No

Have you ever had a blood transfusion? ☐ Yes ☒ No

Marital Status: ☒ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Widowed/Divorced/Remarried

Location prior to living in Myrtle Beach area yes Mexico

Present Occupation/Past Occupations Coast Guard

Review of Body Systems

Do you have a present or past history of any of the following (Please place an appropriate check next to each item):

General	Present	Past	Never
Fever	☐	☑	☐
Chills	☐	☐	☑
Sweats	☐	☐	☑
Weight change (loss or gain)	☑	☐	☐
Weakness	☑	☐	☐
Fatigue	☑	☐	☐
Swollen Glands	☑	☐	☐
Difficulty Sleeping	☑	☐	☐
Dermatologic	**Present**	**Past**	**Never**
New Skin Growths	☐	☐	☑
Change in color or size of skin growth	☐	☐	☑
Rashes	☐	☐	☑
Mouth sores	☐	☐	☑
Hair loss	☐	☐	☐
Sun sensitivity	☐	☐	☑
Fingernail changes	☐	☐	☑
Eyes, Ears, Nose, Throat	**Present**	**Past**	**Never**
Wear eye glasses	☐	☐	☑
Eye pain	☐	☐	☑
Hearing loss	☐	☐	☑
Ringing in ears	☐	☐	☑
Ear infections	☐	☐	☑
Sinus disorders	☐	☐	☑
Post nasal drip	☐	☐	☑
Nose bleeds	☐	☐	☑
Phlegm in throat	☐	☐	☑
Frequent colds or sore throats	☐	☐	☑
Hoarseness	☐	☐	☑
Difficulty swallowing	☐	☐	☑
Breast	**Present**	**Past**	**Never**
Fibrocystic breast disease	☐	☐	☑
Genitourinary	**Present**	**Past**	**Never**
Blood in urine	☐	☐	☑
Pus in urine	☐	☐	☑
Painful urination	☐	☐	☑
Frequent urination	☐	☐	☑
Urgent urination	☐	☐	☑
Kidney infection	☐	☐	☑
Bladder infection	☐	☐	☑
Prostate infection	☐	☐	☑
Impotence	☐	☐	☑
Genital discharge	☐	☐	☑

Pulmonary	Present	Past	Never
Shortness of breath	☐	☐	☑
Wheezing	☑	☐	☐
Chronic Cough	☐	☐	☑
Blood-streaked sputum	☐	☐	☑
Bronchitis	☐	☑	☐
Pneumonia	☐	☐	☑
Asthma	☐	☐	☑
Abnormal chest x-ray	☐	☐	☑
Cardiovascular	**Present**	**Past**	**Never**
Chest Pain	☐	☐	☑
Chest pain w/ walking/exercise	☐	☐	☑
Heart murmur	☐	☐	☑
Rheumatic fever	☐	☐	☑
Fainting	☐	☐	☑
Swelling in ankles	☐	☐	☑
Sleep on more than one pillow	☐	☐	☑
Calf or leg pain	☐	☐	☑
Varicose veins	☐	☐	☑
Abnormal electrocardiogram	☐	☐	☑
Gastrointestinal	**Present**	**Past**	**Never**
Nausea	☐	☐	☑
Vomiting	☐	☐	☑
Indigestion	☐	☐	☑
Heartburn	☐	☐	☑
Recurring diarrhea	☐	☐	☑
Frequent constipation	☐	☐	☑
Recent change in bowel habits	☐	☐	☑
Blood in bowel movements	☐	☐	☑
Black bowel movements	☐	☐	☑
Jaundice	☐	☐	☑
Hemorrhoids	☐	☐	☐
Rheumatologic	**Present**	**Past**	**Never**
Pain, stiffness or swelling in joints	☐	☐	☐
Bursitis	☐	☐	☐
Arthritis	☐	☐	☐
Low back pain	☐	☐	☐
Low back stiffness	☐	☐	☐
Numbness or tingling in legs	☐	☐	☐
Foot pain	☐	☐	☐

Neurologic	Present	Past	Never
Recurrent headaches	☐	☐	☐
Migraine headaches	☐	☐	☐
Fainting	☐	☐	☐
Dizziness	☐	☐	☐
Memory loss	☐	☐	☐
Seizures	☐	☐	☐
Visual disturbances (blurred/double)	☐	☐	☐
Speech difficulty	☐	☐	☐
Muscle weakness	☐	☐	☐
Muscle paralysis	☐	☐	☐
Ringing in ears	☐	☐	☐
History of head injury	☐	☐	☐

Endocrine	Present	Past	Never
Frequent Urination	☐	☐	☐
Urination at night	☐	☐	☐
Muscle cramps/weakness	☐	☐	☐
Weight change	☐	☐	☐
Heat/cold intolerance	☐	☐	☐
Tremors	☐	☐	☐
Difficulty climbing stairs	☐	☐	☐
Difficulty arising from chair	☐	☐	☐
Palpitations	☐	☐	☐
Hair Loss	☐	☐	☐
Excessive hair growth	☐	☐	☐

Person Completing Form — Relationship to Patient: Interpreter

Signature — Date

****

☐ Hx. Reviewed with patient - no changes

☐ Hx. Reviewed with patient - see note for changes

Physician Signature — Date: 8/29/08

☐ Hx. Reviewed with patient - no changes

☐ Hx. Reviewed with patient - see note for changes

Physician Signature — Date

☐ Hx. Reviewed with patient - no changes

☐ Hx. Reviewed with patient - see note for changes

Physician Signature — Date

STRAND REGIONAL SPECIALTY ASSOCIATES
CONSULTATION

Patient Name: Hector Gomez Fragoso
Date of Birth: 1/1/1951
Date of Exam:
Chart #: 81323
SSN:

RECEIVED SEP 0 3 2008

CONSULTATION REQUESTED BY: Key Risk.

Linda Renew
P.O. Box 1918
Columbia SC 29202
Fax #: 336-665-8052

The patient's medical record from MUSC from 11/01/2007 until 04/21/2008. Evaluations by Medical University of South Carolina, traumatic critical surgery unit followup visits, CT scans performed throughout his hospital stay. Operative reports from his foot injury as well for the evaluation that was done for the traumatic brain injury that the patient is having, a rehabilitation was made as well for the intake sheet that was performed here at Strand Regional Specialty Associates on 08/29/2008.

CHIEF COMPLAINT: "I am doing poorly."

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old Hispanic-speaking male who has come in here for evaluation of his condition. The patient has been complaining of severe and persistent headaches. These are prominent, persistent. This is described being 9-8/10. This is going to the top of the head particularly where he has the scar. All in all, the patient has also complaining of foot pain described being 8/10. The patient is having significant dizziness particularly when he moves around and perform any type of activities. Superimposed to the symptoms that the patient is having there are neck pain with tightness that unable him to ambulate and perform very well that is shooting into his left hand.

The patient has also been complaining of difficulty with shortness of breath. The worse when he lays down and he is not able to hold the saliva and start coughing, prominent, persistent, that are present all the time. He also has difficulty with concentration and performing complex tasks. He feels sometimes irritable and slowly and steadily getting worse. He has not been taking any medication because he felt that it was helping him, but he is taking too much. This is something that is prominent. Nothing makes it better or worse. It just remained the same. This problem was started on 11/01/2007. He was working Marion County and sitting up a roof and apparently the threshold roof that the patient was laying up the crane cables dislodged and broke in the mid air and hit him on the head and fractured his foot. The patient is amnestic over the whole event. Last thing he remembers is settling everything on the roof to set up the threshold himself. The next thing he remembers is two weeks state of waking up in the hospital and since then this

appears to be present. The patient has been transferred to MUSC where he was taken care until discharge and followups.

ALLERGIES: Significant for no known drug allergy.

PAST MEDICAL HISTORY: He has no medical problems, has not had any surgeries. He has never been in the hospital.

CURRENT MEDICATIONS: Current medications that he is taking were none.

FAMILY HISTORY: Significant for the mother's age 44, has a history of high blood pressure. Dad is aged 45. He is without any medical problems.

SOCIAL HISTORY: There are two brothers. No sisters and no kid. The patient smokes a couple of cigarettes a day. He said that he was discharged from the hospital he had not smoked until recently. He has only been half a pack per day for the last four years. The patient drinks four to six beers a month. There is no drug use. He never had any blood transfusions that he knows. He is single. He is from the Department of Mexico, in Mexico, and he is a construction worker.

REVIEW OF SYSTEMS: General: The patient has some difficulty with weakness, fatigues. Dermatological: There is not problem noted there. HEENT: The ear, nose, and throat is negative. GU: Review of systems has been negative. Pulmonary: The patient has been complaining of wheezing and cough. Cardiovascular: Negative. GI: Negative. Rheumatological: The patient is complaining of stiffness and swelling of the neck. There is foot pain on the right. Neurological: There is headaches, dizziness that are present, and visual disturbances when the headaches happen. Endocrine: Negative.

PHYSICAL EXAM:

VITAL SIGNS:	Weight: 185 pounds. Height is 5 feet 6 inches. Blood pressure: 124/80.
GENERAL:	The patient is in no apparent distress, well groomed, adequate for stated age. Mini-Mental status was performed in Spanish and this is one out of three at five minutes. He has difficulty performing complex drawings and serial seven is four out of five. He has good drawing. Good repetition. He is able to write normally. Good orientation to time, date, and space.
HEENT:	Ears are clear.
SKIN:	The wounds appeared to be well healed. Tracheostomy and amputation on foot appears to be well healed.

NEUROLOGIC EXAMINATION:

GENERAL:	Neurologically he is alert, oriented x3, MMS 28/30, 2/3at 5 min,poor drawing.

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	The patient is lurched forward.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	2+ from the right side with downgoing toes, 3+ from the left side with downgoing toes.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL:	Pain with hyperextension of the neck.

MEDICAL DECISION MAKING: The patient is a 27-year-old Hispanic speaking male status posttraumatic brain injury with associated headache. This headackes appeared to be musculoskeleta and s/p skull fracture lin nature. The patient had a skull based fracture with a frontal bone fracture with superimposed subdural and epidural hematomas that have resolved. He also had frontal lobe contusion. At this moment there is not available in the report any MRIs nor electroencephalograms present. The dizziness appeared to be directly related to an inner ear injury most likely from his skull based fracture. The patient had difficulty concentrating and that appears to be directly related to the injury that he has suffered and after effect typical of this type of injury. The shortness of breath that the patient has presented could be anxiety attacks or could be damage from the tracheostomy that the patient is had. The foot pain is from the injury that he has suffered. We will defer to orthopedics for evaluation of the patient condition. The difficulty concentrating and performing tasks with irritability is directly aftereffects from the injury that he suffered. Apparently the neck pain that the patient has presented has been never evaluated and possibility of cervical disc and joint disease and/or spinal stenosis in this patient is present.

RECOMMENDATIONS: At this moment a neuropsychological evaluation in Spanish should be done to see which areas have deficit and what can be done to improve or maximize the recovery and function of this patient. An MRI of the brain to see if there is any lingering effects from the injury that he has suffered will be indicated as well for the cervical spine to make sure that there is no cervical pathology as a culprit for the patient findings. An EMG of the left upper arm and right lower extremity to evaluate the possibility of having a lumbar and cervical radiculopathy should be performed. An auditory evoked potential and electronystagmogram and 24 hrs. EEGto evaluate the inner ear and make sure that this paroxysmal event that the patient is having is not associated with seizure, as well for the irritability that the patient has presented to see how the brain

is functioning. For the treatment of the patient condition Robaxin 500 mg three times a day for treatment of the headache and the musculoskeletal component that the patient is suffering will be ordered, Neurontin 300 mg three times a day, not only to stabilize his mood, but more important to control the symptoms of paresthesias, headaches and dizziness will be indicated. Vicodin ES p.r.n. for pain will be prescribed. Pulmonary evaluation to make sure that his trachea and lungs are working properly will be indicated. I agree with the orthopedic evaluation. At this moment vestibular desensitization exercises will be prescribed. The patient has blurred vision that he had presented to me to be evaluated if the treatment and symptomatology of the dizziness does not resolve completely. A followup appointment will be arranged to see the result and course of his injuries. At that time we will reassess the need for further treatment or investigation.

George Sandoz, MD

GS/smw

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Fragoso, Hector
DOB:
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 9/16/2008

EXAM: MRI BRAIN WITH CONTRAST

HISTORY: Pain. Complaining of headaches, memory loss, slurred speech since injury at work November 2007.

COMPARISON STUDIES: None given.

TECHNIQUE: Axial T2, FLAIR, gradient echo, diffusion, and T1 pre- and postcontrast and sagittal T2 of the brain.

FINDINGS: The brain parenchyma is normal. There are no abnormal areas of enhancement. There are no T2 weighted or acute diffusion weighted abnormalities. There are no extraaxial fluid collections and the sulci, cisterns, and ventricles are normal. The major vessels of the circle of Willis are patent. The midline structures including the corpus callosum, basal ganglia, pineal gland, quadrigeminal plate, brainstem, and visualized cord are normal. Incidental note is made of severe right mastoiditis. The paranasal sinuses are otherwise clear. Susceptibility artifact in the subcutaneous tissues of the left scalp could be from the prior trauma. No areas of susceptibility artifact are seen within the cranial vault to suggest prior intracranial hemorrhage.

IMPRESSION:
1. Right mastoiditis.
2. Otherwise, unremarkable MRI of the brain.

Robb Hoehlein, MD
RH / rc

DD: 9/17/2008
DT: 9/17/2008
Job: 6859428

This document has been electronically reviewed and signed.

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Fresnoso, Hector
DOB:
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 9/16/2008

EXAM: MRI CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Pain after heavy object fell onto head in November 2007.

COMPARISON STUDIES: None given.

TECHNIQUE: Sagittal T1 and T2, coronal STIR, and axial T2 and gradient echo of the cervical spine.

CONTRAST: None.

FINDINGS: The alignment, visualized posterior fossa, cervical cord, marrow, and paraspinous soft tissues are normal.

C2-3 and C3-4: Normal.

C4-5: There is a 3 mm left intraforaminal high T2 signal probable disc protrusion (image 10 series 105 and image 8 series 102). This appears to significantly narrow the left neuroforamen and likely compresses the supradjacent nerve root. The right neural foramen and central canal are normal.

C5-6: There is early disc desiccation with a minimal disc osteophytic bulge but no significant stenosis.

C6-7: Normal.

C7-T1: Mild disc desiccation with a minimal disc osteophytic bulge slightly asymmetric to the right without significant stenosis.

T1-2 through T4-5: Normal.

IMPRESSION: There is a probable left intraforaminal focal disc protrusion at C4-5 resulting in moderate left neural foraminal stenosis. The protrusion is located beneath the exiting left C5 nerve root. A CT myelogram could be helpful if this is clinically ambiguous.

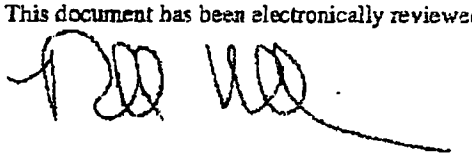
Robb Hoehleln, MD
RH / sl

DD: 9/17/2008
DT: 9/17/2008
Job: 6859479

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

Patient: Fragoso, Hector
MRN: 584760
Exam: MRI CERVICAL SPINE WITHOUT CONTRAST

This document has been electronically reviewed and signed.



Strand Regional Specialty Associates LLC

SPINE & NEUROLOGIC INSTITUTE
NEUROLOGICAL SURGERY
David B. Kee, Jr., M.D.
Eugene M. Giddens, M.D.
C. Todd Beebe PA-C

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Julian N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
Jeff A. Benjamin, D.O.

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Erin L. Kirby, P.A.-C

VISION & EYE SURGERY
EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

September 16, 2008

Jeff Chandler

Re: Hector Gomez Fragoso
DOB: 1/1/1951
SSN: N/A

Dear Mr. Chandler:

As you know after reviewing the findings that the patien is having and after reviewing the complaints that the patient had presented, he is noted to have a transverse process injury at the level of L3-L4 and also a transverse spinous process at the level of C7. Upon reviewing the patient complaints and the major symptoms that he has are located on the cervical spine, there was no complaints from the lumbar spine. Regarding the treatment, medications as before were given to the patient and seen how he has performed under those conditions and the therapy was given with medication. The rest of them appear to be resolved except the one in the neck and an MRI for that area and evaluation was scheduled.

Please do not hesitate to call me if you have any other further question regarding this patient condition.

Sincerely,

George Sandoz, MD

GS/smw

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP
Patient Name: Hector Gomez-Fragoso
Date of Birth:
Date of Exam: 10/2/2008
Chart: 81323
SSN:

CHIEF COMPLAINT: "I have been doing fairly well."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic speaking male who has come in here secondary to the complaint of having dizziness. Since the last visit and given antibiotic, there is some relief of symptomatology, but it continues to be persistent. The headache continues to do well, controlled with the Percocet. The neck is described being 8/10, into the left, more significant. This is associated recently with more low back pain and thoracic pain, but has worsened with activity and when he does activity, he stop, and then he wants to retry. It is very significant. This has happened four to five times a week. This unable him to perform any of his ADLs. Still has not been to neuropsychological testing. He has been having difficulty getting his medication, not because they are not being ___, but because he is not able to get a valid ID.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:

VITAL SIGNS:	Weight: 189 pounds. Height is 5 feet 7 inches. Pulse: 80.
GENERAL:	The patient is in moderate distress, well groomed, well kept.

NEUROLOGIC EXAMINATION:

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	The patient is lurched forward.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	3+ throughout downgoing toes.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL: Pain with hyperextension and hyperflexion of the neck. Positive for straight leg raise. Trigger point located on the thoracic area.

MEDICAL DECISION MAKING:

1. The patient presented here with headaches and vertigo. Inner ear damage, we will check electronystagmogram and an abnormal mastoid process is present on MRI. This appears to be inflammatory, possibility of infection is present, although unlikely.
2. Neck pain. MRI of the cervical spine shows herniated disc at the level of C5 particularly at the level into the left, which correlates with the clinical findings the patient is having. The symptomatology that he has presented with his back might represent worsening condition of his neck or previous injury as he did before.

RECOMMENDATIONS: We will reorder his Percoce. No seizure medication will be given just because the patient had a normal electroencephalogram. An MRI of the lumbar and thoracic spine will be scheduled, and according to those findings, we will see if it is necessary to pursue any treatment. We will continue with the medication that he is on.

George Sandoz, MD

GS/smw

Ocean Spine & Neurological Inst.
8170 Rourke Street
Myrtle Beach, SC 29572
(843) 449-2336

Patient: Gomez Fragoso, Hector
Sex: Male
Age:
I.D.#: A81323-1
Ref. M.D.:

Physician: Dr Sandoz
Test Date: 10/03/08

History/Comments:

DOB 10-04-80. Paresthesia/vertigo/syncope

Evoked Potential Study

Left Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	501	6.0	15.9	19.4	24.5
	501				

Evoked Potential Study

Right Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	536	9.3	13.8	17.2	23.4
	504				

Evoked Potential Study

Left Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42-N50	Amp2 (uV) N7-N17
	500	4.2	16.3	26.7	39.3	49.0	35.2	0.3	1.1
	500								

Patient: Gomez Fragoso, Hector Test Date: 10/03/08
I.D.#: A81323-1

Evoked Potential Study

Right Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42 - N50	Amp2 (uV) N7-N17
	500	6.2	20.8	27.8	40.3	53.3	34.2	0.9	
	500								

Auditory Evoked Potential Study

Left: 71 nHL dB Stimulus Right: 0 dB Noise

Left Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.9	2.7	3.6	4.5	5.4	6.1	0.0
	501							

Auditory Evoked Potential Study

Left: 0 dB Noise Right: 71 nHL dB Stimulus

Right Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.7	2.2	3.0	4.0	5.3	6.0	0.1
	501							

Visual Evoked Potential Study

24 Screen Divisions (width)

Left Visual Nerve

Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPI1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	77.5	112.5	160.5	48.0	5.4
	128					

Patient: Gomez Fragoso, Hector Test Date: 10/03/08
I.D.#: A81323-1

Visual Evoked Potential Study

- 24 Screen Divisions (width)

Right Visual Nerve

Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPl1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	75.0	112.0	148.0	36.0	8.8
	128					

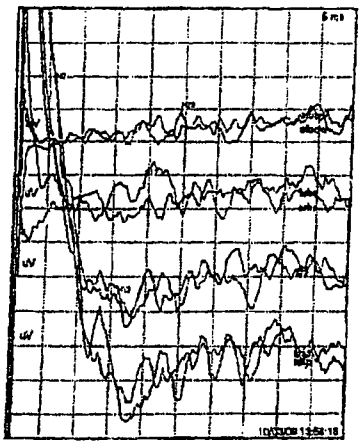
Summary/Interpretation:
The Visual Evoked Response test shows borderline P-100 responses bilaterally. The Brainstem Auditory and Upper/Lower EXtremity Somatosensory Evoked Response Tests are within normal limits. Clinical correlation is recommended.

George Sandoz, M.D.

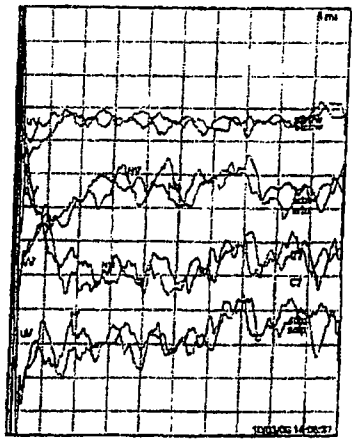
Patient: Gomez Fragoso, Hector
I.D.#: A81323-1

Test Date: 10/03/08

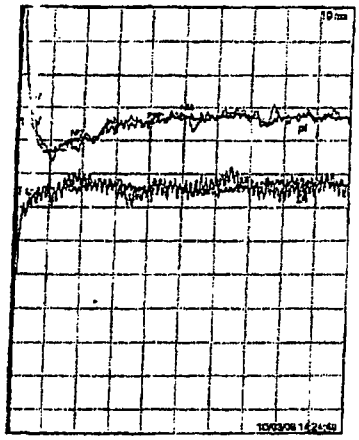
L. Median EP



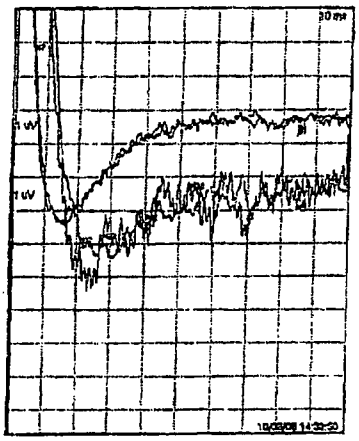
R. Median EP



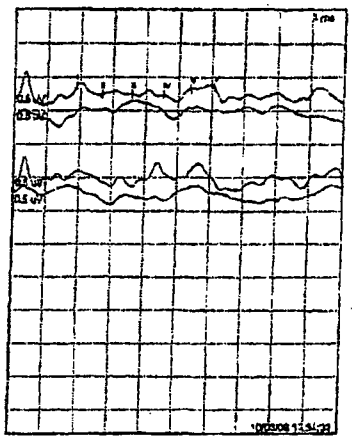
L. Tibial EP



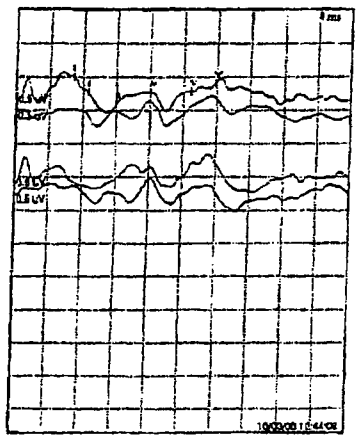
R. Tibial EP



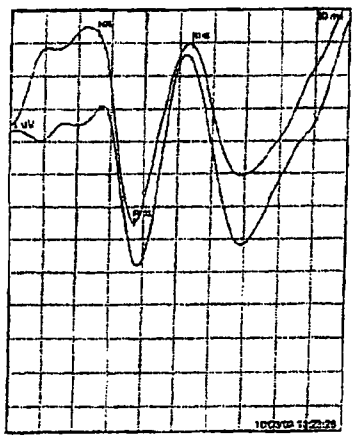
L. Audio EP



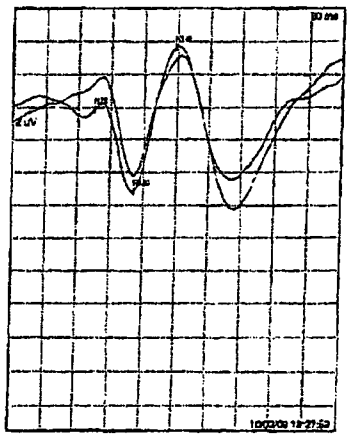
R. Audio EP



L. Visual EP



R. Visual EP



Strand Regional Specialty Associates
Neurophysiology Neuroscience Orthopaedic
Ophthanlmology
Phone (843) 449 2336 (843) 692-2100

Test Date: 10/2/2008

Patient:	Hector Gomez Fragoso	**DOB:**	10 /4/1980	**Physician:**	George Sandoz, M.D.
ID#:	<DATA 81323	**Sex:**	Male	**Ref Phys:**	
				Technician:	

Patient Complaints:
Patient is a 28 year-old male who presents with neck pain back pain numbness tingling pain pain in the upper lower extremities. Ending temp 88 degree.

EMG & NCV Findings:
Starting temp 87.3 degree.All nerve conduction studies (as indicated in the following tables) were within normal limits.

All F Wave latencies were within normal limits.

All H Reflex latencies were within normal limits.

All examined muscles (as indicated in the following table) showed no evidence of electrical instability.

Impression:

1. Normal NCS / EMG of the left upper and right lower extremities.
2. No active denervation.
3. Clincal correlation is suggested.

George Sandoz, M.D.

Nerve Conduction Studies

Anti Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (μV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Sural Anti Sensory (Lat Mall)											
Calf		3.5	<4.5	30.3	>5.0	Calf	Lat Mall	3.5	0.0		
Site 2		3.6		23.7							
Site 3		3.5		25.9							
Site 4		3.4		19.2							

Ortho Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (μV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median Ortho Sensory (Wrist)											
Palm		1.8	<2.3	75.5	>40	Palm	Wrist	1.8	0.0		
Site 2		1.9		74.0							
Site 3		1.8		68.1							
Left Ulnar Ortho Sensory (Wrist)											
Palm		1.7	<2.2	30.9	>11	Palm	Wrist	1.7	0.0		
Site 2		1.6		29.2							
Site 3		1.7		24.4							
Site 4		1.7		29.5							

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median Motor (Abd Poll Brev)											
Wrist		3.5	<4.5	7.4	>3	Elbow	Wrist	3.3	19.0	57.6	>48
Elbow		6.8		5.5							
Right Peroneal Motor (Ext Dig Brev)											
Ankle		3.7	<6.6	3.8	>2	B Fib	Ankle	5.7	25.0	43.9	>42
B Fib		9.4		3.5		Poplt	B Fib	1.3	9.0	69.2	>42
Poplt		10.7		3.4							
Right Tibial Motor (Abd Hall Brev)											
Ankle		4.0	<6.6	15.4	>2	Knee	Ankle	6.9	32.0	46.4	>42
Knee		10.9		12.6							
Left Ulnar Motor (Abd Dig Minimi)											
Wrist		3.1	<3.6	11.0	>5	B Elbow	Wrist	3.1	19.0	61.3	>48
B Elbow		6.2		8.8		A Elbow	B Elbow	1.4	9.0	64.3	>48
A Elbow		7.6		8.6							

F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)
Left Median (Mrkrs) (Abd Poll Brev)			
	24.29	<32	
Right Peroneal (Mrkrs) (EDB)			
	43.85	<56.4	
Right Tibial (Mrkrs) (Abd Hallucis)			
	42.80	<55	
Left Ulnar (Mrkrs) (Abd Dig Min)			
	20.00	<32	

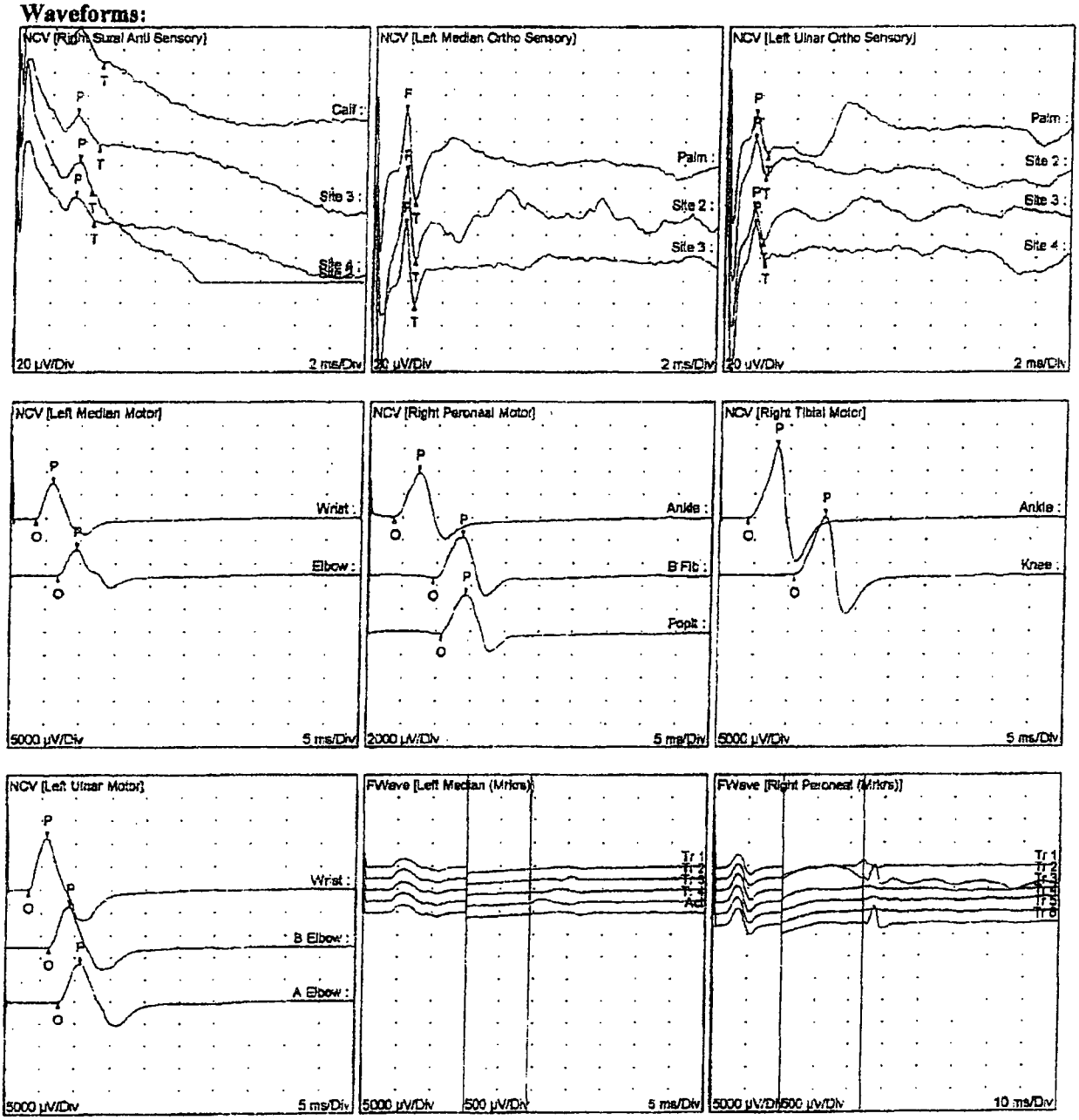
H Reflex Studies

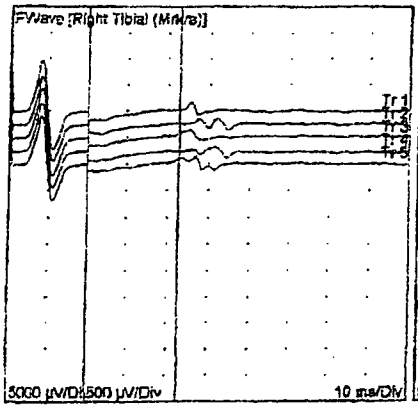
NR	H-Lat (ms)	Lat Norm (ms)	L-R H-Lat (ms)
Left Tibial (Gastroc)			
	23.64	<32	0.00
Right Tibial (Gastroc)			
	23.64	<32	0.00

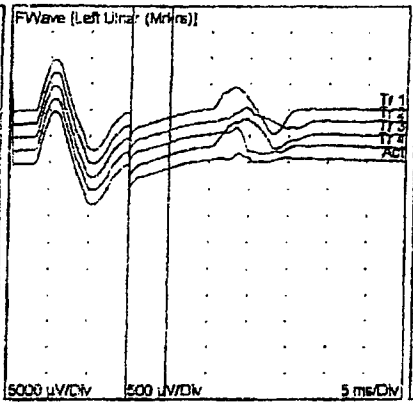
EMG

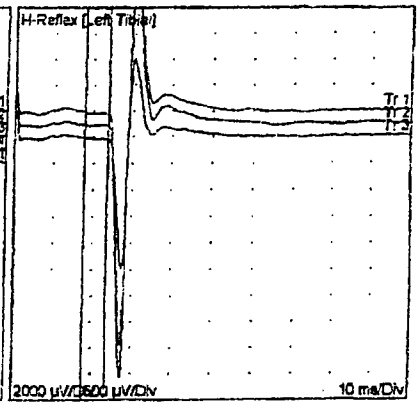
Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Fascis	Comment
Left	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	VastusLat	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	TensorFascLat	SupGluteal	L4-5, S1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	Iliopsoas	Femoral	L2-3	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	

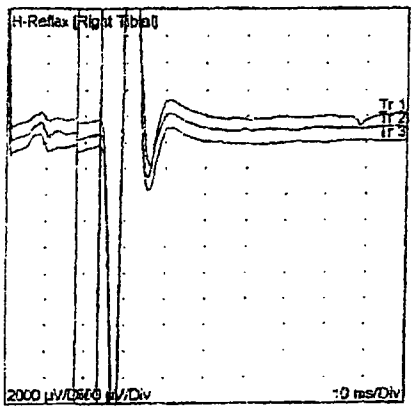
Waveforms:


NCV [Right Sural Ant Sensory]
Calf :
Site 3 :
Site 4 :
20 µV/Div
2 ms/Div
NCV [Left Median Ortho Sensory]
Palm :
Site 2 :
Site 3 :
20 µV/Div
2 ms/Div
NCV [Left Ulnar Ortho Sensory]
Palm :
Site 2 :
Site 3 :
Site 4 :
20 uV/Div
2 ms/Div
NCV [Left Median Motor]
Wrist :
Elbow :
5000 µV/Div
5 ms/Div
NCV [Right Peronaal Motor]
Ankle :
B Fib :
Popt :
2000 µV/Div
5 ms/Div
NCV [Right Tibial Motor]
Ankle :
Knee :
5000 µV/Div
5 ms/Div
NCV [Left Ulnar Motor]
Wrist :
B Elbow :
A Elbow :
5000 µV/Div
5 ms/Div
FWave [Left Median (Mrkrs)]
Tr 1
Tr 2
Tr 3
Tr 4
Acl
5000 µV/Div
500 µV/Div
5 ms/Div
FWave [Right Peroneal (Mrkrs)]
Tr 1
5000 µV/Div
500 µV/Div
10 ms/Div


FWave [Right Tibial (Mrk/a)]
Tr 1
Tr 2
Tr 3
Tr 4
Tr 5
5000 µV/Div
500 µV/Div
10 ms/Div


FWave [Left Ulnar (Mrk/s)]
Tr 1
Tr 2
Tr 3
Tr 4
Acc
5000 µV/Div
500 µV/Div
5 ms/Div


H-Reflex [Left Tibial]
Tr 1
Tr 2
Tr 3
2000 µV/Div
500 µV/Div
10 ms/Div


H-Reflex [Right Tibial]
Tr 1
Tr 2
Tr 3
2000 µV/Div
10 ms/Div

Strand Regional Specialty Associates
8170 Rourk Street
Myrtle Beach, SC

Tel:

Patient Report - ENG

Patient ID:	
Patient:	Gomez-Fragoso, Hector
Birthdate:	
Gender:	Male
Physician:	Dr George Sandoz
Referring facility:	None
Referral reason:	Vertigo/paresthesia/syncope
Operator:	Default, Operator
Report date:	10/2/2008

Results:

This ENG Study shows right canal paresis. Clinical correlation is recommended.

George Sandoz, M.D.

GN Otometrics

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP
Patient Name: Hector Gomez-Fragoso
Date of Birth:
Date of Exam: 10/10/2008
Chart: 81323
SSN:

CHIEF COMPLAINT: "I continue to have spells."

HISTORY OF PRESENT ILLNESS: The patient is a 27-year-old Hispanic speaking male, status post work related injury on 11/01/2007 where he had an injury to his back, neck, right foot, and had spell with dizziness, difficulty performing his ADLs. Since the last visit, the patient has started on Neurontin. The symptoms that he has from pain has improved. He continues to rely on the Vicodin approximately four times a day to control the symptoms and he is tolerating the methocarbamol well.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:

VITAL SIGNS:	Are not taken.
GENERAL:	The patient appears to be in no apparent distress, well groomed, well kept; adequate for stated age.

NEUROLOGIC EXAMINATION:

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Weber to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	Normal gait and tandem walk.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	Normoreflexive with plantar flexor response.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL:	Pain with hyperextension and hyperflexion of the neck.

MEDICAL DECISION MAKING: The patient presented here with the complaint of dizziness, spells that suggest that the patient is having seizures, low back pain, but by history the patient had an injury on the lumbar spine, no evidence of any damage at this moment, no neuropathy. From the cervical standpoint, the patient has presented here

with mild disc bulge. From the evidence of the brain, this was reviewed by me and it suggests that there is a right temporal lobe injury. Despite that, the cuts are not fine. This was reviewed with the radiologist and he feels that there is something in there, but is too soft with the findings that the patient is having, which correlates with an injury.

RECOMMENDATIONS: We are still awaiting for the 24-hour EEG. We will see how he performs with the increase of the dose of the Neurontin, and if increased dose control the symptoms, then no further treatment will be indicated. If it does not, an epidural steroid injection will be indicated. Followup appointment will be arranged. Medication in the form of gabapentin 600 mg three times a day, Vicodin ES four times a day, and Robaxin 500 mg three times a day will be given. Followup appointment will be arranged.

George Sandoz, MD

GS/smw

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Fragoso, Hector
DOB:
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 10/17/2008

EXAM: MRI OF THE THORACIC SPINE WITHOUT CONTRAST

HISTORY: Pain. Injury one year ago.

TECHNIQUE: Sagittal T1, T2 and STIR, coronal T1 and axial T2 of the thoracic spine.

CONTRAST: None.

FINDINGS: The alignment, thoracic cord, marrow and paraspinous soft tissues are normal. There may be an old T7 superior endplate compression versus Schmorl's node without significant height loss. The T6-T7 disc is mildly desiccated as well. There are no other significant degenerative changes. The central canal and neural foramina are normal throughout.

IMPRESSION: Nearly normal thoracic spine MRI with potentially an old mild superior endplate compression fracture of T7 versus a Schmorl's node.

Robb Hoehlein, MD
RH / lb

DD: 10/20/2008
DT: 10/20/2008
Job: 7014625

This document has been electronically reviewed and signed.

