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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE FULL COMMISSION
Of the South Carolina Workers' Compensation Commission

T. Scott Beck, Workers' Compensation Commissioner

WCC File No.: 1211338
Appellate Case No.: 2015-000693

RECEIVED

AUG 20 2015

SC Court of Appeals

Keith Case,

Employee, Appellant,

v.

J. Crawford Logging, Inc.

Employer,

And

Palmetto Timber Fund SIF

Carrier,
Respondents

RECORD ON APPEAL

Charles J. Hodge (S.C. Bar No. 02537)
HODGE & LANGLEY LAW FIRM, PC
P.O. Box 2765
Spartanburg, SC 29304
(864) 585-3873
Attorney for the Appellants

August 18, 2015

Other Counsel of Record:
John W. Rabb, Jr., Esquire
PO Box 1481
Columbia, SC 29202
(803) 714-9606
Attorney for Respondents

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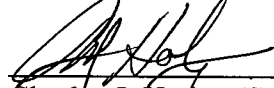
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Certificate of Counsel

Charles J. Hodge, counsel for Appellant, certifies by signing below that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

HODGE & LANGLEY LAW FIRM, PC



Charles J. Hodge (S.C Bar No. 02537)
Attorney for Appellant

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1211338

Keith Case, Employee,	)	
Claimant,	)	
	)	
vs.	)	ORDER
	)	
J. Crawford Logging, Inc.,	)	
Employer,	)	
	)	
Palmetto Timber Fund,	)	
Carrier,	)	
Defendants.	)	

This matter came before the undersigned Commissioner on September 19, 2013. This matter involves an admitted injury to the lower extremities. A dispute arose between the parties regarding compensability of the spine. The carrier allowed Dr. Charles Kanos to evaluate the claimant and authorized a lumbar MRI. During his treatment Dr. Kanos directed the claimant to undergo a cervical MRI. The Defendants opposed this. A Form 21 Stop Payment Request was issued by Defendants on July 26, 2013 following a 14B which had been signed by the treating physician for the leg injuries on May 9, 2013.

The claimant's counsel moved for the deposition of Dr. Kanos to be held to specifically address the causal connection issues. Defendants opposed this.

After careful consideration the undersigned Commissioner believes that the record in this matter should be frozen except for Dr. Kanos' deposition. The hearing will be reset for December 10, 2013 at 11:00 a.m. In any event the undersigned Commissioner shall retain jurisdiction over the matter and the parties have agreed to travel where necessary to have it heard. It is understood credit may go back to May 9, 2013 14B date or the date the Form 21 was filed on July 26, 2013.

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED,

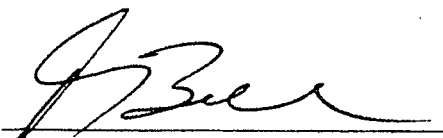
1. This matter shall be reset for December 10, 2013 at 11:00 a.m.
2. The record shall remain frozen except for Dr. Kanos' deposition.

IT IS SO ORDERED.

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Amy Bracy on October 31, 2013


The Honorable T. Scott Beck

EXHIBITS:

1. Pictures of wound.
2. Deposition of Dr Charles Kanos, MD
3. Deposition of Dr Jason Folk MD

STATEMENT OF THE CASE:

This is an admitted injury to the right lower extremity. The matter originally came before the undersigned on September 19, 2013. A dispute arose regarding the compensability of the spine. The carrier allowed Dr Charles Kanos to evaluate the claimant and authorized a lumbar MRI. The MRI was read as unremarkable. Dr Kanos directed the Claimant to undergo a cervical MRI. The defendants opposed this. A form 21 Stop Payment Request was issued by Defendants based on a Form 14B signed by the treating physician for the leg injury. Claimant's counsel moved and was granted a continuance to take the deposition of Dr Charles Kanos on the causation issue. The request was granted and the record was frozen and the Defendant's request for a credit of TTD was preserved from May 9, 2013 and continuing. The undersigned retained jurisdiction. This is the re-set of that original hearing addressing all issues including stop payment of TTD, permanency of the RLE and compensability of the spine as it may relate to the original lower extremity injury. The cervical MRI conducted on 4/17/2014 which would have been excluded by my prior ruling freezing the record is being admitted pursuant to the stipulation of both parties.

Claimant asserts the neck is compensable and he is in need of additional medical care. He concedes MMI for the right knee but takes the position that permanency is premature until the neck is treated and he is released. The Carrier asserts the Claimant is at MMI on May 9, 2013, that the injury is limited to the right leg only, based on the 14B of Dr Folk MD, that the Claimant is entitled to an award of PPD to his right leg, and they seek a credit for overpayment of TTD from May 9, 2013 to the present and specifically deny and injury to the Claimant's spine and rely on the deposition testimony of Dr. Kanos MD.

FINDINGS OF FACT:

After reviewing the pleadings, prior orders, medical submissions, and argument of both parties, and the testimony of the Claimant, I make the following findings of fact:

1. On August 27, 2012, the Claimant sustained bilateral lower extremity injuries in a logging accident within the course and scope of his employment with J Crawford Logging, Inc.
2. Claimant testified he was a pulpwood driver for J Crawford Logging. He was coming down off a trailer on the day in question when a log rolled and he fell between 8-

11 feet. He was wearing a hard hat. He fell face forward. He got "a hole" knocked in his left leg and he "slammed on his right knee". (Tr.pg. 11). He testified he hurt from the neck down after the accident. He was bruised from head to toe. (Tr. Pg 14). Currently, the Claimant testified he walks with a crutch. Claimant testified that last night after standing for 2 minutes the right knee starting stinging. He testified he does not drive, but does have a valid CDL with a tanker endorsement.

3. The Claimant was treated by Dr Jason Folk MD. He was diagnosed with patellofemoral pain syndrome, right knee. No surgery was indicated. On April 24, 2013, Dr Folk noted "his right knee has no effusion, he has diminished patellar tendon mobility, but patellar mobility is good. No pain at extremities of motion, stable ligamentous exam, no crepitation through an active range of motion". He was released prn, but there was a referral for lumbar pain. On May 9, 2013, Dr Folk MD executed a Form 14 B assigning a 3% impairment to the right knee and noted the Claimant could return to work with no restrictions and would not need future medical care. I find no evidence of impairment to the left knee.

4. Based on the above medical findings and the testimony of the Claimant as well as my personal observation of both of the Claimant's legs, I find the Claimant is entitled to an award of 10% permanent partial disability to the right lower extremity.

5. The Claimant saw Dr Charles Kanos on May 20, 2013 as a referral for low back pain. A lumbar MRI was recommended. The MRI was read as unremarkable and no treatment was recommended. There were no complaints of neck pain by the Claimant at the May 20, 2013 appointment. In fact, I find nothing in any of the medical records where the Claimant complained of neck pain until his return to Dr Kanos on July 1, 2013, nearly 11 months , post accident. On July 1, 2013, the Claimant was positive for a Hoffman's test which could indicate some compression in the neck. Dr. Kanos specifically noted this was not present in the May visit. A cervical MRI was recommended.

6. In his deposition, Dr Kanos was unable to provide an opinion to a reasonable degree of medical certainty that the cervical pain was causally related to the accident of 8/27/2012. He was repeatedly asked about this during his deposition but he was unable to provide the necessary causation opinion. Depo. of Kanos, pg 14-15, 17, 19.

7. Based on the deposition of Dr. Kanos, I find the Claimant has failed to carry his burden of proof of proving a compensable injury to his neck.

8. The Claimant reached MMI for his compensable right lower extremity on 5/9/13, and the Defendant's are entitled to stop payment of TTD.

9. Defendant's are entitled to a credit for TTD paid beyond 5/9/13.

10,. Based on the 14B from Dr. Folk, the Claimant is not entitled to future medical care for the right lower extremity.

CONCLUSIONS OF LAW:

1. Section 42-9-30(16) provides the schedule and period of disability and compensation for PPD to the right lower extremity.

2. The Claimant has the burden of providing facts that would bring his injuries within the workers' compensation law. See Jennings v. Chambers Dev. Co., 335 S.C. 249, 254, 516 S.E.2d 453, 456 (Ct. App. 1999) (stating, "[t]he

claimant has the burden of proving facts that will bring the injury within the workers' compensation law, and such award must not be based on surmise, conjecture, or speculation"). Equally compelling is the evidentiary principle that 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).

3. Claimant has failed to carry his burden of proving a compensable injury to his neck.

ORDER:

1. Claimant is entitled to 10% PPD to the right lower extremity.
2. Claimant is not entitled to future medical care for the right lower extremity.
3. Defendant's are entitled to stop TTD and are entitled to a credit for TTD paid beyond 5/9/2013.
4. Claimant's request for benefits for his neck is denied.

AND IT IS SO ORDERED



T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

August 27, 2014

By: Amy Bracy, Administrative Assistant to Commissioner Beck

Keith Case, Employee, Claimant)
)
v.)
)
J Crawford Logging, Employer)
)
and)
)
Palmetto Timber Fund, SIF, Carrier)

-6-

which would have been excluded by the prior ruling freezing the record was admitted pursuant to the stipulation of both parties.

Claimant asserted the neck is compensable and he is in need of additional medical care. He conceded MMI for the right knee but took the position that permanency is premature until the neck is treated and he is released. The Defendants assert the Claimant is at MMI on May 9, 2013, that the injury is limited to the right leg only, based on the 14B of Dr Folk MD, that the Claimant is entitled to an award of PPD to his right leg, and they seek a credit for overpayment of TTD from May 9, 2013 to the present and specifically deny an injury to the Claimant's spine and rely on the deposition testimony of Dr. Kanos MD.

The Single Commissioner made the following findings of fact:

1. On August 27, 2012, the Claimant sustained bilateral lower extremity injuries in a logging accident within the course and scope of his employment with J Crawford Logging, Inc.
2. Claimant testified he was a pulpwood driver for J Crawford Logging. He was coming down off a trailer on the day in question when a log rolled and he fell between 8-11 feet. He was wearing a hard hat. He fell face forward. He got "a hole" knocked in his left leg and he "slammed on his right knee". (Tr.pg. 11). He testified he hurt from the neck down after the accident. He was bruised from head to toe. (Tr. Pg 14). Currently, the Claimant testified he walks with a crutch. Claimant testified that last night after standing for 2 minutes the right knee starting stinging. He testified he does not drive, but does have a valid CDL with a tanker endorsement.
3. The Claimant was treated by Dr Jason Folk MD. He was diagnosed with patellofemoral pain syndrome, right knee. No surgery was indicated. On April 24, 2013, Dr Folk noted "his right knee has no effusion, he has diminished patellar tendon mobility, but patellar mobility is good. No pain at extremities of motion, stable ligamentous exam, no crepitation through an active range of motion". He was released prn, but there was a referral for lumbar pain. On May 9, 2013, Dr Folk MD executed a Form 14 B assigning a 3% impairment to the right knee and noted the Claimant could return to work with no restrictions and would not need future medical care. I find no evidence of impairment to the left knee.
4. Based on the above medical findings and the testimony of the Claimant as well as my personal observation of both of the Claimant's legs, I find the Claimant is entitled to an award of 10% permanent partial disability to the right lower extremity.
5. The Claimant saw Dr Charles Kanos on May 20, 2013 as a referral for low back pain. A lumbar MRI was recommended. The MRI was read as unremarkable and no treatment was recommended. There were no complaints of neck pain by the Claimant at the May 20, 2013 appointment. In fact, I find nothing in any of the medical records where the Claimant complained of neck pain until his return to Dr Kanos on July 1, 2013, nearly 11 months , post accident. On July 1, 2013, the Claimant was positive for a Hoffman's test which could indicate some compression in the neck. Dr. Kanos

specifically noted this was not present in the May visit. A cervical MRI was recommended.

6. In his deposition, Dr Kanos was unable to provide an opinion to a reasonable degree of medical certainty that the cervical pain was causally related to the accident of 8/27/2012. He was repeatedly asked about this during his deposition but he was unable to provide the necessary causation opinion. Depo. of Kanos, pg 14-15, 17, 19.

7. Based on the deposition of Dr. Kanos, I find the Claimant has failed to carry his burden of proof of proving a compensable injury to his neck.

8. The Claimant reached MMI for his compensable right lower extremity on 5/9/13, and the Defendant's are entitled to stop payment of TTD.

9. Defendant's are entitled to a credit for TTD paid beyond 5/9/13.

10. Based on the 14B from Dr. Folk, the Claimant is not entitled to future medical care for the right lower extremity.

The following Conclusions of Law were made:

CONCLUSIONS OF LAW:

1. Section 42-9-30(16) provides the schedule and period of disability and compensation for PPD to the right lower extremity.

2. The Claimant has the burden of providing facts that would bring his injuries within the workers' compensation law. See Jennings v. Chambers Dev. Co., 335 S.C. 249, 254, 516 S.E.2d 453, 456 (Ct. App. 1999) (stating, "[t]he claimant has the burden of proving facts that will bring the injury within the workers' compensation law, and such award must not be based on surmise, conjecture, or speculation"). Equally compelling is the evidentiary principle that 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).

3. Claimant has failed to carry his burden of proving a compensable injury to his neck.

The following Order was issued:

ORDER:

1. Claimant is entitled to 10% PPD to the right lower extremity.
2. Claimant is not entitled to future medical care for the right lower extremity.
3. Defendant's are entitled to stop TTD and are entitled to a credit for TTD paid beyond 5/9/2013.
4. Claimant's request for benefits for his neck is denied.

Based on our review of the entire record and argument of counsel, we hereby make the following:

FINDINGS OF FACT:

1. The Commission has the power to weigh the evidence as presented at the initial hearing and, after careful review in the instant case, the Commission agrees with all of the Finding of Facts and Conclusions of Law stated above and for all of the reasons set forth by the Single Commissioner and accordingly finds that the Decision and Order is Affirmed in Full.

Based upon the foregoing Findings of Fact, it is the determination of the Commission that:

CONCLUSION OF LAW:

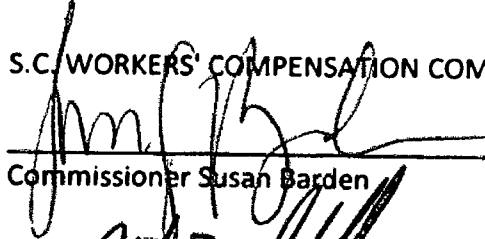
1. In an Appellate Review, the Full Commission is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2 162 (1992)

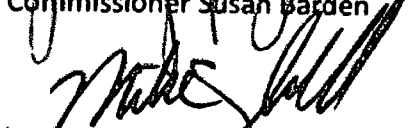
ORDER:

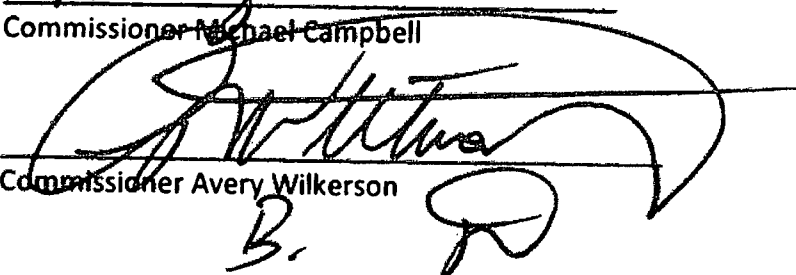
The Order of the Single Commissioner filed in the above entitled matter on August 27, 2014, is hereby affirmed by the Panel and same shall constitute the Decision and Order of the Appellate Panel.

By:

S.C. WORKERS' COMPENSATION COMMISSION


Commissioner Susan Barden


Commissioner Michael Campbell


Commissioner Avery Wilkerson

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Eugenia Hollmon on March 10, 2015

South Carolina Workers' Compensation Commission

612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
803) 737-5723
www.wcc.sc.gov



WCC File #: 1211338
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Keith Case SSN: 247-59-4639 Employer's Name: J. Crawford Logging, Inc.
Address: 573 Goldmine Rd Address: 183 Estes Road
City: Pauline State: SC Zip: 29374 City: Union State: SC Zip: 29379
Home Phone: (864) 316-2620 Work Phone: _____ Insurance Carrier: Palmetto Timber Fund
Preparer's Name: Charles J. Hodge Law Firm: Hodge & Langley, PC Preparer's Phone #: (864) 585 - 3873

Complete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at Lines 6, 7, 8, and 9, and file this form in duplicate.

Claim for workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 8/27/12

☒ Injury ☐ Illness ☐ Repetitive Trauma

- 1a. The claimant sustained an injury to Spine & Both lower extremities (Part(s) of Body Injured) on 8/27/12 (Month/Day/Year) in Union county, state of South Carolina.
- 1b. Body part(s) affected are: Spine & Both lower extremities
- Briefly describe how the accident occurred. Claimant was on the back of the truck when log rolled onto his leg causing him to fall off, injuring both lower extremities.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the Employer on 8/27/12 (Month/Day/Year) in the following manner:
Reported to Supervisor Jimmy Crow
- ☒ 6. Due to injury, the claimant is in need of (check one):
☒ (a) medical examination and treatment for: Spine & Both lower extremities
☐ (b) additional medical examination and treatment for: _____
- ☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
To be determined.
- ☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):
☒ (1) General Disability: ☐ Total ☒ (2) Specific Disability: ☐ Total
☐ (3) Wage Loss ☒ Partial ☒ Partial
- ☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of: _____
- 10a. At the time of the injury, the Claimant was paid weekly wages of \$Pending Form 20, and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:
None other than above.
- 11a. Further grounds or unusual aspects of claim:
Payment of all causally related medicals, payment of TTD, TPD, if applicable, and Permanency; CERIVCAL SPINE MRI ORDERED BY TREATING PHYSICIAN DR. CHARLES KANOS
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident:
SRMC, 101 E. Wood St, Sptbg; Pacolet Family Medicine, 7221 S. Pine St, Pacolet, SC; Regional Wound Healing Center, 101 E. Wood St, Sptbg; Carolina Neurology, 541 Floyd Rd, Sptbg; Steadman Hawkins, 200 Patewood Dr, Gville; Proaxis Therapy, 727 SE Main St, Simpsonville, SC; SE Neuro & Spine, 109 Doctors Dr, Gville
- 11c. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe: _____
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☐ 13a. I am filing a claim. I am not requesting a hearing at this time.
- ☐ 13b. I am requesting a hearing. A \$25 fee is required.
14. Estimated time needed for hearing: 30 minutes

verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature: [Signature] Attorney for Claimant: hodgecharles@hotmail.com Date: 7/16/13
Title: _____ Email: _____
NCC Form # 50 Employee's Notice of Claim and/or Request for Hearing
Revised 9/07



WCC File #: 1211338
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: Keith Case SSN: 247-59-4639 Employer's Name: J Crawford Logging Inc
Address: 573 Goldmine Rd. Address: 183 Estes Road
City: Pauline State: SC Zip: 29374 City: Union State: SC Zip: 29379
Home Phone: 864 316-2620 Work Phone: _____ Insurance Carrier: PTFSIF
Date of Injury: 8/27/2013
Preparer's Name: John W Rabb, Jr Law Firm: Allen Kopet Preparer's Phone #: 803 714-9606

Date of Injury or Illness: 8/27/2013 Estimated time for hearing: 45 minutes
Complete each information blank. Clearly specify when contentions are admitted in part and denied in part. The Employer/Carrier in answer to the claim, respectfully shows:

1. It is ☒ **Admitted** ☐ **Denied** the employee sustained an injury or illness on or about the date set forth in the Form 50. The reasons for denial are:
Employer admits right knee only, all other body parts denied.
2. It is ☒ **Admitted** ☐ **Denied** both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:
3. It is ☒ **Admitted** ☐ **Denied** the relationship of employer and employee existed at the time in question. The reasons for denial are:
4. It is ☒ **Admitted** ☐ **Denied** at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:
5. It is ☒ **Admitted** ☐ **Denied** notice of injury was given the employer. The reasons for denial are:
6. It is ☐ **Admitted** ☒ **Denied** the employee ☐ **Needs** ☐ **Is Entitled to Additional** medical care as a result of injury or illness. The reasons for denial are:
Claimant has been treated and released for his right knee injury.
7. It is ☐ **Admitted** ☒ **Denied** the employee is entitled to temporary total disability for the period(s) of : Claimant has been released and is at MMI.
8. It is ☐ **Admitted** ☒ **Denied** the employee is permanently disabled. The reasons for denial are:
To be Determined.
9. It is ☐ **Admitted** ☒ **Denied** the employee has serious disfigurement.
10. It is contended that an average weekly wage of \$ 635.94 applies, according to attached Form 20 as provided by law.
11. Further contentions, grounds of defense, or unusual aspects are:
See attached.

- ☐ **Mediation**
- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
 - ☐ b. Mediation is required pursuant to Reg. 67-1802.
 - ☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
 - ☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature: [Signature] Attorney: jrabb@allen-kopet.com Title: _____ Email: _____ Date: 7/26/2013

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Refer to R. 67-1801 for mediation. Questions about the use of this form may be directed to the Commission's Judicial Department at 803-737-5675 or judicial@wcc.sc.gov or mediation@wcc.sc.gov. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

Claimant has been treated and released for the right knee injury. Claimant complained of low back pain so Carrier set up an evaluation with Dr. Kanos for causation purposes(see Consent Order). Lumbar MRI was read as unremarkable with no stenosis. No treatment was recommended. Claimant now wants approval for a cervical MRI, which is denied. This is a right knee claim.

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500
 Post Office Box 1715
 Columbia, South Carolina 29202-1715
 (803) 737.5675 www.wcc.sc.gov



WCC File #: 1211338

Carrier File #: _____

Carrier Code #: _____

Employer FEIN #: _____

Claimant's Name: Keith Case SSN: 247-59-4639Address: 573 Goldmine RoadCity: Pauline State: SC Zip: 29374Home Phone: 864 316-2620

Work Phone: _____

Preparer's Name: John RabbLaw Firm: Allen-KopetEmployer's Name: J Crawford Logging IncAddress: 183 Estes RoadCity: Union State: SC Zip: 29379Insurance Carrier: PTFSIFPreparer's Phone #: 803 714-9606The date of injury reported on Form 12A is: 8/27/2013 (m/d/yyyy)**Check appropriate section(s). The Employer's Representative requests a hearing to:**

- I. ☒ **Stop payment of compensation.** Claimant has reached maximum medical improvement and Claimant continues to receive temporary compensation payments. The employer's representative requests a hearing pursuant to § 42-9-260(D) to stop payment of temporary compensation. A hearing requested pursuant to this section must be held within sixty days of the date of the request.

Claimant reached maximum medical improvement on 5/9/2013 (m/d/yyyy) (copy of medical report must be attached).Compensation payments are current as of 7/28/13 (m/d/yyyy) and shall continue until otherwise ordered or until Form 17 is signed by the claimant.A Form 17 was offered and refused on 7/26/2013 (m/d/yyyy).

- II. ☐ **Address suspension, termination, or reduction of temporary disability payments for any cause.**

☐ a. At any time pursuant to § 42-9-260(E).☐ b. After the one-hundred-fifty day period has expired pursuant to § 42-9-260(F), R.67-505 and R.67-506.

The basis for the termination/ suspension is _____

- III. ☐ **Determine if compensation is due** pursuant to § 42-9-10, § 42-9-20 or § 42-9-30 and, if so, in what amount, based on the following grounds:

Claimant reached maximum medical improvement on _____ (m/d/yyyy) (copy of medical report must be attached).

- IV. ☒ **Request Credit for Overpayment of temporary compensation pursuant to § 42-9-210.**

- V. ☐ **Determine amount of compensation for claims involving a fatality.**

☐ a. Payment of unpaid balance of compensation when employee dies pursuant to § 42-9-280.☐ b. Amount of compensation for death of employee due to accident pursuant to § 42-9-290.

- VI. ☐ **Mediation**

☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.☐ b. Mediation is required pursuant to Reg. 67-1802.☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Failure to respond pursuant to Reg. 67-208 B in writing or by submission of a Form 22 may result in ordered mediation pursuant to Reg. 67-1801 B.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Charlie Hodges, Esqaddress PO Box 2765, Spartanburg SC 29304on the 26 day of July, 2013.by ☒ first class postage ☐ certified mail ☐ personal service. A \$25.00 filing fee and updated Form 18 is required.Preparer's Signature: John Rabb

Attorney

Title

jrabb@allen-kopet.com

Email

Date

Questions about the use of this form should be directed to the Judicial Department at 803-737-5675, or judicial@wcc.sc.gov or mediation@wcc.sc.gov
 Refer to Regulations 67-211, 67-504, 67-505, 67-506; and 67-510.



Claimant's Name: Keith Case
Address: 573 Goldmine Road
City: Pauline State: SC Zip: 29374
Home Phone: (864) 316-2620 Work Phone: () -
Preparer's Name: Charles J. Hodge

Employer's Name: J. Crawford Logging, Inc.
Address: 183 Estes Road
City: Union State: SC Zip: 29379
Carrier: Palmetto Timber Fund
Preparer's Phone #: (864) 585-3873

claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$423.98 2. AWW: \$635.94 Date of Injury: 8/27/12
3. Type of injury and body part(s): Spine & Both lower extremities
4. Facts in controversy: Payment of past, present, and future medical expenses, payment of TTD, TPD if applicable
And Permanency; TREATMENT FOR SPINE INCLUDING 2ND MRI ORDERED BY DR. CHARLES KANOS
5. Legal issues involved: Same as #4 above.
6. Unusual aspects: None
7. Witnesses (designate if expert):* Close friend or family member
8. Exhibits: See APA submissions
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See APA Submissions; Deposition of Dr. Charles Kanos
10. Name, address, and specialty, if any, of the treating physician: Spartanburg Regional Medical Center; Pacolet Family Medicine;
Regional Wound Healing Center; Steadman Hawkins; Proaxis Therapy; Carolina Neurology; SE Neuro & Spine Institute
11. Impairment rating(s); body part(s); physician and date of opinion: 10% impairment to the left lower extremity; 2% impairment to
the right lower extremity; 5% impairment to the spine; by Dr.
Carol Kooistra on 12/27/12
12. I am amending my Form 50/51 in the following manner: _____

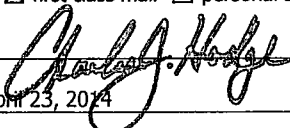
Mediation

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is required pursuant to Reg. 67-1802.
☐ c. Mediation is requested by consent of the Parties pursuant to Reg. 67-1803.
☐ d. Mediation has been conducted by a duly qualified mediator and resulted in an impasse.

Questions regarding mediation may be submitted to mediation@wcc.sc.gov.

Verify the contents of this form are accurate and true to the best of my knowledge.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to: SC Workers' Compensation Commission and Mr. John W. Rabb, Jr., on the 4th day of September, 2013, by ☒ first class mail ☐ personal service ☐ certified mail.

Signature: 

Email: hodgecharles@hotmail.com

Date of hearing: April 23, 2014

Time needed for hearing: 30 minutes

Questions about the use of this form should be directed to the Jurisdictional Commissioner. Refer to Regulations 67-204 through 67-211 and Regulations 67-601 through 67-615; as well as Regulation 67-1801. File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports. * Commissioners reserve the right to admit expert witnesses at hearings.



Claimant's Name: Keith Case Employer's Name: J Crawford Logging, Inc.
Address: 573 Goldmine Road Address: 183 Estes Road
City: Pauline State: SC Zip: 29374 City: Union State: SC Zip: 29379
Home Phone: 864 316 2620 Work Phone: _____ Carrier: PTF SIF
Preparer's Name: John W Rabb Preparer's Phone #: 803 714 9606

A claim for workers' compensation benefits is made based on the following grounds:

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$423.98 2. AWW: \$ 635.94 Date of Injury: 8/27/12
3. Type of injury and body part(s): Both lower extremities, alleged hip and back.
4. Facts in controversy: Both lower extremities are admitted. Claimant is still treating with authorized physician and PT and is not at MMI. Claimant is now alleging hip and back pain and requesting treatment.
5. Legal issues involved: Same as above.
6. Unusual aspects: none
7. Witnesses (designate if expert):* Christine @ Proaxis Therapy
8. Exhibits: Deposition of Dr Folk MD, scheduled for April 18th.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
All medicals submitted at prior hearing along with updated PT notes attached with Notice of Witnesses.
10. Name, address, and specialty, if any, of the treating physician: Dr Jason Folk MD
11. Impairment rating(s); body part(s); physician and date of opinion: NA
12. I am amending my Form 50/51 in the following manner: _____

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: [Signature]

Email: jrabb@allen-kopet.com

Date of hearing: April 24th

Time needed for hearing: 30 minutes

On behalf of ☐ Claimant ☒ Employer

File this form and proof of service on the opposing party according to R.67-611. Do not send medical reports.

* Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

KEITH L. CASE,

Employee

-VS-

J. CRAWFORD LOGGING, INC.,

Employer

and

PALMETTO TIMBER FUND,

Carrier

WCC FILE NO.
1211338

Pursuant to Notice of the Workers' Compensation
Hearing taken on the 23th day of April 2014, heard
before the Honorable T. Scott Beck, and commencing at
the hour of 2:50 p.m. in Columbia, South Carolina.

Tatum Court Reporting
P.O. Box 248
Edgefield, SC 29824
706.207.5483
ctatumcr@gmail.com

APPEARANCES

Charles J. Hodge, Esq.
Hodge & Langley Law Firm, PC
PO Box 2765
Spartanburg, SC 29306
864.585.3873
hodgecharles@hotmail.com
REPRESENTING THE EMPLOYEE

John W. Rabb, Jr., Esq.
Allen Kopet & Associates, PLLC
PO Box 1481
Columbia, SC 29202
803.714.9606
jrabb@allen-kopet.com
REPRESENTING THE EMPLOYER/CARRIER

ALSO PRESENT

Mike Hainley
Claims Manager

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EXHIBITS

<u>NUMBER</u>	<u>DESCRIPTION</u>	<u>PAGE</u>
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Defendant Exhibit No. 1	Deposition Transcript Of Dr. Folk	4

LEGEND OF THE TRANSCRIPT

dashes [--] intentional or purposeful interruption
 [ph] denotes phonetically written
 [sic] written as said

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P R O C E E D I N G S

(Whereupon, the Deposition Transcript of Dr. Kanos was premarked Claimant's Exhibit No. 1.)

(Whereupon, the Deposition Transcript of Dr. Folk was premarked Defendant's Exhibit No. 1.)

COMMISSIONER BECK: Today's date is April 23, 2014. This is Workers' Compensation File Number 1211338. Claimant in this matter is *Keith Case*, represented today by Attorney Charlie Hodge. The Employer is *J. Crawford Logging, Inc.*, Carrier is the *Palmetto Timber Fund*, they are both represented today by Attorney John Rabb. Date of accident in this matter is August 27, 2012. Average weekly wage is \$635.94, yielding a compensation rate of \$423.98. We are here today on Defendant's Form 21, as well as Claimant's Form 50. I've received APAs from the Claimant in this matter, as well as the deposition testimony of Dr. Kanos, which has been marked as Claimant 1, the deposition testimony of Dr. Folk, marked as Defendant's 1. There was also an interim order in this matter freezing the record on September 19, 2013 with the exception of the

1 Kanos deposition.

2 It's been brought to my attention there was an
3 MRI conducted on April 17 of 2014, which would be
4 excluded based on that ruling. However, the
5 parties have stipulated to allow the admission of
6 that report.

7 Are there any objections to APAs,
8 jurisdiction, venue, or any other matter,
9 Mr. Hodge?

10 **MR. HODGE:** None from the Claimant,
11 Commissioner.

12 **COMMISSIONER BECK:** Mr. Rabb?

13 **MR. RABB:** None, Commissioner, other than the
14 14B that I'd mentioned earlier, which is attached
15 to our --

16 **COMMISSIONER BECK:** That's attached to your
17 pre-hearing brief?

18 **MR. RABB:** Correct.

19 **COMMISSIONER BECK:** All right. Without
20 objection the Commission File becomes a part of the
21 record with the exception of self-serving documents
22 and un-stipulated medical reports.

23 Also during the pre-hearing conference the
24 respective positions of both the parties was
25 discussed. From the standpoint of the Claimant.

1 Claimant is here seeking a finding of
2 compensability to his neck, asserts that he is in
3 need of additional medical treatment for his neck.
4 While he agrees that he is at MMI for the right
5 knee, takes the position that permanency is
6 premature until the neck is treated and released.
7 And further argues that pursuant to Ellison, that
8 he is entitled to have his temporary total
9 disability benefits continue.

10 Mr. Hodge, anything in addition to that you'd
11 like to get on the record or any other matter that
12 we're here to litigate today, sir?

13 **MR. HODGE:** No, sir, your Honor.

14 **COMMISSIONER BECK:** All right. With regard to
15 the Defendant's position. They assert that the
16 Claimant is at maximum medical improvement on
17 May 9, 2013, that the injury is limited to the
18 right leg only, based upon the 14B of Dr. Folk,
19 that the Claimant is entitled to an award of
20 permanent partial disability to his right leg only.
21 They are seeking credit for temporary total
22 disability benefits back to 5/9/13, assert that the
23 Claimant is not entitled to any future medical
24 care, and deny any injury related to this accident
25 to the Claimant's cervical.

1 Mr. Rabb, anything in addition to that with
2 regard to the Defendant's position you'd like to
3 get on the record or any other matter we're here to
4 litigate?

5 MR. RABB: I believe that's our position.
6 Thank you, Commissioner.

7 COMMISSIONER BECK: Mr. Hodge, you may call
8 your first witness, please.

9 MR. HODGE: Your Honor, we call Keith Case.

10 ****

11 Whereupon,

12 KEITH L. CASE,

13 having been first duly sworn,
14 was examined and testified as follows:

15 ****

16 COMMISSIONER BECK: Please state your full
17 name for the record.

18 WITNESS: Keith Lee Case.

19 COMMISSIONER BECK: Mr. Hodge.

20 DIRECT EXAMINATION

21 BY MR. HODGE:

22 Q. Keith, you're five foot ten?

23 A. Yes, sir.

24 Q. How much you weigh now?

25 A. I weigh between 170 and about 185.

1 Q. Okay. In the past did you weigh more?

2 A. Yes, sir.

3 Q. What was your weight before you got hurt?

4 A. About -- well, about 240 to 280, is what I
5 averaged.

6 Q. Okay. And you're down to in the 180 --

7 A. Yes, sir.

8 Q. -- to 185 range? What do you attribute your weight
9 loss to?

10 A. Me being hurt and the pain I'm in.

11 Q. Okay. You and Shannon are married?

12 A. Yes, sir.

13 Q. You have six children?

14 A. No, we have seven.

15 Q. Seven children, excuse me. Date of birth 6/9/71?

16 A. Yes, sir.

17 Q. How old are you now?

18 A. Forty-two.

19 Q. In terms of education, did you get a GED?

20 A. Yes, sir.

21 Q. Last grade of school, was that the 11th grade?

22 A. Yes, sir.

23 Q. All right. Do you have any other education?

24 A. Well, I have the seminary from where I went through
25 Casey Creek Seminary for preaching.

1 Q. Okay. Did you get some kind of certificate or
2 something?

3 A. I lost all that in the fire. Like I told -- as I
4 told Rabb, I lost that in the fire. I have none of
5 that.

6 Q. Okay. Are you -- have you ever preached for money,
7 like, you know, going to places --

8 A. I usually receive money when I preach, but as far
9 as doing it for a living, no, sir.

10 Q. Have you been doing anything for a living since you
11 got hurt?

12 A. No, sir.

13 Q. Your previous work history. You worked at Williams
14 Brothers, what was that?

15 A. That was a chip hauling outfit. And I would climb
16 up and down the trailer, and I would tarp the
17 trailer and rake the chips down, and then I would
18 climb down the ladder and get off, and then I would
19 tarp the trailer, and I would leave the yard with
20 the load.

21 Q. Okay. And Randolph?

22 A. Randolph was a dump truck outfit.

23 Q. What did you do for them?

24 A. I drove for them. I hauled gravel and sand to
25 various concrete places.

1 Q. Okay. McKinney Brothers?

2 A. I hauled pulpwood. I would tarp the logs -- I
3 mean, I would strap the logs down. I would trim
4 the tree with the trim saw, and I would take and
5 use the chainsaw on the backside. And they was
6 times I would lift at excess of 50 pounds to move
7 stuff out of the way so I could leave.

8 Q. All right. You've been with Crawford Logging for
9 several months before this injury, is that right?

10 A. Yes.

11 Q. What did you do for Crawford Logging?

12 A. I hauled pulpwood.

13 Q. Okay. If you're more comfortable you can --

14 A. I don't know which way to turn.

15 Q. Okay. So tell me about the physical duties
16 required for that Crawford Logging job?

17 A. Basically the same thing as McKinney Brothers. I'd
18 have to go in there, and they'd load the wood up,
19 I'd have to strap it down, then I would trim it up
20 -- I'd trim it up with the chainsaw, trim saw, then
21 I would move stuff out of the way -- make sure it
22 was out of the way. Then I would I'd leave the
23 woods with a load and go to the pulpwood yard,
24 unstrap it. I'd climb in and out of the truck all
25 the time, and I would bend over and stuff with no

1 problems or nothing.

2 Q. Okay. Now, I want to talk to you about August 27,
3 2012, that's when you got hurt, right?

4 A. Yes, sir.

5 Q. All right. Tell us what happened.

6 A. I was coming down off the logs and I grabbed a hold
7 of a log and it rolled over and it grabbed my left
8 leg. I pushed off, and when I did I twisted my
9 body and I slammed down onto the tractor frame and
10 it put a hole in my left leg. And I slammed on my
11 right knee. And then when I went down face forward
12 I had my hard hat on, and when I did it slammed
13 down and it crunched my neck down and it jolted my
14 back.

15 Q. How many feet did you fall?

16 A. Between eight and eleven feet.

17 Q. Okay. Now, this -- and I think we have those
18 pictures in there --

19 MR. HODGE: What I'm referring to now is --

20 COMMISSIONER BECK: One fifty-two, one fifty-
21 three.

22 MR. HODGE: Yes, sir. I think it starts --
23 151 is where mine start.

24 Q. But so we'll kind of understand about the --

25 A. That's the left leg.

1 Q. Okay. And that's the one that got the hole knocked
2 in it?

3 A. Yes, sir.

4 Q. So we're talking about kind of a tractor that could
5 haul 18-wheeler, but it hauls a flatbed?

6 A. No, it's a tractor. Pulpwood -- pulpwood trailer.

7 Q. Okay. The trailer --

8 A. The tractor is a regular tractor, it can haul any
9 kind of trailer.

10 Q. That's what I'm saying --

11 A. This particular day I had a pulpwood trailer.

12 Q. Pulpwood trailer, is that kind of a flat --

13 A. No, this has standards on it. It's a hollow
14 trailer and it has standards on the side, and then
15 they fill it with wood.

16 Q. I see. And how high up do these standards go?

17 A. Fifteen -- well, no, actually, about thirteen feet,
18 'cause they can't go above the standards with a
19 load of wood.

20 Q. Thirteen feet. And that day, when you got hurt,
21 how much wood was on there?

22 A. About three quarters of it, 'cause they done took a
23 bout off.

24 Q. Okay. And so what position in this apparatus of
25 this trailer are you in when the log rolls over on

1 you?

2 A. Middle of the trailer when it rolled over and
3 grabbed my leg and I pushed off.

4 Q. Okay. Now let's talk about all the parts of your
5 body that hit. Obviously, we know your leg did.
6 What other parts of your body hit?

7 A. My right knee hit, my left hip's out of whack, it's
8 messed up, I hit -- I slammed down onto my elbow,
9 there's a scar on my elbow, they x-rayed it. My
10 shoulder is hurt, and I hit my neck -- when I hit,
11 like I said, my neck on down hurts.

12 Q. And when you landed did you --

13 A. Yes, sir.

14 Q. -- kind of duck your head at the same time?

15 A. No -- well, no, I just -- I was thrown down, I
16 didn't have time to duck or do nothing. I was just
17 -- when I released and hit I was just slammed -- I
18 slammed down on it.

19 Q. Dr. Kanos references in his deposition that you had
20 numbness in your hips and both legs --

21 A. Yes, sir.

22 Q. -- to the knees --

23 A. Yes, sir.

24 Q. -- after the fall?

25 A. Yes, sir, I told them that at the hospital. As I

1 recall, I told them at the hospital that I hurt --
 2 I told them I hurt from my neck down. I was
 3 bruised from my neck down to my -- head to toe,
 4 basically, I was bruised.