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Ernesto Hector
DOB:
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 10/17/2008

EXAM: MR OF THE LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Injury one year ago with persistent pain.

COMPARISON STUDIES: None.

TECHNIQUE: Sagittal T2 with and without contrast fat-sat, coronal T1, and axial T1 and T2 of the lumbar spine.

CONTRAST: None.

FINDINGS: The distal cord is normal terminating at L1. There is mild subcutaneous edema in the flanks. The alignment, marrow, and paraspinal soft tissues are normal. The visualized portions of the SI joints and hips are normal.

The discs, neural foramina, central canal, and facets are normal from T12-L1 through L5-S1. The axial T2-weighted images are limited by motion despite repeat attempts although the exam remains diagnostic.

IMPRESSION: Normal MRI of the lumbar spine.

Robb Hoehlein, MD
RH / hc

DD: 10/20/2008
DT: 10/20/2008
Job: 7014655

This document has been electronically reviewed and signed.

900 21ST AVENUE NORTH
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(843) 916-1700
(843) 916-9460 FAX

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP
Patient Name: Hector Gomez-Fragoso
Date of Birth: 1/1/1951
Date of Exam: 10/24/2008
Chart: 81323
SSN:

RECEIVED NOV 1 3 2008

CHIEF COMPLAINT: "I continue to do about the same."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic speaking male who is coming here secondary to the complaint of having neck pain, back pain, ear pain and recently is noted to have right shoulder pain. The more he does the more it hurt. The less he perform the better it is, but it is always there. All in all, the symptoms that the patient is having is significant, persistent, exacerbated by movement, improved somewhat by rest. Medication is giving some relief and he continues to rely heavily on it.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient's database.

PHYSICAL EXAM:

VITAL SIGNS:	Stable.
GENERAL:	The patient is in moderate distress well groomed, well kept, adequate for stated age.
CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Rinne to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	Normal gait and tandem walk.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	Normoreflexive with plantar flexor response.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL:	Pain with hyperextension and hyperflexion of the neck.

MEDICAL DECISION MAKING: The patient presented here secondary to the complaint of having symptom status post work related injury with neck pain with episodes of dizziness, episode of syncope in the past. This has been worked up and has shown no evidence of any seizure and nor any evidence of any damage of the brain. Despite that review of the MRI shows some mild abnormality in the temporal lobe. No fine _____ over this area. The back pain and neck pain appeared to be just associated

with cervical spondylosis. No evidence of any fracture process or pedicles is noted on the MRI on the lumbar or in the cervical spine.

RECOMMENDATIONS: At this moment, the patient is only taking over-the-counter medication. Apparently, he is not able to obtain any payment for the medications from workman comp standpoint. At this moment, symptomatology of ear pain is significant. Reason why ear, nose, and throat consultation will be given, an orthopedic consult for the right shoulder pain will be scheduled. Followup appointment will be arrange.

George Sandoz, MD

DICTATED BUT NOT READ

GS/ams

cc: Workman Compensation.

Mr. _____

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP

Patient Name: Hector Gomez-Fragoso
Date of Birth:
Date of Exam: 11/25/2008
Chart: 81323
SSN: 999-99-9999

CHIEF COMPLAINT: "I continue to hurt."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic-speaking male who has come in here status post work-related injury where he was hit in the head with severe injuries throughout. Recently, he has undergone neuropsych testing. Today, this has not been available. He continues to have a headache. This is described being 7/10, prominent, persistent. Foot hurting, this is described being 7-8/10. The symptom that the patient is having is into his neck. This is 8/10 when turning, difficulty sleeping, unable him to ambulate and perform any of his activity. The patient has been also complaining of low back pain due to worsening and sitting down longtime position. It takes a while for him to keep going. He continues to have difficulty hearing on the right ear. He gets short of breath every time that he start working.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:

VITAL SIGNS:	Weight: 192 pounds. Height: 5 feet 5 inches.
GENERAL:	The patient is well groomed, well kept; adequate for stated age, obese, having moderate distress.

NEUROLOGIC EXAMINATION:

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Weber to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	The patient is lurched forward.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	3+ throughout downgoing toes.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL:	Pain with hyperextension and hyperflexion of the neck.

Positive for trigger point throughout the neck. Positive for straight leg raise. Pain with hyperextension of the back.

MEDICAL DECISION MAKING:

- The patient is a very complex white male who appears to have traumatic brain injury. At this moment, the patient has not had any of the further spells. He is tolerating the Robaxin and Neurontin well. Prescription for pain medication with control substance that has not been able to done due to lack of ID here in the United States. Headache does appear to be related to the contusive injury that the patient is having.

Foot pain evaluated by the orthopedics.

Cervical spinous process fracture that continue to bother him. No surgical pathology was noted on the MRI. Treatment will be indicated.

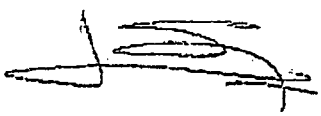
Low back pain. This appears to be associated with a compression fracture and transverse process fracture as noted in the past. This appears to be doing fairly stable at this moment, but continue to bother him.

Traumatic brain injury. Still awaiting the evaluation by the neuropsychology testing.

Shortness of breath that might be associated with tracheomalacia.

Vertigo with mastoiditis present.

RECOMMENDATIONS: An epidural steroid injection of the cervical spine will be given. Physical therapy will be scheduled. Percocet 10/650 mg will be given. Treatment for his mastoiditis with Augmentin 500 mg to one tablet three times a day for 10 days will be given. We are still awaiting for the pulmonary consult to evaluate his trachea and ear, nose, and throat evaluation for the mastoiditis is still pending. Followup appointment will be arranged.



George Sandoz, MD

GS/smw

cc: Mr. Chandler.

Linda _____, case nurse manager.
Fax #: 336-665-8052

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP
Patient Name: Hector Gomez-Fragoso
Date of Birth:
Date of Exam: 1/6/2009
Chart: 81323
SSN:

CHIEF COMPLAINT: "I continue to do poorly."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic male status post work-related injury in May 2008. Since his last visit, he has been doing about the same. The headaches that he has are described being 8/10, comes and goes every two to three days. Nothing makes it better. Nothing makes it worse. He has recently been taking Neurontin and Voltaren without great deal of relief. He continues to have difficulty obtaining the Percocet for the control of this pain secondary to lack of documentation. The neck pain is described being 8/9, sharp in nature that is shooting mostly into the left leg. The low back pain is described being 8/10, going up into his back. This is something that is prominent, persistent. Nothing makes it better or worse. At this point, he still has not known if he has virtual results of the neuropsychological testing and no notes were noted.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:

VITAL SIGNS:	Weight: 190 pounds. Blood pressure: 124/74. Pulse: 72.
GENERAL:	The patient is in moderate distress, well groomed, well kept; adequate for stated age.

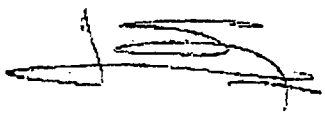
NEUROLOGIC EXAMINATION:

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	Normal gait and tandem walk.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	2+ throughout downgoing toes.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL: Trigger point located in mid spine in the cervical and lumbar area. Pain with hyperextension of the back.

MEDICAL DECISION MAKING: The patient presented here status post work-related injury where he had a traumatic brain injury with the description that the patient suffer. At this moment, the headaches appear to be chronic, posttraumatic in nature. Cervical and lumbar disc disease with associated fracture of the spinous process, this fracture is noted in the CT scan done at MUSC.

RECOMMENDATIONS: At this point, an epidural steroid injection of the cervical spine will be made trying to control the pain. We will continue with the Neurontin and the Voltaren. Add to this treatment, Ultram 50 mg q.6h. or daily will be given. We will continue with the same prescription that the patient is having. A followup appointment will be arranged.



George Sandoz, MD

GS/smw

STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP
Patient Name: Hector Gomez-Fragoso
Date of Birth:
Date of Exam: 2/17/2009
Chart: 81323
SSN:

CHIEF COMPLAINT: "I continue to hurt."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic-speaking male status post work related injury. Since the last visit, the patient has been doing fairly well. Medication has given some relief, but continues to rely on it for the control of the symptoms. He still has not gotten the treatment that is required for an epidural steroid injection due to the neck injury, which has been taken care at MUSC. The dizziness has continued to be improved with the use of the meclozine. Headaches are still persistent and the patient has not had any other loss of consciousness.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:

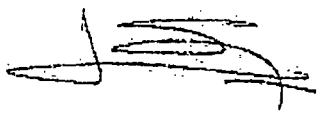
VITAL SIGNS:	Stable.
GENERAL:	The patient is well groomed, well kept; adequate for stated age, obese.

NEUROLOGIC EXAMINATION:

CRANIAL NERVES:	Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.
MOTOR:	Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.
GAIT/STATION:	Normal gait and tandem walk.
SENSORY:	Intact for pinprick, touch, and position.
DTRs:	Normoreflexive with plantar flexor response.
CEREBELLAR:	Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.
MECHANICAL:	Pain with hyperextension and hyperflexion of the neck.

MEDICAL DECISION MAKING: The patient presented here secondary to the complaint of episodes of dizziness, headaches, episode of loss of consciousness, and

traumatic brain injury type of picture. All in all, the symptomatology that the patient is having continues to be improved with the usage of medication and the decision to continue taking Neurontin 600 mg will be given. We will increase the dose to three times a day, and according to those findings, we will see if it is necessary to pursue any other treatment or investigation. Followup appointment will be arranged.



George Sandoz, MD

GS/smw

LabCorp
Laboratory Corporation of America

LabCorp Burlington
1447 York Court
Burlington, NC 27215-3361
Phone: 800-762-4344

Specimen Number	Patient ID	Control Number	Account Number	Account Phone Number	Route
148-277-3225-0	164930	20047432387	39709150	843-449-2336	--

Patient Last Name: FRAGOSO
Patient First Name: HECTOR
Patient Middle Name:
Patient SS#:
Patient Phone: 843-241-8478
Total Volume:
Age (Y/M/D): 28/07/24
Date of Birth:
Sex: M
Fasting: No
Patient Address:

Account Address:
Strand Regional Specialty Asso
8171 Rourk Street
Myrtle Beach SC 29572

Additional Information:
UPIN: F90332

Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID
05/28/09 09:57	05/28/09	05/29/09 11:38ET	SANDOZ , G	1013975010	

Tests Ordered:
CBC With Differential/Platelet; Urinalysis, Routine; Basic Metabolic Panel (8); Drawing Fee

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	6.6		x10E3/uL	4.0 - 10.5	01
RBC	5.40		x10E6/uL	4.10 - 5.60	01
Hemoglobin	16.4		g/dL	12.5 - 17.0	01
Hematocrit	49.2		%	36.0 - 50.0	01
MCV	91		fL	80 - 98	01
MCH	30.3		pg	27.0 - 34.0	01
MCHC	33.3		g/dL	32.0 - 36.0	01
RDW	13.4		%	11.7 - 15.0	01
Platelets	166		x10E3/uL	140 - 415	01
	Please note reference interval change				
Neutrophils	42		%	40 - 74	01
Lymphs	**49**	**High**	%	14 - 46	01
Monocytes	7		%	4 - 13	01
Eos	1		%	0 - 7	01
Basos	1		%	0 - 3	01
Neutrophils (Absolute)	2.8		x10E3/uL	1.8 - 7.8	01
Lymphs (Absolute)	3.2		x10E3/uL	0.7 - 4.5	01
Monocytes(Absolute)	0.5		x10E3/uL	0.1 - 1.0	01
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	01
Urinalysis, Routine					
Urinalysis Gross Exam					01
Specific Gravity	1.029			1.005 - 1.030	01
pH	5.5			5.0 - 7.5	01
Urine-Color	Yellow			Yellow	01
Appearance	**Cloudy**	**Abnormal**		Clear	01
WBC Esterase	Negative			Negative	01
Protein	Trace			Negative/Trace	01
Glucose	Negative			Negative	01
Ketones	Negative			Negative	01
Occult Blood	Negative			Negative	01
Bilirubin	Negative			Negative	01
Urobilinogen, Semi-Qn	0.2		mg/dL	0.0 - 1.9	01
Nitrite, Urine	Negative			Negative	01

FRAGOSO, HECTOR	164930	148-277-3225-0	Seq #4647

DUPLICATE FINAL REPORT Page 1 of 2

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1447 York Court
Burlington, NC 27215-3361
Phone: 800-762-4344

Patient Name					Specimen Number		
FRAGOSO, HECTOR					148-277-3225-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
39709150	164930	20047432387	05/28/09 09:57	05/29/09	M	28/07/24	10/04/80

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Microscopic Examination					
Microscopic follows if indicated.					01
Basic Metabolic Panel (8)					
Glucose, Serum	87		mg/dL	65 - 99	01
BUN	11		mg/dL	5 - 26	01
Creatinine, Serum	1.02		mg/dL	0.76 - 1.27	01
eGFR	>59		mL/min/1.73	>59	
eGFR AfricanAmerican	>59		mL/min/1.73	>59	
Note: Persistent reduction for 3 months or more in an eGFR <60 mL/min/1.73 m2 defines CKD. Patients with eGFR values >/=60 mL/min/1.73 m2 may also have CKD if evidence of persistent proteinuria is present. Additional information may be found at www.kdoqi.org.					
BUN/Creatinine Ratio	11			8 - 27	
Sodium, Serum	140		mmol/L	135 - 145	01
Potassium, Serum	4.1		mmol/L	3.5 - 5.2	01
Chloride, Serum	103		mmol/L	97 - 108	01
Carbon Dioxide, Total	22		mmol/L	20 - 32	01
Calcium, Serum	10.2		mg/dL	8.5 - 10.6	01

01 BN LabCorp Burlington Dir: William F Hancock, MD
1447 York Court, Burlington, NC 27215-3361
For inquiries, the physician may contact Branch: 800-762-4344 Lab: 800-762-4344

FRAGOSO, HECTOR	164930	148-277-3225-0	Seq #4647

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Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	05/19/2009 9:45 AM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with headache, neck pain, dizziness, low back pain and back pain.

History of Present Illness
1. headache (follow-up)
Onset: 19 Month(s) ago. Severity: moderate. It occurs constantly, has 30-60 minutes duration, and is unchanged. Location was entire head. There was radiation to posterior. The describes it as debilitating, lancinating, pressure and worsening with laughter and almost loc. It occurred due to recent head trauma. Symptom is aggravated by valsalva. Relieving factors include prescription drugs. Associated symptoms include blurred vision, nausea and vertigo.
2. neck pain (follow-up)
Additional comments:
8/10 into both arms severe
3. dizziness (follow-up)
Additional comments:
with head movement.
4. low back pain
Onset: 19 Month(s) ago. Severity level is moderate-severe. The problem is stable. It occurs persistently. Location of pain was lower back and legs. The describes the pain as an ache, burning and deep. Context: bending forward and bending over. Symptoms are aggravated by ascending stairs, changing positions and coughing. Symptoms are relieved by pain meds/drugs and rest.
5. Back Pain
Additional comments:
abdominal area severe associated with UTI, started on left now on right.

Past Medical History
Reviewed, no changes. Last detailed document: 05/19/2009.

Family History

Yes / No	Disease Detail	Family Member	Name	Age
	Alive and well	Brother		
	Alive and well	Brother		
	Alive and well	Father		
	Alive and well	Mother		

Social History
Tobacco:
Patient is a tobacco user.
4.00 years.
Alcohol:
There is a history of alcohol use.

Beer approximately 1 beer d was consumed occasionally -

Allergies
No known allergies.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
9:41 AM	5.0	3.00				

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
9:41 AM	198.00					35.07	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
9:41 AM	138/72	sitting	left		manual	adult

Measured By

Time	
9:41 AM	Penny Powers

Physical Exam
Constitutional:
Level of distress is awake & alert, in pain. Nourishment type is obese. Overall appearance is age appropriate.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .
Babinski: Reflexes normal. .
Kernig's sign: Negative.
Brudzinski's sign: Negative.

Clinical Assessment
The patient is a 28-year old male who presents with headache, neck pain and dizziness. The patient is compliant with medication. Not responding to current treatment. s/p esi on cervical spine without resolution

Assessment/ Plan
Lumbar / lumbosacral degenerative disc (722.52)
Cervical disc degeneration (722.4)
Migraine, unspecified (346.90)
Abdominal pain, epigastric (789.06)

Document generated by: george sandoz 05/19/2009
Gomez-Fragoso, Hector

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	06/02/2009 2:30 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with headache, dizziness and loss of consciousness.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate. It occurs constantly, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to anterior. The patient describes it as debilitating, sharp and worst ever. Symptom is aggravated by head position and stress. Relieving factors include relaxation.
2. dizziness
3. loss of consciousness

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Physical Exam
Constitutional:
Level of distress is mild distress, in pain. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment

The patient is a 28-year old male who presents with headache, dizziness and loss of consciousness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Intracranial injury of other and unspecified natur (854.01)
Variants of migraine with intractable migraine, so (346.21)
Dizziness and giddiness (780.4)
Degeneration of lumbar or lumbosacral intervertebr (722.52)
discussed findings still c/o having kidney pain, work up negative in the past. Continue with management, also awaiting neuropsych evaluation, interview in Spanish. MMI and Impairment rating given.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Diet plan: weight reduction			
completed	Discussed risk/benefits/side effects of treatment			

Instructions / Education

Status	Completed	Order	Reason
completed	08/07/2009	Continue current medication	
completed	08/07/2009	Activity as tolerated	
completed	08/07/2009	Risks/ benefits of treatment plan	
completed	08/07/2009	Potential for abuse	
completed	08/07/2009	Reviewed medications	
completed	08/07/2009	Pain management	
completed	08/07/2009	Medication side effects	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up for increased symptoms		854.01	-today	08/07/2009
completed	Follow-up for medication side effect		854.01	-today	08/07/2009

Document generated by: George Sandoz 08/07/2009

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates LLC

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C. Todd Beebi PA-C

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Julian N. Hayes, M.D.
Barbara L. Sarb, D.O.
Michael McCaffrey, M.D.
George M. Sandoz, M.D.
eff A. Benjamin, D.O.

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Frederick J. Hamilton, D.O.
David Eversman, N.D.
in L. Kirby, P.A.-C

OCEAN VISION LASER EYE SURGERY
YE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

June 03, 2009

To Whom It May Concern:

Re: Hector Gomez Fragoso
DOB:
SSN:

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who was involved in a work-related injury on 11/01/2007. At this moment, he was seen by MUSC Orthopaedics for cervical and lumbar injury as well for a traumatic brain injury. The patient continued to have headaches and required to take medications. Today, he was started on pain management. After evaluation of the AMA Guidelines, Sixth Edition from the standpoint of the headache, the patient has 3% impairment of the whole body. From the standpoint of the dizziness, the patient has a class II as noted on table 11-4 of 9% impairment of the whole body. From the traumatic brain injury, the patient's impairment rating is of 20% as noted on the table 13-8. This still has pending impairment ratings from the lumbar and cervical spine and this will be addressed by MUSC Orthopaedics. The patient will require to take medication on a chronic basis. Assessment of his memory changes and inability to perform ADLs will be indicated. Pain medication add to the present and medication for the treatment of attention deficit disorder is required for the care of this patient. He will be required to be evaluated on a quarterly basis minimally for refill of prescriptions. Followup appointment will be arranged in a month to reassess the condition.

Sincerely,

George Sandoz, MD

GS/mlp

cc: Jeff Chandler

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	07/07/2009 2:30 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with head injury, dizziness and headache.

History of Present Illness

1. head injury (follow-up)

Onset: sudden. The severity of the symptoms is moderate. The symptoms have 11-1-07. Ventilator support was used in the hospital. The location of the injury is in the bilateral frontal region and bilateral cervical region. The location of pain is facial, head and neck. The patient describes the pain as aching and burning. The mechanical force causing the injury was contra-coup and coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Other relieving factors tried: unable to get control substance. Associated symptoms include incoordination, irritability, memory difficulty and speech difficulty.

2. dizziness

Onset was sudden. Severity is moderate. The duration of each episode is Year(s). The problem is unchanged. It occurs persistently. The patient describes it as (an) imbalance and spinning. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by bending. Relieving factors include VDE.

3. headache

Onset: sudden. Severity: moderate. Duration: Year(s). The problem is unchanged. Location was entire head. There was radiation to anterior. The describes it as blinding. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position.

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Height

Time	Ft	In	Cm	Last Measured	Method	%
3:35 PM	5.0	2.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
3:35 PM	200.00					36.58	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
3:35 PM	148/88	sitting	left		manual	adult

Gomez-Fragoso, Hector

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse	Pattern	Resp
3:35 PM				80	regular	

Measured By

Time	
3:35 PM	Penny Powers

Physical Exam

Constitutional:
Level of distress is irritable, in pain, moderate distress. Nourishment type is obese. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
Thoracic spine has muscle spasm, mildly reduced ROM
Lumbar spine has muscle spasm, moderately reduced ROM
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: positive right.
Comments: MMS26/30

Clinical Assessment

The patient is a 28-year old maleWith Traumatic brain Injury, Headacke, dizzinessdificult with complex tasks. The patient is compliant with medication. Compliant with current therapy. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan

Dizziness (780.4)
Migraine, intractable, variants (346.21)
Intracranial injury of other and unspecified natur (854.01)
Late effect of intracranial injury without mention (907.0)
S/p TBI, with complicated Migraine, Dizziness and Cervical and Lumbar pain, Paitent has not had hi sNeuropsych evaluation, unable to obtain control substance that is not having the treatment neede to maximize his recovery and improve his condition to reinstate this patient to get gainfull employment, sample of Ultram and rx given. Interview was performed in spanish.

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Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Strand Regional Specialty Associates LLC

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	08/12/2009 9:45 AM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with head injury, headache and dizziness.

History of Present Illness
1. head injury (follow-up)
Onset: sudden. The symtoms are severe. The symptoms have not changed. Ventilator support was used in the hospital. The location of the injury is in the bilateral temporal region. The location of pain is facial and head. The mechanical force causing the injury was coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Relieving factors tried include narcotic analgesics. Associated symptoms include Battle's sign, headache, personality change, stiff neck and visual disturbance.
2. headache (follow-up)
Onset: sudden. Severity: mild-moderate. It occurs daily, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to posterior. The patient describes it as debilitating and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position and stress. Relieving factors include prescription drugs. Associated symptoms include dizziness.
3. dizziness (follow-up)
Onset was sudden. Severity is mild. The duration of each episode is 5-15 minutes. The problem is unchanged. It occurs intermittently. The patient describes it as (an) imbalance. It occurs sponataneously. It occurs while exercising and sitting. Symptom is aggravated by rapid movement. Relieving factors include position change.

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Physical Exam
Constitutional:
Level of distress is mild distress, due to pain. Nourishment type is overweight. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
Lumbar spine has muscle spasm, moderately reduced ROM
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .

Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the left
Glossopharyngeal: normal.
Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment
The patient is a 28-year old male who presents with head injury, headache and dizziness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan
Intracranial injury of other and unspecified natur (854.01)
Awaiting for Neuro psych eval before give patient MMI and IR
Variants of migraine with intractable migraine, so (346.21)
continue with ultran for treatment of headacke.
Dizziness and giddiness (780.4)
Tolerating VDE's and interview was conducted in spanish.

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Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates
LLC

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David Everman, M.D.
Erin L. Kirby, P.A.-C

OCEAN VISION A EYE SURGERY
EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

August 20, 2009

To Whom It May Concern:

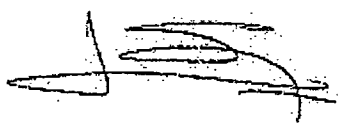
RE: Hector Gomez Fragoso
DOB:
Chart: 81323

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who I have seen since 09/16/2008 secondary to a traumatic brain injury on 11/01/2007. He _____ for a traumatic brain injury. At this moment from the injury that the patient has suffered, he is totally and permanently disabled. After evaluation of the AMA Guidelines, Guides to Evaluation of the Permanent Impairment Rating, fifth edition as in table 13-5, the patient has a 29% of whole person. Superimposed to this is associated with the headaches that the patient has presented and this correlates to 2% impairment of the whole body. From the standpoint of the dizziness, the patient has 10% impairment of the whole person. Utilizing a combined value chart, this is a 46% impairment of the whole body. This does not attend to the damage that the patient has suffered from his neck and back as well for his foot.

Please do not hesitate to call me if you have any other further question or investigation in this patient.

Sincerely,



George Sandoz, MD

GS/smw

cc: Jeff Chandler

Strand Regional Specialty Associates LLC

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	11/12/2010 11:30 AM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 30 year old male presents with headache and dizziness.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate. Duration: Year(s). The problem is unchanged. Location was occipital. There was radiation to anterior. The patient describes it as blinding and debilitating. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights and noise. Relieving factors include prescription drugs. Associated symptoms include blurred vision, dizziness, memory loss, neurological symptoms, photophobia and vomiting.
2. dizziness
Onset was gradual. Severity is moderate. The duration of each episode is Month(s). The problem is unchanged. The patient describes it as (an) spinning. It occurs sponataneously. Denies aggravating factors. Denies relieving factors. Additional information: coughup blood.

Allergies
No known allergies.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
1:02 PM	5.0	7.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
1:02 PM	208.00					32.57	

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse	Pattern	Resp
1:02 PM				70		

Measured By

Time	
1:02 PM	Penny Powers

Physical Exam

Clinical Assessment
The patient is a 30-year old male who presents with headache and dizziness. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Dizziness and giddiness (780.4)
due to tbi doing fair with therappy.
Variants of migraine with intractable migraine, so (346.21)
Stop oxycodone and trial with nucynta and push up dose.
Intracranial injury of other and unspecified natur (854.01)
Trial with celexa and need to find pmd for couh blood etiology ? due to intubation.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	11/12/2010	Continue current medication	
completed	11/12/2010	Risks/ benefits of treatment plan	
completed	11/12/2010	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up for increased symptoms		780.4	-today	11/12/2010	
completed	Follow-up if symptoms persist / worsen			780.4	11/12/2010	
completed	Follow-up for medication side effect		780.4	-today	11/12/2010	
scheduled	Office visit	Continue current treatment	780.4	-today		11/12/2010
scheduled	Office Visit	Follow-up on medication	780.4	-today		11/12/2010

George M. Sandoz MD

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NEUROLOGY

MICHAEL McCAFFREY, MD
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JEFF A. BENJAMIN, DO
SC 00501 / DEA BB4121567

BARBARA L. SARB, DO
SC 00412 / DEA BS3322663

NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, MD
SC 20125 / DEA BS3769621

For [illegible] Age

Address Date 11/23/10

℞ [illegible]

LABEL
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NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, MD
SC 20125 / DEA BS3769621

For Gomez Fragoso, Hector Age

Address Date 1/20/10

℞ Tylenol #3
ATC q6h
#120

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GEORGE M. SANDOZ, MD
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For [illegible] Age

Address Date 11/3/10

℞ [illegible]

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GEORGE M. SANDOZ, MD
SC 20125 / DEA BS3769621

For [illegible] Age

Address Date 11/12/10

℞ [illegible]

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NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, MD
SC 20125 / DEA BS3769621

For [illegible] Age

Address Date 11/12/10

℞ [illegible]

LABEL
REFILL 0 - 1 - 2 - 3 - 4 - 5 - PRN

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Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	01/05/2011 4:30 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 30 year old male presents with headache.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate-severe. It occurs daily, has Year(s) duration, and is worse. Location was occipital. There was radiation to anterior. The patient describes it as debilitating, sharp and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Relieving factors include prescription drugs.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Tylenol-codeine No.3 as needed	300mg-30mg	120	take 1 tablet by ORAL route every 6 hours
Amitriptyline Hcl every 6 hours	25 Mg	60	take 1 - 2 tablet (25MG) by ORAL route
Treximet	85mg-500mg	18	1 poq 12 hrs
Celexa day	20 Mg	30	take 1 tablet (20MG) by ORAL route every

Allergies
No known allergies.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
5:14 PM	5.0	5.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
5:14 PM	211.00					35.11	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
5:14 PM	138/78	sitting				

Measured By

Time	
5:14 PM	Penny Powers

Physical Exam
Constitutional:

Level of distress is moderate dis ess. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment
The patient is a 30-year old male who presents with headache. The patient is compliant with medication. Not responding to current treatment. Need to alter current therapy. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan
Variants of migraine with intractable migraine, so (346.21)
Failure to control hi ssymptoms, trial nucynta, consider botox and further w/u with new mri.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	01/19/2011	Activity as tolerated	
completed	01/19/2011	Continue current medication	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
scheduled	Office Visit	Follow-up on medication		346.21	-today	01/19/2011
completed	Follow-up for medication side effect		346.21	-today	01/19/2011	
completed	Follow-up for increased symptoms		346.21	-today	01/19/2011	
completed	Follow-up if symptoms persist / worsen			346.21	01/19/2011	
scheduled	Office visit	Continue current treatment		346.21	-today	01/19/2011

George M. Sandoz MD

Document generated by: George Sandoz 01/19/2011

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	01/19/2011 4:45 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 30 year old male presents with headache.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate-severe. It occurs daily, has Year(s) duration, and is worse. Location was occipital. There was radiation to anterior. The patient describes it as blinding, debilitating and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Denies relieving factors. Associated symptoms include blurred vision, dizziness, memory loss, neurological symptoms and performance changes.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Nucynta	100 Mg	60	take 1 tablet (100MG) by ORAL route every 6 hours as needed
Tylenol-codeine No.3	300mg-30mg	120	take 1 tablet by ORAL route every 6 hours as needed
Amitriptyline Hcl	25 Mg	60	take 1 - 2 tablet (25MG) by ORAL route every 6 hours
Treximet	85mg-500mg	18	1 poq 12 hrs
Celexa	20 Mg	30	take 1 tablet (20MG) by ORAL route every day

Allergies
No known allergies.

Vital Signs

Physical Exam
Constitutional:
Level of distress is moderate distress, due to pain. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has tender, moderate pain w/motion
Lumbar spine has muscle spasm, moderately reduced ROM
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .

Deep Tendon Reflexes: symm. ically increased.
Babinski: Reflexes normal. .

Clinical Assessment
The patient is a 30-year old male who presents with headache. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Need to alter current therapy.

Assessment/ Plan
Variants of migraine with intractable migraine, so (346.21)
Failure again with nucynta, due to his neck pain and back pain and shoulder pain methadone 5 mg tid given, trial for botox also.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	01/19/2011	Continue current medication	
completed	01/19/2011	Risks/ benefits of treatment plan	
completed	01/19/2011	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	
completed	Follow-up for increased symptoms		346.21	-today	01/19/2011	
completed	Follow-up for medication side effect		346.21	-today	01/19/2011	
completed	Follow-up if symptoms persist / worsen			346.21	01/19/2011	
scheduled	Office Visit	Follow-up on medication		346.21	-today	01/19/2011
scheduled	Office visit	Continue current treatment		346.21	-today	01/19/2011

George M. Sandoz MD

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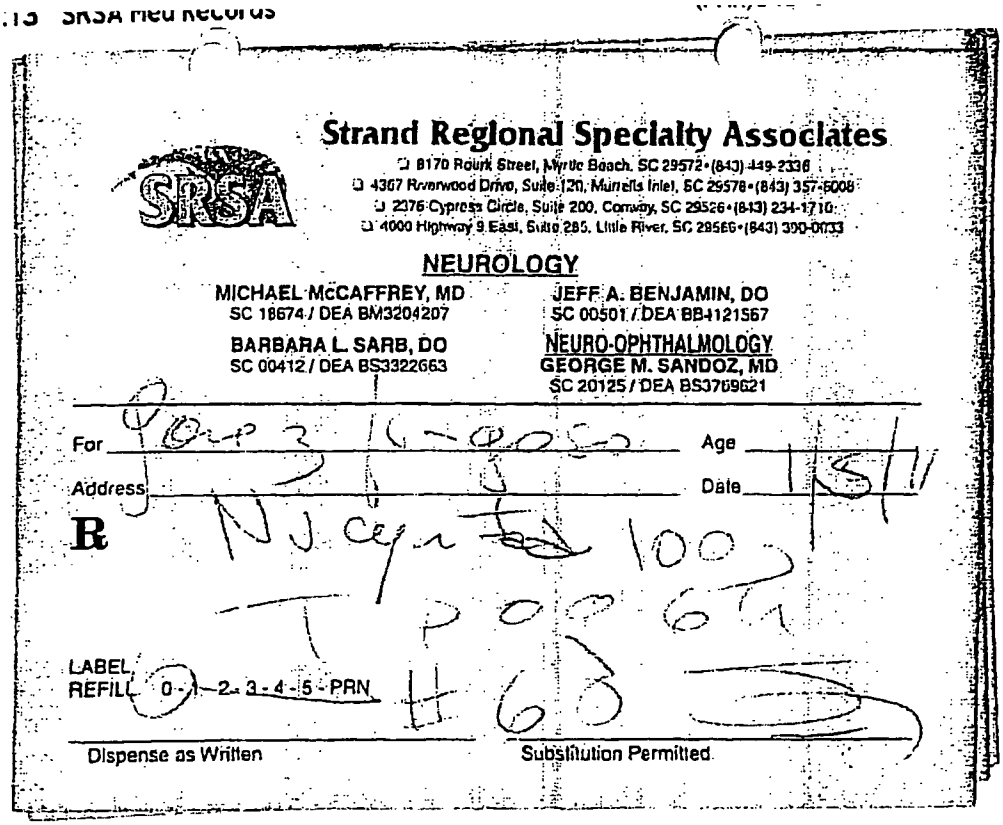
Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572



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NEUROLOGY

MICHAEL McCAFFREY, MD
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BARBARA L. SARB, DO
SC 00412 / DEA BS3322663

NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, MD
SC 20125 / DEA BS3769621

For Hector Gomez-Fragoso Age 35

Address [illegible] Date 1/5/11

℞ Neurontin 100 mg

1 po qhs

LABEL
REFILL 0 - 1 - 2 - 3 - 4 - 5 - PRN #60

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GRAND STRAND SPECIALTY ASSOCIATES

8170 Rourk Street • Myrtle Beach, SC 29572 • Office 843-449-2336 Fax 843-692-2145

NEUROLOGY

MICHAEL MCCAFFREY, M.D.
SC LIC # 15674 • DEA # BM1204207

JEFF A. BENJAMIN, DO
SC LIC # 00501 • DEA # BB4121567

BARBARA L. SAUL, DO
SC LIC # 00412 • DEA # BS1322663

NEURO-OPHTHALMOLOGY
GEORGE M. SANDOZ, M.D.
SC LIC # 20125 • DEA # BS3769621

Patient Name Gomez-Fragoso Date 6/19/11

Address

R Levetiracetam SR
500 mg
#90

☐ unless checked, label with drug name

Refill 0 times (No refill unless indicated)

M.D. M.D.

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

Atlantic Physical Therapy (H# 3436) ☒PT ☐OT ☐ST ☐DR
Previous Patient? Yes No ☒MB ☐NC ☐CW ☐CF

Person Calling In Referral Linda Renew Therapist MHG Scheduled On: 12/16 Time: 7:30
Gladys - 992-7791

Patient Information

Social Security #	Title	Last Name	First Name	MI
		Gomez-Fagoso	Hector	

Street Address (Road or Street) | (Apartment Number or Second Address Line)

Zip Code | City | State

Home Phone: | Cell Phone (Patient Data): | Referring Doctor (Include Contact Info If New Referring Physician): Dr. Woolf @ MUSC

Birthday | Age: 28 | Sex (M, F): M | Diagnosis: (L) Shoulder & Neck/Lumbar | Prescribed Frequency

Marital: ☐M-Married ☐W-Widowed ☐S-Single ☐D-Divorced ☐X-Separated
Employment: ☐R-Retired ☐F-Full ☐P-Part ☐N-None
Student: ☐P-Part ☐F-Full ☐N-None
Relationship to Insured: ☐SE-Self ☐SP-Spouse ☐OT-Other ☐CH-Child

Have You Had Home Health in last 60 days? ☐Yes ☐No
If yes, which Home Health Agency?
Date of their last visit?
Have you had therapy at another office in the last year? ☐Yes ☐No
If yes, what practice?

Employer Name & Address

Zip Code | City | State | Phone | Ext

Insurance Information

Primary Insurance Company Name	Insurance Telephone #	Policy/ID #	Group #

Secondary Insurance Company Name	Insurance Telephone #	Policy/ID #	Group #

Workers Comp Carrier (if applicable)	Insurance Telephone #	Claim #	Out of Work
Key Risk.		1000021953	☒Yes ☐No

Adjustor and/or Rehabilitation Nurse	Telephone Number	Fax Number
Lind Renew	1-8006057366 ext 7822	fax 3366658052

Complete Next Section If Coverage Is NOT In Patient's Name Or If Patient is a Minor Child

Social Security #	Title	Last Name	First Name	MI

Birthday (REQUIRED)	Sex (M, F)	Relationship to Patient:

Is This Treatment Due To An Accident? Yes ___ No ___; If Yes Complete Below

Employment related: ☐Yes ☐No	Accident Related: ☐Auto ☐Other ☐No	If auto, state where accident occurred:	Date of first symptom or accident: 11-01-07

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.

HECTOR GOMEZ F. 12-16-08
Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

730 HECTOR GOMEZ F. 12-16-08
Signed P777 Date

Vocational Form

Patient:	**Hector Gomez-Fragoso**	**Account #:**	3436
Diagnosis:	Muscle Weakness-General; Stiffness of joint not elsewhere classified: multiple sites; Joint Pain-Mult Jts; Spasm of muscle	**Evaluation Date:**	12-16-2008
Therapist:	Melissa H Gray PT		

Work: ____N/A (Retired) (If N/A Skip to Item 2)

1. Occupation: construction :

Length of time with company: _____ **Receiving WC** ✓ **Yes** ____ **No**

Presently Working _____ **Yes** ✓ **No** **Able to return to work** ___ **Yes** ___ **No** ?

Will client return to present job ___ **Yes** ___ **No** ?

Does patient have a vocational rehabilitation or insurance specialist ___ **Yes** ___ **No?**

Would patient benefit from: ___ **Voc Rehab** ___ **SSI** ___ **VA/GI BILL** ___ **Social Service**

___ **Career Counseling** ___ **Home Health** ___ **Counseling.**

Military Service: _____ **Yes** ___ **No** **Eligible for VA Benefits** ___ **Yes** ___ **No**

Eligible for VA educational re-training ____ **Yes** ____ **No**

2. Personal:
Patient lives: ✓ **Alone** ___ **Spouse** ___ **Relatives** ___ **Friends** ___ **Other/With Assistance**

Upon completion of Rehab, patient will live:

✓ **Alone** ___ **Spouse** ___ **Relatives** ___ **Friends** ___ **Other/With Assistance**

Transportation: ✓ **Independent** ___ **has help** ___ **needs help** _____

Needs help with ADL: ✓ **No** ___ **Has help** ___ **Yes**

3. Rehabilitation Potential:
Patient tries to help self ✓ **Yes** ___ **No**

Use available Help: ✓ **Yes** ___ **No**

Will client be able to return to previous ADL? ✓ **Yes** ___ **No**

DATE: January 30, 2009

NAME: Gomez-Fragoso, Hector

RECOMMENDATIONS AND PLANS FOR REMEDYING PROBLEMS AND MEETING VOCATIONAL NEEDS.

PATIENT'S RECORD WAS REVIEWED WITH NO RECOMMENDATION MADE FOR VOCATIONAL SERVICE INTERVENTION. The patient is retired and is expected to be able to return to previous level of ADL.