5 Q. Now, in fairness, we've seen all these records and
 6 there's not a whole lot of mention about any neck
 7 pain, most of it's in the low back, is that right?

8 A. Yes, sir.

9 Q. Okay. I want you to tell us, after you recovered,
 10 initially, from this big ole hole in your leg, tell
 11 us about the back and the legs and how that
 12 progressed.

13 A. Slowly. It's the -- the upper back's worse now
 14 than it was.

15 Q. Okay. But let's talk about the lower back first --
 16 or the legs, okay?

17 A. The legs hurt and the lower -- the lower back, it
 18 hurts too, 'cause I lay at nighttime, if I move a
 19 certain way it'll crunch and crack.

20 Q. Did you begin to notice numbness in --

21 A. Soon as I fell. When I went to Dr. Bruton I told
 22 Dr. Bruton I was numb on the outside. And if I'm
 23 correct, they sent me for a MRI on my blood veins
 24 to see if I had a blood clot.

25 Q. Okay. But nobody ever checked your neck out?

1 A. No, sir.

2 Q. All right.

3 A. No, sir. Dr. Bruton told me --

4 **MR. RABB:** Objection to what Dr. --

5 **COMMISSIONER BECK:** Sustained.

6 Q. Let's not talk about what Dr. Bruton said.

7 A. Yes, sir. I'm sorry.

8 Q. At some point we know you got to Dr. Kanos.

9 A. Yes, sir.

10 Q. And to the Carrier's credit, they allowed you to be
11 evaluated for your low back.

12 A. Yes, sir.

13 Q. Because you have this numbness and all that
14 business down your legs.

15 A. Yes, sir.

16 Q. You understand that the MRI of the lumbar spine
17 didn't show anything that would explain those kind
18 of symptoms?

19 A. Yes, sir.

20 Q. Your second visit to Dr. Kanos, do you remember
21 when he did some tests on you?

22 A. Yes, sir. He told me --

23 **MR. RABB:** Objection to what he told him.

24 **COMMISSIONER BECK:** Sustained.

25 Q. Okay. Don't talk about what he told you. But

1 after he examined you did he recommend a cervical
2 MRI?

3 A. Yes, sir. He told me I needed --

4 **MR. RABB:** Objection to what he told him.

5 Q. Okay. Try not to say that, okay? It's a legal
6 thing. Just listen to my question and --

7 A. Sorry.

8 Q. -- just answer my question. That's okay.

9 So we've been in this fuss about the cervical
10 MRI, but you finally got one, is that right?

11 A. Yes, sir.

12 Q. Now, you're walking with a crutch?

13 A. Yes, sir.

14 Q. What happens if you don't walk with that crutch?

15 A. If I go like to the grocery store, or go to Home
16 Depot, somewhere like that and I don't have the
17 crutch the pain gets so bad I have to ride around
18 in a wheelchair.

19 Q. Do you have pain everyday?

20 A. Yes, sir.

21 Q. What does your pain feel like?

22 A. About a six.

23 Q. Okay. But what is it -- in a word picture, what --

24 A. Like the upper part where my neck is it's like
25 somebody's got a needle stuck in the middle of my

1 back and it hurts constantly.

2 Q. Okay. But the problems are still your legs?

3 A. Yes, sir, they's problems in my legs, too. My
4 knees -- if I stand on my leg -- like last night I
5 stood up, probably, two minutes and my right knee
6 stings so bad I can't stand it.

7 Q. You came down here in a car?

8 A. Yes, sir.

9 Q. Well, how many times did you have to --

10 A. We stopped three times.

11 Q. Who drove?

12 A. Shannon, 'cause I have trouble driving right now.

13 Q. Okay. Well, what have you been able -- what would
14 you have been able to do work-wise from the time
15 you got hurt up to now?

16 A. Nothing.

17 Q. Do you know how to do anything else other than this
18 pulpwood stuff?

19 A. No, all I do is drive.

20 Q. Okay. How long can you drive now or do you drive?

21 A. No, I don't drive right now.

22 Q. So you can't drive?

23 A. No, sir.

24 Q. Haven't been able to since?

25 A. No, sir. And my left leg hurts, too.

1 Q. Do you want to get your neck fixed?

2 A. Yes, sir.

3 Q. Are you ready to get back to work?

4 A. Yes, sir.

5 MR. HODGE: I think that's all I have.

6 COMMISSIONER BECK: Mr. Rabb.

7 CROSS-EXAMINATION

8 BY MR. RABB:

9 Q. Mr. Case, I just have a few questions for you. How
10 old are your children?

11 A. Okay. Fifteen, fourteen, twelve, ten, eight,
12 Kara's three, and then a newborn, he's six months.

13 Q. So ya'll just had another child --

14 A. Yes, sir.

15 Q. -- recently, is that correct?

16 A. Yes, sir.

17 Q. And you have a three year old?

18 A. Yes, sir, we had her when I went to work at Jimmy
19 Crawford.

20 Q. Okay. Can we see what your left leg or right leg
21 looks like now? Could you roll it up and let the
22 Commissioner see? I know we had some pictures of
23 what it looked like earlier.

24 A. (Complies.) There's my right leg. It's ripped
25 open and if you feel right there they's damaged

1 tissue all in there.

2 Q. Just let us just take a look at it. Can we look at
3 your left leg?

4 A. (Complies.) It's all the way up through here
5 (indicating).

6 Q. Down to the left of your calf is where we're
7 talking about here, and then on across there's a
8 little area there?

9 A. That's a scratch right there (indicating).

10 Q. Oh, okay. So mostly what we're talking about is
11 right here a little above your calf on the left
12 leg?

13 A. I also got -- I also had an infection in it, if you
14 remember, where they had to go in there and send me
15 to the Wound Center and it was actually all the way
16 up through here on the inside (indicating).

17 Q. Okay. Thank you. You're not having any problems
18 with either one of your arms, are you?

19 A. (No response.)

20 Q. Your arms are okay, you're not having any issues
21 with your arms, are you?

22 A. Well, if I do like this and stuff (demonstrating)
23 it hurts my back, but my arms, no, sir.

24 Q. You're not having any kind of pain running down
25 your arms or --

1 A. I have pain in my neck. If I sit like this for so
2 long I'll have tingling that runs down my arms.

3 Q. Do you recall -- go ahead.

4 A. Oh, I'm sorry.

5 Q. Do you recall telling Dr. Kanos at your last visit
6 that you were not having any problems with your
7 arms?

8 A. Yes, sir.

9 Q. Okay. Do you have a valid drivers license, sir?

10 A. Yes, sir, I've got a CDL, Class A, with a tanker --
11 well, no, a tanker -- well, no, a tanker
12 endorsement on it.

13 Q. CDL with a tanker endorsement?

14 A. Yes, sir.

15 Q. Okay. Do you know when it was last renewed?

16 A. They suspended it. Oh, you're talking about the
17 license? License was last renewed -- I don't know.
18 If you'll give me a second I'll get it. It was
19 last renewed -- it expires 2015, so it would have
20 been 2010, if you want to look at it.

21 Q. That's fine. That's your regular drivers license?

22 A. No, this is Class A CDL.

23 Q. That's your CDL?

24 A. Yes, sir.

25 Q. Okay. So it won't renew again until when?

1 A. 2015.

2 Q. And when was it last renewed?

3 A. 2010.

4 Q. 2010?

5 A. If I'm correct, CDLs are every -- well, hang on,
6 let's see. Let's see when it shows here. Hang on.
7 Yeah, it's 2010.

8 **WITNESS:** Is there any way I can step out and
9 get a drink of water?

10 **MR. RABB:** I don't have any more questions,
11 Commissioner.

12 **COMMISSIONER BECK:** Mr. Hodge, anything
13 further?

14 **MR. HODGE:** Nothing further.

15 **COMMISSIONER BECK:** Any other witness?

16 **MR. HODGE:** No, sir.

17 **COMMISSIONER BECK:** Any witnesses on behalf
18 the Defendants?

19 **MR. RABB:** No, sir, other than the medical and
20 the depositions are what we'll be relying on,
21 Commissioner.

22 **COMMISSIONER BECK:** All right. That will
23 conclude this proceeding.

24 *****

25 (Whereupon, the hearing concluded at 3:08 p.m.)

STATE OF SOUTH CAROLINA
CERTIFICATE

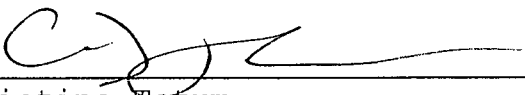
Be it known that I, Christine Tatum, a Professional Court Reporter and Notary Public, did hear the matter of **Keith L. Case -vs- J. Crawford Logging, Inc.**, Workers' Compensation File No. 1211338 on, Wednesday, April 23, 2014, in Columbia, South Carolina, before the Honorable T. Scott Beck;

That the witness(s) were duly sworn under pains and penalties of perjury to testify to the truth, the whole truth, and nothing but the truth;

That the foregoing pages constitute a true and accurate transcription of the testimony given at that time and place aforesaid to the best of my skill and ability;

I further certify that I am not counsel or kin to any of the parties to this cause of action, nor am I interested in any matter of its outcome.

In Witness whereof, I have hereunto set my hand this 23rd Day of April 2014.



Christine Tatum
Notary Public For South Carolina
My Commission Expires December 29, 2021

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1211338

KEITH L. CASE,	)	
	)	FULL COMMISSION HEARING
CLAIMANT,	)	PANEL B
vs.	)	
	)	COMMISSIONER BARDEN
CRAWFORD LOGGINS,	)	COMMISSIONER WILKERSON
INCORPORATED,	)	COMMISSIONER CAMPBELL-CHAIR
	)	
AND	)	
	)	
PALMETTO TIMBER FUND,	)	
	)	
CARRIER,	)	
DEFENDANTS.	)	
	)	

 **COPY**

THE WORKERS' COMPENSATION HEARING, TAKEN BEFORE
CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR THE
STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF
2:01 P.M., TUESDAY, NOVEMBER 18, 2014, SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION, 1333 MAIN STREET,
COLUMBIA, SOUTH CAROLINA 29202.

**CORA ELLIS BRUTON
COURT REPORTER
131 BROWNING COURT
LEXINGTON, SOUTH CAROLINA 29073
803-397-0189**

APPEARANCES**FOR THE CLAIMANT**

CHARLES J. HODGE, ESQUIRE
 HODGE LAW, PC
 POST OFFICE BOX 2765
 SPARTANBURG, SOUTH CAROLINA 29304-2765
 864-585-3873

FOR THE DEFENDANT

JOHN W. RABB, ESQUIRE
 ALLEN, KOPET & ASSOCIATES. PLLC
 POST OFFICE BOX 1481
 COLUMBIA, SOUTH CAROLINA 29202
 803-714-9606

REPORTED BY

CORA ELLIS BRUTON
 COURT REPORTER
 131 BROWNING COURT
 LEXINGTON, SOUTH CAROLINA 29073
 803-397-0189

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CERTIFICATE.	16

EXHIBITS

(No Exhibits Proffered)

1 THE COURT REPORTER: Today is November 18, 2014.

2 This is South Carolina Workers' Compensation Case
3 Number 1211338. This is the case of Keith L. Case,
4 Claimant, versus Crawford Logging, Incorporated,
5 Employer and Palmetto Timber Fund is the Carrier.

6 The Appellant is the Claimant, represented by
7 Attorney Charles J. Hodge. The Respondent is
8 represented by Attorney John W. Rabb.

9 Each side is allowed ten minutes for oral
10 argument and the Appellant three minutes in reply.
11 You are requested to argue the grounds of exception
12 and stay within the record.

13 THE COURT: Mr. Hodge.

14 BY MR. HODGE: May it please the Commission?
15 It's a pleasure to be with y'all today. You know, it
16 occurs to me when I think about what we do I think
17 we're dot connectors and as -- as a Commissioner, as a
18 professional in this workers' compensation profession
19 it's important for us to connect the dots to gain the
20 whole picture. Now in this case, Keith Case was a
21 logger with a limited education, he's got seven kids
22 and he fell off 11 feet; he fell off of a logging
23 trailer. He landed on his -- his leg, he crunched his
24 neck, he landed on his elbow and he was hurt bad.
25 From the get-go he complained of numbness in the lower

1 extremities and that's really important in this case.
2 The leg was the most visible injury. It required I
3 think at least two surgeries. So that was the
4 predominant aspect from the get-go and the -- the case
5 was admitted by the Carrier and temporary total
6 benefits were paid. Because Mr. Case continued to
7 complain of this leg numbness and this back pain he
8 was referred to Dr. Charles Kanos. Kanos is a
9 Neurosurgeon in Greenville. So the first time Dr.
10 Kanos sees him he gets, again, the history of numbness
11 in the lower extremities and he said, well, and it's
12 logical, he's got some back pain complaints, let's do
13 an MRI of the lumbar spine. The Carrier authorized
14 it, does the MRI of the lumbar spine and there's
15 really not a whole lot of pathology. Goes back to Dr.
16 Kanos, on his second visit Dr. Kanos does a test; it's
17 called Hoffman's Test. And this Hoffman's Test comes
18 back positive and it's an important test and it's
19 really, I guess, other doctors can do it, but it's a
20 neurosurgical test. Because you're looking for what's
21 causing this -- this weirdness in the lower
22 extremities. Lumbar spine MRI is normal. And when
23 that happens you immediately go to let's look at the
24 neck, let's look at the cervical spine. So that's
25 where we got in the fuss, the Carrier didn't want to

1 do a cervical MRI because my client had no complaints
2 of neck pain. Well, the law in this state is the
3 Claimant doesn't have to diagnose himself. In fact,
4 if the Claimant misdiagnoses himself the Commission,
5 through our Supreme Court, cannot determine that
6 that's substantial evidence. So Dr. Kanos orders the
7 cervical MRI, it's denied, we go in front of the
8 hearing with Commissioner -- the Commissioner --
9 single Commissioner. Single Commissioner says, well,
10 I'll tell you what, I'm going to let you go take Dr.
11 Kanos' deposition and then you come back to me, but
12 I'm closing the record. So -- and -- and by the way,
13 I'm looking at this guy for this whole two years.
14 I've got a feeling I know what's going on. He goes
15 from 250 pounds to 180 pounds, he's hardly able to
16 walk. He uses the cane, he's getting worse and worse
17 day by day and I see it, and that's why I'm pursuing
18 this. I want to find out what's going on with this
19 guy's cervical spine. Well we go take Dr. Kanos'
20 deposition and I ask him the question, "Given all
21 these facts, given that he's got these symptoms, do
22 you believe to a reasonable degree of medical
23 certainty and most probably the need for the cervical
24 MRI is due to the fall?" And he says, "Yes." Well,
25 Johnny's a great lawyer and Johnny presents him with a

1 question worded in a different manner and to that one
2 question he says, "Well, I really can't say to a
3 reasonable degree of medical certainty." And that's
4 what the Commissioner hangs his hat on. In the
5 meantime, because I know what's going on with this
6 guy, I figured out a way to get him a cervical MRI and
7 to their credit to allow justice to happen, they let
8 this MRI in. And the MRI shows, guess what, spinal
9 cord impingement at not one level, but two levels.
10 Now I expect counsel to say well, the report says mild
11 and minimum. Spinal cord impingement with a guy who
12 has this constellation of symptoms whether it's
13 minimal, mild or whatever, it's like being a little
14 bit pregnant. You've either got it or you don't and
15 something's happening to this guy right before our
16 very eyes. So in the deposition with Dr. Kanos this
17 exchange occurs. "If a person has a cord injury does
18 it necessarily mean that that person has pain?" This
19 is found on page 20 of his deposition. Answer; "No."
20 And we know that cord injuries produce weird
21 sensations just like burn injuries. "You can't -- the
22 fact that the Claimant doesn't diagnose himself,
23 doesn't say he has neck pain does not mean he has --
24 doesn't have a cord injury from that fall. And by the
25 way, there's no other mechanism for his -- his

1 situation. No other evidence in the record except for
2 that fall to cause this problem. So a cervical MRI is
3 going to tell you the story if he's got a cord injury
4 or if he's got some significant disc injury?" Answer;
5 "That's right, I don't know if he's going to have a
6 cord injury." What I want to do is explain his
7 hyperflexia. And of course we know that that
8 hyperflexia is explained by the cord injury. And this
9 is -- is in response to that question, Mr. Rabb's
10 going to tell you, well, the doctor said, you know, he
11 didn't -- he couldn't answer his question to a
12 reasonable degree of medical certainty. So on page 16
13 in follow-up to that question; "And since the lumbar
14 didn't pan out, I found a new finding. It might have
15 been the neck all along. That's my logic, no more, no
16 less. Yeah, his paresthesia in his legs may have been
17 explained by the neck, something that based on the
18 mechanism of the injury we could have just missed it."
19 And in his deposition he goes on to talk about how
20 that's often the case. So we're dot connectors,
21 Commissioners, and what we've got to do is we've got
22 to take each piece of evidence, and that's what the
23 Order ignores. The Order ignores the findings of the
24 cervical MRI which fit right within what Dr. Kanos
25 said. Now, we didn't get a chance to go talk to Dr.

1 Kanos again because the single Commissioner closed the
2 record. Our purpose here is to connect the dots, get
3 the picture and find out what's really going on with
4 the guy. The constellation of his symptoms, falling
5 11 feet, landing on his face, crunching his neck,
6 losing from 240 pounds to 184 pounds. I'm not here
7 for -- it would have been simple to say okay, let's
8 just get a little impairment to the leg, let's take
9 our money and move on. I'm here because this guy's
10 got a neck injury and it was caused by this fall and
11 he's got seven kids and he doesn't have any other
12 means of -- of income. And what our duty here is
13 because workers' comp is a form of social legislation,
14 our burden here is not to place the burden on all
15 society as a whole, it's to remediate this problem and
16 it's to remediate it in the context of workers'
17 compensation. And so we're dot connectors. The
18 picture is clear. This man needs some justice, and
19 what he really needs is, he needs treatment for his
20 neck. We fix him, we can get him back on his feet.
21 And that's the purpose of this law. Thank you.

22 THE COURT: Thank you. Mr. Rabb.

23 BY MR. RABB: Good afternoon, Commissioners.

24 It's my pleasure to be here today on behalf of
25 Palmetto Timber Fund and the Employer in this matter,

1 J. Crawford Logging. Let me just go back in time just
2 from the beginning and go forward and I think that
3 will -- that will be very educational for us. Mr. --
4 Mr. Case was hurt on August the 27th of 2012 when he
5 fell and he injured his lower extremities. He injured
6 his lower extremities when he fell. The first time we
7 ever heard -- or anybody ever heard of him crunching
8 his neck or having any cervical issue or problem would
9 have been over ten months later, so that -- that
10 premise is undisputable. He was treated by, after the
11 fall, Pacolet Family Medicine treated him for a period
12 of time. Those APAs are in the record, there are no
13 complaints of any cervical issue or neck issue or no
14 description of his neck or a cervical problem after
15 this happened. He was treated at Stedman Hawkins for
16 six months; six months for his lower extremity by Dr.
17 Folk. Dr. Folk released him on July the 24th of 2012,
18 July 24th, 2012 Dr. Folk released him for his lower
19 extremity, gave him a three percent impairment to his
20 right leg. He's able to return to work without
21 restriction, no need for future medical care. That's
22 April 24th, 2012 -- excuse me, April 24th, 2013; I
23 apologize. April 2013 Folk releases him with a 14-B,
24 three percent, no restrictions, return to work, no
25 mention of a cervical complaint, no mention of a neck

1 injury, no mention of any symptomology whatsoever in
2 his neck at that time. Also went to PT for six weeks.
3 PT records, there's nothing there, okay? He's
4 referred by Dr. Folk to Dr. Charles Kanos not because
5 of a neck injury or cervical injury, because he's
6 having some lower back issues; that's in the record,
7 it's a lower extremity issue. He's having some lower
8 back issues. He goes and sees Dr. Kanos. We -- we
9 set that up, we agreed to do that. Dr. Kanos sees him
10 on May the 20th of 2013, so now we're on May 20, 2013,
11 nine months after the accident, lower back issues, we
12 sent him to Dr. Kanos and he reports May 20th of 2013
13 doesn't mention a thing about a cervical problem, neck
14 problem. When I fell I crunched my neck, nothing,
15 absolutely nothing. Lower back, we paid for an MRI,
16 it's negative, there's nothing there. Dr. Kanos says
17 in his report and in his deposition "No treatment is
18 indicated." He did a Hoffman's test on May the 20th,
19 2013 to test Mr. -- that Charlie was telling you about
20 and when he did it the first time it was negative.
21 That Hoffman's Test Charlie was talking -- it was
22 negative. He comes back July the 1st, 2013, over ten
23 months after the accident and for the very first time
24 anywhere in any medical record we see neck pain, the
25 first time; and then he does the Hoffman's Test and it

1 is positive at that point in time. So we do go take a
2 deposition and we do go back and forth asking Dr.
3 Kanos about it, but at the end of the day this is what
4 he said, and you can read the deposition. And I asked
5 him, I said, "Doctor, talking about the 11 months
6 post-accident, the Hoffman's Test was negative in May,
7 your notes indicate it was negative in May?" "Yes,
8 uh-huh." That was his response. "It's not present?"
9 "Right." "And suddenly it shows up two months later
10 and 11 months after the accident?" "Yes." "How can
11 you then make belief that it's all causally related to
12 the fall from 11 months ago?" Dr. Kanos' response; "I
13 can't say that to a reasonable degree of medical
14 certainty." "Okay." "Again, I cannot say in that
15 respect." That's Dr. Kanos' direct response to
16 whether he can relate this to the fall from 11 months
17 ago. You know, it is about connecting the dots, but
18 the dots have to be connected by law to a reasonable
19 degree of medical certainty; that's the law. Can't
20 just connect dots, it has to be done to a reasonable
21 degree of medical certainty. In this case what we
22 have is no history of a complaint to the neck until
23 over 11 -- over ten months later. We had a doctor,
24 neurosurgeon, who's given an opinion that says he
25 can't state to a reasonable degree of medical

1 certainty which is the legal standard; that the issue
2 that's come up in his neck is related to the fall from
3 11 months ago and it's their burden of proof. It's
4 their burden of proof, not -- not ours. They have to
5 establish by a preponderance of the evidence there's a
6 causal relationship. At best, and I don't subscribe
7 to this, I think -- I think the doctor was very clear
8 in the deposition, was very clear; but at best, giving
9 him the benefit of the doubt there is a contradiction
10 in terms of the neurosurgeon's responses to the
11 questions. I don't think there is; I think it's clear
12 if you read it, and that's what Commissioner Beck
13 thought. But in viewing it in their -- and
14 (inaudible) to the Claimant, there is perhaps some
15 contradiction in that. It's their burden of proof.
16 That's what the single Commissioner said, that they
17 don't -- they don't get to just kind of get close,
18 they have to establish by preponderance of the
19 evidence there was a causal relationship between the
20 fall and the issue that's now arisen in his neck; and
21 they didn't do it. There's no medical history to
22 document it and the -- and the neurosurgeon
23 specifically said, I can't link it up, guys. I can't
24 do it. The award to the leg was appropriate, it was
25 over three times what the 14-B said. I'm -- I'm not

1 sure if there was even an exception to that, but that
2 was the appropriate award, we believe, to the leg and
3 based on the evidence that was put in the record; and
4 I'm going to invite you to read the Claimant's
5 testimony in the record as well, because I believe
6 it's very telling. The lack of any medical
7 documentation whatsoever in the neurosurgeon's
8 deposition and the failure to establish causation by a
9 reasonable degree of medical certainty as required by
10 law, the single Commissioner did exactly what he
11 should have done, which is go, I can't order this,
12 there is not -- there is not sufficient evidence to do
13 it. And for that reason we would ask you to sustain
14 Commissioner Beck's opinion and award. Thank you.

15 THE COURT: Thank you.

16 MR. HODGE: All right. In -- in listening to
17 counsel it -- it sounds to me like he's making the
18 argument that it's the Claimant's fault that he didn't
19 diagnose himself. And of course, our Supreme Court
20 has been very clear that fault is not to be a part of
21 these kind of proceedings. In the case of McGuffin
22 versus Sangamo, 307 S.C. 184, 414 S.E. 2d, 162, it's a
23 1992 case, Chief Justice Toal held, and it was a
24 unanimous decision, that the workers' compensation
25 Claimant's own misdiagnosis of the cause of her back

1 pain did not constitute substantial evidence from
2 which the Commission could infer that the Claimant's
3 injury did not result from a work related accident as
4 the treating physicians testified. Page ten of Dr.
5 Kanos' deposition he says, "The test was not positive
6 when I saw him on May 20th, but it was positive when I
7 saw him on July 1st. I felt the cervical spine MRI
8 was most appropriate as it might have been the problem
9 all along. I might have been wrong just ordering the
10 lumbar MRI." And then at page 15, and this is
11 questions by Mr. Rabb. He says, "In terms of your
12 saying he had no upper extremity symptoms whatsoever?"
13 Answer; "And then the Hoffman's, no one's probably
14 checked for a Hoffman's other than me. It's the
15 neurosurgeon. I don't expect a family or whoever to
16 do it. I certainly don't expect Dr. Folk, a hip
17 doctor to do it. So with those symptoms my notes
18 really didn't indicate neck -- the mechanism of the
19 injury and it comes in hyperflexic I thought it was
20 all related at the time." So Commissioners, how are
21 we supposed to look at this law? I mean is this
22 supposed to be construed in favor of the injured
23 worker or not? Perhaps a remedy for you, and I
24 understand it might be a dilemma, but think about this
25 now. This guy's on society right now. No income,

1 seven kids, wife doesn't work outside the home, even
2 though she works a lot inside the home with seven
3 kids. What's the remedy? Simple remedy, send us back
4 to Dr. Kanos, take his deposition. Be real simple.
5 We've got the cervical MRI now, not that they paid for
6 it, but we got it and we know he's got cord
7 impingement. Let's go see what Dr. Kanos has to say
8 about that or put all the dots together because it
9 makes a clear picture and reverse the case and give
10 him the treatment for his neck that he needs. You've
11 got the ability and the power to make this right. I'm
12 going all the way up on this, it doesn't matter. I'm
13 going to get justice for this guy. He's entitled to
14 it. Thank you.

15 THE COURT: Thank you. That concludes this
16 proceeding.

17 The hearing concluded at 1:57 p.m.)
18
19
20
21
22
23
24
25

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)

CERTIFICATE

BE IT KNOWN THAT I TOOK THE FOREGOING
WORKERS' COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN
AND FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF 15 TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT THE TIME AND PLACE AFORESAID TO THE BEST OF MY SKILL AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 17TH DAY OF MAY,
2015.

CORA ELLIS BRUTON
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES DECEMBER 31, 2024

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1211338

EMPLOYEE/CLAIMANT: KEITH CASE

EMPLOYER: J. CRAWFORD LOGGING, INC.

INSURER: PALMETTO TIMBER FUND



COPY

DEPOSITION OF CHARLES C. KANOS, M.D.

PURSUANT TO NOTICE, THE WITHIN DEPOSITION OF
CHARLES C. KANOS, M.D. WAS TAKEN BY THE
EMPLOYER/INSURER ON THE 7TH DAY OF APRIL, 2014,
COMMENCING AT THE HOUR OF 4:49 P.M. AT THE OFFICES OF
SOUTHEASTERN NEUROSURGICAL AND SPINE INSTITUTE, 109
DOCTORS DRIVE, GREENVILLE, SOUTH CAROLINA, ATTENDED BY
COUNSEL AS FOLLOWS:

**JILL BISHOP EDWARDS
VERBATIM REPORTER**

**DIXY MOORE TURNER ASSOCIATES, INC.
Certified Verbatim Reporters
836 SHORESBROOK DRIVE
Spartanburg, South Carolina 29301
(864) 574-1313 OR (864) 680-5757
DIXYMT@ATT.NET**

APPEARANCES

CHARLES J. HODGE, ESQUIRE, OF THE FIRM
HODGE AND LANGLEY, P.C.
229 MAGNOLIA STREET
POST OFFICE BOX 2765
SPARTANBURG, SOUTH CAROLINA 29304
CHODGE@HODGELAWFIRM.COM
AKING@HODGELAWFIRM.COM

ATTORNEY FOR THE EMPLOYEE/CLAIMANT,

JOHN W. RABB, JR., ESQUIRE, OF THE FIRM
ALLEN KOPET AND ASSOCIATES, P.L.L.C.
POST OFFICE BOX 1481
COLUMBIA, SOUTH CAROLINA 29202
JRABB@ALLEN-KOPET.COM

ATTORNEY FOR THE EMPLOYER/INSURER.

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CERTIFICATE OF NOTARY PUBLIC.....	23

EXHIBITS:

PLAINTIFF'S EXHIBIT NUMBER ONE, MARKED, MEDICAL EXAMINATION REPORT, ATTACHED.....	4
PLAINTIFF'S EXHIBIT NUMBER TWO, MARKED, MEDICAL EXAMINATION REPORT, ATTACHED.....	4

1 PURSUANT TO NOTICE AND/OR AGREEMENT TO TAKE
2 DEPOSITIONS, THE WITHIN DEPOSITION WAS TAKEN BY THE
3 ABOVE-NAMED COURT REPORTER, A NOTARY PUBLIC FOR THE STATE
4 OF SOUTH CAROLINA, BY CONSENT OF ALL PARTIES AT THE
5 OFFICES OF SOUTHEASTERN NEUROSURGICAL AND SPINE
6 INSTITUTE, GREENVILLE, SOUTH CAROLINA.

7 * * * * * * * * * * * * * * *

8 **STIPULATIONS:**

9 IT IS AGREED BY AND BETWEEN COUNSEL FOR THE PARTIES
10 AS FOLLOWS:

- 11 1. THE DEPOSITION IS BEING TAKEN PURSUANT TO THE
12 RULES OF THE SOUTH CAROLINA WORKERS'
13 COMPENSATION COMMISSION.
- 14 2. THE READING AND SIGNING OF THE DEPOSITION
15 TRANSCRIPT ARE **WAIVED** BY THE WITNESS AND THE
16 PARTIES.

17 * * * * * * * * * * * * * * *

18 (PRIOR TO GOING ON THE RECORD, THE COURT REPORTER MARKS
19 PLAINTIFF'S EXHIBIT NUMBER ONE, MEDICAL EXAMINATION
20 REPORT, ATTACHED; AND PLAINTIFF'S EXHIBIT NUMBER TWO,
21 MEDICAL EXAMINATION REPORT, ATTACHED.)

22 THE WITNESS WAS DULY SWORN TO TELL THE TRUTH, THE
23 WHOLE TRUTH AND NOTHING BUT THE TRUTH CONCERNING THE
24 MATTER HEREIN:

25 **CHARLES C. KANOS, M.D.,**

1 BEING FIRST DULY SWORN, TESTIFIED ON HIS OATH AS FOLLOWS:

2 **EXAMINATION BY MR. HODGE:**

3 Q. DR. KANOS, THANK YOU FOR BEING HERE.

4 A. SURE.

5 Q. I'M CHARLIE HODGE. I REPRESENT KEITH CASE. WE'RE
6 HERE TODAY ABOUT MR. CASE, AND WE'RE REALLY FOCUSING
7 ON ONE ISSUE, IF YOU WILL. THIS WAS A MAN WHO HAD A
8 HISTORY OF -- AND I'M KIND OF GOING BY YOUR NOTE.
9 HE WAS A 41-YEAR-OLD MAN. ON AUGUST 27, 2012, HE
10 CLIMBED DOWN SOME LOGS. A LOG ROLLED OVER AND
11 STRUCK HIS LEFT KNEE. HE FELL DOWN ON HIS KNEES ON
12 THE TRACTOR FRAME. HE THEN FELL ON HIS ELBOW. HE
13 HAD X-RAYS OF THE KNEES, TIBIA AND ELBOW. AND YOU
14 NOTED THAT HE HAD HAD NUMBNESS IN HIS HIPS AND BOTH
15 LEGS TO THE KNEES, WHICH HAD BEEN PRESENT SINCE THE
16 INJURY?

17 A. CORRECT. THAT'S WHAT MY NOTE SAYS.

18 Q. ALL RIGHT. AND THEN THE -- I WANTED TO SHOW YOU A
19 COUPLE OF PICTURES. I'M NOT GOING TO PUT THEM INTO
20 EVIDENCE, BUT I DID WANT YOU TO UNDERSTAND THE
21 GRAVITY OF THE FALL. THAT WAS PART OF THE
22 LACERATIONS TO THE LEG ---

23 A. LEFT KNEE, YEAH. OKAY.

24 Q. RIGHT. THE RECORDS FROM DR. FOLK INDICATED THAT HE
25 FELL ABOUT TEN FEET. IN ANY EVENT, AFTER YOU SAW

1 HIM, YOU NOTED PARESTHESIAS AND NUMBNESS INTO THE
2 LEGS. IS THAT RIGHT?

3 BY MR. RABB:

4 WHAT NOTE ARE YOU MAKING REFERENCE TO, CHARLIE?

5 BY MR. HODGE:

6 IT WOULD PROBABLY BE THE MAY 20, 2013, NOTE.

7 BY THE WITNESS:

8 OKAY. WHERE DO I SAY THAT, THAT HE HAD
9 PARESTHESIAS?

10 BY MR. RABB:

11 YEAH, I'M JUST LOOKING FOR WHERE HE SAYS THAT.

12 THAT'S WHAT I'M LOOKING FOR.

13 BY MR. HODGE:

14 LET'S SEE. MAYBE I'M -- I TELL YOU WHAT.

15 LET'S JUST TAKE THE NOTE.

16 EXAMINATION RESUMED BY MR. HODGE:

17 Q. LET'S LOOK AT THE 5-20 NOTE.

18 A. THAT'S WHAT I'M LOOKING AT.

19 Q. OKAY. YOU DID SAY THAT HE HAD NUMBNESS IN HIS HIPS
20 AND BOTH LEGS TO THE KNEES.

21 A. I DID. YEAH, MY NOTE SAYS HE'S HAD NUMBNESS IN HIS
22 HIPS AND BOTH LEGS TO THE KNEES.

23 Q. OKAY. IN THAT TIME, HE WAS COMPLAINING OF LOW BACK
24 PAIN?

25 A. YES.

1 Q. THE PAIN WAS CONSTANT ---

2 A. YES.

3 Q. DIFFUSE DOWN TO HIS KNEES?

4 A. YES.

5 Q. HE WALKED WITH A LIMP AND HAD A CRUTCH.

6 BY MR. HODGE:

7 I DON'T - I'M JUST TRYING TO CUT TO THE CHASE.

8 THAT'S ---

9 BY MR. RABB:

10 YEAH. I JUST WANTED TO FOLLOW EXACTLY WHERE

11 YOU ARE IN THE NOTE. THAT'S ALL, CHARLIE. I

12 GOTCHA.

13 BY MR. HODGE:

14 OKAY.

15 EXAMINATION RESUMED BY MR. HODGE:

16 Q. NOW, YOU DIDN'T HAVE ANY HISTORY OF HIM HAVING ANY

17 ISSUES ---

18 A. OH, I SEE WHERE IT SAYS IT. IT'S THE THIRD TO LAST

19 SENTENCE. HE HAS PARESTHESIAS AND NUMBNESS INTO HIS

20 LEGS.

21 Q. OKAY.

22 A. THAT'S THE SECOND SENTENCE ---

23 BY MR. RABB:

24 I SEE IT.

25 BY MR. HODGE:

1 GOOD.

2 **BY THE WITNESS:**

3 I SAID I WOULD RECOMMEND A LUMBAR M.R.I. HE'S
4 TO STAY OUT OF WORK UNTIL FOLLOW UP APPOINTMENT.
5 OKAY.

6 **EXAMINATION RESUMED BY MR. HODGE:**

7 Q. ALL RIGHT. AND JUST SO WE'LL KNOW, I'VE MARKED AS
8 PLAINTIFF'S EXHIBIT ONE A MEDICAL EXAMINATION REPORT
9 FOR COMMERCIAL DRIVER'S LICENSE. AND ON THE RIGHT-
10 HAND COLUMN, THEY'VE GOT SOME INDICATION WHETHER HE
11 HAD ANY KIND OF A SPINAL INJURY OR DISEASE AND
12 CHRONIC LOW BACK PAIN. AND THAT'S CHECKED NO. IS
13 THAT RIGHT?

14 A. RIGHT.

15 Q. ON THAT EXHIBIT? NOW, WE'VE GOT ONE THAT WAS
16 COMPLETED JANUARY 17TH OF 2014.

17 **BY MR. RABB:**

18 DO YOU HAVE A COPY OF THAT ONE, CHARLIE? I
19 DON'T HAVE THAT.

20 **BY MR. HODGE:**

21 I GAVE IT TO YOU.

22 **BY MR. RABB:**

23 I'VE GOT THE ONE FROM 2-17-12.

24 **BY MR. HODGE:**

25 OH, I DIDN'T GIVE YOU THE 2014?

1 BY MR. RABB:

2 I DON'T SEE IT.

3 BY MR. HODGE:

4 I'VE GOT A COPY FOR YOU RIGHT HERE.

5 EXAMINATION RESUMED BY MR. HODGE:

6 Q. SO, IN ANY EVENT, DR. KANOS, YOU ORDERED A LUMBAR
7 M.R.I. WITH CONTRAST.

8 A. YES.

9 Q. THEN I THINK YOU SAW HIM ---

10 A. I SAW HIM AGAIN ON 7-1-13.

11 Q. RIGHT. AND THE LUMBAR SPINE M.R.I., HAVE YOU GOT A
12 COPY OF THAT, TOO?

13 A. I KNOW WHAT I WROTE. I SAID IT'S MOSTLY
14 UNREMARKABLE. I CAN LOOK AT THE ---

15 Q. RIGHT, MOSTLY UNREMARKABLE. IT HAD SOME MILD DISK
16 SPACE NARROWING ---

17 A. IT DIDN'T EXPLAIN HIS SYMPTOMS. YEAH, I DIDN'T
18 THINK IT EXPLAINED HIS SYMPTOMS THAT HE WAS HAVING.

19 Q. OKAY. SO, THEN YOU SEE HIM ON JULY 1, 2013.

20 A. YES.

21 Q. AND THAT'S WHAT WE'RE HERE ABOUT, BECAUSE THE
22 CARRIER'S TAKING ISSUE WITH THE FACT THAT THEY DON'T
23 BELIEVE THE NECK PAIN WAS CAUSALLY RELATED TO THE
24 FALL.

25 A. YES.

1 Q. AND THAT'S WHAT I'M HERE TO ASK YOU ABOUT.

2 A. OKAY.

3 Q. SO, TELL ME WHY YOU BELIEVE HE OUGHT TO HAVE A
4 CERVICAL M.R.I.

5 A. I -- ON THAT SECOND VISIT, I LOOKED FOR -- IT'S
6 CALLED A MYELOPATHIC REFLEX, WHERE YOU FLICK THE
7 FINGER. AND I WANTED TO SEE IF THE SPINAL -- IF IT
8 WILL INDICATE THAT THERE'S SOME PATHOLOGY SPINAL
9 CORD COMPRESSIVE IN THE NECK. NOW, I DIDN'T HAVE --
10 THAT TEST WAS NOT POSITIVE WHEN I SAW HIM ON 5-20,
11 BUT IT WAS POSITIVE WHEN I SAW HIM ON 7-1-13. I
12 JUST FELT, TO EXPLAIN HIS SYMPTOMS, THE CERVICAL
13 SPINE M.R.I. WAS MOST APPROPRIATE. IT MIGHT HAVE
14 BEEN THE PROBLEM ALL ALONG. I MIGHT HAVE BEEN
15 WRONG, ORDERING JUST THE LUMBAR M.R.I.

16 Q. AND GIVEN THE ENTIRETY OF THE SEQUENCE, THE FALL,
17 THE SEVERITY OF THE INJURY ---

18 A. YEAH.

19 Q. UNDERSTANDING THAT THE LEGAL STANDARD IS SIMPLY MORE
20 LIKELY THAN NOT, DO YOU BELIEVE MORE LIKELY THAN NOT
21 HIS NEED FOR THE CERVICAL M.R.I. IS BECAUSE OF THE
22 FALL?

23 A. YES.

24 Q. OKAY.

25 BY MR. HODGE:

1 THAT'S ALL.

2 EXAMINATION BY MR. RABB:

3 Q. DOCTOR, MY NAME IS JOHN RABB AND I REPRESENT THE
4 LOGGING COMPANY IN THIS CASE. I JUST WANT TO FOLLOW
5 UP ON A COUPLE OF QUESTIONS WITH YOU.