Gloria Timmons, EDS DATE: 1/30/09

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

	Phone	Fax
Myrtle Beach	843-293-7713	843-293-1855
North Myrtle Beach	843-249-7232	843-280-0206
Conway	843-234-0015	843-234-0017
Carolina Forest	843-903-4940	843-903-4945

P.O. Box 1145 Myrtle Beach, SC 29578

Plan of Care - Initial Evaluation
DATE of EVALUATION: 12-16-2008

Shane K Woolf MD
96 Jonathon Lucas Street
Charleston,SC 29425

PATIENT: Hector Gomez-Fragoso **DOB:** **Patient Account#:** 3436
DIAGNOSIS: Muscle Weakness-General 728.87 Stiffness of joint not elsewhere classified: multiple sites 719.59 Joint Pain-Mult Jts 719.49 Spasm of muscle 728.85
PHYSICIAN DIAGNOSIS/PROBLEM: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP.
Precautions: Nonunion fracture of C7 spinous process

PROBLEM LIST: Mr. Gomez-Fragoso presented today with the following problems that will be addressed with skilled therapy services:
- Complaint of cervical, left shoulder and LB pain
- Complaint of headache
- Decreased ROM - cervical, lumbar and left shoulder
- Decreased strength/stabilization
- Muscle spasm at cervical/upper trapezius area
- Impaired function

LONG-TERM GOALS:
- Decrease subjective complaint of pain (cervical/LB/left shoulder) to self-manageable level
- Decrease complaint of headache to self-manageable level
- Increase cervical ROM to: flexion = 50 deg; extension = 30 deg; bilateral side bending = 30 deg each; bilateral rotation = 50 deg each
- Increase trunk ROM by 5 deg each direction
- Increase left shoulder AROM to equal right
- Improve strength/stabilization to WFL
- Decrease spasm/tissue density at cervical/upper trapezius area to min/mod
- Able to turn head to drive with less difficulty and able to reach with left UE without difficulty
- Patient independent with home exercises and management of symptoms

TREATMENT CARE PLAN (Modalities & Exercises PRN):
- PT Evaluation
- Physical Therapy Re-Evaluation
- Physical Performance Test/Measure
- Moist heat/Ice
- Therapeutic Exercise
- Therapeutic Activity
- Ultrasound
- Manual Therapy
- Unattended Electrical Stimulation
- Mechanical Traction

PLAN: We will see Mr. Gomez-Fragoso 3 time(s) per week for 8 week(s). Certify from: to .

ESTIMATED DISCHARGE: 2/09 **REHAB POTENTIAL:** good

Thank you for allowing me to participate in the care of this patient.

Applies to Medicare Beneficiaries only:

I certify that my patient requires outpatient rehabilitation services that are reasonable and necessary. I have written and/or reviewed the plan of care.

_____ Date:_____

Melissa Gray PT

Tue Jul 2008 07/22/08 14:36:47
This note has been electronically signed by
Melissa H Gray PT

Shane K Woolf MD

Atlantic Physical Therapy & Rehab. 3650 Coalition Drive Myrtle Beach, SC 29578 Phone: 843-293-7713, FAX: 843-293-1855

Mechanism of Injury: Patient is a 28 year old male referred to PT by Dr. Woolf with diagnosis of: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Patient was injured 11/1/07 when a construction crane struck him on the head causing a small subdural hematoma as well as cervical spinous process and transverse process fractures, also in the thoracolumbar area - per MD report. Patient also sustained a crush injury to right foot and required amputation of 4 toes. Patient without PT treatment thus far.

Past Medical History (Meds): PMH significant for: none
Meds include: 2 pain medications - patient does not know names - states 1 is for foot and 1 for headaches.
Number of meds

Work/Functional Status: Patient presents with complaint of constant pain bilateral cervical area (left greater than right) 8/10. He also complains of constant headache at top of head since injury. Patient reports experiencing constant paresthesia all digits left hand and complains of pain left shoulder with movement. Patient also reports experiencing intermittent LBP. He reports difficulty turning head while driving and reports difficulty using left UE to turn wheel. He is right hand dominant and is able to use left UE for ADL's but with pain left cervical/upper trapezius area. He is able to carry light objects with left UE near body. He is not able to lift anything heavy or reach into full flex/ER/abduction quadrant. Patient reports sleeping prone with head turned.

Co-morbidities Affecting Therapy: 4 digits amputated from right foot

OBJECTIVE TESTS:

Test	Description	Results	Comments
Posture	Posture Narrative	forward head/rounded shoulder posture with decreased lumbar lordosis with right shoulder girdle higher	
Gait	Assistive Device Gait Pattern	none without apparent difficulty	
Cervical ROM in Degrees	Flexion Extension Side Flexion (L) Side Flexion (R) Rotation (L) Rotation (R) Active Shoulder ROM: Flexion Active Shoulder ROM: Abduction Active Shoulder ROM: IR Active Shoulder ROM: ER Active Elbow Extension	30 23 15 25 30 45 (L)=145 deg; (R)=150 deg (L)=140 deg; (R)=170 deg (L)=lower lumbar; (R)= mid back (L)=lim 25%; (R) = WFL (L)= lacking 5 deg; (R) = WFL	 Sitting Sitting
Lumbar Active ROM	Flexion Extension Lateral Flexion (L) Lateral Flexion (R) Rotation (L) Rotation (R)	90 deg 20 deg 18 deg 15 deg 75% ROM 75% ROM	
Strength	Dorsiflexion Knee extension Hip flexion Elbow flexion Elbow extension Shoulder flexion Shoulder abduction IR ER	(B) = WFL (B) = WFL (B) = WFL (L)=4; (R)=WFL (B) = WFL (L) = 4; (R)=WFL (L)=4; (R)=WFL (B) = WFL (L)=4/4+; (R) = WFL	 Pain left upper trapezius Pain left upper trapezius Pain left upper trapezius Pain left upper trapezius
Sensation	Sensation narrative	decreased sensation left posterior forearm/post hand	

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Palpation	Palpation	mod increased density bilateral cervical musculature with tenderness noted; max increased density left upper trapezius with a great deal of tenderness noted; mod/max increased density right upper trapezius with only minimal tenderness noted; mod increased density bilateral medial scapular area with minimal tenderness noted	

Assessment: Patient is a 28 year old male who presents to the clinic with cervical pain/spasm, LBP and headache all affecting his functional activity level. Skilled PT intervention is indicated. Treatment to include: modalities to decrease pain/spasm and therapeutic exercise to improve mobility as well as strength/stabilization. Patient is in agreement with this plan.

Comments:
Patient does not speak English - interpreter present during evaluation/treatment.

Mr. Gomez-Fragoso has been advised that compliance with a home program is vital to a successful rehabilitation program. He has been instructed to discontinue any exercise or activity which increases symptoms.

Electronically signed by Melissa H Gray PT

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Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-16-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise/Description	Units/Reps/Weights	Minutes
PT Evaluation	1/	30
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	1/ HEP instruction (via interpreter) of: CROM (bilateral side bending and bilateral rotation only); scapular retraction; pelvic tilt; trunk rolls; isometric abdominals - tiny steps in place - written copy provided of HEP	10
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine	10
	Total Minutes	**65**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

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Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-17-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports feeling some better after last treatment. He reports some pain left cervical area with HEP. Patient reports less headache today.

OBJECTIVE: Treatment per activity/flowsheet;
Added bridging to HEP

ASSESSMENT: Able to perform LB exercises without increased complaint; reports left anterior shoulder pain with ROM

PLAN: Progress as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

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Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-17-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
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MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	1/ see below	15
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 5 each way	
isometric abdominals - tiny steps in place	1 x 10 each	
bridging	1 x 10	
isometric abs - SLR	1 x 10 each	
supine ROM left shoulder	PROM/AA ROM - all directions	
	Total Minutes	**45**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

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Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-22-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports cervical area pain persists but states headache is now intermittent. He reports (via interpreter) experiencing LBP since Sat which decreased with moist heat today. RTMD (Dr. Woolf) 1/5/09 and Dr. Sandoz 1/6/09

OBJECTIVE: treatment per activity/flowsheet

ASSESSMENT: Increased density persists at cervical/upper trapezius area. Patient with some increased left upper trapezius symptoms after initiating YTB exercises today.

PLAN: Progress as tolerated with exercise program

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Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-22-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10 each way	
isometric abdominals - tiny steps in place	1 x 10 each	
bridging	1 x 10	
isometric abs - SLR	1 x 10 each	
supine ROM left shoulder	PROM/AA ROM - all directions x 5 min	
quadruped - alt UE	1 x 5 each (*)	
pulleys - flexion	1 x 15 (*)	
pulleys - abduction	1 x 10 (*)	
YTB: rowing	1 x 10 (*)	
YTB: shoulder extension	1 x 10 (*)	
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

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Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-24-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports pain persists at cervical area and LB. He reports some relief with MT/STM at cervical area. No increased symptoms after exercise program last treatment. RTMD 1/5/09

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Cooperative and compliant with treatment. Patient reports left upper trapezius symptoms with wall push ups

PLAN: Progress as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

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3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-24-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10 each way	
isometric abdominals - tiny steps in place	1 x 10 each	
bridging	1 x 10	
isometric abs - SLR	1 x 10 each	
supine ROM left shoulder	PROM/AA ROM - all directions x 5 min	
quadruped - alt UE		
pulleys - flexion	1 x 15	
pulleys - abduction	1 x 15 (*)	
YTB: rowing	1 x 10	
YTB: shoulder extension	1 x 10	
YTB: bilateral ER	1 x 10 (*)	
	Total Minutes	**55**

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(Therapist)

Electronically signed by
(Associate)

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Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-30-2008
Patient DOB: **Referred By:** Shane K Woolf MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: RTMD (Dr. Woolf) 1/5/09. Patient continues with complaint of constant pain bilateral cervical area (left greater than right) 8/10. He reports headache at top of head is now intermittent. Patient continues with constant paresthesia all digits left hand and left shoulder pain with movement. Patient reports LBP is now constant since starting PT. Patient reports turning head to drive is still difficult as is using left UE to turn wheel. Patient continues with complaint of pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body.

OBJECTIVE: Treatment per activity/flowsheet; Added to HEP: YTB rowing, bilateral shoulder extension and bilateral ER - written copy provided.
CROM: flexion = 40 deg; extension = 30 deg; left side bending = 12 deg; right side bending = 22 deg; left rotation = 28 deg; right rotation = 58 deg;

AROM shoulder:	Left	Right
Flexion	135 deg	160 deg
Abduction	90 deg	175 deg
IR/ER	limited	--------

Trunk ROM: flexion = 90 deg; extension = 20 deg; left side bending = 22 deg; right side bending = 20 deg; bilateral rotation = 75%;
Strength left shoulder girdle: 3+/4 secondary left upper trapezius pain

ASSESSMENT: Cervical ROM (flexion and right rotation) with improvements as noted above but rest of ROM slightly decreased. Trunk ROM (bilateral side bending) has shown some improvement but rest remain the same. Patient continues with subjective complaints at cervical area - greatest left upper trapezius area - and L/S area. Strength and trunk stabilization still limited as is functional ability.

PLAN: Continue and progress as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

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Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 12-30-2008
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ re-assessment of status & instruction regarding HEP of YTB	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt		
trunk rolls		
isometric abdominals - tiny steps in place		
bridging		
isometric abs - SLR		
supine ROM left shoulder		
quadruped - alt UE		
pulleys - flexion		
pulleys - abduction		
YTB: rowing	1 x 10	
YTB: shoulder extension	1 x 10	
YTB: bilateral ER	1 x 10	
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

TO: Shane K Woolf MD
RE: Hector Gomez-Fragoso DOB:
PT: Moist heat, manual therapy techniques, therapeutic exercise, instruction regarding HEP
DATE: 12-30-2008

Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above for a total of 5 treatments since initial evaluation 12/16/08. Patient continues with complaint of constant pain bilateral cervical area (left greater than right) 8/10. He reports headache at top of head is now intermittent. Patient continues with constant paresthesia all digits left hand and left shoulder pain with movement. Patient reports LBP is now constant since starting PT. Patient reports turning head to drive is still difficult as is using left UE to turn wheel. Patient continues with complaint of pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body.

CROM	12/30/08	12/16/08
Flexion	40 deg	30 deg
Extension	30 deg	23 deg
Left side bending	12 deg	15 deg
Right side bending	22 deg	25 deg
Left rotation	28 deg	30 deg
Right rotation	58 deg	45 deg

AROM shoulder:	12/30/08		12/16/08	
	Left	Right	Left	Right
Flexion	135 deg	160 deg	145 deg	150 deg
Abduction	90 deg	175 deg	140 deg	170 deg
IR/ER	limited		WFL	

Trunk ROM	12/30/08	12/16/08
Flexion	90 deg	90 deg
Extension	20 deg	20 deg
Left side bending	22 deg	18 deg
Right side bending	20 deg	15 deg
Bilateral rotation	75%	75%

Strength left shoulder girdle: 3+/4 secondary left upper trapezius pain

Cervical ROM (flexion and right rotation) with improvements as noted above but rest of ROM slightly decreased. Trunk ROM (bilateral side bending) has shown some improvement but rest remain the same. Patient continues with subjective complaints at cervical area - greatest left upper trapezius area - and L/S

area. Strength and trunk stabi(ion still limited as is functional ability(atient reports some relief at cervical/upper trapezius area following treatment which lasts a few hours. We will plan to continue per present plan of care, progressing as tolerated and appropriate.

Thank you very much for your referral. Please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-02-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: RTMD (Dr. Woolf) 1/5/09 and Dr. Sandoz 1/6/09. Patient reports cervical area pain today 7/10, no headache at treatment time but LBP present.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Able to perform additional exercises without increased complaint but with decreased trunk control/stabilization with sitting gym ball exercise.

PLAN: Progress note sent with patient for MD appointments next week. Progress as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-02-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10 each	
bilateral knee fallout	1 x 10 (*)	
isometric abdominals - tiny steps in place	1 x 10 each	
isometric abdominals - alt UE (short range)	1 x 10 each (*)	
bridging	1 x 10	
isometric abs - SLR	1 x 10 each (*)	
adductor squeeze with ball	1 x 10 (*)	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 5 each	
pulleys - flexion		
pulleys - abduction		
YTB: rowing	1 x 10	
YTB: shoulder extension	1 x 10	
YTB: bilateral ER	1 x 10	
sitting blue gym ball - alt shoulder flexion	1 x 5 each UE (*)	
sitting blue gym ball - alt hip flexion	1 x 5 each LE (*)	
Airdyne (in # 4)	5 min (*)	
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-06-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient seen by Dr. Woolf 1/5/09 who is ordering MRI of neck and shoulder and stated to continue with PT. Patient seen by Dr. Sandoz 1/6/09 who is recommending injection at LB and also stated to continue PT. Patient reports pain is worse at left upper trapezius area today

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Increased density persists at left upper trapezius. Pain persists at cervical/left upper trapezius and L/S area.

PLAN: Continue and progress with exercise program as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-06-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10 each	
bilateral knee fallout	1 x 10	
isometric abdominals - tiny steps in place	1 x 10 each	
isometric abdominals - alt UE (short range)	1 x 10 each	
bridging	1 x 10	
isometric abs - SLR	1 x 10 each	
adductor squeeze with ball	1 x 10	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 5 each	
pulleys - flexion		
pulleys - abduction		
YTB: rowing	1 x 10	
YTB: shoulder extension	1 x 10	
YTB: bilateral ER	1 x 10	
sitting blue gym ball - alt shoulder flexion	1 x 10 each UE	
sitting blue gym ball - alt hip flexion	1 x 10 each LE	
Airdyne (in # 4)	5 min	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT (Therapist)

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-09-2009
Patient DOB: **Referred By:** Shane K Woolf MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Pain at left cervical/upper trapezius area and bilateral LB remains at 8/10. MRI of neck and shoulder today. Patient to see audiologist in Charleston 1/12/09 due to bilateral ear pain.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Increased density left upper trapezius persists.

PLAN: Progress as tolerated.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-09-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10 each	
bilateral knee fallout	2 x 10 (*)	
isometric abdominals - tiny steps in place	2 x 10 each (*)	
isometric abdominals - alt UE (short range)	1 x 10 each	
bridging	2 x 10 (*)	
isometric abs - SLR	1 x 10 each	
adductor squeeze with ball	2 x 10 (*)	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 5 each	
pulleys - flexion		
pulleys - abduction		
RTB: rowing	1 x 10 (*)	
RTB: shoulder extension	1 x 10 (*)	
RTB: bilateral ER	1 x 10 (*)	
UBE	1 min F/ 1 min B (*)	
sitting blue gym ball - alt shoulder flexion	1 x 10 each UE	
sitting blue gym ball - alt hip flexion	1 x 5 each LE (*)	
Airdyne (in # 4)		
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-13-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient had MRI of left shoulder and cervical spine last week - results not known. Patient with dizziness - seen by ENT in Charleston yesterday - provided with HEP of habituation exercises

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Tissue density left upper trapezius still increased

PLAN: Progress as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-13-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	2 x 10 each (*)	
bilateral knee fallout	2 x 10	
isometric abdominals - tiny steps in place	2 x 10 each	
isometric abdominals - alt UE (short range)	1 x 10 each	
bridging	2 x 10	
isometric abs - SLR	2 x 10 each (*)	
adductor squeeze with ball	2 x 15 (*)	
1/2 sit ups	1 x 10 (*)	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 10 each (*)	
quadruped - alt LE	1 x 5 each (*)	
pulleys - flexion		
pulleys - abduction		
RTB: rowing	1 x 10 (*)	
RTB: shoulder extension	1 x 10 (*)	
RTB: bilateral ER	1 x 10 (*)	
UBE	1 min F/ 1 min B	
sitting blue gym ball - alt shoulder flexion	1 x 10 each UE	
sitting blue gym ball - alt hip flexion	1 x 5 each LE	
Airdyne (in # 4)		
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-15-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports pain persists at left upper trapezius area and bilateral LB. No MD appointment scheduled at this time.

OBJECTIVE: Treatment per activity/flowsheet;
Added to HEP: bilateral knee fallout, bridging, 1/2 sit ups, SLR, quadruped - lifting UE's, quadruped - lifting LE's - written copy provided.

ASSESSMENT: Able to initiate HSC and leg press without increased complaint

PLAN: Progress as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-15-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10	
bilateral knee fallout	1 x 10	
isometric abdominals - tiny steps in place	2 x 10 each	
isometric abdominals - alt UE (short range)		
bridging	2 x 10	
isometric abs - SLR	2 x 10 each	
adductor squeeze with ball	2 x 15	
1/2 sit ups	2 x 10 (*)	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 10 each (*)	
quadruped - alt LE	1 x 5 each (*)	
RTB: rowing	1 x 10 (*)	
RTB: shoulder extension	1 x 10 (*)	
RTB: bilateral ER	1 x 10 (*)	
UBE	1 1/2 min each F/B (*)	
sitting blue gym ball - alt shoulder flexion	1 x 10 each UE	
sitting blue gym ball - alt hip flexion	1 x 10 each LE (*)	
Airdyne (in # 4)		
HSC (seat 4)	20# 2 x 10 (*)	
Leg Press (foot 4)	40# 2 x 10 (*)	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-20-2009
Patient DOB: **Referred By:** Shane K Woolf MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: No increased symptoms after last treatment with initiation of leg press and HSC.

OBJECTIVE: Treatment per activity/flowsheet;
Added GTB to scapular strengthening HEP

ASSESSMENT: Increased density persists left upper trapezius region. Patient very cooperative and compliant.

PLAN: Continue x 1 more authorized treatment/ re-assess status then patient to perform independent HEP until RTMD.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-20-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10	
bilateral knee fallout	2 x 10	
isometric abdominals - tiny steps in place	20 x each	
isometric abdominals - alt UE (short range)	10x each	
bridging	2 x 10	
isometric abs - SLR	2 x 10 each	
adductor squeeze with ball	2 x 15	
1/2 sit ups	2 x 10	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 10 each	
quadruped - alt LE	1 x 5 each	
GTB: rowing	1 x 10 (*)	
GTB: shoulder extension	1 x 10 (*)	
GTB: bilateral ER	1 x 10 (*)	
UBE	1 1/2 min each F/B	
sitting blue gym ball - alt shoulder flexion	1 x 10 each UE	
sitting blue gym ball - alt hip flexion	1 x 10 each LE (*)	
Airdyne (in # 4)		
HSC (seat 4)	30# 2 x 10 (*)	
Leg Press (foot 4)	60# 2 x 10 (*)	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-22-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient continues with complaint of constant pain bilateral cervical area (left greater than right) 8/10. He reports headache at top of head is intermittent. Patient continues with constant paresthesia all digits left hand and left shoulder pain with movement. Patient reports LBP is constant at 8/10. Patient reports turning head to drive is still difficult as is using left UE to turn wheel. Patient continues with complaint of pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body. RTMD (Dr. Woolf) 1/27/09.

OBJECTIVE: Treatment per activity/flowsheet;
Trunk ROM: flexion = 90 deg; extension = 23 deg; left side bending = 15 deg; right side bending = 13 deg; bilateral rotation = 50%;
CROM: flexion = 40 deg; extension = 38 deg; left side bending = 23 deg; right side bending = 25 deg; left rotation = 42 deg; right rotation = 68 deg;
AROM left shoulder: flexion = 145 deg; abduction = 115 deg; IR/ER with some pain but WFL mobility;
Strength left UE: Shoulder flexion/abduction = 3+; IR/ER = 4 with left upper trapezius pain

ASSESSMENT: Trunk ROM has decreased while cervical ROM has improved. Left shoulder ROM and strength have shown improvement but are still limited. Patient would benefit from continued treatment in order to improve mobility, strength and therefore function.

PLAN: Patient to RTMD 1/27/09. Await MD recommendation regarding further treatment.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 01-22-2009
Patient DOB: **Referred By:** Shane K Woolf MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ see below & re-assessment of status	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius/medial scapular area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
pelvic tilt	1 x 10	
trunk rolls	1 x 10	
bilateral knee fallout	2 x 10	
isometric abdominals - tiny steps in place	20 x each	
isometric abdominals - alt UE (short range)	15 x each	
bridging	2 x 10	
isometric abs - SLR	2 x 10 each	
adductor squeeze with ball	2 x 15	
1/2 sit ups	2 x 10	
supine ROM left shoulder	AAROM x 5 min	
quadruped - alt UE	1 x 10 each	
quadruped - alt LE	1 x 5 each	
GTB: rowing		
GTB: shoulder extension		
GTB: bilateral ER		
UBE		
sitting blue gym ball - alt shoulder flexion		
sitting blue gym ball - alt hip flexion		
Airdyne (in # 4)		
HSC (seat 4)	30# 2 x 10	
Leg Press (foot 4)	60# 2 x 10	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

TO: Shane K Woolf MD
RE: Hector Gomez-Fragoso DOB:
PT: Moist heat, manual therapy techniques, therapeutic exercise, instruction regarding HEP
DATE: 01-22-2009

Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above for an additional 7 treatments since our last correspondence dated 12/30/08. Patient continues with complaint of constant pain bilateral cervical area (left greater than right) 8/10. He reports headache at top of head is intermittent. Patient continues with constant paresthesia all digits left hand and left shoulder pain with movement. Patient reports LBP is constant at 8/10. Patient reports turning head to drive is still difficult as is using left UE to turn wheel. Patient continues with complaint of pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body.

Trunk ROM:	1/22/09	12/30/08
Flexion	90 deg	90 deg
Extension	23 deg	20 deg
Left side bending	15 deg	22 deg
Right side bending	13 deg	20 deg
Bilateral rotation	50%	75%

CROM:	1/22/09	12/30/08
Flexion	40 deg	40 deg
Extension	38 deg	30 deg
Left side bending	23 deg	12 deg
Right side bending	25 deg	22 deg
Left rotation	42 deg	28 deg
Right rotation	68 deg	58 deg

AROM left shoulder:	1/22/09	12/30/08
Flexion	145 deg	135 deg
Abduction	115 deg	90 deg

IR/ER with some pain but WFL mobility

Strength left UE: Shoulder flexion/abduction = 3+; IR/ER = 4 with left upper trapezius pain

Trunk ROM has decreased while cervical ROM has improved. Left shoulder ROM and strength have shown improvement but are still limited. Patient would benefit from continued treatment in order to improve mobility, strength and therefore function.

Thank you very much for your referral. Please advise regarding continued therapy. Also, please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-11-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient did not show for scheduled appointment

OBJECTIVE:

ASSESSMENT:

PLAN:

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-13-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE:

OBJECTIVE: See flowsheet. Pt to PT with order for cervical and shoulder treatment-order in chart.

ASSESSMENT: Concentrated on cervical and left shoulder strengthening and scapular strengthening ex. Pt reported feeling less tension/mm tightness after treatment.

PLAN: Continue-progress with strengthening.

Tracy M Cobb PT

Tue Jul 2008 07/22/08 13:21:50

Tracy M Cobb PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-13-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral C/T and left shoulder	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat cervical/LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex	x10	
wall climb flex	x5	
Cane ext	x10	
Cane IR	x10	
GTB: rowing	x10	
GTB: shoulder extension	x10	
GTB: ER left	x10	
GTB: IR left	x10	
GTB: ext left	x10	
UBE(F/B)	x5 min	
PROM		
	Total Minutes	**60**

Electronically signed by Tracy M Cobb PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-16-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports no increased pain after initiating strengthening program left shoulder girdle last treatment. He continues with complaint of pain left upper trapezius region. Patient to return to Dr. Merrill 3/4/09; Dr. Woolf 3/16/09 and Dr. Sandoz 2/17/09.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient lacking left scapular stabilization and requires verbal and tactile cues for proper scapular position during exercise program.

PLAN: Check reaction to PRE's and add to HEP at appropriate.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-16-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex	x15 (*)	
Pulleys abduction	10 x (*)	
wall climb flex	x5	
GTB: rowing		
GTB: shoulder extension		
GTB: ER left		
GTB: IR left		
GTB: ext left		
UBE(F/B)		
PROM		
prone extension	1# 1 x 10 (*)	
prone rowing	1# 1 x 10 (*)	
sidelying ER to neutral	1# 1 x 10 (*)	
sidelying shoulder abd 30 deg to 90 deg	no wt 1 x 10 (*)	
supine press ups	1# 1 x 10 (*)	
supine scapular protraction	1# 1 x 10 (*)	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-19-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports pain left upper trapezius area today 7-8/10. No worse symptoms after last treatment with PRE's versus TB the previous treatment

OBJECTIVE: Treatment per activity/flowsheet;
Instruction re: HEP of: prone rowing, prone shoulder ext, sidelying ER to neutral, sidelying shoulder abduction, supine press ups, supine scapular protraction, ER stretch while supine (hands behind head) - written copy provided - patient to perform with 1# wt at home

ASSESSMENT: Patient appeared to understand HEP well via interpreter

PLAN: Progress with exercise program as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-19-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex	20 x (*)	
Pulleys abduction	10 x	
wall climb flex		
GTB: rowing		
GTB: shoulder extension		
GTB: ER left		
GTB: IR left		
GTB: ext left		
UBE(F/B)		
PROM		
prone extension	2# 1 x 10 (*)	
prone rowing	2# 1 x 10 (*)	
sidelying ER to neutral	1# 1 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 1 x 10 (*)	
supine press ups	2# 1 x 10 (*)	
supine scapular protraction	2# 1 x 10 (*)	
ROM left shoulder - supine	PROM x 5 min	
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-24-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports performing PRE's left shoulder girdle at home with 1# weight. He reports (via interpreter) being unsure if he is performing the sidelying exercises correctly.

OBJECTIVE: Treatment per activity/flowsheet;
reviewed sidelying ER and sidelying shoulder abduction HEP with patient via interpreter

ASSESSMENT: Decreased strength noted more with sidelying exercises.

PLAN: Progress with shoulder girdle strengthening as tolerated. Re-assess status next treatment.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-24-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
GTB: shoulder extension		
GTB: ER left		
GTB: IR left		
GTB: ext left		
UBE(F/B)		
PROM		
prone extension	2# 2 x 10 (*)	
prone rowing	2# 2 x 10 (*)	
sidelying ER to neutral	1# 2 x 10 (*)	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10 (*)	
supine press ups	2# 2 x 10 (*)	
supine scapular protraction	2# 2 x 10 (*)	
ROM left shoulder - supine	PROM x 5 min	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-26-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient to return to Dr. Merrill 3/4/09 and Dr. Woolf 3/16/09. Patient continues with complaint of constant pain left upper trapezius area 8/10 and right upper trapezius area 5-6/10. He reports intermittent headaches at top of head. Patient continues with complaint of constant paresthesia all digits left hand. He complains of constant pain left shoulder which increases with movement (7/10.) Patient complains of left upper trapezius area pain with ADL's/functional activities.

OBJECTIVE: Treatment per activity/flowsheet;
CROM: flexion = 45 deg; extension = 25 deg; left side bending = 15 deg; right side bending = 25 deg; left rotation = 50 deg; right rotation = 55 deg;
AROM left shoulder (sitting): flexion = 140 deg; abduction = 120 deg;
PROM left shoulder (supine): flexion = 160 deg; abduction = 175 deg; IR (scaption) = 65 deg; ER (scaption) = 75 deg;
Strength left UE: shoulder flexion = 3+; abduction = 3+; IR = WFL; ER = 3+/4; elbow flexion/extension = WFL;
Scapular winging noted on left a great deal;
Palpation: mod/max increased density left upper trapezius

ASSESSMENT: AROM left shoulder has increased 5 deg in abduction but decreased 5 deg in flexion; CROM still limited by left upper trapezius spasm/pain. Left shoulder girdle strength still lacking and great deal of scapular winging present. Emphasis has been on scapular stabilization/shoulder girdle exercises in order to decrease scapular winging as well as STM to decrease left upper trapezius spasm. Subjective complaints persist to the same degree.

PLAN: Continue per present plan of care, progressing as tolerated and appropriate.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

3/2/09 Cancel pt - PT ill. T. [illegible]

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 02-26-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below & re-assessment of status	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension		
prone rowing		
sidelying ER to neutral		
sidelying shoulder abd 30 deg to 90 deg		
supine press ups		
supine scapular protraction		
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension	RTB 1 x 10 (*)	
TB: left shoulder IR	RTB 1 x 10 (*)	
TB: left shoulder ER	RTB 1 x 10 (*)	
TB: left shoulder flexion	RTB 1 x 10 (*)	
TB overhead: extension/flexion	RTB 1 x 10 each UE (*)	
TB overhead: adduction/abduction	RTB 1 x 10 each UE (*)	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION INC.

TO: Christopher A/2581962 Merrell Md
RE: Hector Gomez-Fragoso DOB:
PT: Moist heat, therapeutic exercise, instruction regarding HEP, manual therapy techniques
DATE: 02-26-2009

Mr. Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above a total of 5 treatments since his return to the clinic to resume PT 2/13/09. Patient continues with complaint of constant pain left upper trapezius area 8/10 and right upper trapezius area 5-6/10. He reports intermittent headaches at top of head. Patient continues with complaint of constant paresthesia all digits left hand. He complains of constant pain left shoulder which increases with movement (7/10.) Patient complains of left upper trapezius area pain with ADL's/functional activities.

CROM:	2/26/09	1/22/09	12/30/08	12/16/09
Flexion	45 deg	40 deg	40 deg	30 deg
Extension	25 deg	38 deg	30 deg	23 deg
Left side bending	15 deg	23 deg	12 deg	15 deg
Right side bending	25 deg	25 deg	22 deg	25 deg
Left rotation	50 deg	42 deg	28 deg	30 deg
Right rotation	55 deg	68 deg	58 deg	45 deg

AROM left shoulder (sitting):	2/26/09	1/22/09	12/30/09
Flexion	140 deg	145 deg	135 deg
Abduction	120 deg	115 deg	90 deg

PROM left shoulder (supine): flex = 160 deg; abd = 175 deg; IR = 65 deg; ER = 75 deg (IR/ER taken in plane of scapula)

Strength left UE: shoulder flexion = 3+; abduction = 3+; IR = WFL; ER = 3+/4
Scapular winging noted on left a great deal. Mod/max increased density persists at left upper trapezius area.

AROM left shoulder has increased 5 deg in abduction but decreased 5 deg in flexion. CROM still limited by left upper trapezius spasm/pain. Left shoulder girdle strength still lacking and great deal of scapular winging present. Emphasis has been on scapular stabilization/shoulder girdle exercises in order to decrease scapular winging as well as STM to decrease left upper trapezius spasm. Subjective complaints persist to the same degree.

Thank you very much for your r(al. Please advise regarding continued (apy. Also, please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 03-05-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports (via interpreter) that MD injected left upper trapezius area yesterday. Patient reports increased symptoms left upper trapezius today due to injection. He is to RTMD (Dr. Merrill) 4/8/09. He is to see Dr. Woolf 3/16/09. Dr. Merrill stated to continue PT if patient/PT feel it is beneficial.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Exercise program decreased today and ROM left shoulder increased today due to increased symptoms since injection yesterday. Patient very tender left upper trapezius trigger point - where injection was given - so MT/STM performed around that area, not over that area.

PLAN: Progress as tolerated with exercise program.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 03-05-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension		
prone rowing		
sidelying ER to neutral		
sidelying shoulder abd 30 deg to 90 deg		
supine press ups		
supine scapular protraction		
ROM left shoulder - supine	PROM x 10 min (*)	
TB: left shoulder extension	RTB 1 x 10	
TB: left shoulder IR	RTB 1 x 10	
TB: left shoulder ER	RTB 1 x 10	
TB: left shoulder flexion	RTB 1 x 10	
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 03-06-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: PT spoke with Linda Renew, case manager for patient, yesterday regarding continued PT. PT informed Linda that MD stated for patient to continue PT if patient believes it is helping him and if PT agrees to continued care for PT to contact MD office for new order. Linda approved verbally 8 more visits and stated for PT to fax MD order once PT has it. PT phoned MD office (Dr. Merrill) 3/5/09 and spoke with Lindsey requesting new order for continued PT. New order received 3/5/09 afternoon and new order was faxed to Linda Renew 3/5/09.

OBJECTIVE:

ASSESSMENT:

PLAN:

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-06-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

TREATMENT/EXERCISES **MD DX/PRECAUTIONS:**

Exercise Description	Units/Reps/Weights	Minutes
	Total Minutes	

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-09-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports "no change" following injection left upper trapezius last week. He reports performing HEP.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Increased density left upper trapezius much less since injection last week despite complaint of pain persisting to the same degree.

PLAN: Progress with scapular stabilization exercise as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-09-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	35
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	10
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex	30 x	
Pulleys abduction	30 x	
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	2# 2 x 10	
prone rowing	2# 2 x 10	
prone horizontal abduction	no wt 1 x 10 (*)	
prone scaption	no wt 1 x 10 (*)	
sidelying ER to neutral	1# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	2# 2 x 10	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

TO: Christopher A/2581962 Merrell Md/ Dr. Woolf
RE: Hector Gomez-Fragoso DOB:
PT: Moist heat, therapeutic exercise, instruction regarding HEP, manual therapy techniques
DATE: 03-09-2009

Mr. Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above a total of 75 treatments since his return to the clinic to resume PT 2/13/09. Patient continues with complaint of constant pain left upper trapezius area 8/10 and right upper trapezius area 5-6/10. He reports intermittent headaches at top of head. Patient continues with complaint of constant paresthesia all digits left hand. He complains of constant pain left shoulder which increases with movement (7/10.) Patient complains of left upper trapezius area pain with ADL's/functional activities.

Patient did receive an injection at left upper trapezius region by Dr. Merrill 3/4/09. Patient reported today "no change" in pain at that region, but tissue density left upper trapezius has decreased since injection last week.

CROM:	2/26/09	1/22/09	12/30/08	12/16/09
Flexion	45 deg	40 deg	40 deg	30 deg
Extension	25 deg	38 deg	30 deg	23 deg
Left side bending	15 deg	23 deg	12 deg	15 deg
Right side bending	25 deg	25 deg	22 deg	25 deg
Left rotation	50 deg	42 deg	28 deg	30 deg
Right rotation	55 deg	68 deg	58 deg	45 deg

AROM left shoulder (sitting):	2/26/09	1/22/09	12/30/09
Flexion	140 deg	145 deg	135 deg
Abduction	120 deg	115 deg	90 deg

PROM left shoulder (supine): flex = 160 deg; abd = 175 deg; IR = 65 deg; ER = 75 deg (IR/ER taken in plane of scapula)

Strength left UE: shoulder flexion = 3+; abduction = 3+; IR = WFL; ER = 3+/4
Scapular winging noted on left a great deal. Mod/max increased density persists at left upper trapezius area.

AROM left shoulder has increased 5 deg in abduction but decreased 5 deg in flexion. CROM still limited by left upper trapezius spasm/pain. Left shoulder girdle strength still lacking and great deal of scapular winging present. Emphasis has been on scapular stabilization/shoulder girdle exercises in order to decrease scapular

winging as well as STM to decre ıeft upper trapezius spasm. Subjective ıplaints persist to the same degree.

Thank you very much for your referral. Please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Melissa Gray PT

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-12-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	12
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)	1 min F/ 1 min B	
prone extension	2# 2 x 10	
prone rowing	2# 2 x 10	
prone horizontal abduction	no wt 1 x 10	
prone scaption	no wt 1 x 10	
sidelying ER to neutral	1# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	2# 2 x 10	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE	10 x (*)	
	Total Minutes	**57**

Electronically signed by Melissa H Gray PT (Therapist)

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-12-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports pain left upper trapezius area still 8/10. RTMD (Dr. Woolf) 3/16/09.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient reports more mobility after manual therapy techniques/soft tissue stretching with decreased tissue density noted but pain at that area remains at 8/10 per patient.

PLAN: Progress note sent with patient for RTMD 3/16/09.

Melissa Gray PT

Tue Jul 2008 07/22/08 14.39 47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-17-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Pt reports that shoulder continues to feel the same. States that MD reports that they may try a different type of injection next visit to DR Merrill (april 8th). Back to see Dr Wolfe in June 29th. Pt reporting that MD thinks that it is coming from the neck not the shoulder.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Pain remains the same, but reporting that it does feel better following completion of MT.

PLAN: Cont per plan of care.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Amy Matheny PTA

Fri Aug 2008 08/01/08 15:08:12

Amy Matheny PTA

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-17-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General

719.49 Joint Pain-Mult Jts

719.59 Stiffness of joint not elsewhere classified: multiple sites

728.85 Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	12
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)	1 min F/ 1 min B	
prone extension	2# 2 x 10	
prone rowing	2# 2 x 10	
prone horizontal abduction	no wt 1 x 10	
prone scaption	no wt 1 x 10	
sidelying ER to neutral	1# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	2# 2 x 10	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE	10 x (*)	
	Total Minutes	**57**

Electronically signed by Melissa H Gray PT (Therapist)

Electronically signed by Amy Matheny PTA (Associate)

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-19-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM left cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)	2 min F/ 2 min B (*)	
prone extension	3# 2 x 10 (*)	
prone rowing	3# 2 x 10 (*)	
prone horizontal abduction	1# 2 x 10 (*)	
prone scaption	1# 2 x 10 (*)	
sidelying ER to neutral	2# 2 x 10 (*)	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	3# 2 x 10 (*)	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE	10 x (*)	
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT (Therapist)

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-19-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports "feeling the same."

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient reports entire left shoulder girdle fatigued by end of exercise program with increased weight during PRE's.