6 A. OKAY.

7 Q. DID YOU HAVE A CHANCE TO MEET WITH MR. HODGE PRIOR
8 TO THE DEPOSITION?

9 A. NO.

10 Q. OKAY. AND I WANT TO TAKE A LOOK AT YOUR ADDRESSING
11 THE LUMBAR AS WELL AS THE CERVICAL. WITH REGARDS TO
12 THE LUMBAR, YOUR 5-20-2013 NOTE INDICATES HE WAS
13 REFERRED TO YOU BY DR. FOLK FOR EVALUATION OF LOW
14 BACK PAIN. IS THAT CORRECT?

15 A. YES.

16 Q. OKAY. AND WHEN YOU EVALUATED HIM ON MAY THE 20TH OF
17 2013, DID HE INDICATE TO YOU THAT HE HAD ANY ISSUES
18 OR PROBLEMS CONCERNING HIS NECK OR CERVICAL SPINE?

19 A. LOOKING AT THE REVIEW OF SYMPTOMS, I DIDN'T -- IN MY
20 NARRATIVE, I DIDN'T ADDRESS THAT.

21 Q. OKAY. IF HE HAD MADE SOME COMPLAINTS TO YOU ON 5-
22 20-2013 ABOUT HIS NECK OR CERVICAL SPINE, WOULD YOU
23 HAVE NOTED THAT?

24 A. USUALLY, BUT NOT GUARANTEED, BUT PROBABLY WOULD
25 HAVE.

1 Q. OKAY. AND AS A RESULT OF THAT VISIT FOR THE
2 REFERRAL FOR LOW BACK PAIN, YOU DID OR REQUESTED AN
3 M.R.I.

4 A. YES.

5 Q. FOR THE LUMBAR. IS THAT CORRECT?

6 A. YES. YES.

7 Q. AND YOUR DETERMINATION, AFTER READING THAT M.R.I.,
8 WAS IT WAS UNREMARKABLE? IS THAT CORRECT?

9 A. YES.

10 Q. OKAY. WAS THERE ANY RECOMMENDED TREATMENT THAT YOU
11 HAD FOR HIS LUMBAR OR LOWER BACK AS A RESULT OF
12 THAT?

13 A. NOT AT THAT TIME.

14 Q. ARE YOU AWARE OF ANY NOTES -- WELL, LET ME BACK UP.
15 WHAT NOTES DID YOU REVIEW PRIOR TO SEEING MR. CASE?

16 A. I DIDN'T -- I HAVE SINCE THIS TIME STARTED
17 DOCUMENTING WHAT NOTES HAVE BEEN PRESENT AT THE TIME
18 OF THE VISIT, BUT I DON'T KNOW. I HAVE A BIG PILE
19 OF NOTES HERE, AND I DON'T KNOW WHERE IT CAME FROM.

20 Q. OKAY. DO YOU KNOW WHETHER YOU'VE REVIEWED THOSE
21 NOTES?

22 A. DO I KNOW WHEN I REVIEWED THEM?

23 Q. WHETHER YOU HAVE REVIEWED THEM?

24 A. I -- NO, I DON'T RECALL WHETHER THESE WERE PRESENT
25 AT THE TIME OF THE OFFICE OR NOT, BUT I HAVE THEM

1 HERE TODAY. AND I HAVEN'T REALLY LOOKED AT THEM
2 TODAY.

3 Q. OKAY. DOCTOR, AND THEN THE NEXT VISIT, THE ONLY
4 OTHER VISIT YOU HAD WITH HIM IS JULY 1, 2013?

5 A. YES.

6 Q. AND ON JULY 1, 2013, YOU JUST NOTED THERE WAS -- AND
7 YOU CAN HELP ME WITH WHAT THIS IS. WHAT IS A
8 HOFFMANN? YOU SAID NEGATIVE VERSUS A POSITIVE
9 HOFFMANN.

10 A. HOFFMANN'S, I MENTIONED THAT EARLIER. THAT IS A
11 SIGN THAT MAY SHOW THAT THERE'S SOME COMPRESSION IN
12 THE NECK. YOU KNOW, I'M TRYING TO LOOK FOR A REASON
13 TO EXPLAIN THIS MAN'S SYMPTOMS. AND I DID NOTE IN
14 MY NOTE THAT THAT WAS NOT POSITIVE ON THE LAST
15 VISIT. I MIGHT HAVE MISSED IT. SOMETIMES -- I
16 DON'T KNOW WHAT THAT MEANS. BUT I FOUND IT POSITIVE
17 TODAY, INDICATING THERE MAY BE A PROBLEM WITH HIS
18 NECK.

19 Q. AND ASSUMING THAT YOU DIDN'T MISS IT ON THE MAY
20 VISIT, SOMETIME BETWEEN MAY 20TH AND JULY THE 1ST IS
21 WHEN THE POSITIVE HOFFMANN WOULD HAVE SHOWN UP. IS
22 THAT CORRECT?

23 A. WELL, IT SHOWED UP ON JULY 1ST AND I WROTE THAT IT
24 WASN'T PRESENT ON MAY 20TH.

25 Q. OKAY. WHAT, EXACTLY, IS THAT, JUST FOR A LAY

1 PERSON?

2 A. IT'S A SIGN THAT THERE'S -- YOUR SPINAL CORD IS
3 ACTING ABNORMALLY, USUALLY FROM COMPRESSION. AND
4 YOU GET A JUMPINESS USUALLY WHEN YOU HAVE -- YOUR
5 SPINAL CORD IN YOUR NECK'S GETTING COMPRESSED.
6 REFLEXES TEND TO BE EXAGGERATED. AND THAT'S ANOTHER
7 TYPE OF REFLEX THAT WE'RE CHECKING.

8 Q. OKAY. AND DOCTOR, IF THE MEDICAL RECORDS INDICATE
9 THAT THERE HAD NEVER BEEN A POSITIVE HOFFMANN -- AND
10 JUST TO BACK UP. THE DATE OF THIS ACCIDENT WAS
11 AUGUST 27, 2012. IF THE MEDICAL RECORDS NEVER
12 INDICATED ANY POSITIVE HOFFMANN UP UNTIL JULY THE
13 1ST.

14 A. OKAY.

15 Q. AND THE MEDICAL RECORDS INDICATE THAT THERE WAS NO
16 COMPLAINTS OF ANY ISSUES WITH HIS NECK OR CERVICAL
17 AREA, THIS IS NOW 11 MONTHS AFTER THE ACCIDENT.

18 A. ELEVEN MONTHS, YEAH.

19 Q. YOU'RE ABLE TO STATE TODAY, WITHIN A REASONABLE
20 DEGREE OF MEDICAL CERTAINTY, THAT MOST PROBABLY A
21 SYMPTOM THAT SHOWS UP 11 MONTHS LATER IS DIRECTLY
22 RELATED TO A FALL THAT HAPPENED THE PRIOR YEAR ON
23 AUGUST 27TH?

24 BY MR. HODGE:

25 LET ME OBJECT TO THE FORM OF THE QUESTION ONLY

1 IN THAT IT PRESUMES. SO I'M OBJECTING TO IT BEING
2 MISLEADING BECAUSE IT PRESUMES THAT HOFFMANN'S CHECK
3 WAS SPECIFICALLY CHECKED FOR.

4 **BY THE WITNESS:**

5 WITH THE QUESTION -- WITH - STATED LIKE THAT, I
6 CANNOT. KNOWING THAT - I MEAN, I'VE HAD TWO
7 DIFFERENT QUESTIONS HERE NOW.

8 **BY MR. RABB:**

9 OKAY.

10 **BY THE WITNESS:**

11 EXCUSE ME FOR ONE SECOND. CAN YOU HOLD FOR ONE
12 SECOND?

13 **BY MR. RABB:**

14 TAKE YOUR TIME.

15 **BY MR. HODGE:**

16 OFF THE RECORD.

17 **(OFF THE RECORD)**

18 **EXAMINATION RESUMED BY MR. RABB:**

19 Q. I'LL GO AHEAD AND LET YOU EXPLAIN YOUR ANSWER,
20 DOCTOR.

21 A. OKAY. IN TERMS OF YOUR SAYING THAT HE HAD NO UPPER
22 EXTREMITY SYMPTOMS WHATSOEVER ---

23 Q. RIGHT.

24 A. AND THEN THE HOFFMANN'S -- NO ONE'S PROBABLY CHECKED
25 FOR A HOFFMANN'S OTHER THAN ME. I'M THE

1 NEUROSURGEON. I DON'T EXPECT A FAMILY OR WHOEVER TO
2 DO IT. I CERTAINLY DON'T EXPECT DR. FOLK, A HIP
3 DOCTOR, TO CHECK IT.

4 Q. CORRECT.

5 A. SO, WITH THOSE SYMPTOMS AND HE HAD ZERO NECK
6 COMPLAINTS AT ANY POINT DURING THAT TIME, MY NOTES
7 DIDN'T REALLY INDICATE NECK. THE MECHANISM OF
8 INJURY AND HE COMES IN HYPERREFLEXIC, I THOUGHT IT
9 ALL WAS RELATED AT THE TIME. THAT'S AT THE TIME.
10 THAT'S WHEN I -- BASED ON THE HISTORY THAT HE TOLD
11 ME. WHEN YOU'RE SAYING THAT HE HAD ZERO NECK
12 COMPLAINTS FOR 11 MONTHS AND THEN THEY SHOW UP ONE
13 DAY -- AND I'M TRYING TO EXPLAIN HIS SYMPTOMS IN HIS
14 LEG.

15 Q. I UNDERSTAND.

16 A. AND SINCE THE LUMBAR DIDN'T PAN OUT, I FOUND A NEW
17 FINDING. IT MIGHT HAVE BEEN THE NECK ALL ALONG.
18 THAT'S MY -- THAT'S MY LOGIC. NO MORE, NO LESS.
19 YOU KNOW, IT MIGHT HAVE BEEN THE ---

20 Q. IT MIGHT HAVE BEEN.

21 A. IT COULD SOMETIMES -- IT'S NOT -- YEAH, HIS
22 PARESTHESIAS IN HIS LEGS MAY HAVE BEEN EXPLAINED BY
23 A NECK SOMETHING THAT, BASED ON THE MECHANISM OF HIS
24 INJURY, WE COULD HAVE JUST MISSED IT.

25 Q. OKAY. AND I GUESS WHAT I'M TRYING TO FIND OUT IS --

1 AND I REALIZE WE DON'T HAVE A FINDING, AT THIS
2 POINT, AS A RESULT OF AN M.R.I. OF HIS NECK. AND SO
3 IT MAY BE DIFFICULT FOR YOU TO GIVE A FINAL
4 DIAGNOSIS IN THAT REGARD.

5 A. YEAH. I'M TRYING TO EXPLAIN THIS SYMPTOM, AS
6 DEBILITATED AS HE APPEARED WITH A NORMAL LUMBAR
7 M.R.I.

8 Q. AND I GUESS MY QUESTION WOULD BE WOULDN'T IT MAKE
9 MORE SENSE IF YOU WERE ABLE TO DO THE M.R.I. OF THE
10 CERVICAL BEFORE YOU GAVE US AN ANSWER TO THE ISSUE
11 OF CAUSATION?

12 A. OH, OKAY. THAT'S AN INTERESTING TAKE ON THIS. NO,
13 I DON'T THINK THAT WOULD MATTER BECAUSE MY -- I --
14 WELL, IF YOU WANT ME TO -- WHAT IF IT SHOWED
15 SOMETHING SIGNIFICANT, THAT WOULD MEAN HIS NECK IS
16 WORSE THAN -- BECAUSE YOU SEEMED SHOCKED BY HOW I
17 JUST RESPONDED TO THAT.

18 Q. WELL, I -- GO AHEAD. I'LL ---

19 A. ALL RIGHT. YEAH, PLEASE. SO, IN TERMS OF THE -- IN
20 TERMS OF HIS NECK, I DON'T KNOW IF I CAN DO
21 CAUSATION AFTER LOOKING AT THE M.R.I. I KNOW WHAT
22 THE GUY TOLD ME. HE HAD A BAD FALL.

23 Q. RIGHT.

24 A. SO, I JUST HAVE TO UNDERSTAND WHAT THE FACTS ARE
25 HERE. IS IT THAT -- IS IT THE GETTING AN M.R.I. OR

1 CLAIMING A CERVICAL INJURY, JUST WHY WE'RE HERE
2 TODAY? THAT'S WHAT I JUST WANT TO KNOW.

3 BY MR. HODGE:

4 WELL, I MEAN, IN FAIRNESS, AND I THINK BOTH OF
5 US -- I DON'T MIND ADDRESSING ---

6 BY THE WITNESS:

7 I JUST WANT TO KNOW WHAT THE ISSUE IS HERE. IS
8 IT THAT THE NECK WASN'T ---

9 BY MR. HODGE:

10 THEY WON'T AUTHORIZE THE M.R.I. BECAUSE THEY
11 SAY IT'S NOT RELATED.

12 BY THE WITNESS:

13 NECK CERVICAL M.R.I., NOT RELATED.

14 BY MR. HODGE:

15 YEAH.

16 BY THE WITNESS:

17 ALL RIGHT. YEAH, AND I PROBABLY OPENED UP A
18 CAN OF WORMS SHOOTING THE NECK BY BEING THOROUGH.
19 BUT I CHECKED THE HOFFMANN AND THE HYPERREFLEXIA.
20 AND I'M JUST TRYING TO EXPLAIN IT. SO, YOU WERE
21 ASKING ME BEFORE IF THE C SPINE IS NEGATIVE, THEN I
22 WOULD SAY HE'S HAD NO NECK PAIN. IS THAT WHAT YOU
23 WERE ASKING ME BEFORE?

24 EXAMINATION RESUMED BY MR. RABB:

25 Q. YES. AND THE OTHER ISSUE IS IF IT'S NEGATIVE IN MAY

1 BECAUSE YOUR NOTES INDICATE IT WAS NEGATIVE IN MAY.

2 A. UH-HUH.

3 Q. IT'S NOT PRESENT.

4 A. RIGHT.

5 Q. AND SUDDENLY, IT SHOWS UP TWO MONTHS LATER AND 11
6 MONTHS AFTER THE ACCIDENT.

7 A. YEAH.

8 Q. HOW CAN YOU THEN MAKE THE LEAP THAT IT'S ALL
9 CAUSALLY RELATED TO THE FALL FROM 11 MONTHS AGO?

10 A. I CAN'T SAY TO A DEGREE OF MEDICAL CERTAINTY.

11 Q. OKAY.

12 A. I CANNOT SAY IN THAT RESPECT.

13 Q. OKAY.

14 A. AND I CAN SAY THAT IT MAY HAVE BEEN A PROBLEM IN THE
15 NECK ALL ALONG. MAYBE I DIDN'T DO THE EXAM WELL
16 ENOUGH. I'M TRYING TO EXPLAIN THE MAN'S IMPAIRMENT.
17 SO, HIS NECK MAY NOT HAVE ANY -- MAY NOT HAVE
18 CONTRIBUTED ONE BIT. AND IF I FIND THAT A CERVICAL
19 M.R.I. WAS NORMAL, THEN I'M CERTAINLY NOT GOING TO
20 CONTRIBUTE HIS NECK TO IT. I'M JUST TRYING TO
21 EXPLAIN THIS. IT MIGHT BE WISE FOR ME, YOU KNOW, IF
22 ANYTHING, FOR ME TO RE-EXAMINE AND SEE THE GUY
23 AGAIN. BUT THAT'S UP TO YOU ALL.

24 **BY MR. RABB:**

25 I DON'T THINK I HAVE ANY MORE QUESTIONS,

1 CHARLIE.

2 **FURTHER EXAMINATION BY MR. HODGE:**

3 Q. DOCTOR, IF A PERSON HAD A CORD INJURY IN THE
4 CERVICAL SPINE, DO THEY NECESSARILY HAVE PAIN OR
5 SYMPTOMS THAT ARE ASSOCIATED WITH, LIKE, A DISK TYPE
6 THING?

7 A. I DON'T QUITE UNDERSTAND THE QUESTION.

8 Q. IN OTHER WORDS ---

9 A. IF A PERSON HAS A CORD INJURY. I GOT THAT PART.

10 Q. CORD INJURY.

11 A. YEAH, CORD INJURY. WHAT DO YOU ---

12 Q. DOES IT NECESSARILY MEAN THAT THE PERSON HAS PAIN?

13 A. NO.

14 Q. IN FACT, NEUROPATHIC PAIN, OR EXCUSE ME. AN INJURY
15 TO THE CORD CAN RESULT IN KIND OF THESE WILD
16 REFLEXES THAT THE PERSON NOT HAVE THE PAIN THAT'S
17 TYPICALLY ASSOCIATED WITH A NECK INJURY?

18 A. THAT'S POSSIBLE, YES. THAT'S POSSIBLE.

19 Q. SO, THE CERVICAL M.R.I. IS GOING TO TELL YOU THE
20 STORY. IF HE'S GOT A CORD INJURY OR IF HE'S GOT
21 SOME KIND OF SIGNIFICANT DISK INJURY ---

22 A. THAT'S RIGHT. I DON'T KNOW IF HE'S GOING TO HAVE A
23 CORD INJURY.

24 Q. OKAY.

25 A. WHAT I WANT TO DO IS EXPLAIN HIS HYPERREFLEXIA THAT

1 I SAW ON JULY 1, 2013.

2 Q. RIGHT.

3 A. AND WITH THE INFORMATION THAT I HAD, I WAS UNDER THE
4 PRESUMPTION THAT HE FELL OFF LOGS. THIS WAS A
5 MASSIVE INJURY AND THIS WAS RELATED TO THE -- YOU
6 KNOW, AND I ONLY KNOW WHAT HE TOLD ME IN THE TEN
7 MINUTES I WAS IN THE ROOM WITH HIM.

8 Q. DID YOU ALSO KNOW THAT HE ALSO LANDED ON HIS ELBOW,
9 THAT ACTUALLY X-RAYS WERE TAKEN OF THE ELBOW?

10 A. I DON'T -- I CAN'T SAY I KNOW OFF THE TOP OF MY HEAD
11 HE LANDED ON HIS ELBOWS. I KNOW HE EXPLAINED A
12 SIGNIFICANT SORT OF AN INJURY WITH LOGS AND
13 SUSTAINED SOME SHIN INJURY.

14 Q. WELL, IN YOUR HISTORY, JUST ---

15 A. I DON'T KNOW EXACTLY. I'M SURE HE WENT THROUGH IT
16 AND I DIDN'T WRITE EVERY DETAIL THAT HE TOLD ME
17 ABOUT IT. I SUMMARIZED IT. WE TRY TO SUMMARIZE IT.

18 Q. SURE. WELL, I THINK IT IS IN YOUR NOTE, THOUGH.
19 I'M LOOKING AT YOUR NOTE ---

20 A. I DO HAVE THAT IN THERE?

21 Q. YOUR 5-20 NOTE.

22 A. OKAY.

23 Q. YOU SAY HE FELL DOWN ON HIS KNEES. HE THEN FELL ON
24 HIS ELBOW. HE'S HAD X-RAYS OF HIS KNEES, TIBIA AND
25 ELBOW.

1 A. I MEAN, IT SOUNDS LIKE IT'S A SIGNIFICANT KIND OF A
2 FALL, INJURY TYPE THING THAT I'M SEEING.

3 Q. RIGHT.

4 A. AT THE TIME, WHICH I IMAGINE ON 7-1, WAS I THINKING
5 IT WAS CONCEIVABLE THAT HE COULD HAVE SUSTAINED A
6 NECK INJURY? I'M NOT SAYING HE DOES -- NOW I GET
7 YOUR QUESTION. I JUST HAVEN'T HEARD IT THAT WAY
8 BEFORE. I DO A LOT OF THESE.

9 BY MR. HODGE:

10 WELL, THANK YOU, DOCTOR. I APPRECIATE YOUR
11 HELP.

12 BY MR. RABB:

13 OKAY, DOC. THANKS.

14 (THERE BEING NO FURTHER QUESTIONS, THIS DEPOSITION
15 CONCLUDED AT THE HOUR OF 5:08 P.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 1211338

EMPLOYEE/CLAIMANT: KEITH CASE

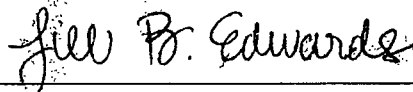
EMPLOYER: J. CRAWFORD LOGGING, INC.

INSURER: PALMETTO TIMBER FUND

I, JILL BISHOP EDWARDS, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING **22** PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING DEPOSITION OF **CHARLES C. KANOS, M.D.** TAKEN ON THE 7TH DAY OF APRIL, 2014.

THAT THE WITNESS WAS DULY PLACED UNDER OATH AND ADMONISHED TO SPEAK THE WHOLE TRUTH. THAT THE ORAL DEPOSITION WAS DULY TAKEN AND TRANSCRIBED AS TO THE QUESTIONS PROPOUNDED AND THE ANSWERS GIVEN.

THAT ALL THE OFFERED EXHIBITS, STIPULATIONS AND OBJECTIONS, IF ANY, INVOLVED IN THIS CASE ARE DULY ATTACHED OR INCLUDED HEREIN.



JILL BISHOP EDWARDS
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 7/14/20

* THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.

HSE, KELLY

80 ✓

649-F (Rev. 2/08) (6045)

Medical Examination Report FOR COMMERCIAL DRIVER FITNESS DETERMINATION

1. DRIVER'S INFORMATION

Driver completes this section.

Driver's Name (Last, First, Middle) <u>Case, Keith L.</u>		Social Security No. <u>247-594639</u>	Birthdate <u>06/09/77</u>	Age <u>40</u>	Sex ☒ M ☐ F	☐ New Certification ☒ Recertification ☐ Follow Up	Date of Exam <u>2-17-12</u>
Address <u>573 Gold Mine Road</u>		City, State, Zip Code <u>Pauline SC 29374</u>		Work Tel: <u>(864) 237-5788</u> Home Tel: <u>(864) 237-5788</u>		Driver License No. <u>004136908</u>	License Class ☒ A ☐ C ☐ B ☐ D ☐ Other
							State of Issue <u>SC</u>

2. HEALTH HISTORY

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

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

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

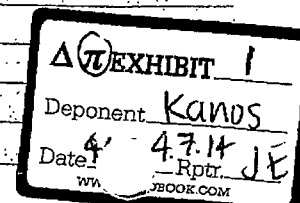
I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature

Keith Case

Date 2-17-12

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



7. PHYSICAL EXAMINATION

Height: 5'10" (in.) Weight: 242 (lbs.) Name: Last, Case First, Keith Middle, _____

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

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

See Instructions to the Medical Examiner for guidance.

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

*COMMENTS:

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

☒ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate

☐ Does not meet standards

☐ Meets standards, but periodic monitoring required due to _____

Driver qualified only for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other _____

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

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

- ☐ Wearing corrective lenses
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption. Driver must present exemption at time of certification.
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone. (See 49 CFR 391.62)
- ☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's Signature [Signature]

Medical Examiner's Name Dr. Dennis R. Drinkall DC

Address 11489 SC Hwy 121 Newberry SC 29108

Telephone Number _____

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

Medical Examination Report

FOR COMMERCIAL DRIVER FITNESS DETERMINATION

Employer Name _____

649-F (6045)

1. DRIVER'S INFORMATION

Driver completes this section

Driver's Name (Last, First, Middle) <u>Case Keith Lee</u>	Social Security No. <u>247-59-4639</u>	Birthdate <u>6-9-71</u> MM/DD/YYYY	Age <u>42</u>	Sex ☒ M ☐ F	New Certification ☐ Recertification ☒ Follow-up ☐	Date of Exam <u>1-17-14</u>
Address <u>573 Goldmine Rd Pauline, S.C</u>	City, State, Zip Code <u>Pauline SC 29374</u>	Work Tel <u>864 316-2620</u>	Home Tel: ()	Driver License No. <u>004136908</u>	License Class ☒ A ☐ B ☐ C ☐ D ☐ Other	State of Issue <u>S.C</u>

2. HEALTH HISTORY

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

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

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

August 27th
Accident at work in Sept 2012 - injury from cervical to lumbar
presently walking with crutch. Says needs wheelchair if no crutches - hBpain worst
spot - numbness both legs. Dr. Canos MD in Greenville.

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

Driver's Signature

Keith Case

Date

1-17-14

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

EXHIBIT 2
Deponent KANOS
Date 4-1 Rpt. JE
www.1800BOOK.COM

TESTING (Medical Examiner completes Section 3 through 7) Name: Last, Case First, Keith Middle, Lee

3. VISION

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

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

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/ <u>15</u>	20/	Right Eye <u>90</u> °
Left Eye	20/ <u>15</u>	20/	Left Eye <u>90</u> °
Both Eyes	20/ <u>15</u>	20/	<u>all fields intact</u>

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

Applicant meets visual acuity requirement only when wearing:
☐ Corrective Lenses

Monocular Vision: ☐ Yes ☒ No

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

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

4. HEARING

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

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right ear <u>5</u> Feet	Left Ear <u>5</u> Feet
--	----------------------------	---------------------------

b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI 224.5-1951)

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

5. BLOOD PRESSURE/ PULSE RATE

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

Blood Pressure	Systolic <u>122</u>	Diastolic <u>78</u>
----------------	------------------------	------------------------

Driver qualified if $\leq 140/90$.

Pulse Rate: ☒ Regular ☐ Irregular

67

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

6. LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

URINE SPECIMEN	SP. GR. <u>1.010</u>	PROTEIN <u>neg</u>	BLOOD <u>neg</u>	SUGAR <u>neg</u>
----------------	-------------------------	-----------------------	---------------------	---------------------

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

Other Testing (Describe and record)

7. PHYSICAL EXAMINATION

Height: 10 (in.)

Weight: 116 (lbs.)

Name: Last, Case

First, Keith

Middle, Lee

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

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

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

*COMMENTS:

Bmi- 25.4
neck- 16

pinch injury - not able to drive at this time

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

- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
☐ Does not meet standards
☐ Meets standards, but periodic monitoring required due to _____
 Driver qualified only for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other

Temporarily disqualified due to (condition or medication) back injury

Return to medical examiner's office for follow up on July 17th, 2014

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

- ☐ Wearing corrective lenses
☐ Wearing hearing aid
☐ Accompanied by a _____ waiver/ exemption. Driver must present exemption at time of certification.
☐ Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (See 49 CFR 391.62)
☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's signature [Signature]

Medical Examiner's name Dennis R. Drinkall, DC

Address 11489 SC Highway 121 Newberry, SC 29108

Telephone Number: 803-276-8833 Fax: 803-276-8837



GREENVILLE HEALTH SYSTEM

CASE, KEITH

42 Y old Male, DOB: 06/09/1971
573 GOLDMINE RD, PAULINE, SC-29374
Home: 864-316-2620

Guarantor: CASE, KEITH

PCP: None Identified Referring: Interventional
Radiologist Spartanburg Regional Medical Center External

Visit ID: 167134030

Appointment Facility: SE Neuro & Spine Institute

07/01/2013

Progress Note: Charles C. Kanos

Current Medications

None

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Family: Hypertension, stroke, cancer

Social History

Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol.

Smoking Status > 13 years old Are you a: Never smoker.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Musculoskeletal:

Loss of muscle strength yes. Painful joints yes. Swelling of joints yes.

Integumentary:

Breast discharge from nipples no. Skin rash no.

Neurological:

Difficulty remembering no. Loss of consciousness no. Seizures, unknown type no.

Psychological:

Feels nervous no. Depression yes.

Hematologic/Lymphatic:

Bleeds excessively after injury or minor surgery no. Bruises easily no.

Allergic, Infectious, and Immunologic:

Hives no. Infections (unusual) no.

Reason for Appointment

1. WC. Injury date 08/27/12 Follow up on low back pain

History of Present Illness

Lumbar Spine/Lower Back:

Location: Lumbar region. Quality: burning, stabbing, pins and needles, numbness. Severity: Pain Score (scale of 1 to 10)

7. Timing: 08/27/12. Referred or radiating symptoms bilateral lower extremity. Setting in which it first occurred: fall off a tractor. Aggravating factors: none identified. Relieving factors: none identified.

Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Location of pain: back, leg(s), Quality/Description of pain: stabbing, tingling numbness, What, if any, medication have you taken for this pain? None, Pain Scale used: Number Scale 6, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

Previous Treatments / Therapies:

Chiropractic Therapy: none. Injection therapy: none. Medications: none. Physical therapy: with no benefit.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 204, Wt kg 92.53, BMI 29.27, BP unable to obtain, HR unable to obtain, Pain score 6/10.

Examination

Imaging Studies:

MRI Lumbar MRI 06/13/13 GHS PACS.

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Psych: appropriate mood and affect, normal speech.

Neurological:

Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3.

Assessments

1. NECK PAIN - 723.1 (Primary)

Genitourinary:Decreased interest in sex **no**.Urination **no** problems.Respiratory:Cough **no**. Shortness of breath or difficulty breathing **no**. Wheezing **no**.Cardiovascular:Chest pain **no**. Irregular heartbeat or feeling of fast, pounding heartbeat **no**.Shortness of breath **no**.Constitutional Symptoms:Fatigue **no**. Fever and chills **no**.Unintentional weight change **yes**.Eyes:Loss of vision **yes**.Ears, Nose, Mouth, and Throat:Hearing loss **no**. Ringing in ears **no**.**Treatment****1. NECK PAIN**

Referral To:

Reason: WC: C Spine MRI w/wo contrast

2. Others

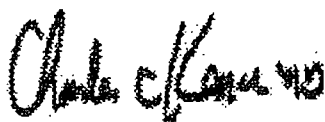
42 year old man last seen 6 weeks ago. He had an 8-27-2012 injury after falling over logs. His main complaint is low back pain and numbness in the lateral aspects of his legs. He has no problems with his arms. He had a negative Hoffman's at last visit. His MRI is mostly unremarkable. I don't see any significant stenosis. He still uses one crutch and is markedly impaired. He has a positive Hoffman's today but he was negative last time. PE: positive Hoffman's, toes are mute, 2+ knee jerks bilaterally, 2+ ankle jerks bilaterally I'm going to get a C Spine MRI since he didn't have these findings before. I will keep him out of work.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up

p mri, prn



Electronically signed by Charles Kanos, MD on 07/10/2013 at 03:41 PM EDT

Sign off status: Pending

SE Neuro & Spine Institute
109 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7150
Fax: 864-797-7145

Patient: CASE, KEITH DOB: 06/09/1971 Progress Note: Charles C. Kanos 07/01/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

**SE Neuro & Spine Institute-Upper
111 Doctors Drive
Greenville, SC 29605
864-797-7150**

PHYSICIAN INFORMATION

Requesting: Kanos, Charles

PATIENT INFORMATION

Name: CASE, KEITH
DOB: 06/09/1971
Sex: male
Tel: 864-316-2620

REPORT DETAILS

Procedure Name: MRI Spine
Lumbar wo contrast, EMI
Session Id: 13187821

REPORT DATES

Order: 06/13/2013
Procedure: 06/13/2013 19:08:00

REPORT**Exam :MRI LUMBAR SPINE W/O CON**

See Below for Report

ORDERING MD: CHARLES KANOS, MD
LOCATION: SOUTHEASTERN NEURO AND SPINE INSTITUTE
111 DOCTORS DRIVE
GREENVILLE, SC, 29605

RK600122 - MRI LUMBAR SPINE W/O CON 06/13/2013 19:08**EXAM#:**
13187821

ORDERED BY: Dr. CHARLES KANOS, MD
ADMISSION DATE/TIME: 06/13/2013 17:45
REASON FOR EXAM: LBP, NUMBNESS-----
RESULT:

KEITH CASE

LUMBAR SPINE MRI

42-year-old man with given clinical history of low back pain and lower extremity numbness.

The patient also describes bowel and bladder dysfunction. Parasagittal T1, turbo spin echo T2, and STIR sequences were acquired as well as axial T1 turbo spin echo T2 weighted images from L2 to S1. There is mild disc desiccation at L4-5. Intrinsic signal intensity and heights of the remaining disc spaces are well preserved throughout. The conus is normally positioned. No discrete marrow signal abnormalities other than a sizable interosseous hemangioma to the right of midline in the L5 vertebral body as well as early reactive signal changes in the marrow adjacent to the inferior end plate of L4.

L2-3: Negative.

L3-4: Mild facet arthropathy. No significant canal or foraminal stenosis.

L4-5: Mild disc space narrowing and mild to moderate disc desiccation. Broad based posterior bulging of the annulus and mild bilateral facet arthropathy. This results in mild canal and foraminal narrowing without appreciable displacement or distortion of the nerve roots within the canal or foramina.

Patient: CASE, KEITH DOB: 06/09/1971

L5-S1: Mild facet arthropathy. No significant canal or foraminal stenosis.

The conus is normally positioned.

IMPRESSION:

1. DEGENERATIVE CHANGES IN THE DISC AT L4-5 AND MILD FACET ARTHROPATHY AT EACH LEVEL FROM L3 TO S1.
2. CHANGES AT L4-5 ARE ASSOCIATED WITH MILD CANAL AND BILATERAL FORAMINAL STENOSIS BUT THERE IS NO EVIDENCE OF ASSOCIATED DISTORTION OR DEFLECTION OF THE NERVE ROOTS.
3. INTRAOSSEOUS HEMANGIOMA L5.

TRANSCRIPTIONIST: MARIE, GRAY

TRANSCRIBE TIME/DATE: 6/14/2013 8:54:00 AM

READ BY: STEVEN G. MILAM, MD,

SIGNED BY:

0 ELECTRONIC SIGNATURE / MILAM, MD, STEVEN G.

Patient: CASE, KEITH DOB: 06/09/1971



GREENVILLE HEALTH SYSTEM

CASE, KEITH

41 Y old Male, DOB: 06/09/1971
573 GOLDMINE RD, PAULINE, SC-29374
Home: 864-316-2620

Guarantor: CASE, KEITH

PCP: None Identified Referring: Interventional
Radiologist Spartanburg Regional Medical Center
Appointment Facility: SE Neuro & Spine Institute

05/20/2013

Progress Note: Charles C. Kanos

Current Medications

None

Past Medical History

No Medical History.

Surgical History

No Surgical History documented.

Family History

Family: Hypertension, stroke, cancer

Social History

Alcohol men 18-65 yrs Assessment
completed: today, Alcohol intake: patient
does not drink alcohol.
Smoking Status > 13 years old Are you a:
Never smoker.

Allergies

N.K.D.A

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Musculoskeletal:

Loss of muscle strength yes. Painful
joints yes. Swelling of joints yes.

Integumentary:

Breast discharge from nipples no. Skin
rash no.

Neurological:

Difficulty remembering no. Loss of
consciousness no. Seizures, unknown
type no.

Psychological:

Feels nervous no. Depression yes.

Hematologic/Lymphatic:

Bleeds excessively after injury or minor
surgery no. Bruises easily no.

Allergic, Infectious, and Immunologic:

Hives no. Infections (unusual) no.

Genitourinary:

Reason for Appointment

1. WC. Injury date 08/27/12 New patient seen at the neurosurgical
consultation at the request of WC for the evaluation of low back pain

Assessments

1. Low back pain - 724.2 (Primary)
2. Numbness - 782.0

Treatment

1. Low back pain

Referral To:

Reason:WC: Lumbar MRI w/o contrast

2. Numbness

Referral To:

Reason:WC: Lumbar MRI w/o contrast

3. Others

41 year old man referred by Dr. Folk and accompanied by Ms.
Galloway. I have Dr. Folk's notes for review along with notes from
Spartanburg Wound Healing Center. He injured himself on 8-27-2012.
He was climbing down some logs and the log rolled over, striking his
left knee. He fell down on his knees on the tractor frame. He then fell
on his elbow. He's had x rays of his knees, tibia and elbow. I have the
emergency room reports. He's had numbness in his hips and both legs
to the knees. He says that has been present since the injury. He denies
any pain prior to the incident. The laceration to his left shin was
infected and he got extensive treatment for that. He was diagnosed
with a patellofemoral pain syndrome. He complains of low back pain.
The pain is constant and it's in his diffuse lower region down to his
knees. He has a stinging pain and diffuse low back pain. He walks with
a limp and has a crutch. PE: midline lumbar tenderness, bend to 45
degrees with pain, no lumbar step offs, 2+ knee jerks, 2+ ankle jerks
bilaterally, normal LE strength and motor, normal UE strength and
motor, no troch tenderness, decreased light touch in anterior thighs,
normal sensation below knees, normal DF/PF bilaterally, normal inner
thigh pinprick, negative Hoffman's, no myelopathic gait. He states that
he had no pain prior to this injury. He had immediate back pain among
other injuries following the injury. It appears that this work related. He
has paresthesias and numbness into his legs. I would recommend a
lumbar MRI w/contrast. He is to stay out of work until his follow up:

Decreased interest in sex **no**.

Urination no problems.

Respiratory:

Cough **no**. Shortness of breath or difficulty breathing **no**. Wheezing **no**.

Cardiovascular:

Chest pain **no**. Irregular heartbeat or feeling of fast, pounding heartbeat **no**.

Shortness of breath **no**.

Constitutional Symptoms:

Fatigue **no**. Fever and chills **no**.

Unintentional weight change **yes**.

Eyes:

Loss of vision **yes**.

Ears, Nose, Mouth, and Throat:

Hearing loss **no**. Ringing in ears **no**.

Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

MU Counseling: BMI Management plan provided? Yes, Dietary counseling provided? Yes, Activity counseling provided? Yes.

Follow Up

p mri, prn

History of Present Illness

Lumbar Spine/Lower Back:

Location: Lumbar region. Quality: burning, stabbing, pins and needles, numbness. Severity: Pain Score (scale of 1 to 10) 7. Timing: 08/27/12. Referred or radiating symptoms bilateral lower extremity. Setting in which it first occurred: fall off a tractor. Aggravating factors: none identified. Relieving factors: none identified.

Pain:

Pain Screening: Any pain at this time? Yes, Pain is chronic, Location of pain: back, leg(s), Quality/Description of pain: burning, stabbing, tingling numbness, What, if any, medication have you taken for this pain? None, Pain Scale used: Number Scale 7, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

Previous Treatments / Therapies:

Chiropractic Therapy: none. Injection therapy: none. Medications: none. Physical therapy: with no benefit.

Vital Signs

Ht 70, Ht Cm 177.8, Wt lbs 226, Wt kg 102.51, BMI 32.42, BP 128/72, HR 75, Pain score 7/10.

Examination

General Exam:

General Appearance: well groomed, well developed and well nourished, communicates normally. Psych: appropriate mood and affect, normal speech.

midline lumbar tenderness, bend to 45 degrees with pain, no lumbar step offs, 2- knee jerks, 2+ ankle jerks bilaterally, normal LE strength and motor, normal UE strength and motor, no troch tenderness, decreased light touch in anterior thighs, normal sensation below knees, normal Df/PF bilaterally, normal inner thigh pinprick, negative Hoffman's, no myelopathic gait.

Neurological:

Cerebellar: Rapid alternating movements of, fingers and hands are symmetrical, Nose to finger to nose coordination is normal. Cranial Nerves: 2nd cranial nerve: Fundoscopic with sharp discs, visual fields full and symmetrical, 3rd, 4th, and 6th cranial nerves: Extraocular muscles with full conjugate range of motion, without nystagmus or complaints of diplopia, 5th Cranial Nerve: Facial sensation intact and

symmetrical to light touch and pinprick, , 7th Cranial Nerve: No facial asymmetries at rest or to grimacing, 8th Cranial Nerve: Hearing intact and symmetrical, 11th Cranial Nerve: Symmetrical bulk and strength of the sternocleidomastoid muscles, and shoulder scrug, 12 Cranial Nerve: Midline tongue with full ROM. Cranial Nerves: CN's III and VII grossly intact. Gait: normal. Mental Status: Orientation normal to time, place, person, and situation, Alert & oriented x 3.