PLAN: Progress as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436 **Date:** 03-23-2009
Patient DOB: **Referred By:** Christopher A/2581962 Merrell Md
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	1# 1 x 10; 2# 1 x 10 (*)	
prone scaption	1# 2 x 10	
sidelying ER to neutral	2# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	3# 2 x 10 (*)	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE	10 x	
RTB - bilateral shoulder scaption	from low anchor 1 x 10 (*)	
RTB - bilateral horizontal abduction	1 x 10 (*)	
cables: mid rows	2 plates 1 x 10 (*)	
cables: low rows	2 plates 1 x 10 (*)	
cables: high rows	2 plates 1 x 10 (*)	
	Total Minutes	**55**

Electronically si[illegible] by
(Associate)

[illegible] by Melissa H C[illegible] PT

P839

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-23-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient reports some increased pain at cervical area after increased exercise last treatment.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient reports entire left shoulder girdle fatigued by end of exercise program with increased exercises.

PLAN: Progress as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-23-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General
719.49 Joint Pain-Mult Jts
719.59 Stiffness of joint not elsewhere classified: multiple sites
728.85 Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	1# 1 x 10; 2# 1 x 10 (*)	
prone scaption	1# 2 x 10	
sidelying ER to neutral	2# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	3# 2 x 10 (*)	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE	10 x	
RTB - bilateral shoulder scaption	from low anchor 1 x 10 (*)	
RTB - bilateral horizontal abduction	1 x 10 (*)	
cables: mid rows	2 plates 1 x 10 (*)	
cables: low rows	2 plates 1 x 10 (*)	
cables: high rows	2 plates 1 x 10 (*)	
	Total Minutes	**55**

794

Electronically signed by Melissa H ay PT
(Therapist)

Electronically ied by
(Associate)

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-26-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General
719.49 Joint Pain-Mult Jts
719.59 Stiffness of joint not elsewhere classified: multiple sites
728.85 Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	2# 2 x 10 (*)	
prone scaption	1# 2 x 10	
sidelying ER to neutral	2# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	1# 2 x 10	
supine press ups	3# 2 x 10	
supine scapular protraction	2# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB: left shoulder extension		
TB: left shoulder IR		
TB: left shoulder ER		
TB: left shoulder flexion		
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE	1 x 10 each with emphasis on scapular retraction	
quadruped - RS left UE		
RTB - bilateral shoulder scaption	from low anchor 1 x 10	
RTB - bilateral horizontal abduction	1 x 10	
cables: mid rows	2 plates 1 x 10	
cables: low rows	2 plates 1 x 10	
cables: high rows	2 plates 1 x 10	
	Total Minutes	**60**

796

Electronically signed by Melissa H ay PT
(Therapist)

Electronically ed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-26-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: No increased symptoms after last treatment.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient reports entire left shoulder girdle fatigued by end of exercise program - tends to elevate left shoulder girdle and requires tactile cues to stabilize scapula

PLAN: Progress as tolerated

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-30-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: No new complaints.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient reports entire left shoulder girdle fatigued by end of exercise program - tends to elevate left shoulder girdle and requires tactile cues to stabilize scapula

PLAN: Re-assess status next treatment

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 03-30-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	25
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	2# 2 x 10	
prone scaption	1# 2 x 10	
sidelying ER to neutral	3# 2 x 10 (*)	
sidelying shoulder abd 30 deg to 90 deg	2# 2 x 10 (*)	
supine press ups	3# 2 x 10	
supine scapular protraction	3# 2 x 10 (*)	
ROM left shoulder - supine	PROM x 5 min	
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE		
quadruped - RS left UE		
RTB - bilateral shoulder scaption	from low anchor 1 x 10	
RTB - bilateral horizontal abduction	1 x 10	
cables: mid rows	2 plates 1 x 10	
cables: low rows	2 plates 1 x 10	
cables: high rows	2 plates 1 x 10	
sitting shoulder flexion with scap add	2# 1 x 10 (*)	
sitting scaption with scapular adduction	2# 1 x 10 (*)	
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT (Therapist)

800

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-02-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient to return to Dr. Merrill 4/8/09. He continues with complaint of constant pain left upper trapezius area 8/10 and right upper trapezius area 6-7/10. He also complains of constant cervical area pain and intermittent headaches at top of head. Patient continues with complaint of constant paresthesia all digits left hand. He complains of constant pain left shoulder which increases some with movement (8/10). Patient complains of left upper trapezius area pain with ADL's/functional activities. He does report increased mobility left shoulder despite pain persisting.

OBJECTIVE: Treatment per activity/flowsheet;
CROM: flexion = 40 deg; extension = 25 deg; left side bending = 20 deg; right side bending = 20 deg; left rotation = 40 deg; right rotation = 50 deg;
AROM left shoulder (sitting): flexion = 165 deg; abduction = 145 deg;
PROM left shoulder (supine): flexion = flexion = 160 deg; abduction = 175 deg; IR = 55 deg (taken at 90 deg abduction); ER = 80 deg (taken at 90 deg abduction):
Strength left UE: shoulder flexion = 3+; shoulder abduction = 3+; IR = WFL; ER = 4/4+
Scapular winging noted on left a great deal
Palpation: min/mod increased density bilateral upper trapezius

ASSESSMENT: AROM left shoulder has increased while CROM has decreased. Strength left shoulder ER has improved but shoulder flexion/abduction strength is still limited at 3+ each. Emphasis has been placed on scapular stabilization/ shoulder girdle strengthening in order to decrease scapular winging but winging persists. Subjective complaints persist to the same degree.

PLAN: Continue x 1 more treatment prior to RTMD 4/8/09. Increase rowing weights on cables.

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-02-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure	1/ re-assessment of status	10
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	2# 2 x 10	
prone scaption	1# 2 x 10	
sidelying ER to neutral	3# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	2# 2 x 10	
supine press ups	3# 2 x 10	
supine scapular protraction	3# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE		
quadruped - RS left UE		
RTB - bilateral shoulder scaption	from low anchor 1 x 10	
RTB - bilateral horizontal abduction	1 x 10	
cables: mid rows	2 plates 1 x 10	
cables: low rows	2 plates 1 x 10	
cables: high rows	2 plates 1 x 10	
sitting shoulder flexion with scap add		
sitting scaption with scapular adduction		
	Total Minutes	**70**

Electronically signed by Melissa H Gray PT (Therapist)

802

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

TO: Christopher Merrell MD
RE: Hector Gomez-Fragoso DOB:
PT: Moist heat, therapeutic exercise, manual therapy techniques, instruction regarding HEP
DATE: 04-02-2009

Mr. Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above for an additional 7 treatments since our last correspondence dated 3/9/09. He continues with complaint of constant pain left upper trapezius area 8/10 and right upper trapezius area 6-7/10. He also complains of constant cervical area pain and intermittent headaches at top of head. Patient continues with complaint of constant paresthesia all digits left hand. He complains of constant pain left shoulder which increases some with movement (8/10). Patient complains of left upper trapezius area pain with ADL's/functional activities. He does report increased mobility left shoulder despite pain persisting.

CROM:	4/2/09	2/26/09	12/16/09
Flexion	40 deg	45 deg	30 deg
Extension	25 deg	25 deg	23 deg
Left side bending	20 deg	15 deg	15 deg
Right side bending	20 deg	25 deg	25 deg
Left rotation	40 deg	50 deg	30 deg
Right rotation	50 deg	55 deg	45 deg

AROM left shoulder (sitting):	4/2/09	2/26/09
Flexion	165 deg	140 deg
Abduction	145 deg	120 deg

PROM left shoulder (supine):	4/2/09	3/9/09
Flexion	160 deg	160 deg
Abduction	175 deg	175 deg
IR (taken at 90 deg abduction)	55 deg	65 deg (taken in scapular plane)
ER (taken at 90 deg abduction)	80 deg	75 deg (taken in scapular plane)

Strength left UE:	4/2/09	3/9/09
Shoulder flexion	3+	3+
Shoulder abduction	3+	3+
IR	WFL	WFL
ER	4/4+	3+/4

Scapular winging noted on left a great deal

Palpation: min/mod increased [illegible]ty bilateral upper trapezius

AROM left shoulder has increased while CROM has decreased. Strength left shoulder ER has improved but shoulder flexion/abduction strength is still limited at 3+ each. Emphasis has been placed on scapular stabilization/ shoulder girdle strengthening in order to decrease scapular winging but winging persists. Subjective complaints persist to the same degree but tissue density left upper trapezius has decreased.

Thank you very much for your referral. Please advise regarding continued therapy. Also, please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Melissa Gray PT

Melissa H Gray PT

4/17/08 DC'd as no new order from MD

MHGray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-06-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: RTMD 4/8/09. Patient reports symptoms are "the same."

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Control during PRE's is improving

PLAN: Progress note sent with patient for RTMD.

Melissa Gray PT

Tue Jul 2008 07/22/08 14 39 47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-06-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General

719.49 Joint Pain-Mult Jts

719.59 Stiffness of joint not elsewhere classified: multiple sites

728.85 Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	10
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	2# 2 x 10	
prone scaption	1# 2 x 10	
sidelying ER to neutral	3# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	2# 2 x 10	
supine press ups	3# 2 x 10	
supine scapular protraction	3# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE		
quadruped - RS left UE		
RTB - bilateral shoulder scaption	from low anchor 2 x 10 (*)	
RTB - bilateral horizontal abduction	2 x 10 (*)	
cables: mid rows	4 plates 1 x 10 (*)	
cables: low rows	4 plates 1 x 10 (*)	
cables: high rows	4 plates 1 x 10 (*)	
sitting shoulder flexion with scap add		
sitting scaption with scapular adduction		
	Total Minutes	**55**

Electronically signed by Melissa H Gray PT (Therapist)

806

Electronically signed by (Associate)

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-09-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

MD DX/PRECAUTIONS: DX: Left AC Joint Arthritis, Left shoulder posttraumatic stiffness, RC strain, C7 spinous process nonunion with paracervical pain, LBP. Precautions: Nonunion fracture of C7 spinous process

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Physical Performance Test/Measure		
Therapeutic Exercise	2/ left shoulder girdle - see below	30
Therapeutic Activity		
Ultrasound		
Manual Therapy	1/ MT/STM bilateral cervical/upper trapezius area while sitting	15
Unattended Electrical Stimulation		
Mechanical Traction		
Moist heat/ice	1/ moist heat left upper trapezius area/ LB while supine - pre rx	15
EXERCISES INCLUDE:		
Pulley flex		
Pulleys abduction		
wall climb flex		
GTB: rowing		
UBE(F/B)		
prone extension	3# 2 x 10	
prone rowing	3# 2 x 10	
prone horizontal abduction	2# 2 x 10	
prone scaption	1# 2 x 10	
sidelying ER to neutral	3# 2 x 10	
sidelying shoulder abd 30 deg to 90 deg	2# 2 x 10	
supine press ups	3# 2 x 10	
supine scapular protraction	3# 2 x 10	
ROM left shoulder - supine	PROM x 5 min	
TB overhead: extension/flexion		
TB overhead: adduction/abduction		
quadruped - lift alt UE		
quadruped - RS left UE		
RTB - bilateral shoulder scaption	from low anchor 2 x 10	
RTB - bilateral horizontal abduction	2 x 10	
cables: mid rows	4 plates 1 x 10	
cables: low rows	4 plates 1 x 10	
cables: high rows	4 plates 1 x 10	
sitting shoulder flexion with scap add		
sitting scaption with scapular adduction		
	Total Minutes	**60**

Electronically signed by Melissa H Gray PT (Therapist)

807

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-09-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient seen by MD in Charleston yesterday - patient to have ESI 4/16/09 at cervical area then follow up with MD 1 week later.

OBJECTIVE: Treatment per activity/flowsheet

ASSESSMENT: Patient with good understanding of HEP

PLAN: Hold PT at this time until patient receives ESI and follows up with MD. Await MD recommendation at that time

Melissa Gray PT

Tue Jul 2008 07/22/08 14.39.47

Melissa H Gray PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-17-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

SUBJECTIVE: Patient seen by MD who did not order more PT - per Linda Renew - rehab nurse/case manager. Patient therefore D/C'd from PT at this time.

OBJECTIVE:

ASSESSMENT:

PLAN:

Melissa Gray PT

Tue Jul 2008 07/22/08 14:39:47

Melissa H Gray PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector G. Fragoso **Patient ID #:** 3436 **Date:** 04-17-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	719.59	Stiffness of joint not elsewhere classified: multiple sites
719.49	Joint Pain-Mult Jts	728.85	Spasm of muscle

TREATMENT/EXERCISES **MD DX/PRECAUTIONS:**

Exercise Description	Units/Reps/Weights	Minutes
	Total Minutes	

Electronically signed by Melissa H Gray PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

Physical Therapy Discharge Summary
DATE of DISCHARGE: 04-17-09

PATIENT: Hector G. Fragoso **DOB:** **Patient account#:** 3436
PHYSICIAN: Merrell MD
DIAGNOSIS: Muscle Weakness-General 728.87 Stiffness of joint not elsewhere classified: multiple sites 719.59 Joint Pain-Mult Jts 719.49 Spasm of muscle 728.85

SUBJECTIVE: See Daily Progress Note from 4/9/09

HOME PROGRAM: HEP: trunk stabilization mat exercises, theraband scapular stabilization exercises and PRE's left shoulder girdle

SERVICE FROM: 12-16-08 TO: 04-09-09

Test	Description	Results	Comments
Posture	Posture Narrative		
Gait	Assistive Device		
	Gait Pattern		
Cervical ROM in Degrees	Flexion		
	Extension		
	Side Flexion (L)		
	Side Flexion (R)		
	Rotation (L)		
	Rotation (R)		
	Active Shoulder ROM: Flexion		
	Active Shoulder ROM: Abduction		
	Active Shoulder ROM: IR		
	Active Shoulder ROM: ER		
	Active Elbow Extension		
Lumbar Active ROM	Flexion		
	Extension		
	Lateral Flexion (L)		
	Lateral Flexion (R)		
	Rotation (L)		
	Rotation (R)		
Strength	Dorsiflexion		
	Knee extension		
	Hip flexion		
	Elbow flexion		
	Elbow extension		
	Shoulder flexion		
	Shoulder abduction		
	IR		
	ER		
Sensation	Sensation narrative		
Palpation	Palpation		

ASSESSMENT: See MD summary from 4/2/09

Goals		Results

Atlantic Physical Therapy & Rehab. 3650 Coalition Drive Myrtle Beach, SC 29578 Phone: 843-293-7713, FAX: 843-293-1855

Decrease subjective complaint of pa cervical/LB/left shoulder) to self-manageable level	Partially Met
Decrease complaint of headache to self-manageable level	Partially Met
Increase cervical ROM to: flexion = 50 deg; extension = 30 deg; bilateral side bending = 30 deg each; bilateral rotation = 50 deg each	Partially Met
Increase trunk ROM by 5 deg each direction	Met
Increase left shoulder AROM to equal right	Partially Met
Improve strength/stabilization to WFL	Partially Met
Decrease spasm/tissue density at cervical/upper trapezius area to min/mod	Met
Able to turn head to drive with less difficulty and able to reach with left UE without difficulty	Partially Met
Patient independent with home exercises and management of symptoms	Met

DISCHARGE PLAN/INSTRUCTIONS: Discharged from PT due to MD not ordering additional PT per Linda Renew case manager.

Thank you for allowing me to participate in the care of this patient.

Melissa Gray PT

Tue Jul 2009 07:23:06 14:39:47

This report was electronically signed by Melissa H Gray PT.

Atlantic Physical Therapy & Rehab. 3650 Coalition Drive Myrtle Beach, SC 29578 Phone: 843-293-7713, FAX: 843-293-1855

P859

Atlantic Physical Therap 3436 ☒ PT ☐ OT ☐ ST ☐ DR 3436-2
Previous Patient? (Yes) No ☒ MB ☐ Nurse ☐ CW ☐ CF

Person Calling In Referral Translator Therapist MHG Scheduled On: 7/21 Time: 10:30
Carmen Fuentes MC. 7/23 10:30

843-849-4088

Patient Information

Social Security #	Title	Last Name	First Name	MI
		Gomez-Fragoso	Hector	G.

Street Address (Road or Street) | (Apartment Number or Second Address Line)

Zip Code | City | State

Home Phone: | Cell Phone (Patient Data): | Referring Doctor (Include Contact Info If New Referring Physician) (MUSC) Christopher Merrell

Birthday	Age	Sex (M, F)	Diagnosis	Prescribed Frequency

Marital: ☐M-Married ☐W-Widowed ☐S-Single ☐D-Divorced ☐X-Separated

Employment: ☐R-Retired ☐F-Full ☐P-Part ☐N-None

Student: ☐P-Part ☐F-Full ☐N-None

Relationship to Insured: ☐SE-Self ☐SP-Spouse ☐OT-Other ☐CH-Child

Have You Had Home Health in last 60 days? ☐ Yes ☐ No

If yes, which Home Health Agency?

Date of their last visit?

Have you had therapy at another office in the last year? ☐ Yes ☐ No

If yes, what practice?

Employer Name & Address
Tade Construction

Zip Code | City: Little River | State: SC | Phone | Ext

fax

Insurance Information

Primary Insurance Company Name	Insurance Telephone #	Policy/ID #	Group #
Wendy Link	800-942-0225 X7939 (while Linda on Vaca)		

Secondary Insurance Company Name	Insurance Telephone #	Policy/ID #	Group #
Linda Renew			

Workers Comp Carrier (if applicable)	Insurance Telephone #	Claim #	Out of Work
Key Risk			☐ Yes ☐ No

Adjustor and/or Rehabilitation Nurse	Telephone Number	Fax Number
Scott Rackley	800-6557366	

Complete Next Section If Coverage Is NOT in Patient's Name, Or If Patient is a Minor Child

Social Security #	Title	Last Name	First Name	MI

Birthday (REQUIRED)	Sex (M, F)	Relationship to Patient:

Is This Treatment Due To An Accident? Yes ____ No ____; If Yes Complete Below

Employment related: ☐ Yes ☐ No	Accident Related: ☐ Auto ☐ Other ☐ No	If auto, state where accident occurred:	Date of first symptom or accident:

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.

HECTOR GOMEZ F 7/22/09
Signed Date

I authorize payment of medical benefits directly to this practice for the services rendered.

HECTOR GOMEZ F 7/22/09
Signed Date

813
P860

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

	Phone	Fax
Myrtle Beach	843-293-7713	843-293-1855
North Myrtle Beach	843-249-7232	843-280-0206
Conway	843-234-0015	843-234-0017
Carolina Forest	843-903-4940	843-903-4950
Murrells Inlet	843-652-0137	843-652-0138

P.O. Box 1145 Myrtle Beach, SC 29578

Plan of Care - Initial Evaluation
Date of Evaluation: 07-23-2009
Myrtle Beach Office

Christopher A Merrell MD
96 Jonathan Lucas St CSB#708
Charleston,SC 29425

PATIENT: Hector Gomez-Fragoso **DOB:** **Patient Account#:** 3436-2
DIAGNOSIS: Cervicalgia 723.1 Stiffness of joint not elsewhere classified: multiple sites 719.59
REFERRAL DIAGNOSIS/PROBLEM: Cervical pain C4-5 disk protrusion

LONG-TERM GOALS:
- Decrease pain/spasms to self manageable level < = 4/10
- Improve posture
- Increase cervical AROM to rotation 70 deg B to allow improved function
- Resume normal level of function with lifts and carries
- Patient independent with home exercises and management of symptoms

TREATMENT CARE PLAN (Modalities & Exercises PRN):
- PT Evaluation
- Physical Therapy Re-Evaluation
- Ultrasound
- Moist heat/Ice
- Group Therapy
- Mechanical Traction
- Manual Therapy
- Unattended Electrical Stimulation
- Therapeutic Exercise
- Therapeutic Activity

PLAN: We will see Mr. Gomez-Fragoso 2 time(s) per week for 4 week(s). Certify from: to .

ESTIMATED DISCHARGE: August 2009 **REHAB POTENTIAL:** good

Thank you for allowing me to participate in the care of this patient.

M D Chanaca PT

Tue Jul 2008 07/22/08 14:42:09
This note has been electronically signed by Mark D Chanaca PT

Applies to Medicare Beneficiaries only:

I certify that my patient requires outpatient rehabilitation services that are reasonable and necessary. I have written and/or reviewed the plan of care.

_____ Date:_____
Christopher A Merrell MD

Mechanism of Injury: Patient is a 28 year old male referred to PT by Dr Merrell with diagnosis of: cervical pain c4/5 disk protrusion. Patient was injured 11/1/07 when a construction crane struck him on the head causing a small subdural hematoma as well as cervical spinous process and transverse process fractures, also in the thoracolumbar area. Patient also sustained a crush injury to right foot and required amputation of 4 toes. He reports L sided neck pain at 8/10 dull ache that increases with AROM. Pain extends into B bhoulders, but worse on L. Recent X-Ray and MRI show disk bulge. Pt has frequent HA. He does not speak English and presents with translator(who will not be attending future appointments). Pt reports constant L UE numbness to the fingers and intermitant numbness to the R hand.

Past Medical History (Meds): PMH significant for: None, Same injury pt treated in PT for back current pain 6-9/10 and the shoulder.
Meds include: Gabapentin, Naproxin, and 1 for HA
Number of meds

Work/Functional Status: Client reports limited function with lifts, carries, and elevated work. He is not working now as a construction worker

Co-morbidities Affecting Therapy: Time since onset

OBJECTIVE TESTS:

Test	Description	Results	Comments
Posture	Posture Narrative Forward head Cervical Lordosis Rounded Shoulders Thoracic Kyphosis	C-spine held in R side flexion increased increased increased	
Cervical ROM in Degrees	Flexion Extension Side Flexion (L) Side Flexion (R) Rotation (L) Rotation (R) Active Shoulder ROM	40 40 15 25 50 50 flexion L 120;R 130. Abduction L 130;R165	
Sensation	light touch	decreased sensation reported B UE	
Palpation	Tissue density: Cervical paraspinals	Increased density paraspinals and B upper traps though greater on the L. Tender to palpation C 4 to C6	
Strength	Cervical Muscles UE Right UE Left	4-/5 4/5 4-/5	
ADLs - Housework	light housework heavy housework laundry cooking shopping lifting carrying	impaired impaired impaired impaired impaired impaired impaired	

Assessment: Pt presents with significant stiffness of the mid c-spine. There was improvement in L rotation following treatment today with rotation from 50 deg to 55 deg. Pt will benefit from physical therapy intervention to address impairments and facilitate return to work/prior functional status. Pt is in agreement with this plan.

Comments:

Mr. Gomez-Fragoso has been advised that compliance with a home program is vital to a successful rehabilitation program. He has been instructed to discontinue any exercise or activity which increases symptoms.

Electronically signed by Mark D Chanaca PT

Atlantic Physical Therapy & Rehab. 3650 Coalition Drive Myrtle P863), SC 29578 Phone: 843-293-7713, FAX: 843-293-1855

Atlantic Physical Therapy & Rehabilitation, Inc.

Phone: Fax:

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-23-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation	1	20
Physical Therapy Re-Evaluation		
Ultrasound		
Group Therapy		
Mechanical Traction		
Manual Therapy	1/PA Mobs C4 and C5	15
Unattended Electrical Stimulation	1/post IFC with Ice	15
Therapeutic Exercise	1/HEP instruction per handout given. Pt instructed to stop if symptom exacerbation	10
Therapeutic Activity		
	Total Minutes	**60**

Electronically signed by (Therapist)

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

Phone: Fax:

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-23-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE:

OBJECTIVE:

ASSESSMENT:

PLAN:

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-29-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	12
Group Therapy		
Mechanical Traction		
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	18
Therapeutic Activity		
moist heat	pre-PT	10
AAROM/Stretching with C-spine	in supine post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy	gentle occipital release and manual traction with C-spine AA ROM	
Airdyne UE's	5 min	
Bilat shoulder ext rotation	YTB x 15; focus on posture stabilization	
Bilat shoulder extension	YTB x 15; focus on posture stabilization	
	Total Minutes	**55**

Electronically signed by Dargan Ervin PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-29-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: still having neck pain; feels looser but still hurts

OBJECTIVE: point tender in upper cervcial musculature; added US and some light resisted and endurance exercise

ASSESSMENT: no problem with increased activity today

PLAN: to follow up here on 7/31/09

Dargan Ervin PT

Fri Aug 2008 08/01/08 13:01:32

Dargan Ervin PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-31-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	12
Group Therapy		
Mechanical Traction		
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature	15
Unattended Electrical Stimulation	1/ with MH prior to treatment	15
Therapeutic Exercise	1/	18
Therapeutic Activity		
moist heat	pre-PT	
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	7 min	
Bilat shoulder ext rotation	YTB x 20; focus on posture stabilization	
Bilat shoulder extension	YTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	YTB x 20; focus on posture stabilization	
Shoulder flexion	Alt R/L; standing at wall with stabilized posture; x 10 each UE	
	Total Minutes	**60**

Electronically signed by Dargan Ervin PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 07-31-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: felt looser after last visit but the neck still hurts; pain about the same

OBJECTIVE: he remains tight and point tender in upper cervcial musculature; e-stim with moist heat prior to other interventions today

ASSESSMENT: again, no problem with increased activity today

PLAN: to follow up here on 8/4/09

Dargan Ervin PT

Fri Aug 2008 08/01/08 13:01:32

Dargan Ervin PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-04-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General
719.59 Stiffness of joint not elsewhere classified: multiple sites
723.1 Cervicalgia

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	12
Group Therapy		
Mechanical Traction	1/cervical traction 15# 30s/10s x	14
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature	15
Unattended Electrical Stimulation		15
Therapeutic Exercise	1/	18
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	7 min	
Bilat shoulder ext rotation	RedTB x 20; focus on posture stabilization	
Bilat shoulder extension	RedTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	RedTB x 20; focus on posture stabilization	
Mid row	red band 20	
Low Row	red band 20	
Shoulder flexion		
	Total Minutes	**89**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-04-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Felt same after traction

OBJECTIVE: Treatment per grid

ASSESSMENT: Added traction without symptom exacerbation

PLAN: Progress traction to 18-20#

Tue Jul 2008 07:22:08 14:42:09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-06-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General
719.59 Stiffness of joint not elsewhere classified: multiple sites
723.1 Cervicalgia

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	10
Group Therapy		
Mechanical Traction	1/cervical traction 19# 30s/10s x	14
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	RedTB x 20; focus on posture stabilization	
Bilat shoulder extension	RedTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	RedTB x 20; focus on posture stabilization	
Mid row	red band 20	
Low Row	red band 20	
Shoulder flexion		
	Total Minutes	**68**

Electronically signed by Tracy M Cobb PT (Therapist)

Electronically signed by Amy Matheny PTA (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-06-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports that neck feels about the same, didn't feel much of a pull with traction last visit.

OBJECTIVE: Treatment per grid
Pt noted that pull of traction was not too much during treatment time.

ASSESSMENT: Increased traction weight this date to 19#, with some increased soreness in neck following treatment. Traction weight increased seemed to increase some symptoms of neck pain this date upon sitting up after treatment.

PLAN: Cont with progression of exercise and stretching and traction if beneficial. May need to try manual traction rather than mechanical.

Tracy M Cobb RPT

Tue Jul 2008 07/22/08 13:21:50

Tracy M Cobb PT

Amy Matheny PTA

Fri Aug 2008 08/01/08 16:08:12

Amy Matheny PTA

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-11-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	10
Group Therapy		
Mechanical Traction		
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	RedTB x 20; focus on posture stabilization	
Bilat shoulder extension	RedTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	RedTB x 20; focus on posture stabilization	
Mid row	red band 20	
Low Row	red band 20	
Shoulder flexion		
	Total Minutes	**54**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-11-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports no new c/o

OBJECTIVE: Treatment per grid

ASSESSMENT: Tried manual traction without change in symptoms. May benefit from progressing mechanical traction to 25#

PLAN: Cont with progression of exercise and stretching and traction

Tue Jul 2008 07/22/08 14.42.09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-13-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/1.8 w/cm to cervical area	10
Group Therapy		
Mechanical Traction	1/intermitent 25# 30s/10s	15
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	RedTB x 20; focus on posture stabilization	
Bilat shoulder extension	RedTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	RedTB x 20; focus on posture stabilization	
Mid row	red band 20	
Low Row	red band 20	
Shoulder flexion		
	Total Minutes	**69**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC
PHYSICAL THERAPY &
REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-13-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports no new c/o

OBJECTIVE: Treatment per grid. Progressed mechanical traction to 25#

ASSESSMENT: Able to tolerate progression of traction

PLAN: Cont with progression of exercise and stretching and traction

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-18-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound		
Group Therapy		
Mechanical Traction	1/intermitent 25# 30s/10s	15
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	RedTB x 20; focus on posture stabilization	
Bilat shoulder extension	RedTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	RedTB x 20; focus on posture stabilization	
Mid row	red band 20	
Low Row	red band 20	
Shoulder flexion		
	Total Minutes	**59**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC
PHYSICAL THERAPY &
REHABILITATION, INC.

TO: Christopher A Merrell MD
RE: Hector Gomez-Fragoso DOB:
PT: Cervical pain C4-5 disk protrusion
DATE: 08-18-2009

Mr. Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above.

Pt reports no lasting change in neck pain since beginning therapy for the neck. Pain is rated as constant 8/10 dull ache L side of the neck. He does report short term decrease in pain following traction.

Pt is tender to palpation L upper trap. Cervical ROM as follows:

	7/23/09	8/18/09
flexion	40	40
extension	40	52
Side flex L	15	27
Side flex R	25	27
Rot L	50	80
Rot R	50	72

Pt has shown progress with ROM. Still has significant tenderness L upper trap. Have progressed traction up to 25# at this point. Pt has completed the 6 authorized visits. Treatment was ordered 2-3x/week for 4-6 weeks. Pt may further progress with additional treatment as ordered.

Plan to progress ROM, traction, and stabilization.

Thank you very much for your referral. Please advise regarding continued therapy. Also, please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

M D Chanaca PT

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

Myrtle Beach	North Myrtle Beach	Conway	Carolina Forest	Murrells Inlet
843-293-7713	843-249-7232	843-234-0015	843-904-4940	843-652-0137
Fax 843-293-1855	Fax 843-280-0206	Fax 843-234-0017	Fax 843-904-4945	Fax 843-652-0138

P.O. Box 1145 832 Beach, SC 29578

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-18-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports no lasting change in neck pain since beginning therapy for the neck. Pain is rated as constant 8/10 dull ache L side of the neck. He does report short term decrease in pain following traction.

OBJECTIVE: Treatment per grid.
Pt is tender to palpation L upper trap. Cervical ROM as follows:

	7/23/09	8/18/09
flexion	40	40
extension	40	52
Side flex L	15	27
Side flex R	25	27
Rot L	50	80
Rot R	50	72

ASSESSMENT: Pt has shown progress with ROM. Still has significant tenderness L upper trap. Have progressed traction up to 25# at this point. Pt has completed the 6 authorized visits. Treatment was ordered 2-3x/week for 4-6 weeks. Pt may further progress with additional treatment as ordered.

PLAN: Plan to progress ROM, traction, and stabilization.

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-20-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports no new c/o

OBJECTIVE: Treatment per grid.

ASSESSMENT:

PLAN: Plan to progress ROM, traction, and stabilization.

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-20-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/2.0 w/cm2 1mhz L upper trap	10
Group Therapy		
Mechanical Traction	1/intermitent 27# 30s/10s	15
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	GreenTB x 20; focus on posture stabilization	
Bilat shoulder extension	GreenTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	GreenTB x 20; focus on posture stabilization	
Mid row	Green band 20	
Low Row	Green band 20	
Shoulder flexion B	3# 2 x 10	
B Shoulder abduction	3# 2 x 10	
	Total Minutes	**69**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-25-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports no new c/o See MD note sent with pt

OBJECTIVE: Treatment per grid.

ASSESSMENT:

PLAN: Plan to progress as appropriate after pt sees MD

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-25-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/2.0 w/cm2 1mhz L upper trap	10
Group Therapy		
Mechanical Traction	1/intermitent 27# 30s/10s	15
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	GreenTB x 20; focus on posture stabilization	
Bilat shoulder extension	GreenTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	GreenTB x 20; focus on posture stabilization	
Mid row	Green band 20	
Low Row	Green band 20	
Shoulder flexion B	3# 2 x 10	
B Shoulder abduction	3# 2 x 10	
	Total Minutes	**69**

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-27-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87 Muscle Weakness-General
719.59 Stiffness of joint not elsewhere classified: multiple sites
723.1 Cervicalgia

MD DX/PRECAUTIONS: Cervical pain C4-5 disk protrusion

TREATMENT/EXERCISES

Exercise Description	Units/Reps/Weights	Minutes
PT Evaluation		
Physical Therapy Re-Evaluation		
Ultrasound	1/2.0 w/cm2 1mhz L upper trap	10
Group Therapy		
Mechanical Traction		
Manual Therapy	1/STM/DFM to the cervical paravertebral musculature. Manual cervical traction	15
Unattended Electrical Stimulation		
Therapeutic Exercise	1/	14
Therapeutic Activity		
moist heat	pre-PT	15
AAROM/Stretching with C-spine	seated post US and MT; gentle stretching with rotation and lateral flexion bilaterally	
Manual Therapy		
Airdyne UE's	5 min	
Bilat shoulder ext rotation	GreenTB x 20; focus on posture stabilization	
Bilat shoulder extension	GreenTB x 20; focus on posture stabilization	
Bilat shoulder horizontal abduction	GreenTB x 20; focus on posture stabilization	
Mid row	Green band 20	
Low Row	Green band 20	
Shoulder flexion B	3# 2 x 10	
B Shoulder abduction	3# 2 x 10	
	Total Minutes	**54**

Electronically signed by Mark D Chanaca PT (Therapist)

Electronically signed by (Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-27-2009
Patient DOB: **Referred By:** Christopher A Merrell MD

Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: Pt reports getting injection from MD yesterday. Did not get order for therapy and MD did not say anything about it.

OBJECTIVE: Treatment per grid.

ASSESSMENT: Did not do traction due to pt getting injection yesterday.

PLAN: Plan to contact MD to see if he is ordering continued therapy.

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

TO: Christopher A Merrell MD
RE: Hector Gomez-Fragoso DOB:
PT: Cervical pain C4-5 disk protrusion
DATE: 08-25-2009

Mr. Hector Gomez-Fragoso has been seen in our Myrtle Beach office for treatment as noted above.

Pt reports no lasting change in neck pain since beginning therapy for the neck. Pain is rated as constant 8/10 dull ache L side of the neck. He continues to report short term decrease in pain following traction. Have also used heat, exercise, home program, ultrasound, and manual therapy.

Pt is tender to palpation L upper trap. Cervical ROM as follows:

	7/23/09	8/18/09	8/25/09
flexion	40	40	45
extension	40	52	55
Side flex L	15	27	27
Side flex R	25	27	27
Rot L	50	80	80
Rot R	50	72	73

Pt has shown progress with ROM. Still has significant tenderness L upper trap. Have progressed traction up to 27# at this point.

Thank you very much for your referral. Please advise regarding continued therapy. Also, please feel free to contact me if you have any questions or if I can be of assistance in any way. I can be reached at 843-293-7713.

Sincerely,

Mark D Chanaca PT

8/31/09 MD Did not order additional therapy DLCPT

Myrtle Beach	North Myrtle Beach	Conway	Carolina Forest	Murrells Inlet
843-293-7713	843-249-7232	843-234-0015	843-904-4940	843-652-0137
Fax 843-293-1855	Fax 843-280-0206	Fax 843-234-0017	Fax 843-904-4945	Fax 843-652-0138

P.O. Box 1145 M[illegible]840 [illegible]each, SC 29578

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

3650 Coalition Drive Myrtle Beach, SC 29578
Phone: 843-293-7713 **Fax:** 843-293-1855

Physical Therapy DAILY TREATMENT NOTE

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-31-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

SUBJECTIVE: MD did not order additional therapy.

OBJECTIVE:

ASSESSMENT:

PLAN: D/C PT

Tue Jul 2008 07/22/08 14:42:09

Mark D Chanaca PT

Atlantic Physical Therapy & Rehabilitation, Inc.

3650 Coalition Drive Myrtle Beach, SC 29578

Phone: 843-293-7713 Fax: 843-293-1855

Physical Therapy Daily Activity Note

Patient Name: Hector Gomez-Fragoso **Patient ID #:** 3436-2 **Date:** 08-31-2009
Patient DOB: **Referred By:** Christopher A Merrell MD
Diagnosis:

728.87	Muscle Weakness-General	723.1	Cervicalgia
719.59	Stiffness of joint not elsewhere classified: multiple sites		

TREATMENT/EXERCISES **MD DX/PRECAUTIONS:**

Exercise Description	Units/Reps/Weights	Minutes
	Total Minutes	

Electronically signed by Mark D Chanaca PT
(Therapist)

Electronically signed by
(Associate)

ATLANTIC PHYSICAL THERAPY & REHABILITATION, INC.

Physical Therapy Discharge Summary
DATE of DISCHARGE: 08-31-09

PATIENT: Hector Gomez-Fragoso **DOB:** **Patient account#:** 3436-2
PHYSICIAN: Merrell MD
DIAGNOSIS: Muscle Weakness-General 728.87 Cervicalgia 723.1 Stiffness of joint not elsewhere classified: multiple sites 719.59

SUBJECTIVE:

HOME PROGRAM: See daily note

SERVICE FROM: TO:

Test	Description	Results	Comments
Posture	Posture Narrative		
	Forward head		
	Cervical Lordosis		
	Rounded Shoulders		
	Thoracic Kyphosis		
Cervical ROM in Degrees	Flexion		
	Extension		
	Side Flexion (L)		
	Side Flexion (R)		
	Rotation (L)		
	Rotation (R)		
	Active Shoulder ROM		
Sensation	light touch		
Palpation	Tissue density:		
	Cervical paraspinals		
Strength	Cervical Muscles		
	UE Right		
	UE Left		
ADLs - Housework	light housework		
	heavy housework		
	laundry		
	cooking		
	shopping		
	lifting		
	carrying		

ASSESSMENT:

Goals	Results
Decrease pain/spasms to self manageable level < = 4/10	
Improve posture	
Increase cervical AROM to rotation 70 deg B to allow improved function	
Resume normal level of function with lifts and carries	
Patient independent with home exercises and management of symptoms	

DISCHARGE PLAN/INSTRUCTIONS:

Thank you for allowing me to participate in the care of this 843 .

This report was electronically signed by Mark D Chanaca PT.

Atlantic Physical Therapy & Rehab. 3650 Coalition Drive Myrtle Beach SC 29578 Phone: 843-293-7713, FAX: 843-293-1855

P891

Transcript of the
Deposition of

George M. Sandoz, M.D.

8/6/2010

Fragosa vs. Kade Construction, LLC, et al.
0717624

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 0717624

Hector G. Fragosa,	:
Claimant,	:
vs.	:
Kade Construction, LLC,	:
Employer,	:
AND	:
Key Risk Management Services, Inc.,	:
Carrier/Defendants.	:

Deposition of GEORGE M. SANDOZ, M.D., taken before Michele E. Starkey, Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 1:29 p.m., Friday, August 6, 2010, at Strand Regional Specialty Associates, 8170 Rourk Street, Myrtle Beach, South Carolina.