Charles C. Kanos

Electronically signed by Charles Kanos , MD on 05/24/2013
at 04:12 PM EDT

Sign off status: Completed

SE Neuro & Spine Institute
109 Doctors Drive
Greenville, SC 29605
Tel: 864-797-7150
Fax: 864-797-7145

Patient: CASE, KEITH DOB: 06/09/1971 Progress Note: Charles C. Kanos 05/20/2013

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Progress Note

Patient: CASE, KEITH
DOB: 06/09/1971 **Age:** 41 Y **Sex:** Male
Phone: 864-316-2620
Address: 573 GOLDMINE RD, PAULINE, SC-29374
Pcp: None Identified

Provider: Jason Folk, MD
Date: 04/24/2013

Subjective:**CC:**

1. WCR: RT KNEE.

HPI:Interim History:

Prior Assessment LT PFPS (Patellofemoral Pain Syndrome) - This is a 41 year old male with bilateral anterior knee pain from a logging accident. Date of Injury: NDOI. Treatment to Date: 2.7.13: refill Norco 5, refer to Kanos for spine eval; 12.5.12: steroid injection; physical therapy, conservative management (10.24.12). Response to treatment: patient states feeling worse since last visit. Pain: **not satisfactorily controlled**, Severity: pain = 5, sharp, dull, aching, constant.

Pain:

Pain Screening: Any pain at this time? Yes, Location of pain: right, knee(s), Quality/Description of pain: constant, aching, dull, sharp, What, if any, medication have you taken for this pain? Other, Pain Scale used: Number Scale, Face Scale 5, Is your pain satisfactorily controlled now? No.

HPI:

He comes in today for evaluation of his right lower extremity, right knee itself continues to be doing well, he has occasional burning pain over the anteromedial aspect of the knee after prolonged standing or prolonged use.

ROS:

No changes found in review of system since last checked 10.24.12.

Family History: Family: Hypertension, stroke, cancer

Social History: Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Never smoker.

Medications: norco 325 mg-5 mg tablet 1 tab(s) every 6-8 hours, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 222, Wt kg 100.7, BMI 31.85, BP 129/91, HR 83, Pain score 5.

Past Orders:**Examination:**General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect. Skin No rashes, lesions, or ulcers.

On physical examination, his knee has no effusion, he has diminished patellar tendon mobility, but patellar mobility is good. No pain at extremes of motion, stable ligamentous exam, no crepitation through an active range of motion.

Assessment:**Assessment:**

1. PFPS (Patellofemoral Pain Syndrome) - 719.46 (Primary)
Right lower extremity pain, knee pain is better.

Plan:**1. PFPS (Patellofemoral Pain Syndrome)**

I am going to get an Impairment rating on his right knee and then he is scheduled to be evaluated for his lumbar spine at the middle portion of May. JF/nl.

2. Others Continue norco tablet, 325 mg-5 mg, 1 tab(s), orally, every 6-8 hours .

Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

Immunizations:**Therapeutic Injections:****Labs:****Preventive:**

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: prn

Provider: Jason Folk, MD

Patient: CASE, KEITH **DOB:** 06/09/1971 **Date:** 04/24/2013

Electronically signed by Jason Folk M.D. on 05/03/2013 at 03:58 PM EDT

Sign off status: Completed

Progress Note

Patient: CASE, KEITH
DOB: 06/09/1971 **Age:** 41 Y **Sex:** Male
Phone: 864-316-2620
Address: 573 GOLDMINE RD, PAULINE, SC-29374
Pcp: None Identified

Provider: Jason Folk, MD
Date: 02/07/2013

Subjective:**CC:**

1. WCR: RT KNEE RCK/DOI 8.27.12.

HPI:Interim History:

Prior Assessment LT PFPS (Patellofemoral Pain Syndrome) - This is a 41 year old male with bilateral anterior knee pain from a logging accident. Date of Injury: NDOI. Treatment to Date: 12.5.12: steroid injection; physical therapy, conservative management (10.24.12). Response to treatment: patient states feeling the same since last visit. Pain: 5/10.

Pain:

Pain Screening: Any pain at this time? Yes, Quality/Description of pain: intermittent, dull, Is your pain satisfactorily controlled now? No, Plan for inadequately controlled pain: Reassessment of pain at next visit.

HPI:

He comes in today for evaluation of his knees, doing well. His chief complaint is his lumbar spine, which he has been bothered with all along. He indicates that he indicated this to the initial treating doctor from his initial injury, but was dismissed. He continues to have trouble with lower lumbar discomfort. His knees seem to be coming along well. He is concerned about some swelling he has had in his lower extremities, as well.

ROS:

No changes found in review of system since last checked 10.24.12.

Family History: Family: Hypertension, stroke, cancer

Social History: Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Never smoker.

Medications: norco tablet 325 mg-5 mg 1 tab(s) every 6-8 hours, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 247.6, Wt kg 112.31, BMI 35.52, BP 144/91, HR 97, Pain score 5.

Past Orders:**Examination:**General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect. Skin No rashes, lesions, or ulcers.

OOW: 6 WEEKS

On physical examination today, his legs look good, I do not see any discrete significant degree of swelling at all. There are really no edematous changes, he has well healed wounds.

His knees examine nicely. The left knee has some patellofemoral crepitation and no real pain at extremes of range of motion, joint lines are non-tender.

Right knee examines fairly benignly, no effusion, no crepitation, no pain at extremes of motion, 0-140 degrees. Negative straight leg raise, he has some discomfort in paraspinous musculature and midline lower lumbar L-spine.

Assessment:**Assessment:**

1. PFPS (Patellofemoral Pain Syndrome) - 719.46 (Primary)

doing well with regard to his knees.

Plan:

1. PFPS (Patellofemoral Pain Syndrome) Refill norco tablet, 325 mg-5 mg, 1 tab(s), orally, every 6-8 hours, as needed for pain, 30, Refills 0 .

I think his biggest issue is his lumbar spine. I indicated to him at this point, I would encourage him to try to be evaluated for this. We will try to formalize a referral for this, see if his insurance will approve that. He will follow-up with me in six weeks for his knees, at which point, I would anticipate he is probably at maximal medical improvement for his knees. JF/nl.

2. Others

Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

Referral To: Charles Kanos Neurological Surgery

Reason: eval & treat lumbar spine

Immunizations:**Labs:****Preventive:**

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: 6 Weeks post kanos

Provider: Jason Folk, MD

Patient: CASE, KEITH **DOB:** 06/09/1971 **Date:** 02/07/2013

Electronically signed by Jason Folk M.D. on 02/18/2013 at 03:55 PM EST

Sign off status: Completed



STEADMAN HAWKINS
CLINIC of the CAROLINAS

☐ J. Thomas Anderson, M.D.

☐ Sanjitpal (Sonny) Gill, M.D.

☐ Brayton Shirley, M.D.

☐ Brian G. Burnikel, M.D.

☐ Michael J. Kissenberth, M.D.

☐ Paul C. Siffri, M.D.

☐ Kyle J. Cassas, M.D.

☐ Keith Lonergan, M.D.

☐ Stefan J. Tolan, M.D.

☐ Jason W. Folk, M.D.

☐ Timothy P. McHenry, M.D.

☐ Philip Wessinger, M.D.

☐ Stephen P. Geary, M.D.

☐ W. Franklin Sease, M.D.

☐ **WORKER'S COMPENSATION WORK STATUS**

☐ **RETURN TO WORK STATUS**

Patient Name: Keith Case was seen in our office on 2.7.13
Date of Birth: 6.9.71 Date of Injury: 8.27.12

Out of Work until next appointment
Out of Work for (duration): 6 weeks

☐ May Return to Work on _____

☐ May Return to Work with NO RESTRICTIONS

☐ May Return to Work with RESTRICTIONS AS NOTED BELOW

(Circle all that apply)

1. Limit standing to no more than _____ hr/day.
2. Limit sitting to no more than _____ hr/day.
3. Limit walking to no more than _____ hr/day.
4. No lifting over _____ pounds.
5. No climbing of stairs / ladders.
6. No reaching above shoulder level.
7. No squatting.
8. No bending or stooping.
9. No driving mobile equipment.
10. No working on or with moving machinery.
11. No use of R / L / Bil hands.
12. Keep bandaged area clean, dry, and free of trauma.
13. Other Restrictions _____

☐ Has been DISCHARGED for treatment for this accident / illness on _____

☐ MMI has been dictated.

MMI rating is _____
AMA 5th edition page _____ table _____

Follow-up Appointment Date: _____

[Signature]
Physician's Signature

2.7.13
Date

• 864-454-SHCC •

Patewood 454-7422 • Hillcrest 454-6600 • Greer 797-9700

Progress Note

Patient: CASE, KEITH
DOB: 06/09/1971 **Age:** 41 Y **Sex:** Male
Phone: 864-316-2620
Address: 573 GOLDMINE RD, PAULINE, SC-29374
Pcp: None Identified

Provider: Jason Folk, MD
Date: 12/05/2012

Subjective:**CC:**

1. WCR: RT KNEE RCK/DOI 8.27.12.

HPI:Interim History:

Denies : Date of Surgery:.

Prior Assessment PFPS (Patellofemoral Pain Syndrome) - This is a 41 year old male with bilateral anterior knee pain from a logging accident. Date of Injury: NDOI. Treatment to Date: physical therapy, conservative management (10.24.12). Response to treatment: patient states feeling the same since last visit. Pain: Severity: pain = 7, **not satisfactorily controlled**, sharp, dull, intermittent.

Pain:

Pain Screening: Any pain at this time? Yes, Location of pain: right, knee(s), Quality/Description of pain: constant, dull, sharp, What, if any, medication have you taken for this pain? None, Pain Scale used: Number Scale, Face Scale.

HPI:

He comes in today for evaluation of both of his extremities, the right knee is doing well, his wound has healed anteriorly. His left leg wound is apparently healing up nicely. He will hopefully be released, he says "released from this" in the next couple days, I think meaning able to do more with this and less restricted in terms of required crutch ambulation and minimal use.

His left knee continues to be an issue for him. He is also complaining of lumbar discomfort. His knee is a problem in that he finds it difficult to bend it and does not feel as though it works, necessarily well for him.

ROS:

No changes found in review of system since last checked 10.24.12.

Family History: Family: Hypertension, stroke, cancer

Social History: Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Never smoker.

Medications: None

Allergies: N.K.D.A.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 240, Wt kg 108.86, BMI 34.43, BP 132/86, HR 90, Pain score 7.

Examination:General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect. Skin No rashes, lesions, or ulcers.

On physical examination, there is no effusion, but he does have distinct crepitation through an active range of motion, pain at extremes of extension, comfortable flexion up to about 140 but knee flexion and hip flexion kind of gives his back discomfort. He has distinct parapatellar tenderness, lateral facet patellar tenderness, no joint line tenderness. Stable ligamentous exam.

Examination of his hip reveals benign exam, no provocation, flexion, flexion internal/external rotation is non-painful, no pain with FABER maneuver.

Assessment:**Assessment:**

1. PFPS (Patellofemoral Pain Syndrome) - 719.46 (Primary)

Left knee, I think the problem here is largely due to the patellofemoral complaints but continuing to be symptomatic.

Plan:**1. PFPS (Patellofemoral Pain Syndrome)**

Left knee - I think he would profit from intraarticular injection. I think he would also profit from continued therapy. Now, with him being able to do more after healing the left leg wound, I think we will be able to address some of his functional issues and fitness issues. The knee was injected today, after sterile prep, using superolateral approach, 0.25% Marcaine into skin and subcu, down to the level of the joint. At the joint, 1 cc 40 mg. Kenalog and 2 cc 0.25% Marcaine was injected. The plan is to see him back in six weeks for clinical re-evaluation and symptom review. JF/nl.

2. Others

Cont all current medications as directed by prescribing physician(s).

Procedures:Injection:

Injection After verbal consent obtained including a discussion of the risks, benefits, and alternatives, the patient wishes to proceed. Complications discussed include but not limited to: pain, infection, steroid flare, fat necrosis, skin discoloration, and injury to blood vessels or nerves. The anatomic site was sterilized with alcohol/betadine solution and under sterile conditions the anatomic site was injected with a solution of local anesthetic and 1 cc of corticosteroid. The patient tolerated the procedure without immediate complications. Patient is instructed to call the office if any signs or symptoms of infection occur including significant increase in pain, warmth, redness or drainage at the injection site.

Immunizations:**Labs:**

Procedure Codes: 20610 Large joint/bursa, aspiration/injection rt knee, J3301 Kenalog 40 mg (1cc=4units)

Preventive:

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: 6 Weeks

Provider: Jason Folk, MD

Patient: CASE, KEITH **DOB:** 06/09/1971 **Date:** 12/05/2012

Electronically signed by Jason Folk M.D. on 12/17/2012 at 03:13 PM EST

Sign off status: Pending

Progress Note

Patient: CASE, KEITH
DOB: 06/09/1971 **Age:** 41 Y **Sex:** Male
Phone: 864-316-2620
Address: 573 GOLDMINE RD, PAULINE, SC-29374
Pcp: None Identified

Provider: Jason Folk, MD
Date: 10/24/2012

Subjective:**CC:**

1. WCN:RT KNEE/ LT Lower Leg.

HPI:History of Present Illness:

Denies : Sports Activity:.

What: RT Knee/ Rt Lower Leg. Where: LT Lower Leg-TIB-Fib Area. How: Pt states he was on a Log Holder and one of the logs rolled over and pinched his LT Leg, Resulting in the pt falling and hitting a tractor frame. Pain: Severity: pain = 8, aching, throbbing, intermittent.

Pain:

Pain Screening: Any pain at this time? Yes, Location of pain: right, knee(s), Quality/Description of pain: intermittent, aching, throbbing, What, if any, medication have you taken for this pain? Other, Pain Scale used: Number Scale, Face Scale.

HPI:

(Kevin Kruse, M.D. dictating for Dr. Jason Folk)

chief complaint: Bilateral knee pain

This is a 41 year old male who was involved in an accident at work, over two months ago. He is a logger, a log fell on both of his legs and hit his left tibia. He sustained a laceration which then became infected, eventually developing osteomyelitis in his left tibia. This has been treated with wound care as well as Avelox for antibiotics for the left tibia. He has also had bilateral anterior knee pain since his accident, has not sought any treatment for his knees up until this point. He says he has difficulty doing a full squat on both of his knees and most of the pain is anterior. He denies any pain in his knees prior to this incident.

ROS:CONSTITUTIONAL:

Fever no. Weight Loss **yes**. Weight Gain no. Fatigue **yes**. Chills **yes**. Night Sweats no.

-EYES:

Decreased Vision no. Cataracts no.

ENT:

Recent loss of hearing no. Sinusitis no. Headache no.

CARDIOVASCULAR:

Chest Pain **yes**. Irregular Heart Beat no. Poor Circulation no. Leg/feet swelling **yes**. Leg/foot ulcer no.

RESPIRATORY:

COPD no. Asthma no. Persistent Cough no. Shortness of Breath no. Wheezing no. Pneumonia no.

GASTROINTESTINAL:

GERD no. PUD/Gastritis no. Liver Problems no. Stomach Pain no. Diarrhea no. Abdominal Pain no. Nausea/Vomiting no. Black tar-like or bloody stool no.

GENITOURINARY:

Blood in urine no. Pain in urinating no. Unable to urinate no. Bladder Infection no. Frequent Urination no. Difficulty with urination **yes**.

MUSCULOSKELETAL:

Joint Swelling **yes**. Muscle aches no. Joint Pain no. Pain in multiple joints no. Weakness no.

SKIN:

Rash or itching no. Dryness of Skin no. Ulcer no. Cancer no. Open sores no. New Moles no. Poor wound healing no. Skin Infection no.

NEUROLOGICAL:

Paralysis no. Frequent Headaches no. Seizures no. CVA/TIA no. Syncope no. Anxiety/Depression no. Tremors no. Speech Problems no. Feeling of hopelessness no. Sleep

disturbance no. Vision Changes no.

PSYCHIATRIC:

Depression no. Bipolar Disease no.

HEME/LYMP:

Anemia no. Bleeding Problems no. Blood Transfusion no. Bruises no.

ENDOCRINE:

Diabetes no. Thyroid disease no. Heat intolerance no. Cold intolerance no.

ALLERGIC/IMMUNOLOGIC:

Seasonal no. Iodine no. Food Allergies no.

Family History: Family: Hypertension, stroke, cancer

Social History: Alcohol men 18-65 yrs Assessment completed: today, Alcohol intake: patient does not drink alcohol. Smoking Status > 13 years old Are you a: Never smoker.

Medications: Avelox tablet 500 mg 1 tab(s) , other as directed Promethesione 25 mg, Percocet 5/325 mg 1 tab , Ibuprofen tablet 600 mg , Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 70, Ht Cm 177.8, Wt lbs 240, Wt kg 108.86, BMI 34.43, BP 126/87, HR 80, Temp (F) 97.8, Pain score 8.

Past Orders:

Examination:

General:

General Appearance: Well and in no acute distress. Cardiovascular: Regular rhythm by palpation of distal pulse, normal color and temperature, no concerning varicosities on symptomatic side. Lungs: Breathing easily. Psychiatric: Well-oriented with a normal mood and affect. Skin No rashes, lesions, or ulcers.

On physical examination of bilateral legs, he has a full knee extension as well as flexion, bilaterally, no pain with end range of motion. He is stable to varus/valgus stress at 0 and 30 degrees. Negative Lachman, negative posterior drawer, bilaterally. He does have pain with patella grind and does have crepitus bilaterally in both of his knees. He has no significant knee effusion. Both his patellae are stable to medial and lateral translation.

Imaging Studies:

Knee X-Ray: X-rays of his knees show no significant acute injury in all planes, some mild patellofemoral arthritis noted on the Sunrise view. .

Assessment:

Assessment:

1. PFPS (Patellofemoral Pain Syndrome) - 719.46 (Primary)

This is a 41 year old male with bilateral anterior knee pain from a logging accident.

Plan:

1. PFPS (Patellofemoral Pain Syndrome)

The patient likely has some baseline chondromalacia of his patella and has undergone some deconditioning because he has been on crutches for his osteoarthritis tibia since his accident. Overall, I think we can get him better with some diligent physical therapy, conservative management, at this point, so we will get him into some physical therapy for quadriceps strengthening and anterior knee pain program and see him back in six to eight weeks to re-evaluate him. kk/JF/nl

I was physically present during the critical or key portions of the service furnished and in the management of this patient. JF/nl.

2. Others Continue Avelox tablet, 500 mg, 1 tab(s), orally ; Continue other, as directed, Promethesione 25 mg ; Continue Percocet, 5/325 mg, 1 tab, Oral ; Continue Ibuprofen tablet, 600 mg, orally . Cont all current medications as directed by prescribing physician(s).

Immunizations:

Diagnostic Imaging: Tibia/Fibula, 2 views, left, Knee, 4 views, right (complete)

Labs:**Procedure Codes:** 73564 KNEE (4 OR MORE VIEW) X-RAY, 73590 TIBIA/FIBULA (2 VIEWS) X-RAY**Preventive:**

MED RECONCILIATION: Pt. Ed: Current Meds Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.

Follow Up: 6 Weeks**Provider:** Jason Folk, MD**Patient:** CASE, KEITH **DOB:** 06/09/1971 **Date:** 10/24/2012**Electronically signed by Jason Folk M.D. on 11/02/2012 at 04:00 PM EDT****Sign off status:** Completed

Carolina Neurology

541 Floyd Road
Spartanburg, S.C. 29307
Phone (864) 585-6179
Fax (864) 583-5403
Carolinaneurology1@gmail.com

INDEPENDENT MEDICAL EVALUATION**December 27, 2012**

Keith Case
DOB 6/9/71

Records Reviewed:

Wound Care Clinic MBH note: 10/2/12
Pacolet Family Medicine office notes: 9/4/12 to 10/4/12
Wound Center SRMC: 10/10/12 to 12/6/12
SRMC ED notes: 8/27/12 and 8/29/12
Venous Duplex: 9/12/12
MRI left lower extremity: 10/9/12
Dr. Folk office notes: 10/24/12 to 12/5/12
Physical Therapy Notes: 11/1/12 to 12/14/12

Mr. Case is a 41 year old man referred for difficulties subsequent to an injury 8/27/12. At that time his left lower leg was briefly pinned by a log which had rolled from a pile on his truck, at which time he also twisted to free himself and ultimately landed on both knees on the truck frame. He was initially seen at SRMC ED for wound care. Multiple xrays were performed of the left elbow, bilateral knees, and left leg. His wounds were cleansed and sutured and he was seen in follow up one week later for wound care about the right knee and left lower leg. He was seen in for suture removal at Pacolet Family Medicine and continued on antibiotics. One week later he developed increased swelling in the left lower leg. Venous duplex was unremarkable. MRI of the left lower leg was performed 10/9/12 and was consistent with cellulitis with early osteomyelitis. The patient was seen at the wound center and received debridement to the left pre-tibial area followed by protracted PO antibiotics and dressing changes. Ultimately his wound granulated and he was discharged 12/6/12.