Reported by
Michele E. Starkey

APPEARANCES

For the Claimant: Jeffrey C. Chandler, Esq.
Chandler Law Firm
2501 Oak Street
P.O. Drawer 1889
Myrtle Beach, SC 29578

For the Employer/Carrier: Michael W. Burkett, Esq.
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4500 Fort Jackson Boulevard
Columbia, SC 29209

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EXHIBITS

There were no exhibits marked during this deposition.

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Workers' Compensation Act and all applicable rules.

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The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

GEORGE M. SANDOZ, M.D., being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. BURKETT:

Q Dr. Sandoz, my name is Michael Burkett and I represent the employer and its insurance carrier in this workers' compensation matter.

A You got it.

Q Have you had your deposition taken before?

A Yes, I have.

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Q And you understand the testimony you're going to give today is sworn testimony just as if you were testifying at a hearing for this matter?
A Yes, I'm aware.
Q And in fact, in workers' compensation, this testimony will actually be your hearing testimony. Are you aware of that?
A No, I wasn't, but okay.
Q Now you are. Okay, good. Just briefly, you're a board certified neurologist?
A Yes, and ophthalmologist.
Q And ophthalmologist, okay. And how long have you been in private practice here in Columbia -- I mean, in Myrtle Beach?
A Myrtle Beach have been twelve years.
Q Twelve years? And how long have you been private practice in general?
A Twelve years.
Q Twelve years, okay.
A I finished out my training in June of '98 and have been in practice July '98 here in this practice.
Q All right. And just to make sure we establish this for the record, it's my understanding you are fluent in Spanish; is that correct?
A That's correct.

Q And that's probably, sounds like your native language. Is that right?
A Yes, that's --
Q So did you have any trouble communicating with Mr. Fragosa in this claim?
A No.
Q Okay. Basically want to talk to you a little bit about the condition. You have diagnosed him with a traumatic brain injury; is that correct?
A That's correct.
Q And it's my understanding that traumatic brain injury is as a result of the blow he received to the head which actually included a skull fracture; is that correct?
A That's correct.
Q And the skull fracture itself is basically just a break in the skull bone. Like if I were to break my arm, I'd break the bone in my arm; you have a skull fracture, you break your skull bone. Correct?
A Yes, it's a little bit more harder because the bone is called -- it's protected a little bit more vital organ, in this case the brain, so the force that it need to go and inflict is much higher than let's say for your hip.
Q Right.

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A Or your arm.
Q Okay. And but in this case, the records do not indicate that it was a -- that there was no indication of a depressed skull fracture; is that correct?
A No. Basically appear to have just cracked open.
Q Just cracked open, all right. And just so we all understand, the depressed skull fracture would actually be where the -- some of that bone fragment actually pressed into the brain itself?
A Well, or the architect of the bone is depressed.
Q Okay. All right. But no surgical intervention required to repair the skull fracture in this case?
A That's correct.
Q All right. And the last note that I believe we all have from you, as far as treatment dates for Mr. Fragosa, is August of 2009. Does that sound accurate to you, according to your records?
A 2009. Give me one second, I tell you. 12th of August of '09, that's correct.
Q Okay. And you haven't seen him since then?
A No, he has not been seen since then.
Q Okay. And your -- if we look at -- do you have that report in front of you, Doctor, or do you need my copy?

A No, I do have -- sorry. I have everything is electronic. We have electronic medical records and I have, while I'm looking at the computer, it's -- I'm look at the notes.

Q All right, that's fine. I just want to make sure. If you look at the August 12, 2009 note, where in the section for physical exam.

A Yes.

Q And the subsection of neurological?

A Uh-huh.

Q You note "the level of consciousness is normal, orientation is alert and oriented, memory is intact, cranial nerves are intact. Motor reflexes, normal; facial, normal." Looks like his hearing was normal. For the most part, a normal neurological exam; is that correct?

A Except that he has -- the test is where we testing his inner ear function is lateralized into the left.

Q Okay.

A That's the damage -- that suggests that the inner ear, the -- you have two inner ears. The one on the right is damaged so he doesn't hear from that, and that's the area that is damaged, so when you place a tuning fork and give you a pitch sound, he's only hearing on the left and not on the right; meaning

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that the right inner ear is damaged.
Q Okay. Is that from the accident or from something else?
A That is from the accident.
Q From the accident. All right.
A Or directly related to the accident.
Q And just by way of explanation, how is that related to the accident, the damage to that inner ear?
A At the time the concussive injury that the patient had suffered had created an inner ear damage.
Q Okay. I was looking, for example, if you can just look at the May 19, 2009 note, and tell me when you have that in front of you and I will ask you the questions.
A May 19. You got it.
Q Okay. I was looking, unless I'm missing it here, under the neurological -- in the physical exam and neurological, I don't see acoustic listed there. Am I missing it?
A Got it. No, it wasn't --
Q Is it something you test every time or just --
A Not all the time.
Q Okay.
A I mean, I know that the guy had an inner ear damage, and I test if he complains, or like in this case,

the September was just to give him an impairment rating, or a more significant --

Q Right. Now, one of his other complaints that appears to be fairly consistent, and correct me if I'm wrong, throughout the claim or throughout your treatment with him has been some dizziness; is that correct?

A That's the dizziness, exactly.

Q And some headaches that come -- that sometimes are more consistent than other times; is that right?

A Exactly, that's correct.

Q Even though in your August 12th -- I'm just curious about this. In your August 12th, 2009 note that we looked at a minute ago, you've noted memory was intact, and in your clinical assessment, you note mild or moderate memory loss.

A Exactly. When I said, you know, he's alert and oriented times three and intact, is like you ask him what day is it, the place, and the name. Those are the three things, but for anything more complex, you know, no, I don't ask him all the time so that's why I said it's alert and oriented times three.

Q Okay, now --

A And those are the three things that I ask him, what's your name, what's your date of birth, what --

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sorry. What day is today, and what's the place that we are.

Q All right. Now, when we talk about the clinical assessment things he reports to you when he sees you, the dizziness and the headaches, when you put those in your report, those are things we can't test for; is that right? We're relying on the subjective complaints of the patient?

A Yeah, the suggestive complaint of the patient and the history that he had presented with.

Q And that would be -- those complaints would be consistent with the post concussive --

A After the effects of the trauma that he suffer in his head, yes, that's correct.

Q All right. Same thing with memory loss? Do you rely on his subjective information or do you actually test for that memory loss?

A Well, I tested some of that, you know, I give it where and ask him and what he does. One of the things that has always been asked about this one was to do a neuropsych evaluation, a neuropsychological evaluation, but to determine, you know, if this is something that is really directly related or not.

Q Right. Okay. But as far as your concern that headaches and dizziness and that moderate memory

loss, those are the results of that -- do I call it post concussive symptoms?

A Traumatic brain injury.

Q Okay. All right. Now, let's look at -- you wrote two notes; one was August 20, 2009, and one is June 3, 2009.

A Sorry, one is --

Q We'll do August 20th first.

A September, give me one second. August 20th, 2009, yes.

Q All right. And I'm going to start with this one first only because I was looking at all of this and my interpretation is there might be a little error here but I just want you to tell me if I'm right or wrong.

A Okay.

Q You reference the fifth edition and table 13-5 -- the fifth edition of the AMA Guidelines in table 13-5.

A Yes.

Q Now, 13-5 is the table for dementia.

A Well, that's the only thing that I have available for him to go and do the injury.

Q Okay. Well, and the reason I ask, because in the June 3rd, 2009 note, you've got one on the screen,

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you reference the sixth edition of the guidelines and table 13-8, which measures the mental status, cognition, highest integrative function.

A Exactly.

Q Is there -- I know there's a difference because the books are different.

A That's correct.

Q This one on the June 2009 report, you basically put him in class two which is, you know, a moderate category basically.

A Uh-huh.

Q Is that still accurate? Was there a reason you went to the fifth edition? I'm trying to distinguish between the two of them.

A Just because, you know, when I get like in June, I have now that one, in August, I had this one only.

Q Okay.

A So that's the only reason.

Q Is the -- since the June -- since the sixth edition actually gives you a bigger range where you can test alteration of mental status, cognition, highest integrative function, is the June one probably the more accurate assessment since it gave you better guidelines to go by, or what would you say?

A Doesn't really matter, it's just by the edition.

Q Okay. All right.
A You know, this year we're going to go and do this part, I go do the assessment, and when I do the assessment at one time, it's -- this was available.
Q All right.
A And when I do the other one, it's the other one available.
Q I got you. Now, would you agree that -- do you still stand by the two reports, even though you're using two different books? You still agree with both of those reports?
A Yes.
Q Okay. And just for the record, for the sixth edition, we can submit this later, it says alteration in mental status, cognition, highest integrative function that interferes with the ability to assume some normal roles or perform activities of daily living. Is that --
A That's correct.
Q -- a fair assessment of Mr. Fragosa? All right. Now, we've arrived at this because of what you called traumatic brain injury, correct?
A That's correct.
Q As far as physical findings on his brain, if you were to look at scans, is it fair to say there is no

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physical damage to the brain that we can see; is that right?

A There's no evidence of any damage on the brain that we can go and see, that's correct.

Q Okay. So what we're dealing with here are these -- the traumatic brain injury, and sometimes I like to call it because I don't know what else to call it, but I see it often, is the post concussive syndrome --

A Got it.

Q -- which is the same thing.

A This is not a concussion, this is an injury suffered to the brain.

Q Injury suffered to the brain.

A That's why traumatic brain injuy is the preferred term.

Q What's the difference between the jar that a brain takes in a concussion and what he may have had?

A The concussion should resolve.

Q Okay. So we're looking at -- so we call it traumatic brain injury because it's a longer period of time?

A Because there's been some damage and injury to the function of the brain.

Q And we're aware of that because of --

A The history that he gives, the findings that he had initially, and the clinical presentation that he has.
Q Right, and that clinical presentation today is still the moderate memory loss, the dizziness, the headaches?
A The headaches.
Q All right. But just to clarify again, as far as the physical damage to the brain, physical, something we can physically see on a scan, CT, MRI or anything else, we're not going to see anything; is that correct?
A Not in this case.
Q Okay. All right. As far as ongoing, you haven't seen him since August, was he on any medications when you released him or can you tell?
A Initially had placed him on medications but he has been for loss to follow up. Some of the medications that he has were used for the treatment of pain, and -- and that is going into the cervical spine therapy, and I've been giving him for the treatment of the headaches that he has, so I haven't seen him since then.
Q All right.
A I don't know why, and I don't know why he has not

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presented.

Q Okay. Can you tell from your notes whether he's called in for any refills or anything? I don't think he has and I think he told me that, I'm just checking with you.

A The last, you know, contact that I have with any of them is the case nurse manager in 8/24.

MR. BURKETT: Okay. I don't have anything else.

EXAMINATION

BY MR. CHANDLER:

Q Just want to ask you about the MRI findings, Dr. Sandoz.

A Right.

Q You did one and it was -- you ordered one and it was conducted on September 16, 2008. What is significant at all about findings of severe mastoiditis?

A Well, that's the part of the injury that he has suffer and that's why he's dizzy.

Q Okay. So when the radiologist notes that he has severe right mastoiditis, that's telling us what about the injury to the brain?

A That suggests that he had an injury to his head, and if you look, you know, there's also within the

dictation or within the body of the findings, in the last paragraph, and it says sensitivity of the artifact of the subcutaneous tissue of the left skull could be from prior trauma.

Q What is artifact telling us?

A That there is some -- that there is things that shouldn't be there because motion, metal, movement, and it said that there is non-seen that will suggest intracranial hemorrhage, but it doesn't mention anything of sheer injury or what they call basically damage to the brain in the more diffuse manner.

MR. CHANDLER: Okay. Do you --

MR. BURKETT: I don't have -- well, I probably do but it's easier for me to look over your shoulder. Do you have --

MR. CHANDLER: I don't have any other -- well, you know what, I do have a few.

Q I just wanted to clarify the one point about the MRI studies because I thought there was an acute finding.

A Exactly. This is after the, what do you call it, this is here. Then he had done other testing at MUSC.

Q Let me ask you some questions, Dr. Sandoz, about Mr. Gomez Fragosa's cognitive deficits.

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A Uh-huh.
Q You believe that the traumatic brain injury has affected Mr. Fragosa's ability to return to employment?
A To gainful employment, yes.
Q Okay. I believe the history that this guy gave you was that he was a construction worker and he was injured in the construction-related accident. Is that your understanding?
A That's correct.
Q Based on the condition that he has now and the limitations that he has, do you believe that he can return to any kind of former construction-related employment?
A No, I don't think he will be able to.
Q Okay. Would --
A The reason being is because -- not only because of the traumatic injury, I don't think he's able to follow any type of commands, but the most significant change is the inner ear injury that he suffer which is making him unsteady, so any type of high work or ladder or scaffold is out of the question.
Q Okay. Is it your opinion to a reasonable degree of medical certainty that he will need to take

medications for life to control his condition?
A With a certain degree of medical certainty, I believe that the patient will require to take medications on a permanent basis to control the symptoms that he has.
Q Okay. Will he need to have periodic neurological office visits and/or diagnostic studies to kind of monitor his condition?
A That's correct.
Q Okay. Periodic blood work to see how the medications are affecting his body overall?
A Yes. That's correct. Sorry.

MR. CHANDLER: I don't have any other questions.

RE-EXAMINATION

BY MR. BURKETT:
Q Doctor, I'm looking back at this September 16, 2008 MRI study. Explain again, mastoiditis indicates that there -- you could tell -- is that the radiologist picking up on the actual old skull fracture or is that something else?
A No, this is new. The old skull fracture was on the left side. All the -- you know, the brunt of his trauma was in the left side so this injury to the brain, because it's kind of like a solid mass, can

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transmit the energy on the -- of the impact of the bang to the opposite side. So said you hit here, sometimes the injury that you suffer is in the opposite side.

Q Okay. So that's my question. What exactly is the mastoiditis?

A The mastoid is, if you imagine the skull, it will be too heavy if you make it solid bone, so there is the mastoid process like the one that is behind the ear that is full of caverns so it make it lighter, the mastoid.

Q The skull itself?

A It's part of the skull.

Q Part of the skull?

A The temporal bone -- sorry to technical -- the temporal bone has a, you know, has like a con -- like a wave. It has the mastoid process and the temporal bone itself. There are three bones that are stuck together. And one is just to make it, first of all, the head lighter, protect it more, and allow the inner ear to tolerate a change in pressures. Like a sponge there, that in case you go too high or too low, it absorbs the pressure there instead of popping the ear or breaking the ear like sometimes it happens when the pressure goes too high

too quickly. And that's been damaged from the injury that he suffer.

Q Okay. So the mastoid isn't part of the brain, it's part of the --

A Skull.

Q -- skull. Okay. So all right. And --

A Which is the part of the skull that the right inner ear is located, which when we do the testing, the right inner ear is the one that appears to be damaged. So the complaint that the patient is having, the clinical signs, clinical symptoms, the complaint that he has, and the findings that we do on the studies, they're all correlate.

Q All right. The inner ear problem correlates with that mastoiditis?

A Exactly.

Q Which is, I guess, sounds like an inflammation of that area. Is that --

A Well, it's like fluid of the inflammation from the response to the injury that he suffer.

Q Okay. All right. And as far as the cognitive deficits, are you talking academic ability or just -- what kind of things are you talking about with cognitive deficits?

A When I ask him, I mean, I'm asking simple stuff,

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like can you -- how many bricks are -- can you lay in a day, and how many are in a foot, so stuff that he's able to relate, how many feets are there to this, and he's not able to figure that stuff out.

Q All right. And you didn't know him before this accident, did you?

A No, this is the first time I've ever seen him.

Q All right. So is it fair to say he may not have known that stuff before the accident, we just don't know?

A Exactly, I don't know. He's a construction worker. I expected him to know, you know, that stuff.

MR. BURKETT: All right. I don't have anything else.

MR. CHANDLER: I don't have anything. Thank you.

(Deposition was concluded 1:52 p.m.)

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PSYCHOLOGICAL and VOCATIONAL EVALUATION

Name: Hector Gomez Fragoso C/A No: 4:10-CV-00503-TLW

Date of Birth: Age at Evaluation: 30

Date of Evaluation: 10-27-2010 Date of Report: 11-02-2010

Due to Mr. Fragoso's limited English-speaking skills it was necessary to have a translator present throughout this evaluation. The translator was Mr. Jaime Cailson, hired for his services and not related to Mr. Fragoso. Mr. Fragoso seemed comfortable with this procedure and it is believed that the information reported here is an accurate account of his responses and information presented.

Referral and Background Information: Mr. Fragoso is a 30-year-old former Construction Laborer for Builders First Source. He was referred for an independent psychological and vocational evaluation to determine vocational implications, and earnings issues, if any, related to limitations resulting from severe on-the-job injuries, including obvious brain injuries resulting in a loss of consciousness sustained on 11-01-2007.

At the time of his on-the-job injuries, Mr. Fragoso was delivering construction material to a job site when the weight of a crane caused the load to fall onto his head. He experienced a loss of consciousness at the scene, as well as significant blood loss. Trauma records indicate initial vomiting and inability to speak following his injuries. Records indicate he sustained a traumatic brain injury, complex scalp laceration, skull fracture, epidural/ subdural hematoma, clavicular fracture, multiple right phalangeal fractures, open scalp wound, and right frontal contusions. He subsequently required a transmetatarsal amputation, toes 2-5, right foot, which became infected and required revision with irrigation and debridement. Mr. Fragoso continues to experience symptoms typically associated with brain injuries, as well as orthopedic difficulties. These include headaches, dizziness, neck pain, back pain, and shoulder pain, as well as difficulty with gait, balance, and memory loss. He has been unable to return to any gainful employment since the date of his on-the-job injuries.

With the passage of time, now more than 2.5 years after his injuries, *behavioral and cognitive changes have persisted, as will be noted, sufficient to conclude that the brain injuries he sustained, described as post-concussion injuries in multiple records, has resulted in continuing and severe symptoms clearly associated with a physical traumatic brain injury, the result of his on-the-job injuries.*

He has never been married and has no children. Mr. Fragoso arrived promptly for this evaluation and was driven by his interpreter. He does not have a valid South Carolina driver's license, but he knew how to drive prior to the TBI. He indicated that he would be unable to drive at this time due to difficulty with range of motion in his neck, arm pain, pain in his foot due to amputation, as well as cognitive deficits which would result in "errors" when driving. His cognitive mistakes include difficulty in recalling directions to destinations with which he would ordinarily be well familiar.

His general appearance, hygiene and personal grooming were good. He wore a beard. He is 5' 4" in height, and weighs about 190 pounds, a slight gain due, in his opinion, to reduced levels of activity resulting from his injuries. He does not wear glasses, but has begun experiencing blurred vision and photosensitivity since his TBI. As will be noted, this is frequently seen following brain injuries. He does not require the use of a hearing aid, but does now experience ringing in the left ear, as well as sensitivity to noise, other symptoms often associated with brain injuries. Finally, he also has significant mobility limitations due to balance difficulties and noted, "...I walk like a drunk...and I'm not...but I usually catch myself before I fall..." Balance difficulties not accounted for by orthopedic or muscular difficulties are also common following brain injuries. He wriggled and changed positions throughout the evaluation, citing low back, neck and shoulder pain.

At the time of this evaluation he was receiving $266.00 per week in Worker's Compensation benefits, his only income. He continues to experience significant financial hardship as a result of the loss of income resulting from his on-the-job injuries.

Sources of Information:

Medical Records from:

Atlantic Physical Therapy & Rehabilitation, Inc.	Melissa Gray, P.T.
Long Bay Diagnostic Imaging	Robb Hoehlein, M.D.
Mark Wagner, Ph.D.	
MUSC	Monica Zilkoski, M.D.
MUSC Neurology	Mark Wagner, Ph.D.
MUSC Neurosurgery Clinic	Istvan Takacs, M.D.
MUSC Trauma/Critical Care Surgery	E. Douglas Norcross, M.D.
	Christian Minshall, M.D.
	Shane Woolf, M.D.
	Stuart Leon, M.D.
MUSC Rehab Services – Physical Therapy	Paige Thomas, MSRPT
MUSC Rehab Services – Occupational Therapy	Josie Craig, OTR/L
MUSC Radiology Services	Daniel Zapton, M.D.
	James Ravenel, M.D.
	Marques Bradshaw, M.D.
	Dobrinka Dimitrova, M.D.
	Miguel Fernandez, M.D.
MUSC Orthopedics	Shane Woolf, M.D.
	Christopher Merrell, M.D.
	Kyle Kokko, M.D.
MUSC Otolaryngology	Mark Hoy, M.D.

Strand Regional Specialty Associates George Sandoz, M.D.

Psychological Testing and Evaluation Results:
Wechsler Adult Intelligence Scale – Fourth Edition
Wide Range Achievement Test – Revision 4
Bender-Gestalt
Clinical Interview and Behavioral Observations
Mental Status Examination
Brain Injury Screening

Activities of Daily Living: He shares an apartment with two male friends, a financial arrangement that was advantageous even prior to his significant reduction in income following his injuries. He has difficulty navigating the stairs located in the home due to right foot pain. He noted that he would have difficulty climbing ladders and also described phantom pain in the area of the amputation in his foot.

On most days, he gets up at about 9-10 AM and is able to handle his basic personal grooming and toilet needs without assistance, but finds most movement results in significant orthopedic pain. As a result, he has difficulty dressing. He must avoid tub baths due to difficulty pushing himself up in the tub due to shoulder pain. He must essentially perform all chores with the use of only one arm, as a result of the functional deficits in his left arm, as well as numbness and/or pain in the left hand. He also continues to experience a sensation he described as feeling as though he was "not getting enough air when breathing", which also interferes with his ability to perform any sustained activity.

He continues to perform light chores around the home, but only those that can be performed with the use of only one arm. However, he indicated that it is becoming more apparent that his right arm is also weakening due to possible overuse related to the functional deficits in his left arm.

He shops alone, but does not drive to the store, and then requires items be packaged for ease of carrying, essentially with only one hand. He holds onto the grocery cart for stability when shopping. He is unable to exercise due to "...tiring too easily...pain in my arm and neck..." He is not able to sustain much activity, despite efforts to initiate activity due to pain and ease of fatigue "from nothing".

In a typical 8-hour day he indicates he must spend about 50% of the day reclining/ resting on the sofa with his foot elevated due to pain in the area of the amputation there, and also with his left arm/shoulder propped and supported as well, as a result of his physical limitations and pain. He watches television to pass the time, the Spanish channel. He indicated that he has difficulty concentrating even when watching television and doesn't understand what is on, even on Spanish TV.

In a 5-day work week he indicated that he would have to miss about 2 days per week at any potential job due to pain problems and lack of sleep associated with medical conditions that resulted from his on-the-job injuries.

This would of course greatly exceed the number of days available for personal/sick leave in an average job in South Carolina, about 2-weeks per year.

He returns to bed at about 9-10 PM but gets only about 3-4 hours of non-restorative sleep, often interrupted by pain. He noted no prior history of sleep problems, but now requires prescription pain medication at bedtime to assist in getting off to sleep.

As a direct result of his on-the-job injuries he is now able to participate in far fewer social or leisure activities than was the case prior to his injuries. He indicated that his relationships with friends, family and others have also changed as a result of his medical conditions. He noted he could no longer participate in sports, an activity he enjoyed prior to his on-the-job injuries. He indicated difficulty participating in most activities due to balance problems, ease of fatigue, and foot pain.

He also admits that he has inadequate patience and is easily irritated. He noted he has difficulty concentrating and sustaining attention to complete any task. The overall quality of his life has clearly been greatly diminished by his injuries.

Educational Background: He graduated from high school in his native Mexico. While attending high school he participated on sports teams. He has been in the U.S. for the past 7 years, but has had no formal English training and continues to have severe language deficiencies. He has received no further formal training and has no military experience.

Work History: Mr. Fragoso's work history has been entirely as an unskilled laborer, in the United States. He has worked regularly and has a stable work history. At the time of his on-the-job injuries, he was working as a Construction Laborer for Builders First Source for whom he had worked for about the past 2 years. He earned $11.00 per hour, working 40-45 hours per week, $20,000-$25,000 annually.

Work as a Construction Laborer is defined by The Dictionary of Occupational Titles as unskilled and Heavy in physical demands. Such work is actually Very Heavy as performed, at times, requiring that he lift, bend, reach and stoop on a regular basis as part of his essential job duties. Prior work experience in the U.S. included work as a Carpenter/Helper installing kitchen countertops.

He insisted that in his employment he had no personnel or performance problems. He enjoyed his co-workers, his colleagues and got along well with his supervisors. Clearly it is the on-the-job injury in 2007, which began his medical problems.

Medical Problems: The medical aspects of his injury are documented in other reports, and will not be addressed in great detail herein. However, several more recent medical references have vocational significance and are noted accordingly.

On 11-01-07, an initial MUSC Trauma Center evaluation indicated, "...hit in head with part of crane...*LOC at scene*...significant blood loss...vomiting x prior to arrival...unable to speak...complex scalp laceration...*skull fracture*...*epidural/subdural hematoma*...right

clavicular fracture...multiple right phalangeal fractures...open scalp wound washed and closed...*right frontal contusions*...admit to ICU...vent support..."

On 11-01-07, Dr. Shane Woolf noted, "...hit in the head with a crane...he vomited prior to ED arrival...incurred a *large fracture through his skull*, apparently it is open with subdural and epidural fluid collections...right clavicle fracture, as well as fractures of the proximal phalanges of the right foot, 2-12, with traumatic arthrotomies of the 4th and 5th toes, as well as a non-displaced oblique fracture on the right great toe...not a surgical candidate at the moment per neurosurgery..."

Also on 11-01-07, Dr. Istvan Takacs indicated, "...patient is status post *closed head injury with open skull fracture*...recommend ICU admission, frequent neuro checks..."

An x-ray of the head performed by Dr. Dobrinka Dimitrova on 11-01-07 concluded, "...bilateral apical contusions versus atelectasis...right midshaft clavicular fracture..." An x-ray of the right foot indicated, "...fractures of all five sets of phalanges..."

A CT of the brain performed by Dr. Dobrinka Dimitrova on 11-01-07 concluded, "...*comminuted fracture* with small extra-axial *parietal hematoma* at midline at the vertex, worrisome for a small *epidural hematoma*..."

On 11-02-07, Dr. Woolf performed an irrigation and debridement of open fracture of phalanges, closed reduction and percutaneous pinning of hallux second, third, and fifth toe proximal phalax fratures, and nailbed repair fourth and fifth toes.

On 11-07-07, MUSC notes indicated, "...*cranial fractures with head injury*...respiratory failure...right foot crush injury with fractures of all toes...posttraumatic vasospasm..."

On 11-15-07, Dr. Christian Minshall performed a tracheostomy due to the diagnosis of a *closed head injury* with epidural hematoma.

A CT of the chest performed by Dr. Marques Bradshaw on 11-16-07 concluded, "...left lower lobe atelectasis possibly with superimposed pneumonia..." A CT of the chest on 11-18-07 by Dr. Mike Hanley indicated, "...right midshaft clavicular fracture with half shaft displacement...left basilar opacity, likely combination of atelectasis and effusion, but may represent pneumonia..."

An Occupational Therapy Evaluation performed by Josie Craig, OTR on 11-20-07 noted, "...decreased ability to perform ADL's and functional transfers...limited ROM in right shoulder...decreased overall cognitive skills..."

A Physical Therapy Evaluation performed by Paige Thomas, MSRPT on 11-23-07 indicated, "...patient now awaiting possible TMA for right foot gangrene...dizziness with sitting...decreased mobility, decreased ambulation...transfer training, gait training, balance training, therapeutic exercise, wheelchair mobility training..."

An x-ray of the cervical spine performed by Dr. Daniel Zapton on 11-27-07 concluded, "...inferiorly and posteriorly displaced spinous process fractures at C7 and T1..."

On 11-30-07, Dr. Woolf performed a transmetatarsal amputation, toes 2-5, right foot.

On 12-12-07, Dr. Monica Zilkoski noted, "...pain and swelling to the foot...significant wound breakdown and concern for infection at this point...patient is to be admitted to the hospital and plans to revise his amputation with irrigation and debridement, and possible placement of a wound VAC..."

On 12-17-07, Dr. E. Douglas Norcross indicated, "...he complains of some ongoing headaches and some dizziness to changing positions...pain in the right foot...given the severity of his injuries...Lortab prescribed ...continue to follow-up with Neurosurgery and Orthopaedic Surgery..."

On 09-03-08, Dr. George Sandoz noted, "...status *posttraumatic brain injury with associated headache*...headaches appear to be musculoskeletal and status post skull fracture in nature...patient had a skull based fracture with a frontal bone fracture with superimposed subdural and epidural hematomas...he also had frontal lobe contusion ...dizziness appeared to be directly related to an inner ear injury, most likely from his skull based fracture...patient had difficulty concentrating and that appears to be directly related to the injury that he has suffered and after effect typical of this type of injury... shortness of breath could be anxiety attacks or could be damage from the tracheostomy that the patient had...foot pain is from the injury that he has suffered ...difficulty concentrating and performing tasks with irritability is directly after effects from the injury that he suffered...neck pain has never been evaluated and possibility of cervical disc and joint disease and/or spinal stenosis in this patient is present..."

Dr. Sandoz concluded, "...a neuropsychological evaluation in Spanish should be done to see which areas have deficit and what can be done to improve or maximize the recovery and function of this patient...an EMG of the left upper arm and right lower extremity to evaluate the possibility of having a lumbar and cervical radiculopathy should be performed...EEG to evaluate the inner ear and make sure that this paroxysmal event that the patient is having is not associated with seizure, as well for the irritability that the patient has presented to see how the brain is functioning...Robaxin 500mg three times a day for treatment of the headache and the musculoskeletal component that the patient is suffering...Neurontin 300mg three times a day to stabilize mood and control symptoms of paresthesias, headaches and dizziness...Vicodin for pain...pulmonary evaluation to make sure that his trachea and lungs are working properly...I agree with the orthopedic evaluation...vestibular desensitization exercises prescribed...patient has blurred vision that he had presented to me to be evaluated if the treatment and symptomatology of dizziness does not resolve completely..."

An MRI of the brain performed by Dr. Robb Hoehlein on 09-16-08 concluded, "...right mastoiditis..." An MRI of the cervical spine on this same date indicated, "...probable left intraforaminal focal disc protrusion at C4-5 resulting in moderate left neural foraminal stenosis...protrusion is located beneath the exiting left C5 nerve root...CT myelogram could be helpful..."

On 09-16-08, Dr. Sandoz noted, "...he is noted to have a transverse process injury at the level of L3-4 and also a transverse spinous process at the level of C7..."

On 09-17-08, Dr. Kyle Kokko indicated, "...now nine-month followup from surgery complaining of pain in his foot...shooting pain consistent with neuropathic or phantom pain...swelling of the right foot...stressed benefits of having some sort of prosthesis or inserts that he can utilize in his shoes to help him with gait and balance...Neurontin would likely help his phantom pain, increase dose..."

On 10-02-08, Dr. Sandoz noted, "...having dizziness...headache...neck is 8/10, into the left, more significant...associated recently with more low back pain and thoracic pain, but has worsened with activity...*unable to perform any of his ADLs*...presented with headaches and vertigo...inner ear damage we will check electronystagmogram... abnormal mastoid process present on MRI...MRI of the cervical spine shows herniated disc at the level of C5, particularly at the level into the left, which correlates with the clinical findings the patient is having...symptomatology with his back might represent worsening condition of his neck or previous injury...MRI of the lumbar and thoracic spine to be scheduled..." An ENG study on this same date concluded, "...right canal paresis..."

On 10-10-08, Dr. Sandoz indicated, "...dizziness, spells that suggest that the patient is having seizures, low back pain, but by history the patient had an injury on the lumbar spine...from the cervical standpoint, patient has presented with mild disc bulge...from the evidence of the brain, it suggests that there is a right temporal lobe injury..."

On 10-24-08, Dr. George Sandoz noted, "...neck pain, back pain, ear pain and recently noted to have right shoulder pain...the more he does, the more it hurts...the less he performs, the better it is, but it is always there...symptoms significant, persistent, exacerbated by movement, improved somewhat by rest...medication is giving some relief and he continues to rely heavily on it...MRI shows some mild abnormality in the temporal lobe, but no significant lesion...back pain and neck pain...symptomatology of ear pain is significant..."

On 10-30-08, Dr. Mark Wagner noted, "...*postconcussive syndrome*, mild...chronic pain disorder...situational depression...very serious work-related injury result in trauma to his body and skull...skull fracture with acute underlying minor structural change to the brain...*persisting cognitive complaints...exhibiting symptoms of postconcussive syndrome* ...abnormal findings largely in the domain of complex attention and concentration...he may have some element of decreased intellectual efficiency...he does have findings positive for situation depression and pain are also contributing to his functional disability...most likely at maximum medical improvement in terms of her neurologic/brain status...the most treatable aspect of the claimant's current syndrome is pain and depression..."

On 11-25-08, Dr. Sandoz indicated, "...he continues to have a headache...foot hurting ...symptoms into his neck, 8/10 when turning, difficulty sleeping, unable to ambulate and perform any of his activity...also complaining of low back pain due to worsening and sitting down longtime position...it takes a while for him to keep going...continues to have difficulty hearing on the right ear...he gets short of breath every time that he starts working..."

Dr. Sandoz concluded, "...*traumatic brain injury*...he is tolerating Neurontin well... headache does appear to be related to the *contusive injury* that the patient is having...cervical spinous process fracture continues to bother him...low back pain appears to be associated with a compression fracture and transverse process fracture, fairly stable, but continues to bother him...shortness of breath might be associated with tracheomalacia...vertigo with mastoiditis present...epidural steroid injection of the cervical spine given..."

On 01-05-09, Dr. Woolf noted, "...still having pain about the neck and shoulder...low back has been symptomatic without radicular symptoms...upper extremity pain seems to radiate down into the hand globally...low back pain seems to be worse since starting therapy...left AC joint arthritis...left shoulder posttraumatic stiffness...rotator cuff strain... C7 spinous process nonunion with paracervical pain...low back pain...I would also like to assess cervical disks, particularly C5-C8 nerve roots which may explain his upper extremity symptoms altogether..."

On 01-06-09, Dr. Sandoz indicated, "...headache comes and goes every two to three days...nothing makes it better or worse...recently taking Neurontin and Voltaren without great deal of relief...neck pain is 8-9/10, sharp in nature that is shooting mostly into the left leg...low back pain is 8-9/10 going up into his back... headaches appear to be chronic, posttraumatic in nature...cervical and lumbar disc disease with associated fracture of the spinous process...epidural steroid injection of the cervical spine will be given trying to control the pain..."

On 01-22-09, Melissa Gray, P.T. noted, "...patient continues with complaint of constant pain bilateral cervical area (left greater than right)...headache at the top of head is intermittent...constant paresthesia all digits left hand and left shoulder pain with movement...constant low back pain...turning head to drive is still difficult, as is using left upper extremity to turn the wheel...pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body..." Mr. Fragoso continued in physical therapy through 04-09-09, at which time PT was placed on hold until he could receive an ESI.

On 01-27-09, Dr. Woolf indicated, "...he continues to have the same pain, which he localizes to the base of the neck on the left side and in the upper portion of the trapezius...radiating symptoms sometimes down the hand and arm...pain on the dorsum on the right foot just proximal to his transmetatarsal amputation...painful right transmetatarsal amputation stump, with metatarsalgia...small partial thickness infraspinatus tear of the left shoulder...possible C4-5 nerve root impingement...I am more concerned about his neck given his symptoms at the base of the neck and trapezius, as well as radiating symptoms in the upper extremity...he may have some neurogenic pain in the foot along the digital nerves..."

On 02-17-09, Dr. Sandoz indicated, "...medication has given some relief, but continues to rely on it for the control of the symptoms...dizziness has continued to be improved with the use of Meclozine...headaches are still persistent... episode of loss of consciousness, and *traumatic brain injury type of picture*..."

On 04-16-09, Dr. Merrell performed the recommended epidural steroid injection at C6-7.

On 06-02-09, Dr. Sandoz indicated, "...headache occurs constantly...entire head... radiation to anterior...debilitating, sharp and worst ever...aggravated by head position and stress...dizziness...*loss of consciousness*...responding to current treatment...having some difficulty with ambulation...needs some assistance with ADLs...intracranial injury of other and unspecified nature...variants of migraine with intractable migraine...dizziness and giddiness...degeneration of lumbar or lumbosacral intervertebrae..."

On 07-07-09, Dr. Sandoz noted, "...*head injury*...location of injury is in the bilateral frontal region and bilateral cervical region...location of pain is facial, head and neck... pain is aching and burning...the mechanical force causing the injury was *contra-coup and coup*...includes fall...aggravating factors include bending over...incoordination, irritability, memory difficulty and speech difficulty...dizziness occurs persistently... imbalance and spinning...aggravated by bending...headache unchanged, entire head with radiation to anterior...blinding...aggravated by head position...not responding to current treatment...difficulty with ambulation...needs some assistance with ADLs... moderate memory loss...late effect of intracranial injury...status *post TBI with complicated migraine, dizziness and cervical and lumbar pain...*"

At the time of this evaluation, he continues to experience bilateral neck and shoulder pain, shortness of breath, numbness in both hands, right foot pain, range of motion difficulties in the neck, as well as obvious symptoms of having suffered a traumatic brain injury. He also continues to experience frequent migraine headaches, at least weekly, which requires that he return to bed in a dark, quiet room. At the time of this evaluation, Mr. Fragoso is still prescribed Neurontin, but with little effectiveness as to pain management.

References to pain in records exist over an extended period of time. He indicated treatment has included prescription medications, epidural steroid injections, and physical therapy. When asked to describe his pain, he indicated that since his on-the-job injuries he experiences pain at a level 8 on a 10-point scale, at some point of every day, 7-days per week. He noted movement, reaching overhead, and bending exacerbates the pain. His pain is best relieved by prescription medication and resting/reclining. He indicated that he is never without pain and is even unable to sit for 8-hours due to worsening pain symptoms even when being still.

Mental Status Evaluation: He was well oriented to all spheres, and neither demonstrated nor reported any hallucinations or delusional thought processes. He noted no prior mental health history.

He described clinically significant symptoms sufficient to confirm the continued presence of cognitive deficits associated with a brain injury, including a severe level of depression. His cognitive/emotional symptoms include a considerable loss of interest or pleasure which is nearly always present. This includes social withdrawal even from family activities; significant reduction in previous levels of sexual interest or desire; decreased energy, tiredness and fatigue out of proportion to actual activity; impaired ability to concentrate, or make decisions; and is easily distracted with memory difficulties.

These symptoms have clearly resulted in significant distress/ impairment in social, occupational, and other important areas of functioning. These symptoms are not better described by any other general medical condition and there is no evidence of any substance abuse which would cause these same symptoms. In spite of his depression, he denies any suicidal attempts or plans at this time.

He is also continuing to experience classic symptoms associated with anxiety. His anxiety is increased by the fact that he realizes he cannot do what he has done in the past, an anxiety provoking thought.

He does not use illegal drugs and does not consume alcohol. He indicated that he smoked prior to his TBI, but quit following his injuries due to the cigarettes "tasting different". Changes in smell and taste are often symptoms of a traumatic brain injury.

Psychological Test Results: He appeared to cooperate and to give optimal effort during this evaluation. Due to his marked English language deficits, it would have been inappropriate to administer some verbal subtests. Thus, testing consisted of primarily performance subtests and tasks that would not be markedly influenced by language deficits. With those limitations, these results are believed to be valid indicators of his current levels of functioning.

On the Wechsler Adult Intelligence Test – Fourth Edition, using only the performance subtests, he appears to be functioning at no higher than about the "Borderline to Low Average" range of intelligence. Since there is no indication of any developmental delays or other intellectual deficits prior to his graduating from high school in Mexico, it appears, and is reasonable to conclude, that there has apparently been some deterioration in pre-injury levels of functioning.

Again, with his noted lack of English language skills, Reading and Spelling in English would be expected to be markedly limited, of course. On the Wide Range Achievement Test – Revision 4, I was interested in obtaining confirmation as to his limited English language skills. As expected, he has marked Reading limitations. His Reading Standard Score of 27 is only a 2.0 grade level score. However, even his Arithmetic Standard Score of 29 is only a 4.0 grade level score. This would not appear to be consistent with his pre-injury levels of presumed functioning. Regardless of cause, his academic skills are not sufficient for use in work settings in which such skills would be essential.

On the Bender-Gestalt, the quality of his drawings was generally adequate, but did include some errors often associated with cognitive difficulties.

Evidence and Symptoms Associated With An Acquired Physical Brain Injury: There are multiple medical references over an extended period of time confirming that Mr. Fragoso sustained a (physical) traumatic brain injury. He continues to present classic evidence as to the continuing presence of cognitive deficits that resulted from his brain injury. A variety of behavioral symptoms are evident and have been noted, including attentional problems, irritability, anxiety, depression, apathy, and other similar changes in personality.

He has also developed multiple cognitive deficits of such severity as to have caused impairment in occupational and social functioning which clearly represents a marked decline from his previously higher level of functioning. He demonstrates significant memory impairment which continues to confirm the diagnosis of a brain injury and subsequent cognitive deficits.

He also demonstrated difficulty with remote memory at times and was unable to accurately describe all past material related to the conversation. At times his speech was somewhat vague, and he appeared to struggle to find the right word even in his native language. The interpreter confirmed that Mr. Fragoso was struggling to find the word he was wishing to use.

He also has demonstrated disturbances in executive functioning in his daily activities, a common manifestation of brain injuries. He is unable to plan, initiate, sequence, or monitor complex behaviors. It seems obvious that he would have difficulty in sustaining these activities without the monitoring and direction noted. His decline from likely previous levels of functioning have caused significant impairment in occupational functioning and in handling personal finances.

Cognitive deficits resulting from brain injuries are also often accompanied by multiple disturbances of gait. Mr. Fragoso has experienced such deficits as noted in this report. The multiple cognitive impairments that he has experienced are also associated with depression, anxiety, mood and sleep disturbances. Individuals with brain injuries/ cognitive deficits are often especially vulnerable to physical stressors, as well as other psychosocial stressors which tend to exacerbate their deficits and associated problems.

In a publication by the Brain Injury Association of America, some of the common symptoms following brain injuries include, but were not limited to: headaches; sleep problems; lack of patience; short term memory loss; forgets names of friends, colleagues known in past; difficulty with word use/recall; trouble concentrating; slowed ability to process information; organizational problems; major balance problems; depression or mood swings; increased anxiety; easily agitated; changes in vision, appetite, taste, smell, hearing, in balance or muscle coordination; sensitivity to light, sound and temperature. *Mr. Fragoso exhibits literally each and every one of these clinically significant indicators.*

Utilizing the AMA Guides to the Evaluation of Permanent Impairment-5th Edition, specifically Chapter 13 (The Central and Peripheral Nervous System), Mr. Fragoso is assessed as having impairments based on the Clinical Dementia Rating Scale (CDR). This reflects his apparent lack of awareness of some residual cognitive deficits that continue to be present. He is quite compromised in his attention/concentration, speed of mental processing and multitasking. He avoids most social and recreational activities that previously afforded him pleasure. He still has marked physical limitations and restrictions that clearly prevent him from performing the full range of job duties that his past employment setting required.

Based on the CDR ratings, Mr. Fragoso is assessed as having a "Class 2 Impairment", a level of impairment which requires "direction of some activities", resulting in a 15%-29% impairment of the whole person. Using the midpoint in this range, this equates to about a 22% impairment rating. Specifically, this is based on his memory loss; moderate difficulty in handling some activities; as to community affairs he "appears normal to casual inspection", but has limited his activities; as to home and hobbies, he has abandoned most of his leisure and hobby activities he enjoyed prior to his injuries.

Diagnosis: After observing him during this evaluation, and from careful review of records of past behavior and levels of functioning, he is clearly manifesting signs and symptoms consistent with the requirements to establish and/or maintain several diagnoses. He is continuing to experience major pain episodes and references to pain exist in several medical records over an extended period of time. He is also anxious about his future, especially since he realizes that his past work is no longer an option for him, an anxiety-provoking thought for someone at the age of 30. Finally, his multiple losses, personal, financial, social and leisure, all have led to a level of depression.

Therefore the following diagnoses apply, in keeping with all diagnostic requirements for each:

294.1 Cognitive Disorder, Secondary to (Physical) Traumatic Brain Injury
307.89 Pain Disorder
311 Depressive Disorder NOS
300.02 Generalized Anxiety Disorder

These medical/mental conditions are in addition to his other physical medical problems that are well documented in his files.

Vocational Opinion and Rationale: Several factors must be considered in reaching a vocational opinion. They include his age of 30, still defined as a "younger worker", a positive factor; his educational background in Mexico would have been satisfactory in that environment, but is inadequate in an English speaking work environment and, thus, becomes a negative factor; his profound cognitive impairments have significant vocational implications, a negative factor; his stable, but unskilled work history would be positive, but is offset by his inability to perform any work on a sustained basis and thus becoming a negative factor; due consideration must also be afforded to the pain that he experiences on a daily basis, which requires that he spend 50% of the day "resting or reclining" on the sofa with his foot elevated; and his depression and anxiety also interfere with his ability to maintain sufficient attention and concentration, which becomes a negative factor. The most significant negative factor is, of course, the obvious physical brain injury he sustained due to his on-the-job injuries.

Taking all of these factors into consideration, it is my opinion, to a high degree of professional certainty, based on nearly fifty years of vocational rehabilitation and psychology experience, and nearly a decade of experience as the Executive Director of the Brain Injury Alliance of SC, that he has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain, unable to engage in full-time

gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in November 2007.

The rationale for my opinion is essentially based on the following observations:

Credibility: He appeared credible in his description of his limitations and remaining functional capacities. As a result of the limitations on his neck, shoulder, back, hands, and arms, he cannot complete significant tasks or activities on a regular, sustained basis.

It is noted that the information provided during this interview was highly consistent with information reported in other reports. This provided additional confirmation that the responses and description of events and circumstances was candid, was not feigned or exaggerated, and does not appear to represent any symptom magnification.

Medications: He is still prescribed a pain medication, and is carefully compliant with dosages and times as prescribed, and has been so since his injuries. However, in spite of medication, he continues to experience severe pain on a regular basis, as well as headaches. He also experiences the usual and predicted side-effects of medication, including feelings of fatigue and an inability to function at optimal levels while taking his medications. It is also clear that his medications are directly related to his on-the-job injuries, and therefore should be provided by Workers' Compensation.

Pain/Cognitive Factors and Attendance Implications: Even with pain medication he continues to experience significant pain at such levels as to interfere with his ability to sustain physical activity. His cognitive deficits would also cause difficulty in his ability to pay attention to job tasks and job duties for hours each week, on average. The inability to maintain concentration and persistence interferes with the ability to meet production expectation for even unskilled jobs.

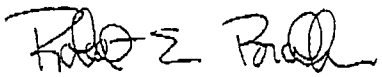
Limitations on Sitting and Standing/Use of Left Arm and Hand: His limitations on sitting and standing, as well as the use of her left arm and hand, are such that vocationally even any sedentary work, which might otherwise have been suggested, is precluded. Vocationally, any work requires some combination of sitting, standing and/or walking, as well as the use of both arms/hands, for a full 8-hour workday, without the need to rest for prolonged periods of time, something he is unable to do in his present condition.

Furthermore, any such jobs would require that he be able to use his neck, shoulder, back, hands and arms repetitively and continuously while meeting minimal production standards. As evidenced during this evaluation, he would not be able to sustain any repetitive activity for an eight-hour basis, day after day, in his present condition.

Summary and Conclusions: Based on all the evidence as described above, consistent with observations during this evaluation and various reports in his file, he would be unable to effectively perform the essential duties in any gainful work activity. It is also clear that the unfortunate combination of factors and characteristics he now faces are directly related to the injuries he sustained while working.

Due to the severity of his symptoms and the wide variety of limitations and descriptions he faces, he remains unable to perform any substantial gainful work activity, which exists in the SC or the national economy. Directly as a result of his on-the-job injuries the only services he could perform are so limited in quality, dependability, or quantity that no reasonably stable market for them exists.

The opinions noted in this report are offered within a reasonable degree of professional certainty, based on more than 45 years of vocational rehabilitation and psychology experience. Thank you for the opportunity to work with you in this matter. If you have any questions, or if I could address additional issues, please do not hesitate to contact me.



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Former Director of the Brain Injury Alliance of South Carolina
Former Director of Brain Injury Division, SC Department of Disabilities & Special Needs

CHANDLER
LAW FIRM

JEFFREY C. CHANDLER, P.C.
FEIN 20-0523540

March 10, 2011

Strand Regional Specialty Associates
Attn: Dr. George Sandoz
8170 Rourk Street
Myrtle Beach, South Carolina 29572

Re: Hector Gomez Fragoso

Dear Dr. Sandoz:

As you are aware, I represent a long standing patient of yours, Mr. Hector Fragoso. Enclosed please find CT scan reports from MUSC which were performed shortly after the accident. You have previously determined in your medical reports and at your deposition in this case that Mr. Fragoso has sustained a traumatic brain injury. After reviewing these reports, I need you to answer to a reasonable degree of medical certainty whether Mr. Fragoso has suffered physical brain damage that has rendered him totally and permanently disabled.

YES or NO (Circle One)

3/17/11

George Sandoz, M.D.

Sincerely,

Jeff Chandler

cc: file

Enclosures: (As noted)

P.O. Drawer 1889 • Myrtle Beach, SC 29578-1889
Office (843) 448-4357 • Fax (843) 448-4005 • jeffchandler@aol.com • www.jeffchandlerlaw.com

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Admitted: 11/01/2007
Discharged: 12/01/2007
Service: Trauma Surgery
Attending: CHRISTIAN T MINSHALL, MD

Referring:

ADMITTING DIAGNOSES:
1. Status post skull fracture.
2. Open complex scalp wound with epidural and subdural hematoma.
3. Bilateral frontal contusions.

HISTORY OF PRESENT ILLNESS: This is a 27-year-old Hispanic male who was hit in the head with part of a construction crane with positive loss of consciousness at the scene, significant blood loss, positive emesis at scene. He was intubated by EMS. This occurred in Marion County after an elevated crane fell and hit him. The patient was attempted to be intubated by Marion County which was unsuccessful. Then, Carolina Lifecare was able to intubate.

REVIEW OF SYSTEMS: Per HPI.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

SOCIAL HISTORY: Questionable use of ETOH.

DISCHARGE PHYSICAL EXAMINATION: Vital signs: Temperature 99.3, heart rate 114, respiratory rate 19, blood pressure 118/81, saturating 99% on room air. Neurologic: Patient alert and oriented. Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs. Lung sounds clear to auscultation bilaterally. Abdomen: Positive bowel sounds, nontender, nondistended. Trauma: PEG tube in place. Extremities: Right foot in dressing, clean, dry, and intact. Moves knee and ankle joints.

DIAGNOSTIC TESTS: CT of the abdomen on 11/01/2007 showed a right adrenal hemorrhage, bilateral L1 and L2 and right L3 transverse process fractures and multiple posterior rib fractures.

CT pelvis on 11/01 showed a high density structure in the rectum of uncertain significance.

CT of the head on 11/01/2007 showed a comminuted fracture with small intraocciptoparietal hematoma at the midline at the vertex, worrisome for a small epidural hematoma.

CT of the chest with contrast on 11/01/2007 showed bilateral lung contusions and/or aspiration. Right clavicle fracture and C7 and T1 spinous process fractures.

Patient has had multiple CTs of the head and chest x-rays.

CONSULTS SERVICE:
Neurosurgery.
Orthopedics.

HOSPITAL COURSE: The patient had a protracted hospital stay. Patient was admitted initially through the trauma bay via trauma protocol and then taken to the STICU for medical management.

Neurology: Patient was managed by neurosurgery for his subdural and epidural hematomas. Patient was also managed for multiple spinous process fractures. Patient has subsequently recovered function. He was ambulating without any difficulties, moving all extremities. Patient alert and oriented x3.

Cardiovascular: Patient remained hemodynamically stable. No acute issues.

Pulmonary: Patient initially intubated en route from Marion County by the air medical services. Patient was subsequently transferred to STICU on the ventilator service. Patient had failure to wean off the ventilator and subsequently had a tracheostomy performed while in the hospital. Subsequently, patient had tracheostomy removed.

Gastrointestinal: A PEG tube was placed for nutritional concerns. Patient tolerated tube feeds throughout his stay. Subsequently, after patient was transferred to floor, tube feeds were held and patient was started on p.o. intake. Patient was tolerating p.o. without any problems. PEG tube remained intact at time of discharge to be pulled out at his appointment with trauma surgery.

Musculoskeletal: Patient with multiple fractures that were initially evaluated and treated by orthopedics. The day prior to discharge, the patient was taken to the operating room by orthopedics to have his 2nd through 5th metatarsals amputated. Patient had a full weightbearing status at time of discharge. Subsequently, physical therapy recommendations no further out of hospital physical therapy needed.

DISCHARGE DIAGNOSIS(ES):
1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. C7 and T1 spinous process fractures.
7. Right rib fractures which included 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.
10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes.

DISCHARGE MEDICATIONS: Patient will go home on oxycodone. He will take 1-2 tabs p.o. q.4-6 h. p.r.n. pain.

DISCHARGE PLANS: Patient will follow up with orthopedic clinic at McClennan-Banks on Wednesday in 2 weeks. Patient will also follow up with trauma clinic on Friday in 2 weeks.

DISCHARGE INSTRUCTIONS: Patient is to call for temperature greater than 101.5, pain not controlled with medicine, redness around or drainage from wound. Additionally, patient is to keep wound dry until seen by orthopedics. Activity as tolerated. Diet as tolerated.

Dictated by: Daniel Schwerin, MD

_____
Daniel Schwerin, MD

_____
CHRISTIAN T MINSHALL, MD
Attending

513512 / 30028 /
JOB: 373087
DD: 12/01/07 01:36 PM
DT: 12/04/07 10:26 PM

Additional CC:_____

DOCID: 18233513512

Edited By DANIEL SCHWERIN MD on 12-19-2007 at 08:27:06 AM
Electronically signed by TODD MINSHALL, MD on 01-09-2008 at 03:22:32 PM

12/12/07 : 03:25pm
OUTPATIENT TO INPATIENT TRANSFER FORM
MEDICAL UNIVERSITY OF SOUTH CAROLINA

MUSC

AMBULATORY CARE SERVICES
OUTPATIENT TO INPATIENT
TRANSFER FORM REPORT

This is a report of patient condition at time of transfer and does not represent a complete patient assessment
(Not to be used for transfers outside MUSC)

TRANSFER

HECTOR GOMEZ
MRN: 2581962

DOB: 01/01/51
AGE: 56 year
SEX: male

Clinic: ORTHOPAEDICS - Phone number: 6-8988

PT TO ADMITTING OFFICE TO WAIT FOR AVAILABLE BED WITH FAMILY/FRIENDS PER DR KEITH MERRILL

ADMITTING DIAGNOSIS: RT FOOT INFECTION, S/P AMPUTATION 2ND THRU 5TH TOES
Service: ORTHO
Resident/fellow: ZILKOSKI
Admitting physician: MERRILL

Vital Signs:
Weight: 33.1 kg **Isolation**: no **Allergy band on: YES**

ALLERGIES:
PENICILLIN

ADDITIONAL VITAL SIGNS:

TIME	TEMP	PULSE	R	SYS	DIA	INITIALS
	98.8	117		138	83	

Labs drawn/Cultures sent: no
Procedure/Diagnostic tests completed at time of clinic visit: no
Cardiac monitor: no
Respiratory treatment: no

PAIN SCORE TODAY: 4 on 12/12/2007
Location of pain: RT FOOT
Pain intensity on a scale of 0 to 10 (visual analogue scale):
Quality:
What, if any, medication does patient take for pain?
Is pain satisfactorily controlled now? no

INTAKE: none	**OUTPUT**: none

Tubes, drains, catheters: none
Dressings: WOUNDS/DRAINS/TUBES/IV SITES:

RN assessment of wound: OPEN WOUND RT FOOT. TISSUE PINK WITH LITTLE DRAINAGE. INTERNAL SUTURES VISIBLE.

Damp to Dry

MEDICATION (given during clinic visit):

Was medication given for pain? no

CURRENT MEDICATIONS:at start of visit:
Rx: OXYCODONE 5 mg 1-2 every 4-6 hours PRN

Medication Reconciliation: reconciled per patient report.

Mental status: alert oriented
Fall Risk: no
Fall risk band on: no **ID band on**: yes
Primary language: Spanish **Sensory barriers**:
Valuables:

NARRATIVE NOTES/OTHER RELEVANT ISSUES: 11/01/2007 CONCTRUCTION ACCIDENT, HIT IN HEAD BY CRANE. SUBDURAL & EPIDURAL HEMATOMA, SKULL FRACTURE, BILAT FRONTAL CONTUSIONS, RESP FAILURE, MULT RIB FX'S.. ORTHO TO OR 11/30 FOR ISCHEMIC RT FOOT, AMPUTATION 2-5TH TOES.
PATIENT HISTORY:
Active Problems:
ISCHEMIC RIGHT FOOT

Recent Lab Results:
HEMATOCRIT: 37.20 on 12/01/2007
HEMOGLOBIN: 12.0 on 12/01/2007
PLATELET COUNT: 519
TRIGLYCERIDES: 202.0 on 11/16/2007
SODIUM: 137.0 on 12/01/2007
POTASSIUM: 3.30 on 12/01/2007
CO2: 24 on 12/01/2007
BUN: 3.0 on 12/01/2007
CREATININE: 0.7 on 12/01/2007
CALCIUM: 9.4 on 12/01/2007
12/12/07
HGBA1C: 5.5 on 11/02/2007
PT: 15.2 on 11/21/2007
INR: 1.16 on 11/21/2007

Past Medical History -

Social History -

12/12/07 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
A7S
MUSC ORTHOPAEDICS FOLLOW-UP NOTE-MCLENNAN BANKS
CHIEF COMPLAINT: Right foot amputation.

SUBJECTIVE: Mr. Gomez is a 26-year-old male who had a crush injury to his foot and developed an ischemic right foot requiring a transmetatarsal amputation of the second through fifth toes on the right foot. He underwent surgery on 11/30/2007 and returned to clinic today for his first postoperative appointment. He has had some pain and swelling to the foot. He has not done any dressing changes as of yet.

PHYSICAL EXAMINATION: The patient's dressings were taken down. He was noted to have essentially complete dehiscence of this wound with fairly significant fibrinous exudate as well as some necrotic tissue. The propylene stitches used on the deep tissues were exposed. There was a foul odor to the wound and his foot was somewhat swollen.

IMAGING STUDIES: No new x-rays were obtained.

IMPRESSION AND PLAN: This is a 26-year-old male who underwent amputation in the second through fifth toes. He has significant wound breakdown and concern for infection at this point. The patient is to be admitted to the hospital and plans to revise his amputation with irrigation and debridement and possible placement of a wound VAC. The patient agrees to this and has signed a consent form for surgery. We will post the case for an add-on for Friday with Dr. Merrill.

_____
Monica Zilkoski, MD
MZ/am:600
DD: 12/12/2007 DT: 12/13/2007
131760

Keith Merrill, M.D., Attending

SIGNED BY MONICA A ZILKOSKI, MD (A7S) 01/18/2008 09:14PM

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Patcom: 103530309
Admitted: 12/12/2007
Discharged: 12/15/2007
Service:
Attending: KEITH D MERRILL, MD

Referring:

ADDENDUM

"Please start at hospital course. Delete whatever is written for hospital course currently. "

HOSPITAL COURSE: Patient was admitted to MUSC Hospital on 12/12/2007 to the orthopedic surgery service for a diagnosis of wound dehiscence from a previously transmetatarsal amputation. Patient was started on IV antibiotics. On 12/14, patient was consented and taken down to the operating room for an irrigation and debridement of the wound under anesthesia. For full details of this operation, please refer to operative report as dictated. Patient tolerated the procedure quite well. Postoperatively he was taken to the PACU and then to the floor in stable condition. His diet was advanced as tolerated. His pain was controlled on p.o. pain medications. Since the nature of the procedure was relatively minor, the patient did quite well. We felt that he was medically safe for discharge on day of procedure. At time of discharge patient was afebrile. His vital signs were stable. His pain was controlled. His wound was packed and dressed. He was instructed to leave this on until he followed up with Orthopedics in 1 week. Patient's weightbearing status was nonweightbearing to that lower extremity.

DISCHARGE DIAGNOSIS(ES): Wound dehiscence from previous transmetatarsal amputation.

DISCHARGE MEDICATIONS:
1. Oxycodone 5-10 p.o. q.4 hours p.r.n. for pain.
2. Colace 100 mg p.o. b.i.d.
3. Bactrim double strength 160/800 mg p.o. b.i.d.

PATIENT DISPOSITION: Patient is discharged to home in stable condition. Patient is to follow up with McClennan-Banks Clinic next Wednesday. Patient's weightbearing status is nonweightbearing, right ower extremity. Patient is instructed to do no driving while on pain nedications. He may have a regular diet. He is to call for any tevers greater than 101.5, any excessive pain, redness, swelling, bleeding, increased drainage from incision site, any opening or pulling apart of incisions, any other problems, questions, and/or pain nedication renewal. Patient may shower if he is able to keep the wound and dressings dry. He is instructed on no soaking wound for 3-4 veeks. Patient is not to change his dressing until followup ippointment.

)ictated by: Mark Perna, MD

Mark Perna, MD

KEITH D MERRILL, MD
Attending

747336 / 38351 / 33295
JOB: 375464
DD: 12/14/07 02:02 PM
DT: 12/18/07 09:19 AM

Additional CC:

DOCID: 18233747336

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Patcom: 103530309
Admitted: 12/12/2007
Discharged: 12/15/2007
Service: Ortopedic Surgery
Attending: KEITH D MERRILL, MD

Referring:

CHIEF COMPLAINT: Foot pain.

HISTORY OF PRESENT ILLNESS: This is a young gentleman who presents after previously having a TMA secondary to a crush injury who presents with a wound dehiscence. Patient came into clinic today with kind-of foul-smelling open wound. Patient denies any fevers, chills, nausea, vomiting, or diarrhea, however.

PAST MEDICAL HISTORY: Patient had a a subdural hematoma as well as some bilateral frontal contusions with his traumatic injury.

PAST SURGICAL HISTORY: Right 2 through 5 transmetatarsal amputation.

SOCIAL HISTORY: The patient denies smoking.

CURRENT MEDICATIONS: Oxycodone.

MEDICAL ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION: He is alert and oriented in no acute distress. Skin is unremarkable. Lungs are clear. Heart is regular. Abdomen is soft, nondistended, nontender. Foot wound is completely dehisced. It is kind-of foul-smelling. There is fibrinous exudate at this point.

HOSPITAL COURSE: Patient was admitted to MUSC Hospital on 12/12/2007 to the orthopedic surgery service for a diagnosis of wound dehiscence from a previously transmetatarsal amputation. Patient was started on IV antibiotics. On 12/14, patient was consented and taken down to the operating room for an irrigation and debridement of the wound under anesthesia. For full details of this operation, please refer to operative report as dictated. Patient tolerated the procedure quite well. Postoperatively he was taken to the PACU and then to the floor in stable condition. His diet was advanced as tolerated. His pain was controlled on p.o. pain medications. Since the nature of the procedure was relatively minor, the patient did quite well. We felt that he was medically safe for discharge on day of procedure. At time of discharge patient was afebrile. His vital signs were stable. His pain was controlled. His wound was packed and dressed. He was instructed to leave this on until he followed up with Orthopedics in 1 week. Patient's weightbearing status was nonweightbearing to that lower extremity.

DISCHARGE DIAGNOSIS(ES): Wound dehiscence from previous transmetatarsal amputation.

DISCHARGE MEDICATIONS:
1. Oxycodone 5-10 p.o. q.4 hours p.r.n. for pain.
2. Colace 100 mg p.o. b.i.d.
3. Bactrim double strength 160/800 mg p.o. b.i.d.

PATIENT DISPOSITION: Patient is discharged to home in stable

condition. Patient is to follow up with McClennan-Banks Clinic next Wednesday. Patient's weightbearing status is nonweightbearing, right lower extremity. Patient is instructed to do no driving while on pain medications. He may have a regular diet. He is to call for any fevers greater than 101.5, any excessive pain, redness, swelling, bleeding, increased drainage from incision site, any opening or pulling apart of incisions, any other problems, questions, and/or pain medication renewal. Patient may shower if he is able to keep the wound and dressings dry. He is instructed on no soaking wound for 3-4 weeks. Patient is not to change his dressing until followup appointment.

Dictated by: Mark Perna, MD

_____
Mark Perna, MD

_____
KEITH D MERRILL, MD
Attending

747043 / 30028 / 36495
JOB: 375460
DD: 12/14/07 01:51 PM
DT: 12/18/07 09:28 AM

Additional CC:_____

DOCID: 18233747043

Edited By ANN SHULER on 12-20-2007 at 03:50:28 PM
Edited By MARK PERNA on 01-14-2008 at 07:52:13 AM
Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:59 PM

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 103530309
Date of Surgery: 12/14/2007
Surgeon: Keith D. Merrill, MD
Assistant(s): Huey Ahn

REOPERATIVE DIAGNOSIS: Wound dehiscence right foot.

POSTOPERATIVE DIAGNOSIS: Wound dehiscence right foot.

PROCEDURES: Irrigation and debridement and partial wound closure of the right foot. CPT code is 28003.

INDICATIONS FOR PROCEDURE: The patient is a young male who had a crane fall on his foot. He underwent amputation of the toes, was seen in clinic the other day with increased drainage, swelling, and wound dehiscence.

DESCRIPTION OF PROCEDURE: After general anesthesia, his right lower extremity was prepped and draped in a sterile fashion. Curette was used to debride some of the soft tissue from out of the dehisced wound. Sutures were removed. The remaining tissue actually looked quite good and after debridement with a rongeur, the plantar pad was pulled up slightly and each end was closed with approximately 3-4 sutures. This left a gap in the middle a couple of centimeters wide and probably 4 cm long. This was dressed with gauze. A culture and sensitivity had been done intraoperatively.

The patient was taken to the recovery room after dressing was applied in good condition. Wet-to-dry dressings will be used.

Dictated by: Keith D. Merrill, MD

Keith D. Merrill, MD
Surgeon

13151 / 33871 /
DB: 375334
DD: 12/14/07 07:50 AM
DT: 12/16/07 08:31 PM

Additional CC:_____

CID: 18233738151

Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:55 PM

Hector Gomez-Fragoso 2581962 6/30/2009

MUSC

Neuroscience and Orthopaedics Associates

Patient: Hector Gomez-Fragoso
Patient ID: 2581962
Sex: Male
Date of Birth:
Age: 28 Years 8 Months
Referring Phys.: Dr. Chris Merrell
Examing Phys.: Dr. Chris Merrell

History / PE: 28 year old man with a history of work-related neck pain and left arm discomfort. It will refer to the hand and is associated with numbness and occasional dysesthesias. Cervical epidural injection previously performed without additional pain relief. He takes gabapentin for pain. Study is ordered to evaluate for cervical radiculopathy vs. median/ulnar neuropathy.

PMH: none

Exam: spurlings positive on left, reflexes wnl at bue, no muscular wasting identified, negative tinels at wrists and elbows. Light touch sensation reduced in nondermatomal distribution on left side at forearm and hand.

Summary:

1. Left median antidromic sensory study to the 3rd digit revealed normal latency and amplitude.
2. Left ulnar antidromic sensory study to the 5th digit revealed normal latency and amplitude.
3. Left radial sensory study revealed normal latency and amplitude.
4. Left median motor study to the APB revealed normal latency, amplitude, and CV.
5. Left ulnar motor study to the ADM revealed normal latency, amplitude, and CV. F-wave wnl.
6. Needle EMG at the LUE and left cervical paraspinals revealed no abnormal spontaneous activity. Normal recruitment and volitional activity was noted.

Conclusion:
Normal study. There is no electrophysiologic evidence of left cervical radiculopathy, left median neuropathy, or left ulnar neuropathy.

Christopher A. Merrell, M.D.

Hector Gomez-Fragoso 2581962 6/30/2009

Sensory NCS

Nerve / Sites	Rec. Site	Peak Lat ms	Pk-Pk Amp µV	Segments	Distance cm	Velocity m/s
L MEDIAN - Dig III Antidr						
Wrist	Dig III	2.85	103.0	Wrist - Dig III	14	68.3
Ref.		4.00	10.0	Ref.		
Palm	Dig III	1.65	51.9	Palm - Dig III	7	60.9
Ref.		2.40	10.0	Ref.		
L ULNAR - Dig V Antidr						
Wrist	Dig V	3.00	78.3	Wrist - Dig V	14	58.3
Ref.		4.00	6.0	Ref.		
L RADIAL - Wrist						
Forearm	Wrist	2.25	49.9	Forearm - Wrist	10	58.8
Ref.		2.80	7.0	Ref.		

Motor NCS

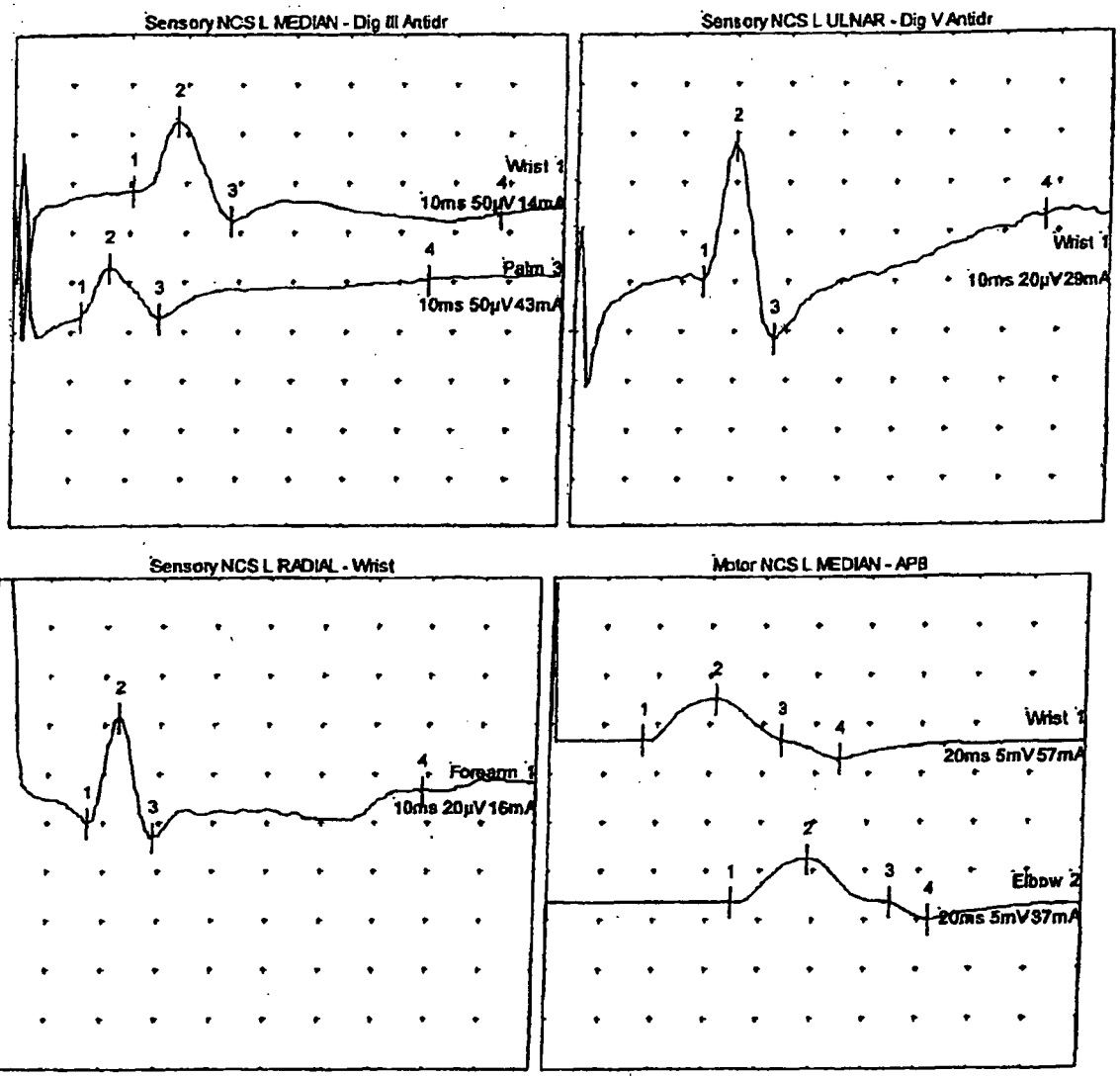
Nerve / Sites	Rec. Site	Lat ms	Amp mV	Rel Amp %	Segments	Dist cm	Velocity m/s
L MEDIAN - APB							
Wrist	APB	3.45	4.3	100	Wrist - APB	8	
Ref.		4.50	4.1		Ref.		
Elbow	APB	6.90	4.5	107	Elbow - Wrist	21	60.9
Ref.					Ref.		49.0
L ULNAR - ADM							
Wrist	ADM	2.85	10.6	100	Wrist - ADM	8	
Ref.		3.70	7.9		Ref.		
B.Elbow	ADM	5.95	8.6	80.8	B.Elbow - Wrist	20	64.5
Ref.					Ref.		52.0
A.Elbow	ADM	8.05	8.4	79.2	A.Elbow - B.Elbow	11	52.4
Ref.					Ref.		43.0

F Wave

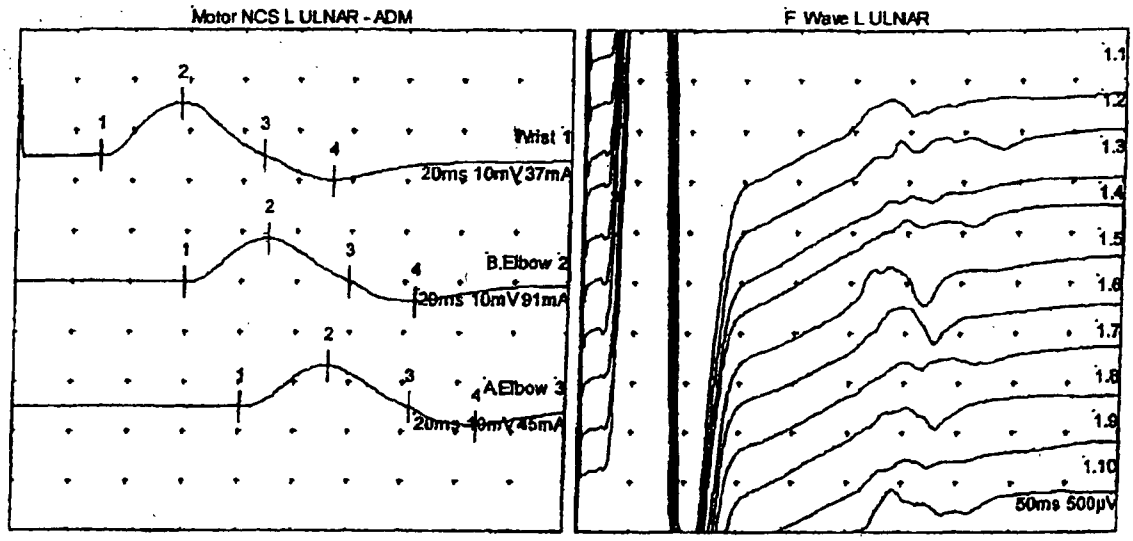
Nerve	Fmin ms
L ULNAR	24.15

EMG Summary Table									
	Spontaneous					MUAP			Recruitment
	IA	Fib	PSW	Fasc	H.F.	Amp	Dur.	PPP	Pattern
L. FIRST D INTEROSS	N	None	None	None	None	N	N	N	N
L. ABD POLL BREVIS	N	None	None	None	None	N	N	N	N
L. PRON TERES	N	None	None	None	None	N	N	N	N
L. FLEX CARPI ULN	N	None	None	None	None	N	N	N	N
L. TRICEPS	N	None	None	None	None	N	N	N	N
L. BICEPS	N	None	None	None	None	N	N	N	N
L. DELTOID	N	None	None	None	None	N	N	N	N
L. CERV PSPINAL	N	None	None	None	None	N	N	N	N

Hector Gomez-Fragoso 2581962 6/30/2009



Hector Gomez-Fragoso 2581962 6/30/2009



Progress Notes

Date Printed: 12/08/09

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/02/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Hector Gomez-Fragoso is a Spanish-speaking man who returns for follow-up today regarding his pain. It is again worse with neck rotation and better at rest. He was previously seen by Dr. Woolf and this was thought not to be shoulder related pain. For this reason, we had performed an EMG and nerve conduction study to evaluate for C5 radiculopathy which was negative. MRI previously performed at Long Bay Diagnostics was reviewed and report stated C4-C5 neuroforaminal narrowing in the left which is moderate in severity. For that reason, initially we did an epidural steroid injection which gave him about two weeks to three weeks of relief before symptoms recurred. Thereafter, we tried a C5 selective nerve root block with no significant benefit. He uses gabapentin and Aleve for symptoms and this is helping minimally.

PAST MEDICAL / SURGICAL HISTORY: Reviewed and unchanged.

SOCIAL HISTORY: Reviewed and unchanged.

FAMILY HISTORY: Reviewed and unchanged.

MEDICATIONS: As per Practice Partner.

REVIEW OF SYSTEMS: Occasional hand numbness into the fourth and fifth digits. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Hawkins is negative. Empty can test is negative. Shoulder range of motion is within normal limits. Cervical range of motion is reduced with end rotation bilaterally. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in all dermatomes at the upper limbs and no wasting is noted. AC joint is nontender. Paraspinal musculature is nontender. Facets are relatively nontender.

RADIOGRAPHIC REVIEW: MRI report of the cervical spine from Long Bay Diagnostics revealed C4-C5 neuroforaminal narrowing on the left, moderate in severity.

ASSESSMENT:
1. Presumed left C5 radiculitis.
2. Neuroforaminal narrowing at C4-C5.
3. History of mild rotator cuff pathology as well.
4. Symptoms consistent with ulnar neuropathy although EMG and nerve conduction study was negative. This is primarily a nocturnal phenomenon.

PLAN:
1. Continue gabapentin and Aleve for anti-inflammatory and analgesic effect and neuropathic pain relief.
2. Continue home exercise program.
3. Obtain a new MRI of the cervical spine as the last one was obtained almost a year ago. If symptoms are persistent, I would like to see these images for ongoing foraminal narrowing at C4-C5. This may be related to his symptoms.
4. I feel that the ulnar neuropathy symptoms that he experiences are predominantly positional in nature and has not given him any significant weakness or daytime symptoms.
5. Follow up with me after MRI and I would also at that point like to have Dr. Glaser review this patient as well as my treatments thus far have been particularly ineffective. If he does have foraminal narrowing, he may be a candidate for surgery.

Christopher Merrell, MD

Printed using Practice Partner®

LONG BAY
DIAGNOSTIC IMAGING

PATIENT: Gomez Fragoso, Hector
DOB:
MRN: 590338
PHYSICIAN: Christopher Merrell, MD
DATE: 12/8/2009

EXAM: CERVICAL MRI WITHOUT CONTRAST

HISTORY: Pain in the left side of the neck and shoulder.

COMPARISON STUDIES: None.

TECHNIQUE: Sagittal T2 FSE, sagittal T2 FSE with fat suppression, sagittal T1 FSE, coronal T1 FSE, axial T2 FSE, axial T2* gradient echo. No contrast.

FINDINGS:
OVERVIEW: No soft tissue mass or abnormal fluid collection is identified. Signal intensity in the musculature is normal and the muscles are symmetric. Lung apices are grossly clear. Central brachial plexus appears unremarkable.

CERVICAL SPINE: No acute fracture or subluxation. Vertebral body heights are preserved and the bone marrow signal intensity is normal. Asymmetric moderate to advanced hypertrophic facet arthropathy is seen on the left side at the levels of C3/4 and C4/5. Remaining facets appear unremarkable. Mild anterior osteophyte formation is seen at the level of C5.

DISC LEVELS: The intervertebral discs of the cervical spine and upper thoracic spine demonstrate normal signal intensity with the exception of C5/6 which is mildly desiccated. Heights of the intervertebral discs are normal. No focal or broad based disc protrusions identified.

On the left at the levels of C3/4 and C4/5 there is asymmetric uncovertebral joint hypertrophy. This combined with the degenerative facet changes results in neural foraminal stenosis at both levels which is mild to moderate. Remaining neural foramen and central canal are patent.

SPINAL CORD: The cord is normal in size, shape and signal intensity. No cord mass or edema.

IMPRESSION:
1. There is asymmetric degenerative facet arthropathy and uncovertebral joint of hypertrophic changes present on the left at C3/4 and C4/5 and degenerative facet changes present on the left. These changes result in a mild to moderate neural foraminal stenosis on the left at both levels.
2. Mild degenerative disc changes present C5/6.

Richard Clinton, MD
RC / ng

DD: 12/9/2009
DT: 12/9/2009
Job: 9394688

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

Progress Notes

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/30/09 : 00:00am
MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
2FG
CHIEF COMPLAINT: Left neck pain and shoulder pain and arm numbness.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 29-year-old man who returns for follow-up today regarding his pain and numbness into his arm. Previously, his pain and numbness was in a C5 distribution, but we tried a C5 selective nerve root block with no significant benefit. Prior to this, we have done an interlaminar epidural steroid injection which gave him about two to three weeks of relief before his symptoms recurred. He has used gabapentin and Aleve with minimal significant relief. He is here for follow-up after repeat MRI which was obtained to evaluate for cervical nerve root pathology.

PAST MEDICAL / SURGICAL HISTORY: Reviewed and unchanged.

SOCIAL HISTORY: Reviewed and unchanged.

FAMILY HISTORY: Reviewed and unchanged.

MEDICATIONS: As per Practice Partner.

REVIEW OF SYSTEMS: Numbness will extend into all five digits today, which is a change from his previous description of his fourth and fifth digits. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Cervical range of motion is normal in all planes except for reduced end rotation. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in the upper extremities. No focal weakness or atrophy. Cervical paraspinal musculature is nontender. Facets are nontender. No cervical lymphadenopathy. No cutaneous changes of the upper limbs and no hand edema. Radial pulses are present and equal.

RADIOGRAPHIC REVIEW: MRI was reviewed by disc. This revealed mild neuroforaminal narrowing on the left side at C4-C5 and C3-C4. Mild degenerative changes at C5-C6.

ASSESSMENT:
1. Left-sided cervical radicular symptoms, but his symptoms changed and at this point it is difficult to identify the particular dermatome of involvement.
2. History of EMG and nerve conduction study which was negative for cervical radiculopathy and did not identify any evidence of ulnar or median neuropathy. This was performed on 06/30/2009.
3. History mild rotator cuff pathology, previously evaluated by Dr. Woolf.

PLAN:
1. Continue gabapentin and Aleve.
2. Continue home exercise program as instructed by physical therapy.
3. Hold off from further injections. I'm appreciative of Dr. Glaser's being able to see him today in consultation.
4. Follow up with me as needed or if symptoms change.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:578

Progress Notes

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

2052227

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 12/31/2009 10:48AM

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South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fragoso
Employer's Name: Kade Construction
Physician's Name: Dr. Christopher Merrell
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC Dept of Orthopaedic Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Christopher Merrell
Phone: (843)792-0601

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to§§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: 2-4-09
Date of last visit: _____

Diagnosis or nature of injury or illness: Cervical radiculitis, Disc protrusion

Body part(s) injured: Cervical Spine Body part(s) affected: Cervical Spine

Date of **Maximum Medical Improvement:** 12-30-09

Based on the **AMA Guidelines**, the claimant has sustained a 11 **% medical impairment** to Whole Person injured body part(s) and a _____ **% medical impairment** to _____ other affected body part(s).

____The claimant is **able to return to work** without restriction.

X The claimant is **able** to return to work **with the following restrictions:**

Pain may limit overhead activities with the left arm.
He may perform overhead activities unless symptoms provide

____The claimant is **unable to return to work** at his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

____**will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

X **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Occasional P.T., oral medications, possible injections.

C Christopher Merrell M.D
Treating Physician

2-8-10
Date

10/30/08 : 00:00am
MUSC NEUROLOGY-INDEPENDENT MEDICAL EVALUATION-RUTLEDGE TOWER
D69
MUSC Department of Neurology
96 Jonathan Lucas Street, Suite 309
PO Box 25060
Charleston, SC 29425

RE: GOMEZ-FRAGOSO, HECTOR
DOB:
DOS: 10/30/2008
CONFIDENTIAL

IDENTIFYING INFORMATION: Hector Gomez-Fragoso is a 28-year-old single Hispanic male that was involved in a work-related injury who presents for evaluation today. He was referred by Michael Burkett of the law firm Willson Carter Baxley who represent the employer's insurance company in this worker compensation claim. The claimant was accompanied to the evaluation by a translator Gladys Lapietra. The records that I had available for review include handwritten MUSC Trauma Admission notes, the discharge summary from MUSC during the hospitalization from 11/01/2007 through 12/01/2007 and all the associated records. These include notes from Orthopedics, Neurosurgery, Trauma Medicine with doctors, Dr. Hartsock, Dr. Langdon, Dr. Istvan Takacs, Dr. Keith Merrill, Dr. Norcross, and Dr. Minshall. There are serial CT studies. I had a couple of physical therapy notes and a speech evaluation progress note. Outpatient follow-up notes from the same services. I also had notes from George Santos, M.D. from Strand Regional Specialty Associates. The claimant was interviewed with the assistance of the interpreter. The claimant was examined with the assistance of the interpreter. Procedure code 990801. I felt that we had a very good communication between the claimant and myself with the assistance of the interpreter. At the conclusion of the evaluation, the interpreter confirmed my impression. Additionally, the claimant stating that he felt information was understood appropriately by me. He signed an informed consent. The caveat to this entire evaluation is the use of an interpreter and the use of tests that were not in Spanish. Both items can reduce the validity of the findings. In an ideal world, a Mexican born or educated neuropsychologist using urban test norms from Central Mexico City would be ideal. It is possible with the translator and non-standardized procedures that I employed, made the tasks more difficult and artificially lowered the claimants scores, suggesting more impairment than actually exists. Of course, the reverse is also possible. In an effort to reduce the confounding effects of the language barrier, I chose primarily nonverbal tests whenever possible and note the above caveat.

HISTORY: The claimant provided the following history. He stated that he was involved in a work-related accident that occurred on 11/01/2007. We were able to determine that this was a Thursday after the lunch hour. He was working for Kane Construction where he had been employed as a laborer/carpenter helper for approximately one year. He was making about $11 an hour. He was amnestic for the accident. He said the last thing that he remembered was that he was on top of a garage working on installing the gables for the roof of the one story garage. The next thing he remembers was waking up at MUSC as an inpatient. He said that he was told that a cable broke and he sustained a crush injury to his head and leg. He said that he was also knocked down one story falling to the ground. He stated that he was transported to MUSC via helicopter. He thought that he was in hospital for approximately one month and possibly woke up about midway into the course and estimated about 15 days after the accident. He said that he had injuries to his head and right foot. On his right foot, four toes were amputated. He said that he also injured his neck and left shoulder. He said that his seventh vertebra is "pointing out." He had a trach.

In terms of today's symptoms Mr. Gomez complains that it is hard for him to remember where he puts things. He complained of pain in his neck and left shoulder. He said that he has hearing loss especially on the left. He complains of occasional blurry vision. He described what sounded like phantom pain in his amputated toes. He also described pain in his left arm with occasional paresthesias in his hand. He complained of headaches. He described being anxious with mood swings. He complained of difficulty swallowing. He complained of a change in his gait because of the amputation. He rated his pain on average as an "8" on a VAS. He said that nothing triggers the pain and it seems to come out from nowhere. He gets relief by laying down. He said on some days he might not have pain and other days he might be in extreme pain. There has been no improvement in the pain symptoms over time.

In terms of treatment he has been on Neurontin and methocarbamol that he receives from Dr. Santos. He said the medicines help with the pain for a while, but then the pain returns. He said that he has been offered cortisone shots for his shoulder, but has declined.

In terms of the mental confusion, he feels that his condition is getting worse over the time. He complains of forgetfulness. When I asked about the functional impact of his forgetfulness, he said that he has trouble remembering conversations and occasionally has difficulty pronouncing words. I pushed him for other examples, but he had difficulty coming up with any specific complaints. Instead he talked about headache pain, other pains, and feelings of anxiety and depression that are getting worse over the time.

In terms of daily activities Mr. Gomez said that he mostly stays around the house and watches television. He does light housekeeping, socializes with friends and does some cooking. He is living on $266 a week and shares expenses with his house mates who are his cousins. He has not been back to work and has not made any attempts. He said that he feels that he is not capable of returning to work. When I asked about the barriers, he said that he speculated that he might forget measurements if he were asked and that he might do something wrong. He said his feet and back get tired when he is standing for a long time and this might interefere with his ability to do manual labor. He also said that he feels pain if he stands for too long, especially in his foot. When I asked, he alos admitted to having difficulty with balance and dizziness and thought this too might interfere with his ability to work. He did not know if he had any work-related restrictions from his doctor.

The claimant said that all of his followup has been with MUSC doctors and then with Dr. Santos. Now he only sees Dr. Santos perhaps on a monthly basis and is being prescribed the two medicines noted above.

In my review of the medical records, I have handwritten notes from initial Trauma Center evaluation. The above injury is described. Intubation was attempted by EMS, which was unsuccessful and then the aircrew was able to intubate the patient enroute on the helicopter. In the acute ER notes, there is a question of somebody smelling alcohol on his breath. I did not see any blood alcohol levels drawn. There is a reference to loss of consciousness at the scene and no Glasgow scores at admission.

I was unable to get the entire inpatient MUSC chart. The MUSC discharge record indicates an admission from the Trauma Service on 11/01/2007. the patient was hospitalized for one month from 11/01/2007 through 12/01/2007. Loss of consciousness and significant blood loss was noted at the scene. Marion County EMS was unsuccessful at intubation, but he was successfully intubated by Carolina LifeCare Helicopter Transport team. He is admitting diagnosis was skull fracture, open complex scalp wound with epidural and subdural hematoma, and bilateral frontal contusions. Acutely he had a CT scan of the abdomen that showed adrenal hemorrhage, bilateral L1 and L2 as well as right L3 transverse process fractures and multiple posterior rib fractures. A CT of the pelvis on 11/01/2007 showed a high density structure of uncertain significance. The CT of the head on 11/01/2007 showed comminuted fracture with small extra occipitoparietal hematoma at the midline at the vertex, worrisome for small epidural hematoma. CT of the chest showed bilateral lung contusions and/or aspiration. He had a fracture of his right clavicle and C7 and T1 spinal process fractures.

Neurosurgery and Orthopedics followed the patient during his protracted hospital stay. His final discharge diagnosis was subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypertension, scalp laceration status post repair, C7 and T1 spinous process fractures, right rib fractures at 7, 8, 9, and 10, bilateral transverse process fractures at L1 and L2 and right L3, right big toe fracture, right fifth toe fracture, fracture of the skull midline to sagittal through the frontal and parietal, placement of PEG tube, tracheostomy, and status post amputation of two through five toes.

Steve Takacs, M.D. saw him on 11/01/2007 and described him as combative at the scene with vomiting. He was trached at the time and Glasgow Coma Scale was 8/10. He had a number of procedures as noted above during his hospitalization. A CT on 11/07/2007 was indicated because of altered mental status and compared with prior studies. A collection of fluid adjacent to the vertex and extensive left-sided frontotemporal soft tissue swelling was noted. A fracture of the left frontal bone extending to the sagittal suture was noted as unchanged. Ultimately, he was discharged home on 12/01/2007.

Orthopedics had a follow-up on 12/12/2007 and there was significant wound breakdown and concern of infection, so he was readmitted for irrigation and debridement. He had an outpatient follow-up on 12/17/2007 with Trauma/Critical Care

and was described as having had made "remarkable neurologic recovery." In the exam he was described as awake, alert, and oriented. Because of the severity of his injuries he was told to follow-up with Neurosurgery. The PEG tube had been pulled. He was given Lortab by Dr. Norcross. Orthopedics saw him two days later for the initial follow-up and there was some confusion about changing the dressing. With the interpreter's help he was taught to change his dressing daily.

Mr. Gomez saw Dr. Takacs on 01/16/2008 and he was described as having a skull fracture with a small thin rimmed subdural hematoma in the right frontal parietal region. At this visit, his Glasgow Coma Scale was 15/15 and he was oriented times 3. The latest CT showed a thin rim without mass effect in the right frontal parietal region. Dr. Takacs felt that he had no basic neurologic sequelae and he was released.

The final follow-up visit at MUSC was with Orthopedics was on 09/17/2008 and Mr. Gomez was complaining of phantom limb pain, as well as difficulty with gait and balance because of the amputation. Prostheses or inserts were discussed and Neurontin was suggested for the pain.

There is a speech eval from 11/21/2007 as an inpatient. Pertinent information included possible mental confusion as he was only able to follow one step commands and could not adequately hold the pencil in the right or left hand in order to copy name or identify pictures scoring 1/3.

On 08/29/2008 the claimant had a follow-up with Dr. Santos. Complaints at that time had to do with severe and persistent headache, dizziness, neck pain, shortness of breath, difficulty swallowing, difficulty with attention and concentration, difficulty with complex tasks, irritability, and the amnesia that was described above. MMSE was 28/30. His neurologic exam was negative except he lurched forward with his gait. Tests were ordered. His MRI from 10/17/2008 was read as normal suggesting structural resolution of the the above acute CT findings. Nerve conduction and EMG studies were negative. Evoked potential was negative. His EEG was within normal limits. Cervical studies were significant for a disk protrusion at C4-5 and 5. A neuropsychological evaluation was ordered.

PAST MEDICAL HISTORY: Per the claimant largely unremarkable. He said that he had kidney stones in 2003. Before the accident he denied any history of a prior head trauma, pains, depression, and anxiety. He denied any significant alcohol or other substance abuse.

MEDICATIONS: Neurontin, methocarbamol.

FAMILY HISTORY: The father and mother were described as alive and well. He had two brothers that were described as alive and well.

SOCIAL HISTORY: The claimant stated he was born and raised in Mexico City. He said that he repeated the second grade. He finished the ninth grade and was unable to tell me if this was the US equivalent of high school. He joked that he did poorly in English, but excelled with typing. He reported that he had been in the US for five years and came to the Myrtle Beach Area because he had cousins that preceded him. In Mexico, he had worked as a clerk in a pharmacy and as a guard for private security. In the US, he worked in a construction industry as a carpenter assistant. His original plan was to come to the US "for a while" and then return to Mexico. His current plans are up in the air with the health and legal situation outstanding. His immediate family lives in Mexico and his extended family in Myrtle Beach and includes a cousin and uncle. Prior to the injury he played soccer. He has had to quit because of gait disturbance and I presume pain.

PHYSICAL EXAMINATION: Weight 191. Blood pressure 140/77. Pulse 77. The patient was ambulatory, spry, and had largely a flat affect. He was cooperative with evaluation and forthcoming with information. He showed me a scar on his forehead that was visible through his hairline. He passed the effort test on the second trial. His MMSE was 28/30, which is in the normal range and consistent with a prior study by Dr Takacs on 11/01/2007. On all of the nonverbal items from the WAIS-III his scores were impoverished and possibly consistent with his educational/vocational background. His estimated an overall index score was 68. On a arithmetic subtest from the WRAT, he had a similar score and did not know how to approach some of the more complicated arithmetic problems reflecting his academic achievement. He had psychomotor slowing on Trails A and C, but scored in weak-normal range for the more cognitively difficult Trails B test. On a visual memory test, he actually scored in the normal range. For simple vigilance he passed the test with a perfect score, but failed the more difficult task of distractibility. He endorsed moderate-to-severe pain in areas described in the history that included his head, neck, shoulder, and left foot. He reported that the pain is generally extreme, causing functional limitations, and reported that the pain adversely affects his mood. He was unable to understand the Likert

Scale and was given a true-false mood inventory to assess his mood. He scored in the extreme range with 27/30 positive and his is consistent with severe depression. He denied any suicidal ideation or attempt.

IMPRESSION:
1. Postconcussive syndrome, mild.
2. Chronic pain disorder.
3. Situational depression.

DISCUSSION: Mr. Gomez had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the the brain. Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury. He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive syndrome. The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. I do not think that the severity of his cognitive deficits represents a major barrier for return to work, especially manual labor. Additionally, he does have findings positive for situational depression and pain are also contributing to his functional disability.

In terms of recovery, Mr.Gomez is most likely at maximum medical improvement in terms of his neurologic/brain status. Fortunately, his cognitive deficits are relatively mild. Pain, dizziness, and balance will probably be the major limiting factor for his capacity to return to manual labor, but I would defer to his neurologist about work-related restrictions in this domain.

The most treatable aspect of the claimant's current syndrome is pain and depression, but unfortunately he has been variably noncompliant with his medications. Something like Cymbalta or another SSRI might double for treatment of both mood and pain related problems. Compliance with this type of treatment may reduce some of his functional disability.

Mark Wagner, PhD
Clinical Neuropsychologist
Associate Professor of Neurology

MW/am1251
dd: 10/31/2008
dt: 11/01/2008
JobID: 760927

cc:Mr. Michael Burkett, Willson Jones Carter Baxley LLC, 501 Wando Park Boulevard, Mount Pleasant, SC 29464

THIS NOTE IS CONFIDENTIAL

SIGNED BY MARK WAGNER, Ph. D. (ATTENDING) (D69) 11/04/2008 11:47AM

SUMMARY SHEET	Test Date: 10/30/2008	
Name:	Hector Gomez-Fragoso	
MRN:	2581962	
Age:	28	
Education	9	
Handedness	Right	
WAIS-III		
	IQ Score	%ile
VIQ	[redacted]	[redacted]
PIQ	68	[redacted]
FSIQ	[redacted]	[redacted]
Subtests	Scaled Score	%ile
Vocabulary		[redacted]
Similarities		[redacted]
Arithmetic		[redacted]
Digit Span		[redacted]
Information		[redacted]
Comprehension		[redacted]
Letter Number Sequence		[redacted]
Picture Completion	5	[redacted]
Digit Symbol	6	[redacted]
Block Design	4	[redacted]
Matrix Reasoning	5	[redacted]
Picture Arrangement		[redacted]
Symbol Search	8	[redacted]
Object Assembly	5	[redacted]
WMS-III	SS	%-ile
Spatial Span	6	9th
CERAD		
MMSE	28 /30	
Gordon CPT	Raw	% ile

Vigilance Correct	30	72
Vigilance Commission	0	68
Distractability Correct	14	0
Distractability Commission	2	50
TOMM	Raw	
Trial 1	42	fail
Trial 2	47	pass
WRAT Arithmetic	Raw	Standard Score
Total Correct	31	73 (5th grade)
Trail Making Test	Raw	T
Part A	49	31
Part B	100	41
Part C	42	36
Geriatric Mood	Total Score	
	27	/30

Brief Visuospatial Memory Test	**Raw**	**T**	**%ile**
Trial 1	8	55	69%
Trial 2	10	52	58%
Trial 3	11	52	58%
Total Recall	29	53	62%
Learning	3	46	34%
Delayed Recall	11	56	66%
Percent Retained	100%		<16th%
Recognition Hits	6		>16th%
Recognition False Alarms	6		<1st%
Recognition Discrimination Index	0		<1st%
Recognition Response Bias	0.93		<1st%

Pain Questionnaire	**Raw**	**Label**
Total Pain-Related Impairment Score	44	Moderately severe impairment

Strand Regional Specialty Associates
Neurophysiology Neuroscience Ortrhopaedic
Ophthanlmology
Phone (843) 449 2336 (843) 692-2100

Test Date: 10/2/2008

Patient:	Hector Gomez Fragoso	**DOB:**		**Physician:**	George Sandoz, M.D.
ID#:	<DATA 81323	**Sex:**	Male	**Ref Phys:**	
				Technician:	

Patient Complaints:
Patient is a 28 year-old male who presents with neck pain back pain numbness tingling pain pain in the upper lower extremities. Ending temp 88 degree.

EMG & NCV Findings:
Starting temp 87.3 degree.All nerve conduction studies (as indicated in the following tables) were within normal limits.

All F Wave latencies were within normal limits.

All H Reflex latencies were within normal limits.

All examined muscles (as indicated in the following table) showed no evidence of electrical instability.

Impression:

1. Normal NCS / EMG of the left upper and right lower extremities.
2. No active denervation.
3. Clincal correlation is suggested.

George Sandoz, M.D.

Ocean Spine & Neurological Inst.
8170 Rourke Street
Myrtle Beach, SC 29572
(843) 449-2336

Patient: Gomez Fragoso, Hector
Sex: Male
Age:
I.D.#: A81323-1
Ref. M.D.:

Physician: Dr Sandoz
Test Date: 10/02/08

History/Comments:

Parestbesia/vertigo/syncope

Evoked Potential Study
Left Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	501	6.0	15.9	19.4	24.5
	501				

Evoked Potential Study
Right Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	536	9.3	13.8	17.2	23.4
	504				

Evoked Potential Study
Left Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42-N50	Amp2 (uV) N7-N17
	500	4.2	16.3	26.7	39.3	49.0	35.2	0.3	1.1
	500								

Patient: Gomez Fragoso, Hector Test Date: 10/02/08
I.D.#: A81323-1

Evoked Potential Study

Right Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42 - N50	Amp2 (uV) N7-N17
	500	6.2	20.8	27.8	40.3	53.3	34.2	0.9	
	500								

Auditory Evoked Potential Study

Left: 71 nHL dB Stimulus Right: 0 dB Noise

Left Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.9	2.7	3.6	4.5	5.4	6.1	0.0
	501							

Auditory Evoked Potential Study

Left: 0 dB Noise Right: 71 nHL dB Stimulus

Right Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.7	2.2	3.0	4.0	5.3	6.0	0.1
	501							

Visual Evoked Potential Study

- 24 Screen Divisions (width)

Left Visual Nerve

Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPI1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	77.5	112.5	160.5	48.0	5.4
	128					

Patient: Gomez Fragoso, Hector Test Date: 10/02/08
I.D.#: A81323-1

Visual Evoked Potential Study

- 24 Screen Divisions (width)

Right Visual Nerve

Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPI1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	75.0	112.0	148.0	36.0	8.8
	128					

Summary/Interpretation:
The Visual Evoked Response test shows borderline P-100 responses bilaterally. The Brainstem Auditory and Upper/Lower EXtremity Somatosensory Evoked Response Tests are within normal limits. Clinical correlation is recommended.

George Sandoz, M.D.

Nerve Conduction Studies

Anti Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Sural Anti Sensory (Lat Mall)											
Calf		3.5	<4.5	30.3	>5.0	Calf	Lat Mall	3.5	0.0		
Site 2		3.6		23.7							
Site 3		3.5		25.9							
Site 4		3.4		19.2							

Ortho Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median Ortho Sensory (Wrist)											
Palm		1.8	<2.3	75.5	>40	Palm	Wrist	1.8	0.0		
Site 2		1.9		74.0							
Site 3		1.8		68.1							
Left Ulnar Ortho Sensory (Wrist)											
Palm		1.7	<2.2	30.9	>11	Palm	Wrist	1.7	0.0		
Site 2		1.6		29.2							
Site 3		1.7		24.4							
Site 4		1.7		29.5							

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P Amp (mV)	Norm O-P Amp	Site1	Site2	Delta-0 (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Left Median Motor (Abd Poll Brev)											
Wrist		3.5	<4.5	7.4	>3	Elbow	Wrist	3.3	19.0	57.6	>48
Elbow		6.8		5.5							
Right Peroneal Motor (Ext Dig Brev)											
Ankle		3.7	<6.6	3.8	>2	B Fib	Ankle	5.7	25.0	43.9	>42
B Fib		9.4		3.5		Poplt	B Fib	1.3	9.0	69.2	>42
Poplt		10.7		3.4							
Right Tibial Motor (Abd Hall Brev)											
Ankle		4.0	<6.6	15.4	>2	Knee	Ankle	6.9	32.0	46.4	>42
Knee		10.9		12.6							
Left Ulnar Motor (Abd Dig Minimi)											
Wrist		3.1	<3.6	11.0	>5	B Elbow	Wrist	3.1	19.0	61.3	>48
B Elbow		6.2		8.8		A Elbow	B Elbow	1.4	9.0	64.3	>48
A Elbow		7.6		8.6							

F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)
Left Median (Mrkrs) (Abd Poll Brev)			
	24.29	<32	
Right Peroneal (Mrkrs) (EDB)			
	43.85	<56.4	
Right Tibial (Mrkrs) (Abd Hallucis)			
	42.80	<55	
Left Ulnar (Mrkrs) (Abd Dig Min)			
	20.00	<32	

H Reflex Studies

Patient: Gomez Fragoso, Hector Test Date: 10/2/2008 Page 3

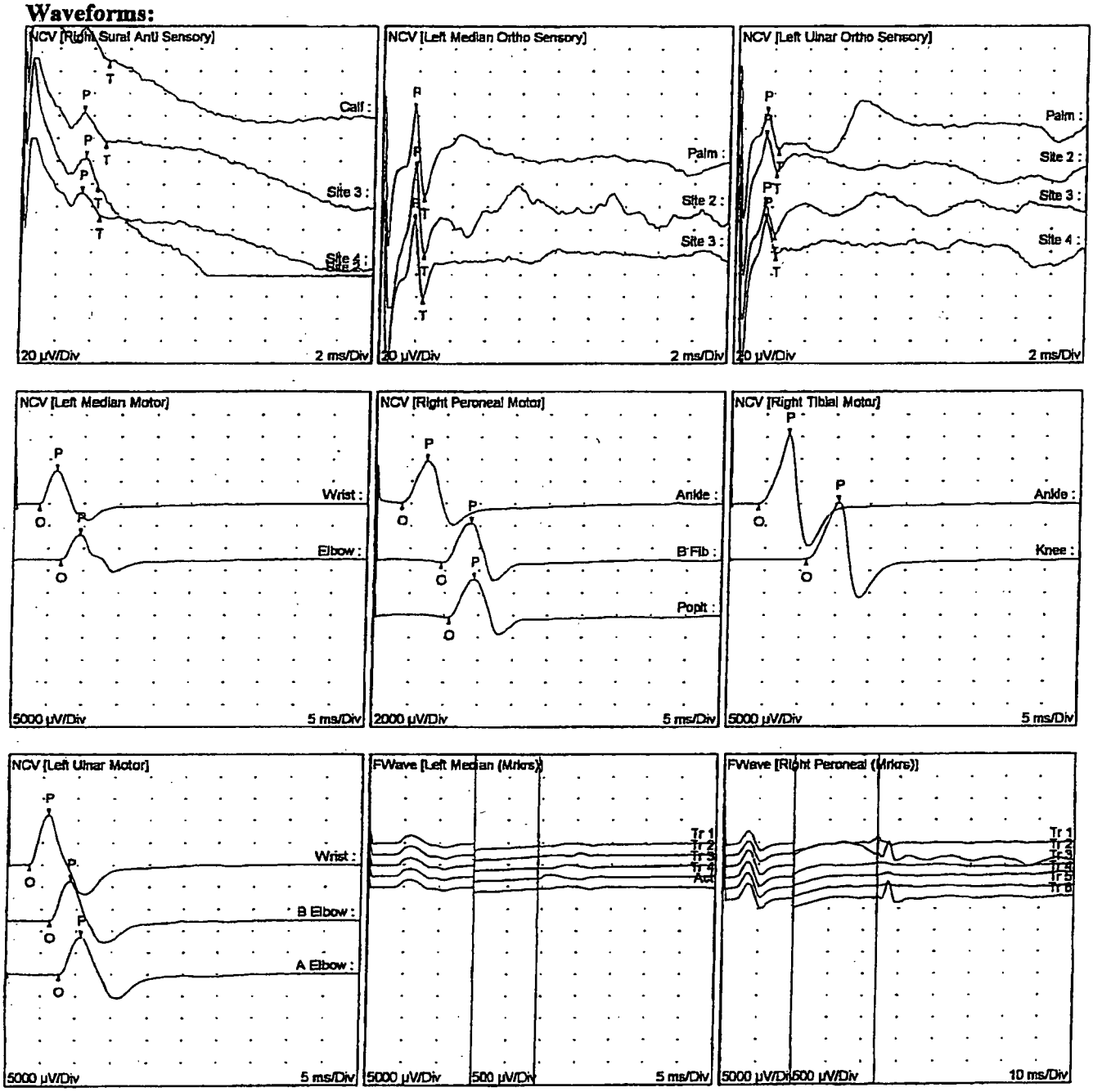
NR	H-Lat (ms)	Lat Norm (ms)	L-R H-Lat (ms)
Left Tibial (Gastroc)			
	23.64	<32	0.00
Right Tibial (Gastroc)			
	23.64	<32	0.00

EMG

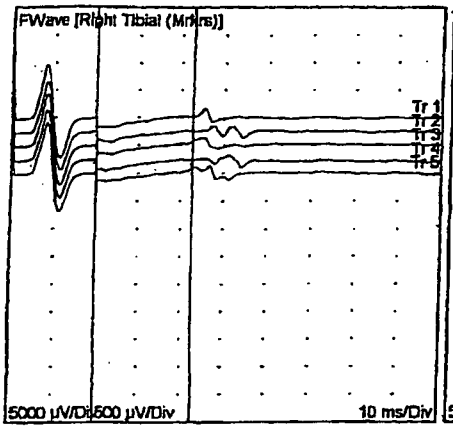
Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Fascics	Comment
Left	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	VastusLat	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	TensorFascLat	SupGluteal	L4-5, S1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Right	Iliopsoas	Femoral	L2-3	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	
Left	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	Absent	

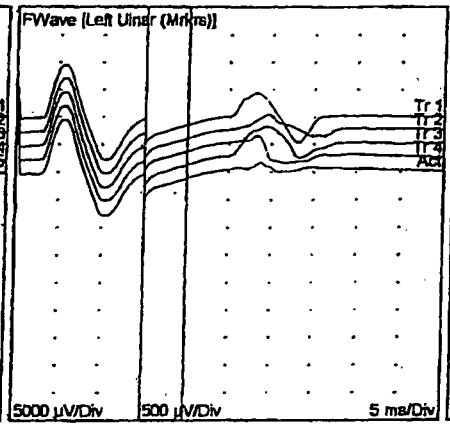
Patient: Gomez Fragoso, Hector **Test Date:** 10/2/2008 **Page 4**

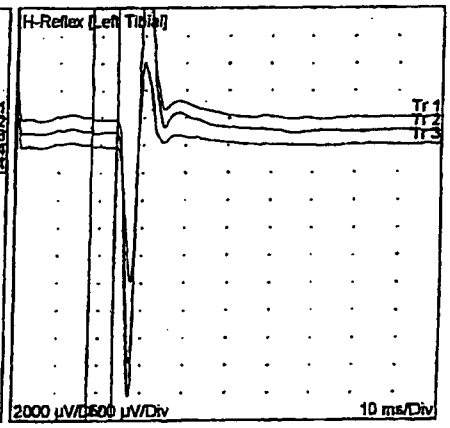
Waveforms:

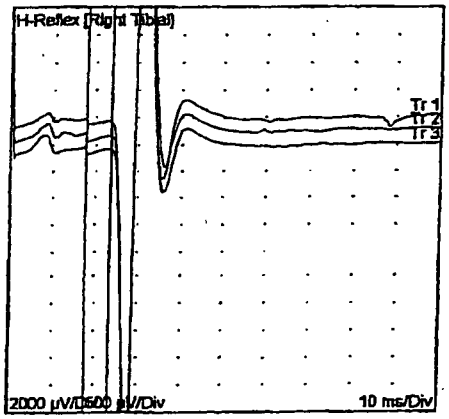


Patient: Gomez Fragoso, Hector **Test Date:** 10/2/2008 **Page** 5









Ocean Spine & Neurological Inst.
8170 Rourke Street
Myrtle Beach, SC 29572
(843) 449-2336

Patient: Gomez Fragoso, Hector
Sex: Male
Age:
I.D.#: A81323-1
Ref. M.D.:

Physician: Dr Sandoz
Test Date: 10/03/08

History/Comments:

DOB 10-04-80. Paresthesia/vertigo/syncope

Evoked Potential Study
Left Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	501	6.0	15.9	19.4	24.5
	501				

Evoked Potential Study
Right Median Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N13	Lat (ms) N17	Lat (ms) N20
	536	9.3	13.8	17.2	23.4
	504				

Evoked Potential Study
Left Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42-N50	Amp2 (uV) N7-N17
	500	4.2	16.3	26.7	39.3	49.0	35.2	0.3	1.1
	500								

Patient: Gomez Fragoso, Hector Test Date: 10/03/08
I.D.#: A81323-1

Evoked Potential Study

Right Tibial Nerve

Set	Sweeps	Lat (ms) N7	Lat (ms) N17	Lat (ms) N20	Lat (ms) P42	Lat (ms) N50	IPI1 (ms) N7-P42	Amp1 (uV) P42 - N50	Amp2 (uV) N7-N17
	500	6.2	20.8	27.8	40.3	53.3	34.2	0.9	
	500								

Auditory Evoked Potential Study

Left: 71 nHL dB Stimulus Right: 0 dB Noise
Left Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.9	2.7	3.6	4.5	5.4	6.1	0.0
	501							

Auditory Evoked Potential Study

Left: 0 dB Noise Right: 71 nHL dB Stimulus
Right Audio Nerve

Set	Sweeps	Lat (ms) I	Lat (ms) II	Lat (ms) III	Lat (ms) IV	Lat (ms) V	Lat (ms) V'	Amp1 (uV) V - V'
	500	1.7	2.2	3.0	4.0	5.3	6.0	0.1
	501							

Visual Evoked Potential Study

24 Screen Divisions (width)
Left Visual Nerve

Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPI1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	77.5	112.5	160.5	48.0	5.4
	128					

Patient: Gomez Fragoso, Hector Test Date: 10/03/08
I.D.#: A81323-1

Visual Evoked Potential Study

- 24 Screen Divisions (width)
Right Visual Nerve

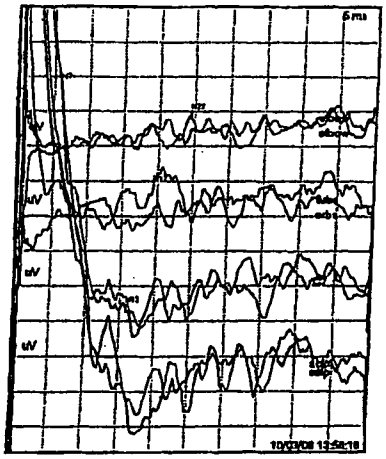
Set	Sweeps	Lat (ms) N75	Lat (ms) P100	Lat (ms) N145	IPI1 (ms) P100 - N145	Amp1 (uV) P100 - N145
	128	75.0	112.0	148.0	36.0	8.8
	128					

Summary/Interpretation:
The Visual Evoked Response test shows borderline P-100 responses bilaterally. The Brainstem Auditory and Upper/Lower EXtremity Somatosensory Evoked Response Tests are within normal limits. Clinical correlation is recommended.

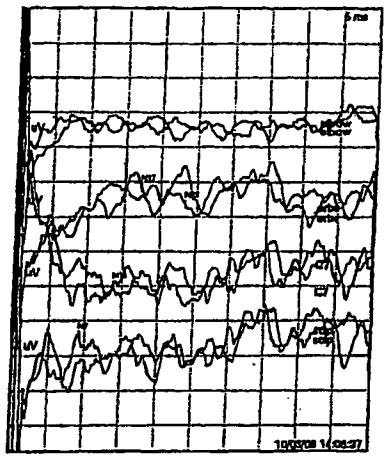
George Sandoz, M.D.

Patient: Gomez Fragoso, Hector Test Date: 10/03/08
I.D.#: A81323-1

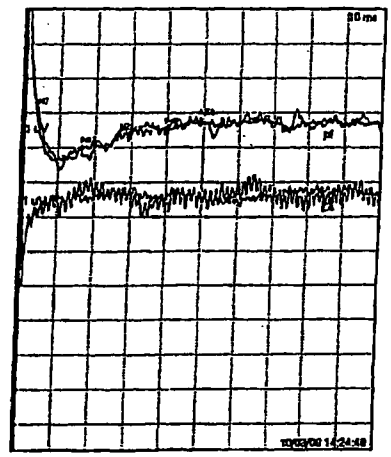
L. Median EP



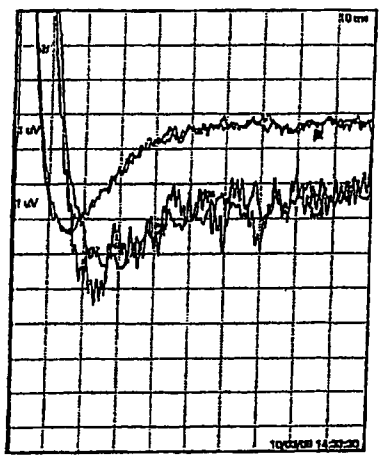
R. Median EP



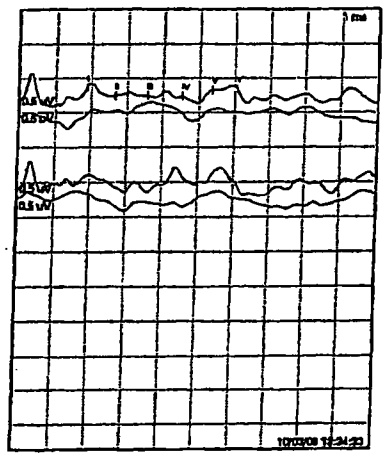
L. Tibial EP



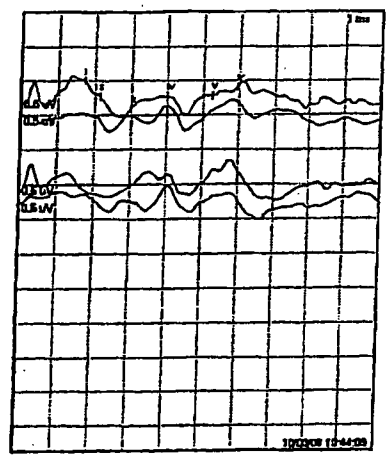
R. Tibial EP



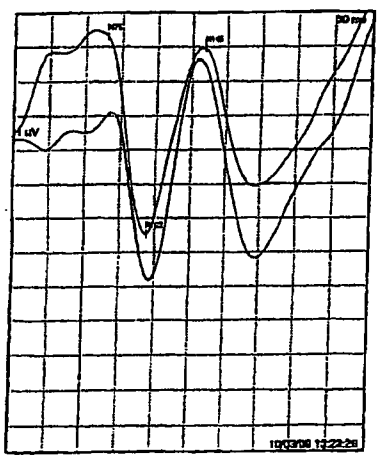
L. Audio EP



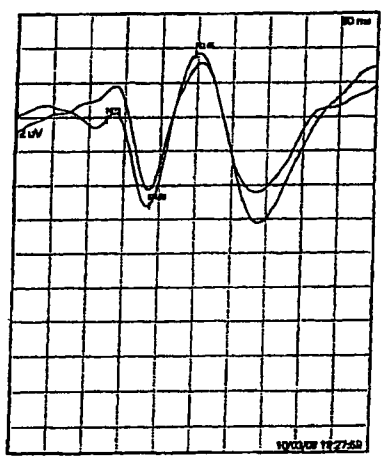
R. Audio EP



L. Visual EP



R. Visual EP



Patient: Gomez-Fragoso, Hector
DOB: **Age:** 28.0
Height: **Weight:**

ID: A81323-1
Gender: Male
BMI: —

Physician: Dr George Sandoz
Referring Physician: Dr George Sandoz

Technician: K

Recording Date: 10/2/2008 **Time:** 4:32 PM
Recorded Time: 2481.6 min. (41.4 hrs.)

Report Date: 10/5/2008

:
Syncope/paresthesia/vertigo

:
THIS IS A 24 HOUR AMBULATORY EEG RECORDING. A baseline EEG was performed prior to the patient leaving the office.Photic stimulation and hyperventilation were done.There were no reported episodes.

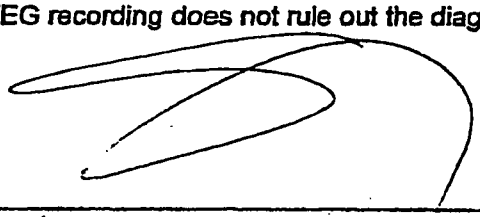
EEG REPORT

GENERAL DISCRIPTION: This was a 19 channel awake and sleep sleep extended EEG recording with International 10/20 electrode placements. The background activity consisted of symmetrical, posterior dominant, medium amplitude 9-12 Hz Alpha. These activities were symmetrical.
No significant slow wave activity was noted. No significant fast activity was noted.

ACTIVATION & SLEEP: Symmetrical attenuation of the background activity with eye opening was noted. Hyperventilation produced no significant changes to the background activity. Photic stimulation produced no significant changes to the background activity.
Deep sleep (stage III & IV) was noted by a decrease in sleep spindle activity and an increase in amplitude of theta and delta activity.

OTHER DATA: No event presses noted, no seizure, no ictal activity, no slowing present in this study.

CLINICAL IMPRESSION:
This EEG is within a wide range of normal limits. No focal abnormality or seizure discharges were noted. The above mentioned EEG Variants have unknown clinical significance.The absence of epiletiform discharges during the EEG recording does not rule out the diagnosis of a seizure disorder.



Dr George Sandoz

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	05/19/2009 9:45 AM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with headache, neck pain, dizziness, low back pain and back pain.

History of Present Illness
1. headache (follow-up)
Onset: 19 Month(s) ago. Severity: moderate. It occurs constantly, has 30-60 minutes duration, and is unchanged. Location was entire head. There was radiation to posterior. The describes it as debilitating, lancinating, pressure and worsening with laughter and almost loc. It occurred due to recent head trauma. Symptom is aggravated by valsalva. Relieving factors include prescription drugs. Associated symptoms include blurred vision, nausea and vertigo.
2. neck pain (follow-up)
Additional comments:
8/10 into both arms severe
3. dizziness (follow-up)
Additional comments:
with head movement.
4. low back pain
Onset: 19 Month(s) ago. Severity level is moderate-severe. The problem is stable. It occurs persistently. Location of pain was lower back and legs. The describes the pain as an ache, burning and deep. Context: bending forward and bending over. Symptoms are aggravated by ascending stairs, changing positions and coughing. Symptoms are relieved by pain meds/drugs and rest.
5. Back Pain
Additional comments:
abdominal area severe associated with UTI, started on left now on right.

Past Medical History
Reviewed, no changes. Last detailed document: 05/19/2009.

Family History

Yes / No	Disease Detail	Family Member	Name	Age
	Alive and well	Brother		
	Alive and well	Brother		
	Alive and well	Father		
	Alive and well	Mother		

Social History
Tobacco:
Patient is a tobacco user.
4.00 years.
Alcohol:
There is a history of alcohol use.

Beer approximately 1 beer daily.was consumed occasionally -

Allergies
No known allergies.

Vital Signs
Height

Time	Ft	In	Cm	Last Measured	Method	%
9:41 AM	5.0	3.00				

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
9:41 AM	198.00					35.07	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
9:41 AM	138/72	sitting	left		manual	adult

Measured By

Time	
9:41 AM	Penny Powers

Physical Exam
Constitutional:
Level of distress is awake & alert, in pain. Nourishment type is obese. Overall appearance is age appropriate.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: DTR's preserved and symmetric. .
Babinski: Reflexes normal. .
Kernig's sign: Negative.
Brudzinski's sign: Negative.

Clinical Assessment
The patient is a 28-year old male who presents with headache, neck pain and dizziness. The patient is compliant with medication. Not responding to current treatment. s/p esi on cervical spine without resolution

Assessment/ Plan
Lumbar / lumbosacral degenerative disc (722.52)
Cervical disc degeneration (722.4)
Migraine, unspecified (346.90)
Abdominal pain, epigastric (789.06)

Document generated by: george sandoz 05/19/2009
Gomez-Fragoso, Hector

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates LLC

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	06/02/2009 2:30 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with headache, dizziness and loss of consciousness.

History of Present Illness
1. headache
Onset: sudden. Severity: moderate. It occurs constantly, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to anterior. The patient describes it as debilitating, sharp and worst ever. Symptom is aggravated by head position and stress. Relieving factors include relaxation.
2. dizziness
3. loss of consciousness

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Physical Exam
Constitutional:
Level of distress is mild distress, in pain. Well nourished. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment

The patient is a 28-year old male who presents with headache, dizziness and loss of consciousness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Intracranial injury of other and unspecified natur (854.01)
Variants of migraine with intractable migraine, so (346.21)
Dizziness and giddiness (780.4)
Degeneration of lumbar or lumbosacral intervertebr (722.52)
discussed findings still c/o having kidney pain, work up negative in the past. Continue with management, also awaiting neuropsych evaluation, interview in Spanish. MMI and Impairment rating given.

Office Services

Status	Order	Reason	Interpretation	Value
completed	Diet plan: weight reduction			
completed	Discussed risk/benefits/side effects of treatment			

Instructions / Education

Status	Completed	Order	Reason
completed	08/07/2009	Continue current medication	
completed	08/07/2009	Activity as tolerated	
completed	08/07/2009	Risks/ benefits of treatment plan	
completed	08/07/2009	Potential for abuse	
completed	08/07/2009	Reviewed medications	
completed	08/07/2009	Pain management	
completed	08/07/2009	Medication side effects	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up for increased symptoms		854.01	-today	08/07/2009
completed	Follow up for medication side effect		854.01	-today	08/07/2009

Document generated by: George Sandoz 08/07/2009

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates
LLC

SPINE & NEUROLOGIC INSTITUTE
NEUROLOGICAL SURGERY
David B. Kee, Jr., M.D.
Eugene M. Giddens, M.D.
C. Todd Beebe PA-C

NEUROLOGY
Julian N. Hayes, M.D.
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George M. Sandoz, M.D.
Jeff A. Benjamin, D.O.

SPORTS
ORTHOPAEDIC SURGERY
SPORTS MEDICINE
Thomas J. Chambers, M.D.
Terry A. Schroxnayder, Jr., M.D.
Frederick J. Hamilton, D.O.
David Evernham, M.D.
Erin L. Kirby, P.A.-C

VISION
EYE SURGERY
EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

June 03, 2009

To Whom It May Concern:

Re: Hector Gomez Fragoso
DOB:
SSN:

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who was involved in a work-related injury on 11/01/2007. At this moment, he was seen by MUSC Orthopaedics for cervical and lumbar injury as well for a traumatic brain injury. The patient continued to have headaches and required to take medications. Today, he was started on pain management. After evaluation of the AMA Guidelines, Sixth Edition from the standpoint of the headache, the patient has 3% impairment of the whole body. From the standpoint of the dizziness, the patient has a class II as noted on table 11-4 of 9% impairment of the whole body. From the traumatic brain injury, the patient's impairment rating is of 20% as noted on the table 13-8. This still has pending impairment ratings from the lumbar and cervical spine and this will be addressed by MUSC Orthopaedics. The patient will require to take medication on a chronic basis. Assessment of his memory changes and inability to perform ADLs will be indicated. Pain medication add to the present and medication for the treatment of attention deficit disorder is required for the care of this patient. He will be required to be evaluated on a quarterly basis minimally for refill of prescriptions. Followup appointment will be arranged in a month to reassess the condition.

Sincerely,

George Sandoz, MD

GS/mlp

cc: Jeff Chandler

MYRTLE BEACH LOCATION
8170 Beach Street
Myrtle Beach, SC 29572
ph. (843) 449-2336
fax (843) 497-2505

MURRELLS INLET LOCATION
4557 Riverboat Drive, #129
Murrells Inlet, SC 29576
ph. (843) 357-9009
fax (843) 357-5619

CONWAY LOCATION
2376 Cypress Circle, Suite 200
Conway, SC 29526
ph. (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 285
Little River, SC 29566
ph. (843) 390-0033
fax (843) 390-0038

LORIS LOCATION
3617 Casey St., Suite D
Loris, SC 29569
ph. (843) 756-9729
fax (843) 390-0038

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	07/07/2009 2:30 PM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with head injury, dizziness and headache.

History of Present Illness

1. head injury (follow-up)
Onset: sudden. The severity of the symptoms is moderate. The symptoms have 11-1-07. Ventilator support was used in the hospital. The location of the injury is in the bilateral frontal region and bilateral cervical region. The location of pain is facial, head and neck. The patient describes the pain as aching and burning. The mechanical force causing the injury was contra-coup and coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Other relieving factors tried: unable to get control substance. Associated symptoms include incoordination, irritability, memory difficulty and speech difficulty.

2. dizziness
Onset was sudden. Severity is moderate. The duration of each episode is Year(s). The problem is unchanged. It occurs persistently. The patient describes it as (an) imbalance and spinning. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by bending. Relieving factors include VDE.

3. headache
Onset: sudden. Severity: moderate. Duration: Year(s). The problem is unchanged. Location was entire head. There was radiation to anterior. The describes it as blinding. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position.

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Height

Time	Ft	In	Cm	Last Measured	Method	%
3:35 PM	5.0	2.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
3:35 PM	200.00					36.58	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
3:35 PM	148/88	sitting	left		manual	adult

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse	Pattern	Resp
3:35 PM				80	regular	

Measured By

Time	
3:35 PM	Penny Powers

Physical Exam

Constitutional:
Level of distress is irritable, in pain, moderate distress. Nourishment type is obese. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
Thoracic spine has muscle spasm, mildly reduced ROM
Lumbar spine has muscle spasm, moderately reduced ROM
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: positive right.
Comments: MMS26/30

Clinical Assessment

The patient is a 28-year old maleWith Traumatic brain Injury, Headacke, dizzinessdificult with complex tasks. The patient is compliant with medication. Compliant with current therapy. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan

Dizziness (780.4)
Migraine, intractable, variants (346.21)
Intracranial injury of other and unspecified natur (854.01)
Late effect of intracranial injury without mention (907.0)
S/p TBI, with complicated Migraine, Dizziness and Cervical and Lumbar pain, Paitent has not had hi sNeuropsych evaluation, unable to obtain control substance that is not having the treatment neede to maximize his recovery and improve his condition to reinstate this patient to get gainfull employment, sample of Ultram and rx given. Interview was performed in spanish.

Document generated by: George Sandoz 08/04/2009

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates

PATIENT:	Hector Gomez-Fragoso
DATE OF BIRTH:	
DATE:	08/12/2009 9:45 AM
VISIT TYPE:	Office Visit

Chief Complaint/Reason for visit:
This 28 year old male presents with head injury, headache and dizziness.

History of Present Illness
1. head injury (follow-up)
Onset: sudden. The symtoms are severe. The symptoms have not changed. Ventilator support was used in the hospital. The location of the injury is in the bilateral temporal region. The location of pain is facial and head. The mechanical force causing the injury was coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Relieving factors tried include narcotic analgesics. Associated symptoms include Battle's sign, headache, personality change, stiff neck and visual disturbance.
2. headache (follow-up)
Onset: sudden. Severity: mild-moderate. It occurs daily, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to posterior. The patient describes it as debilitating and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position and stress. Relieving factors include prescription drugs. Associated symptoms include dizziness.
3. dizziness (follow-up)
Onset was sudden. Severity is mild. The duration of each episode is 5-15 minutes. The problem is unchanged. It occurs intermittently. The patient describes it as (an) imbalance. It occurs sponataneously. It occurs while exercising and sitting. Symptom is aggravated by rapid movement. Relieving factors include position change.

Active Medications (started before visit)
None.

Allergies
No known allergies.

Vital Signs

Physical Exam
Constitutional:
Level of distress is mild distress, due to pain. Nourishment type is overweight. Well developed.
Musculoskeletal:
Cervical spine has muscle spasm, moderately reduced ROM
Lumbar spine has muscle spasm, moderately reduced ROM
Neurological:
Level of Consciousness: Normal.
Orientation: Alert and oriented X 3. Grossly normal intellect. .
Memory: Intact. .
Cranial nerves: II-XII grossly intact. .

Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the left
Glossopharyngeal: normal.
Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment
The patient is a 28-year old male who presents with head injury, headache and dizziness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan
Intracranial injury of other and unspecified natur (854.01)
Awaiting for Neuro psych eval before give patient MMI and IR
Variants of migraine with intractable migraine, so (346.21)
continue with ultran for treatment of headacke.
Dizziness and giddiness (780.4)
Tolerating VDE's and interview was conducted in spanish.

Document generated by: George Sandoz 08/12/2009

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

Strand Regional Specialty Associates LLC

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OCEAN VISION & EYE SURGERY
EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

August 20, 2009

To Whom It May Concern:

RE: Hector Gomez Fragoso
DOB:
Chart: 81323

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who I have seen since 09/16/2008 secondary to a traumatic brain injury on 11/01/2007. He _____ for a traumatic brain injury. At this moment from the injury that the patient has suffered, he is totally and permanently disabled. After evaluation of the AMA Guidelines, Guides to Evaluation of the Permanent Impairment Rating, fifth edition as in table 13-5, the patient has a 29% of whole person. Superimposed to this is associated with the headaches that the patient has presented and this correlates to 2% impairment of the whole body. From the standpoint of the dizziness, the patient has 10% impairment of the whole person. Utilizing a combined value chart, this is a 46% impairment of the whole body. This does not attend to the damage that the patient has suffered from his neck and back as well for his foot.

Please do not hesitate to call me if you have any other further question or investigation in this patient.

Sincerely,

George Sandoz, MD

GS/smw

cc: Jeff Chandler

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Myrtle Beach, SC 29572
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MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5141659

MRN: 002581962
Date Exam Completed: 01/16/2008 09:59
Last Update: 01/17/2008

EXAMINATION: CT of the Brain 01/16/08 09:59:00

ACCESSION NUMBER: 5141659

INDICATION: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS, FRONTAL CONTUSION, SKULL FRACTURES, ASSESS STABILITY

COMPARISON: Head CT 11/7/07

TECHNIQUE: Multiple contiguous axial CT images of the head were performed without IV contrast.

FINDINGS: There is no evidence of new hemorrhage or extra-axial fluid collection. There are no signs of acute infarct. There has been interval resolution of previously visualized left parietal and right temporoparietal soft tissue swelling. Again seen are skull fractures with extension into the sutures as described on prior CT. The fracture do appear to have some healing, but the fracture lines are still present. There's been interval on clearing of the paranasal sinuses with no significant mucosal thickening or fluid levels identified. The orbits are unremarkable.

IMPRESSION:

1. No evidence of acute intracranial process.

2. Healing skull fractures.

DICTATED BY: Dr. CHRISTOPHER MOSES
I have reviewed the images and agree with the findings in this report.

History: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS,FRONTAL CONTUSION,SKULL FRACTURES

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962
Procedure: CT HEAD/BRAIN W/O CONTRAST Date Exam Completed: 01/16/2008 09:59
Accession #: 5141659 Last Update: 01/17/2008

Technologist: VALARIE RADCLIFF
Interpreter 1: ZORAN RUMBOLDT
Interpreter 2: CHRISTOPHER MOSES
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: ZORAN RUMBOLDT
Date Authenticated: 1/17/2008

Progress Notes

Date Printed: 01/08/10

Name: GOMEZ-FRAGOSO, HECTOR ID: 2581962 SEX:M AGE:29

12/30/09 : 00:00am
MUSC ORTHOPAEDICS SPINE SURGERY CENTER NEW PATIENT-MT PLEASANT
D84
Patient: HECTOR GOMEZ-FRAGOSO Birth Date: 10/04/1980 MUH: 2581962 Physician: John A. Glaser, MD
Referral: ** Current Visit: 12/30/2009

New Patient Consultation

HISTORY OF PRESENT ILLNESS:
This is a pleasant 29-year-old gentleman that Dr. Merrell has asked us to see with a chief complaint of neck and left arm pain. He had an injury about two years ago. This was at work. He was hit in the head. He also had some injury to his right foot. He has been seeing Dr. Merrell for this. He has tried injections, medications, and physical therapy. He says he is a generally healthy gentleman. He says that he will have the pain in left greater than right paraspinal region, and he will have numbness diffusely down the arm into all five fingers. He feels the arm is somewhat weak. He denies any leg, bowel, bladder, or constitutional symptoms except where he had his right foot injury.

GENERAL ASSESSMENT - 12/30/2009
APPEARANCE: This is a pleasant, cooperative gentleman. He is alert and oriented. Affect is appropriate. He does not speak English. He is here with an interpreter.
MOBILITY: His gait is basically normal. He is unable to toe raise because of his right foot injury. He is able to heel raise and squat. He has no motor or reflex deficit in his upper extremities. He has decreased sensation to light touch throughout his entire left upper extremity, his neck, and his thorax anteriorly.

DIAGNOSTIC TEST INTERPRETATION:
I reviewed an MRI of his cervical spine which shows some mild degeneration with bulging at C4-5 and C5-6, but there is no neurologic compression.

TREATMENT PLAN 12/30/2009
I discussed this with him through his interpreter. I told him I really do not think I should be getting involved surgically. I think it is a very low likelihood that surgery is going to help. He asked about medication and I deferred this decision to Dr. Merrell. He is taking Cymbalta and Naprosyn already as well as some Neurontin. I will be happy to see him as needed.

John A. Glaser, MD
Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite 708
Charleston, SC 29425
Telephone: 843-792-0601
Facsimile: 843-792-5170

JG/AM:578
2051695

SIGNED BY JOHN GLASER, M.D. (ATTENDING) (D84) 12/31/2009 05:31PM

South Carolina Workers' Compensation Cor sion
1333 Main Street, Suite 500 • Post Office box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fraoso
Employer's Name: Kade Construction
Physician's Name: Dr. Mark Hoy
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC – Otolaryngology Head and Neck Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Mark Hoy
Phone: (843)792-8299

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: 12-1-08
Date of last visit: 4-13-09

Diagnosis or nature of injury or illness: HEAD INJURY / DIZZINESS / EAR PAIN

Body part(s) injured: EAR
Body part(s) affected: EAR

Date of **Maximum Medical Improvement:** 4-13-09 ?

Based on the **AMA Guidelines,** the claimant has sustained a _____ **% medical impairment** to _____ injured body part(s) and a _____ **% medical impairment** to _____ other affected body part(s)

✓ The claimant is **able to return to work** without restriction.

___ The claimant is **able** to return to work **with the following restrictions:**

___ The claimant is **unable to return to work** at his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

✓ **will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

___ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Treating Physician

3-16-16
Date

14B

physician's Statement

644

P984

ith Carolina Workers' Compensation Comm ion
3 Main Street, Suite 500 • Post Office B /15
Columbia, South Carolina 29202-1715
(803) 737-5723
w.wcc.sc.gov

hysician's Statement

Claimant's Name Hector Gomez-Fragoso

Employer's Name: Kade Construction

ysician's Name: Dr. Shane Wolfe

Insurance Carrier: Key Risk Insurance Company

Practice/Clinic: MUSC Dept of Orthopaedic Surgery

SCWCC File No: 0717624

parer's Name: Dr. Shane Wolfe

one: ~~(843)792-0601~~ 843-792-1168

MRN: 2581962

undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident suant to§§**42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

e of first office visit: 12/1/08

Date of last visit: 6/2/19

gnosis or nature of injury or illness: Partial Thickness Left Rotator Cuff Tear

ody part(s) injured: Left Shoulder Body part(s) affected: Left upper extremity

e of **Maximum Medical Improvement:** _____

ased on the **AMA Guidelines,** the claimant has sustained a 1 **% medical impairment** to 1 injured body (s) and a _____ **% medical impairment** to _____ other affected body part(s).

___The claimant is **able to return to work** without restriction. (Regarding the Left shoulder. Please

___The claimant is **able** to return to work **with the following restrictions:** refer to Dr. Merrell re: neck symptoms)

___The claimant is **unable to return to work** at his or her current employment.

the date I last saw this patient, it is **my professional medical opinion** the claimant:

will not need future medical care related to his or her work related injury or illness based on a reasonable degree of dical certainty (more likely than not). (for the Left Shoulder

will need future medical care and treatment related to his or her work related injury or illness based on a reasonable e of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Salt

ing Physician

2/24/20

Date

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

Physician's Statement

Claimant's Name: Hector Gomez-Fragoso
Employer's Name: Kade Construction
Physician's Name: Dr. Kyle Shane Wolfe
Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC Dept of Orthopaedic Surgery
SCWCC File No: 0717624
Preparer's Name: Dr. Shane Wolfe
Phone: (843)792-1168

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to **§§42-15-60, 42-1-172 or 42-11-10.**

Date of Injury or Illness: 11-01-07

Date of first office visit: _____ Date of last visit: 6/29/9

Diagnosis or nature of injury or illness: Transmetatarsal (R) amputation

Body part(s) injured: (R) foot Body part(s) affected: (R) LE

Date of **Maximum Medical Improvement:** 6/29/9

Based on the **AMA Guidelines**, the claimant has sustained a 40 **% medical impairment** to (RLE) injured body part(s) and a 1 **% medical impairment** to Left Shoulder other affected body part(s).

___ The claimant is **able to return to work** without restriction.

16% wp + 1% wp = 17% Combined value

✓ The claimant is **able** to return to work **with the following restrictions:**

No climbing > 6 steps; use safety equipment.

* 17% = Combined Rating for Foot & Shoulder based on whole person %age for each + use of Combined Values Table.

___ The claimant is **unable to return to work** at his or her current employment.

s of the date I last saw this patient, it is **my professional medical opinion** the claimant:

✓ **will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of edical certainty (more likely than not).

___ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable gree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

_____
ating Physician

4/8/10
Date

Apr 09 2010 2:23PM HP LASERJET FAX 8435731577 p.2
Apr 20 10 02:17p Chandler Law 8434484005 p.3
P986

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

WCC File No. 071-632

Hector G. Barrosa, Employee/Claimant, Appellant,

v.

Kaye Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier, Respondents.

BRIEF OF APPELLANT

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ATTORNEYS FOR APPELLANT

Received
SC Court of Appeals

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STATEMENT OF ISSUES ON APPEAL

1. Whether the Workers Compensation Commission erred as a matter of fact and law in finding: "That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply."

2. Whether the Workers' Compensation Commission erred as a matter of fact and law in finding that a neuropsychologist was qualified to give an opinion as to whether "functional studies, such as EEGs, CTs and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury'" when a neuropsychologist's expertise does not extend to reading and interpreting EEGs, CTs and MRIs.

3. Whether the Workers' Compensation Commission erred as a matter of fact and law in arbitrarily disregarding the unrefuted expert medical opinion of Dr. Sandoz that Claimant had suffered a physical brain injury.

4. Whether the Workers' Compensation Commission erred as a matter of fact and law in giving any weight to Dr. Wagner's opinion when the opinion was not stated to a reasonable degree of medical certainty.

5. Whether the Workers' Compensation Commission erred as a matter of law in failing to make specific and detailed findings of fact sufficient for appellate review.

6. Whether the Workers' Compensation Commission erred as a matter of fact and law in failing to award lifetime compensation to Claimant in that he was totally disabled and had suffered physical brain injury.

STATEMENT OF THE CASE

This workers' compensation appeal arises out of an accident suffered by the Appellant, Hector Fragosa, on November 1, 2007. Fragosa's Employer, Kade Construction, LLC, and its Carrier, Key Risk Management Services, Inc., accepted liability and began providing benefits. Employer and Carrier are the Respondents in this appeal.

On March 25, 2011, Respondents filed a Form 21 (Employer's Request for Hearing) seeking to terminate temporary compensation.

Appellant filed a Form 50 (Request for Hearing) on April 8, 2011, alleging he was entitled to lifetime compensation and medical treatment due to permanent and total disability accompanied by physical brain damage. [R. p. 27]. Respondents timely filed a Form 51 (Employer's Answer to Request for Hearing) on April 19, 2011. Respondents admitted the work injury, but denied Fragosa sustained injuries to the extent alleged in the Form 50. [R. p. 29].

The Workers' Compensation set the hearing on the Forms 21, 50 and 51.

The hearing was held on June 28, 2011, before Commissioner Avery B. Wilkerson. The primary issue in dispute was whether Hector Fragosa was permanently and totally disabled with physical brain damage.

Commissioner Wilkerson issued an Order on November 21, 2011, Fragosa: "has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act." [R. p. 13-14, Conclusion of Law 3] He found as a fact that "based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under 42-9-30 and 42-9-10 and physical brain damage does not apply." [R. p. 13, Finding of

Fact 18]. He further found "Under 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled." [R. p. 13, Conclusion of Law 2]

Fragosa timely appealed to the Appellate Panel of the Full Commission on December 5, 2011. [R. p. 25-26]. Oral argument was held before the Appellate Panel on March 19, 2012. The Appellate Panel affirmed the Single Commissioner's Order on May 23, 2012. [R. p. 16-24].

This appeal followed.

STATEMENT OF THE FACTS

Hector Fragosa is 32 years old and originally from Mexico where he obtained the equivalent of a middle school education. He does not speak English and testified through a Spanish interpreter.

On November 1, 2007, Fragosa was working on a construction project for the Employer in Marion, South Carolina. Fragosa was on the roof of a parking garage. He was hit in the head with part of a construction crane which fell onto him knocking him off the roof and onto the ground.

He was transported to MUSC by helicopter Fragosa was hospitalized for one month following his accident – the first two weeks of which he was in a coma. He has no memory of the accident.

Fragosa suffered numerous injuries, to wit (drawn from the discharge summary at MUSC):

1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. CT and T1 spinous process fractures.
7. Right rib fractures which include 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.

10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes. [R. p. 418].

The specific diagnoses related to his traumatic brain injury are (1) skull fracture; (2) open complex scalp wound with epidural and subdural hematoma; and (3) bilateral frontal contusions. [R. p. 418]. The attending physician at MUSC documented dramatic evidence of physical brain injury, reporting: "This patient incurred a large fracture through the skull, apparently it is open, with subdural and epidural fluid collections." [Claimant's APA, page 1].

While in the hospital, Fragosa required a "percutaneous endoscopic gastrostomy tube for continued enteral feeds and nutritional support." [R. p. 172]. The surgeon who implanted the tube, Dr. Stuart Leon, noted: "The patient sustained several injuries, the most significant of which was a closed-head injury with an epidural hematoma. **This injury has left Mr. Gomez neurologically devastated."** [R. p. 172].

The Employer accepted Fragosa's claim and began providing benefits, including treatment from a neurologist, Dr. George Sandoz. Dr. Sandoz made numerous statements throughout his medical records confirming the physical brain injury.

On October 10, 2008 – nearly a year after the accident – Fragosa presented to Dr. Sandoz "with the complaint of dizziness [and] spells that suggest that the patient is having seizures . . . From the evidence of the brain, this was reviewed by me and it suggest that there is a **right temporal lobe injury**. [R. p. 222 (emphasis added)].

Several weeks later on October 24, 2008, Dr. Sandoz reported, "This has been worked up and has shown no evidence of any seizure and nor any evidence of any damage of the brain. **Despite**

that review of the MRI shows some mild abnormality in the temporal lobe." [R. p. 224(emphasis added)].

On November 25, 2008, Dr. Sandoz noted, "The patient is a very complex white male who appears to have **traumatic brain injury.**" [R. p. 227 (emphasis added)].

On January 6, 2009, Dr. Sandoz recorded, "The patient presented here status **post work-related injury where he had a traumatic brain injury** with the description that the patient suffer. At this moment, the **headaches appear to be chronic, posttraumatic in nature.**" [R. p. 229 (emphasis added)].

Six months later on June 2, 2009, Doctor Sandoz continued with the diagnosis of: "**Intracranial injury** of other and unspecified nature." [R. p. 236]. The next day he wrote a letter confirming the brain injury and assigning a 20% impairment rating per the 6th Edition of the AMA Guide: "seen by MUSC Orthopaedics for cervical and lumbar injury as well for a **traumatic brain injury**. . . . From the traumatic brain injury, the patient's impairment rating is of 20% as noted on the table 13-8." [R. p. 237].

On a followup visit on July 7, 2009, Dr. Sandoz noted the specific problems resulting from the brain injury: "The patient is a 28-year old male with traumatic brain injury, headache, dizziness, difficulty with complex tasks." [R. p. 239].

On August 20, 2009, Dr. Sandoz wrote a detailed explanation of Fragosa's impairment and total disability as it relates specifically to the brain injury:

> Mr. Fragosa is a patient of mine who I have seen since 09/16/2008 secondary to a **traumatic brain injury** on 11/01/2007. He ____ for a **traumatic brain injury. At this moment from the injury that the patient has suffered, he is totally and permanently disabled.** After evaluation of the AMA Guidelines, he is totally and permanently disabled. After the evaluation of the AMA Guidelines, Guides to

> Evaluation of the Permanent Impairment Rating, fifth edition as in table 13-5, the patient has 29% of the whole person. Superimposed to this is associated with the headaches that the patient has presented and this correlates to 2% impairment of the whole body. From the standpoint of the dizziness, the patient has 10% impairment of the whole person. Utilizing a combined value chart, this is a 46% impairment of the whole body. This does not attend to the damage that the patient has suffered from his neck and back as well for his foot. [R. p. 242 (emphasis added)]

Table 13-5 is the chart for "Clinical Dementia Rating." [AMA Guides to Permanent Impairment (5th Edition), page 320]. The 29% whole person rating for the brain injury reflects an "impairment [which] requires direction of some activities of daily living." Id.

Dr. Sandoz was deposed on August 6, 2010. He confirmed, "This is not a concussion, this is an injury suffered to the brain. . . . That's why traumatic brain injury is the preferred term. . . . [The difference is the] concussion should resolve." [R. p. 320, lines 12-19]. He further testified that it is called a traumatic brain injury "Because there's been some damage and injury to the function of the brain." [R. p. 320, lines 20-24].

On March 10, 2011, Dr. Sandoz removed all doubt regarding his opinions by answering "YES" to the question "to a reasonable degree of medical certainty whether Mr. Fragosa has suffered physical brain damage that has rendered him totally and permanently disabled." [R. p. 286].

Defense counsel arranged an evaluation with Dr. Mark Wagner, a neuropsychologist. The evaluation took place on October 30, 2008. Dr. Wagner's report is replete with observations of physical brain injury – both the fact of the physical brain injury and the cognitive deficits resulting from that injury. He notes:

> [Mr. Fragosa] had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the brain. . . . He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive

> syndrome.[1] The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. [R. p. 299].

Included in the above description was the incidental statement that: "Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury." [R. p. 299].

Fragosa was also evaluated by Dr. Robert Brabham, a psychologist and certified brain injury specialist, on October 27, 2010. [R. p. 272-285]. Dr. Brabham concluded:

> With the passage of time, now more than 2.5 years after his injuries, *behavioral and cognitive changes have persisted, as will be noted, sufficient to conclude that the brain injuries he sustained, described as post-concussion injuries in multiple records, has resulted in continuing and severe symptoms clearly associated with a* ***physical traumatic brain injury,*** *the result of his on-the-job injuries.* [R. p. 272 (Italics in original; bold added)].

Dr. Brabham further opined: "to a high degree of professional certainty . . . he has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain, unable to engage in full-time gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in November 2007. [R. p. 283-284].

As of the June 28, 2011 trial, Fragosa still suffered from daily headaches, dizziness, short and long term memory deficits, cognitive deficits, and buzzing in both ears – all of which resulted from the physical brain injury. [R. p. 79, line 5-page 83, line 16]. He remains physically and mentally incapable of returning to any kind of work that he has ever done. [R. p. 90, lines 12-15].

---

[1]Post-concussion syndrome is a set of symptoms that a person may experience for weeks, months, or occasionally up to a year or more after a concussion–a mild form of traumatic brain injury. The condition can cause a variety of symptoms: physical, such as headache; cognitive, such as difficulty concentrating; and emotional and behavioral, such as irritability. Continuing symptoms confirm the presence of physical brain damage.

STANDARD OF REVIEW

The guiding principle undergirding our workers' compensation system that the Act is to be liberally construed in favor of the claimant. Carter v. Penny Tire & Recapping Co., 261 S.C. 341, 349, 200 S.E.2d 64, 67 (1973). An award may not rest upon surmise, conjecture, or speculation. Tiller v. Nat'l Health Care Ctr. of Sumter, 334 S.C. 333, 339, 513 S.E.2d 843, 845 (1999). Instead, "[an award] must be founded on evidence of sufficient substance to afford a reasonable basis for it." Wynn v. People's Natural Gas Co. of S.C., 238 S.C. 1, 12, 118 S.E.2d 812, 818 (1961). A court may reverse or modify the Commission's decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are affected by other error of law. Broughton v. South of the Border, 336 S.C. 488, 520 S.E.2d 634, 637 (Ct. App. 1999).

When only one reasonable inference can be deduced from the evidence, it becomes a question of law for the courts. Kinsey v. Champion American Service Center, 268 S.C. 177, 232 S.E.2d 720 (1977). "While the appellate courts are required to be deferential to the full commission regarding questions of fact, this deference does not prevent the courts from overturning the full commission's decision when it is legally incorrect as it is here." Grant v. Grant Textiles, 372 S.C. 196, 641 S.E.2d 869 (2007). The Commission's findings will be reversed when the evidence of a compensable injury is overwhelming. Massey v. W.R. Grace & Co., 286 S.C. 434, 334 S.E.2d 122 (1985)

ARGUMENT

1. Hector Fragosa has suffered physical brain damage and is legally entitled to workers' compensation benefits for life.

Hector Fragosa was hit in the head with a crane which knocked him off a roof onto the ground. He suffered a skull fracture with subdural and epidural hematomas along with frontal lobe contusions – all of which were confirmed with MRI and CT scans. He remained in a coma for 15 days following his accident.[2] Since then, he has suffered from proven cognitive deficits, balance problems, dizziness, seizures, and difficulty with complex tasks. Both his treating neurologist and the Defendants' neuropsychological IME confirm the permanency of the cognitive deficits. The authorized treating neurologist has repeatedly and explicitly stated to a reasonable degree of medical certainty that Fragosa is permanently and totally disabled due to physical brain injury. The evidence of physical brain injury is simply overwhelming. See Pearson v. JPS Converter & Indus. Corp., 489 S.E.2d 219, 327 S.C. 393 (Ct. App. 1997)(affirming award of lifetime benefits for physical brain injury when "[a]t most, one physician, Dr. Woodward, indicated that he could not determine whether the greater cause of Pearson's disability was his psychological deficits or his organic brain damage [and] [n]ot one physician has stated that Claimant's disability is not due to physical brain damage."). The decision below must be reversed.

A. The criteria established under the South Carolina Workers' Compensation Act for physical brain damage.

The Appellate Panel made the legal conclusion"there has not been a physical brain injury as

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[2]The CDC developed a definition of traumatic injury for the Department of Defense and Veterans Administration. Under the CDC's definition, a loss of consciousness longer than 24 hours is classified as a *severe* traumatic brain injury. See Department of Defense and Department of Veterans Affairs (2008). "Traumatic Brain Injury Task Force" http://www.cdc.gov/nchs/data/icd9/Sep08TBI.pdf

it does not meet the criteria established under the South Carolina Workers' Compensation Act." [R. p. 23, Finding of Fact 18]. The Appellate Panel never specified what these criteria might have been or what particular criterion was not met. As such, the Decision and Order is facially inadequate and must be reversed on that basis alone. See Canteen v. McLeod Regional Medical Center, 735 S.E.2d 246, 400 S.C. 551 (Ct. App. 2012)(reversing and remanding to the Appellate Panel with instructions "to cite evidence supporting its position on remand."). However, because the evidence of physical brain injury is overwhelming, this is a case where the Court can reverse the decision below as a matter of law. See Hutson v. South Carolina State Ports Authority,732 S.E.2d 500, 399 S.C. 381 (2012)(reversing Appellate Panel's conclusion because "rank speculation" cannot outweigh competent evidence of disability).

The statute provides that an injured worker "*who has suffered physical brain damage . . .* shall receive the benefits for life." S.C. Code Ann. § 42-9-10 (C) (2007)(emphasis added). The term *physical brain damage* is not further defined in the statute. The Commission apparently added its own criterion that the brain damage must be visible on a CT scan.[3] This additional criterion is drawn from whole cloth. It has no support in medicine or the law; it violates the tenet to liberally construe the Act in favor of the injured worker. See Reed-Richards v. Clemson University, 638 S.E.2d 77, 371 S.C. 304 (Ct.App. 2006)(adopting expansive definition of paraplegia to include "incomplete paraplegia" as "consistent with the legislative purpose of construing workers' compensation laws in

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[3]At oral argument before the Appellate Panel, counsel for Respondents stated: "So traumatic brain injury is the same as physical brain injury; I admit I might have a problem. But I think physical brain injury, in fact, the General Assembly and Legislature has put a burden on us with something we can physically see, something that requires more here." [R. p. 108, lines 20-25). At another point in that same argument, Commissioner Gene McCaskill asked of Respondents' counsel: "as I understand what you're saying if it is a physical brain injury you've got to be able to see it?" [R. p. 111, lines 11-13).