He was also referred to Dr. Folk for bilateral, left > right knee pain and was diagnosed with patellofemoral pain syndrome and chondromalacia. He was enrolled in physical therapy and on 12/5/12 received a cortisone injection to the left knee. He remains in physical therapy and has yet to be released from orthopedic care. His next appointment is 1/23/13.

Keith Case
DOB 6/9/71
December 27, 2012
Page Two

He denies any previous difficulties with his lower extremities, knees or back. He has remained out of work since his injury.

He reports continued difficulties with pain in the lumbosacral region after sitting for 40 minutes. After standing for 30 minutes he develops pain and swelling in the left anterior shin. He reports pain and crepitus to range of motion of the left>right knee. He has noted numbness to the lateral thigh area bilaterally. He uses a crutch or cane to assist with ambulation outside the house. He is utilizing Lortab 5 three per day.

Left elbow difficulties noted initially after the injury have resolved.

He completes a Pain Assessment Questionnaire placing his Self Report of Pain Severity at 14/20, an Activity Limitation Score at 8/10 and an Effect of Pain on Mood Score at 8/10.

Past medical history is otherwise remarkable for carpal tunnel syndrome. He does not smoke cigarettes or drink alcohol. Family history and review of systems are non-contributory.

Examination demonstrates a blood pressure of 125/70 with a weight of 248 pounds and a height of 5'10". Examination of the lumbar spine demonstrates forward flexion of 30 degrees, extension 10 degrees and lateral flexion 15 degrees bilaterally. The quality of flexion and return to erect position are normal. There is palpable spasm to the bilateral lower lumbosacral paraspinous region. Straight leg raising while seated is negative.

Right knee examination demonstrates flexion of 140 degrees with extension lag of -5 degrees. There is audible crepitus with range of motion. A stellate &-shaped mottled scar is present about the anterior knee with the arms measuring 3 cm each and the stem 2 cm.

The left knee demonstrates flexion of 120 degrees with extension lag of -5 degrees with audible crepitus on range of motion. There is an ovoid scar over the anterior shin measuring 2.5 cm in its log axis and 1.5 cm horizontally with puffiness in the region around the scar. The scar is fixed to the subcutaneous tissues and is mottled in appearance.

Neurologic examination demonstrates normal tone, bulk and strength to confrontation with normal sensation to pinprick. Reflexes are 2+ and symmetric. Gait is antalgic favoring the left leg.

Keith Case

DOB 6/9/71

December 27, 2012

Page Three

Impression:

1. Left leg crush injury with resultant osteomyelitis and scarring with continued local soft tissue pain and swelling. All reasonable treatment and diagnostic trials have been pursued.

Based upon the above evaluation and using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Mr. Case would be assessed a 5% impairment of the left lower extremity as a result of his injury of 8/27/12.

2. Left knee patellofemoral syndrome with loss of range of motion and crepitus—additional orthopedic care is recommended and the patient is not at maximum medical improvement.

Based upon the above evaluation and using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Mr. Case currently would be assessed an additional 5% impairment of the left lower extremity as a result of his injury 8/27/12. Additional evaluation and treatment have the potential of altering this rating.

3. Right knee patellofemoral syndrome with loss of range of motion and crepitus—additional orthopedic care is recommended and the patient is not at maximum medical improvement.

Based upon the above evaluation and using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Mr. Case currently would be assessed an additional 2% impairment of the right lower extremity as a result of his injury 8/27/12. Additional evaluation and treatment have the potential of altering this rating.

4. Post traumatic low back pain—my initial impression is that this represents a musculoskeletal etiology, however the reports of bilateral thigh numbness may require additional evaluation with MRI.

Based upon the above evaluation and using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Mr. Case currently would be assessed an additional 5% impairment of the spine as a result of his injury 8/27/12. Additional evaluation and treatment have the potential of altering this rating.

Keith Case
DOB 6/9/71
December 27, 2012
Page Four

5. Post traumatic low back pain—my initial impression is that this represents a musculoskeletal etiology, however the reports of bilateral thigh numbness may require additional evaluation with MRI.

Based upon the above evaluation and using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, Mr. Case currently would be assessed an additional 5% impairment of the spine as a result of his injury 8/27/12. Additional evaluation and treatment have the potential of altering this rating.



Carol A. Kooistra, M.D.



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Dec 14, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 4

Employer: J. CRAWFORD LOGGING
Insured:

proaxistherapy

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 5/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Good.

Daily Comments:

- Pt states his knees feel a little better today, states he thinks the injection helped some. Pt states Dr Folk wanted him to continue with therapy.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/28/2012
- Total Score: 18

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 14, 2012

Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression

- Patellar Grind Test

Left

Normal
Normal
Normal

Left

4/5
4/5
4/5
4/5

Left AROM

0
137

Right

Normal
Normal
Normal

Right

4/5
4/5
+4/5
4/5

Right AROM

0
140

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(This visit)
- Straight Leg Raises - 3 Way
- Straight Leg Raises-Abduction
- Straight Leg Raises-Extension
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip(This visit)
- Adduction Hip(This visit)
- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

Did Not Perform: This visit

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position:

Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position:

Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 4 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 3 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 14, 2012

- Recumbent Bicycle(10 minutes)

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Lunges-Forward
- Lunges-Side Step
- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)
- Wall Squats.
- Closed Kinetic Chain 1

Time Elapsed: 4 Minutes, Additional Detail: with red band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Additional Detail: with red band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
Time Elapsed: 4 Minutes, Description: Stool crawls, Charge As: Therapeutic Exercise, Billing Code: 97110.

Manual Interventions: Joint Complex:

- Patellofemoral Joint(This visit)

Did Not Perform: This visit

Manual Interventions: Soft Tissue:

- Scar Tissue(This visit)

Did Not Perform: This visit

Assessment

Pt tolerated new higher level strengthening activites well today, reporting fatiguing quickly. Pt arrived to therapy again today using his crutches for ambulation, patient was instructed again that he needed to stop using crutches to further strengthen his legs by using his muscles during ambulation.

Plan

Continue LE strengthening, balance training

Kristen Downey, PT(SC Lic: 5366)
Signed on Dec 14, 2012 12:10:42



proaxistherapy

Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Dec 10, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 10
Cxl/Ns: 4

Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee

7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping (difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 5/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Good.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/28/2012
- Total Score: 18

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide

Left
Normal

Right
Normal



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 10, 2012

- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Normal
Normal

Left

4/5
4/5
4/5
4/5

Left AROM

0
137

Normal
Normal

Right

4/5
4/5
+4/5
4/5

Right AROM

0
140

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Straight Leg Raises-Abduction
- Straight Leg Raises-Extension
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip(This visit)
- Adduction Hip(This visit)
- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 4 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 3 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 10, 2012

- Recumbent Bicycle(10 minutes)

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 6 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 6 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Pt met goal for knee ROM and patellar mobility today. New goal added for bilateral LE strength. Pt instructed again to wean off crutches as he continues to use crutches

Plan

Continue LE strengthening, balance retraining, proprioception

Kristen Downey, PT(SC Lic: 5366)
Signed on Dec 10, 2012 11:39:57



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Dec 03, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 9
Cxl/Ns: 4

Employer: J. CRAWFORD LOGGING
Insured:

proaxistherapy

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 7/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Good.

Daily Comments:

- Pt states both of his knees, his left hip and his back are hurting today. States that he feels that his pain is not getting any better. Pt states he has a follow up appt with Dr Folk on Wednesday.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/28/2012
- Total Score. 18

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 03, 2012

Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Normal
Normal
Normal

Left

4/5
4/5
4/5
4/5

Left AROM

0
130

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Normal
Normal
Normal

Right

4/5
4/5
+4/5
4/5

Right AROM

0
125

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Straight Leg Raises-Abduction
- Straight Leg Raises-Extension
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip
- Adduction Hip
- Quad Sets

Exercise Activities: Machines/Weights:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds;
Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing
Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge
As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position:
Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position:
Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 4 Pounds, Repetitions:
10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic
Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine,
Additional Detail: against blue band, Charge As: Therapeutic
Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Position: Supine, Additional Detail: ball
squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing
Code: 97110.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Dec 03, 2012

- Shuttle, Bilat Squat(strength for squatting)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable,
Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic
Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds,
Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As:
Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 6 Minutes, Grade: II/III, Pressure: Oscillatory,
Technique 1: Superior Glide, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Time Elapsed: 6 Minutes, Tx Depth: Moderate, Location: right
patella, Direction: Multidirectional, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Assessment

Pt with normal patellar mobility today, however still reporting pain with patellar mobs. Pt continues to report hip and knee pain with all exercises. Pt has follow up appt with Dr Folk on Wednesday.

Plan

Continue patellar mobs, knee ROM, LE and core strengthening

Kristen Downey, PT(SC Lic: 5366)
Signed on Dec 03, 2012 11:39:36



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 28, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 8
Cxl/Ns: 4
Employer: J. CRAWFORD LOGGING
Insured:

Plan of Care

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

Assessment

Pt still reporting left hip pain with all exercises. Pt continues to report weakness more in the left leg than right with hip and knee strengthening exercises. Pt has been instructed by PT to wean off crutches, however continues to be on crutches at every therapy session. Pt has a follow up appt with Dr Folk next Wednesday.

Problems & Goals

Problem #1 Chief Complaint: Pain: Severity at Worst: 7/10.

LTG Achieve by Dec 13, 2012. in order to tolerate rolling over in bed

Symptomatic Improvements:

- Decreasing Pain: to 4/10.

Problem #2 Range of Motion: Knee: Pre-Treatment.

Left AROM

Right AROM

- Extension

0

0

- Flexion

130

125

LTG Achieve by Nov 29, 2012. to improve ambulation

Range of Motion Improvements to: Knee:

Right AROM

- Flexion

130

Problem #3 Joint Integrity/Mobility.

Left

Right

- Inferior Patellar Glide

Hypomobile/Painful

Hypomobile/Painful

- Lateral Patellar Glide

Hypomobile/Painful

Hypomobile/Painful

- Medial Patellar Glide

Hypomobile/Painful

Hypomobile/Painful

LTG Achieve by Dec 31, 2012. to improve stairs

Improve patella mobility to normal without pain to improve PF mechanics and decrease pain.

Problem #4 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.

LTG Achieve by Nov 29, 2012.

Client Education:

- Independent Home Exercise/Self Care Program.

Problem #5 Questionnaires: Lower Extremity Functional Scale.

- Date:

11/28/2012

- Total Score.

18

Please sign and return

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 28, 2012

LTG Achieve by Jan 30, 2013. to improve ADL's

Questionnaire Improvements: Lower Extremity Functional Scale: Questionnaire:

- Total Score. 50

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 2 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Client Education. Home Exercise Program. Joint Mobilization Techniques. Proprioceptive/Closed Kinetic Chain Activities. Stretching/Flexibility Activities. Therapeutic Activities. Therapeutic Exercise.

A handwritten signature in black ink that reads 'Kristen Downey, PT'.

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 28, 2012 19:05:18



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 28, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 8
Cxl/Ns: 4

Employer: J. CRAWFORD LOGGING
Insured:

Re-Evaluation *Progress Report (No Re-eval Charge)*

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping (difficulty with rolling over in bed) Nightly disturbances
- Walking Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 7/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states he is still having left hip pain and is also having low back pain. States his low back is popping everytime he turns over in bed. Pt states he is still using his crutches because his doctor told him to stay off his left leg and hasn't cleared him to get off crutches yet.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/28/2012
- Total Score: 18

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 28, 2012

Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression

- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Nov 01, 2012

Left

4/5
-4/5
-4/5
-4/5

Right

4/5
-4/5
+4/5
-4/5

Nov 01, 2012

L. Act.

0
130

R. Act.

0
120

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Nov 28, 2012

Left

4/5
4/5
4/5
4/5

Right

4/5
4/5
+4/5
4/5

Nov 28, 2012

L. Act.

0
130

R. Act.

0
125

Right

Negative
Negative

Right

Negative

Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Straight Leg Raises-Abduction
- Straight Leg Raises-Extension
- Terminal Knee Extension (TKE)

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 4 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine, Additional Detail: against blue band, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Position: Supine, Additional Detail: ball squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Isometrics:

- Abduction Hip
- Adduction Hip



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 28, 2012

- Quad Sets

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Did Not Perform: This visit

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraining for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 6 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 6 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Pt still reporting left hip pain with all exercises. Pt continues to report weakness more in the left leg than right with hip and knee strengthening exercises. Pt has been instructed by PT to wean off crutches, however continues to be on crutches at every therapy session. Pt has a follow up appt with Dr Folk next Wednesday.

Problems & Goals

Problem #1 Chief Complaint: Pain: Severity at Worst: 7/10.

LTG Achieve by Dec 13, 2012. in order to tolerate rolling over in bed

Symptomatic Improvements:

- Decreasing Pain: to 4/10.

Problem #2 Range of Motion: Knee: Pre-Treatment.

LTG Achieve by Nov 29, 2012. to improve ambulation

Range of Motion Improvements to: Knee:

- Flexion

Right AROM

130

Problem #3 Joint Integrity/Mobility.

LTG Achieve by Dec 31, 2012. to improve stairs

Improve patella mobility to normal without pain to improve PF mechanics and decrease pain.

Problem #4 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 28, 2012

LTG Achieve by Nov 29, 2012.

Client Education:

- Independent Home Exercise/Self Care Program.

Problem #5 Questionnaires: Lower Extremity Functional Scale.

LTG Achieve by Jan 30, 2013. to improve ADL's

Questionnaire Improvements: Lower Extremity Functional Scale: Questionnaire:

- Total Score. 50

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 2 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Client Education. Home Exercise Program. Joint Mobilization Techniques. Proprioceptive/Closed Kinetic Chain Activities. Stretching/Flexibility Activities. Therapeutic Activities. Therapeutic Exercise.

A handwritten signature in black ink that reads 'Kristen Downey, PT'.

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 28, 2012 19:05:18





Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 21, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 7
Cxl/Ns: 3

Employer: J. CRAWFORD LOGGING
Insured:

proaxistherapy

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states he feels about the same today. States he is still having pain in his left hip and today is having pain in his back.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score. 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 21, 2012

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
4/5
4/5
4/5

Left AROM

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
4/5
+4/5
4/5

Right AROM

0
125

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Terminal Knee Extension (TKE)

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 4 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Isometrics:

- Abduction Hip
- Adduction Hip
- Quad Sets

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine, Additional Detail: against blue band, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Position: Supine, Additional Detail: ball squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 21, 2012

- Recumbent Bicycle(10 minutes)

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 6 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 6 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 65 Minutes

Assessment

Pt showed improvement with left hip strength to 4/5 today. Pt still reporting pain in his left hip with exercises. Pt instructed again to try and wean himself off crutches.

Plan

Continue patellar mobilization, scar mobilization, LE strengthening and balance activities.

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 21, 2012 13:30:40



proaxistherapy

Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 19, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 6
Cxl/Ns: 3
Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping (difficulty with rolling over in bed) Nightly disturbances
- Walking Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states his whole left leg is hurting today. States his hip is also hurting on the left. States he thinks the way that he fell, the left side took most of the injury and thinks this hip pain is a result of his initial injury.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 19, 2012

Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
-4/5
-4/5
4/5

Left AROM

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
-4/5
+4/5
4/5

Right AROM

0
125

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip
- Adduction Hip
- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine, Additional Detail: against blue band, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 2 Minutes, Position: Supine, Additional Detail: ball squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 19, 2012

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Time Elapsed: 2 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 8 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Pt continues to report hip pain during strengthening exercises. Pt showed improvement with left knee ROM to 125 degrees today.

Plan

Continue knee ROM, patellar mobility, LE strengthening, balance and proprioception

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 19, 2012 18:51:10



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 16, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 5
Cxl/Ns: 3

Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping. (difficulty with rolling over in bed) Nightly disturbances
- Walking. Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states he doesn't feel good today. States he is still having pain in his knees and feels weak.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 16, 2012

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression

- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
-4/5
-4/5
-4/5

Left AROM:

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
-4/5
+4/5
-4/5

Right AROM

0
120

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative

Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)

- Straight Leg Raises - 3 Way

- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip

- Adduction Hip

- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(This visit)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine, Additional Detail: against blue band, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 2 Minutes, Position: Supine, Additional Detail: ball squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 16, 2012

- Recumbent Bicycle(10 minutes)

Time Elapsed: 3 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraing for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 8 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Pt tolerated strengthening and standing exercises better today. Pt still reporting bilateral knee pain during all exercises.

Plan

Continue patellar mobilization, knee ROM, LE strengthening

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 18, 2012 21:08:01



proaxistherapy

Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 15, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 4
Cxl/Ns: 3

Employer: J. CRAWFORD LOGGING
Insured:

Cancel/No Show *Patient cancelled appointment*

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

Cancel Reasoning:

- VOID 11.5 GOING TO DT SPART. AW

Geeta Armstrong, PT(SC Lic: 6791)
Signed on Nov 15, 2012 07:38:06



Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 14, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 4
Cxl/Ns: 2

Employer: J. CRAWFORD LOGGING
Insured:

proaxistherapy

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states his knees and hips are hurting today. Pt states he laid in the bed for 2 days after his last therapy session due to being in increased pain.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence.

Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression

- Patellar Grind Test

Left

Hypomobile/Painful
 Hypomobile/Painful
 Hypomobile/Painful

Left

4/5
 -4/5
 -4/5
 -4/5

Left AROM

0
 130

Right

Hypomobile/Painful
 Hypomobile/Painful
 Hypomobile/Painful

Right

4/5
 -4/5
 +4/5
 -4/5

Right AROM

0
 120

Left

Negative
 Negative

Left

Compression Aggravates
 Symptom

Right

Negative
 Negative

Right

Negative

Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Abduction Hip
- Adduction Hip
- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(This visit)

Exercise Activities: Range of Motion:

- Box Stretch(This visit)

Exercise Activities: Aerobic Conditioning:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds,
 Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing
 Code: 97530.

Time Elapsed: 10 Minutes, Position: Flex-Abd-Ext - Lying, Charge
 As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 3 Pounds, Repetitions:
 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic
 Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 3, Position: Supine,
 Additional Detail: against blue band, Charge As: Therapeutic
 Exercise, Billing Code: 97110.

Time Elapsed: 2 Minutes, Position: Supine, Additional Detail: ball
 squeezes, Charge As: Therapeutic Exercise, Billing Code: 97110.
 Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing
 Code: 97110.

Did Not Perform: This visit

Did Not Perform: This visit



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 14, 2012

- Recumbent Bicycle(10 minutes)

Time Elapsed: 3 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Squatting(retraining for stair climbing)
- Step Ups: Forward(retrain squatting to pick up items off floor)

Time Elapsed: 3 Minutes, Weight - Pounds: Body Weight Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 8 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: Superior Glide, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Location: right patella, Direction: Multidirectional, Charge As: Manual Therapy Techniques, Billing Code: 97140.

Assessment

Pt tolerated strengthening exercises well today. Pt still reporting knee pain and grinding with exercises.

Plan

Continue soft tissue mobilization, knee ROM and patellar mobs, LE strengthening

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 14, 2012 11:48:49



proaxistherapy

Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 12, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 3
Cxl/Ns: 2

Employer: J. CRAWFORD LOGGING
Insured:

Cancel/No Show *Patient cancelled appointment*

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

Cancel Reasoning:

- VOID 11.5 GOING TO DT SPART. AW

Geeta Armstrong, PT(SC Lic: 6791)
Signed on Nov 12, 2012 11:29:33



proaxistherapy

Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 09, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 3
Cxl/Ns: 1
Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping (difficulty with rolling over in bed) Nightly disturbances
- Walking Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Pt states his knees are hurting today. States he is having a good deal of stiffness in his legs today as well.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 09, 2012

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression

- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
-4/5
-4/5
-4/5

Left AROM

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
-4/5
+4/5
-4/5

Right AROM

0
120

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative

Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)

- Straight Leg Raises - 3 Way

- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(for improved sit to stand)

Exercise Activities: Range of Motion:

- Box Stretch

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Manual Interventions: Joint Complex:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 12 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 1 Cord, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 09, 2012

- Patellofemoral Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory,
Technique 1: Superior Glide, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Location: right
patella, Direction: Multidirectional, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Assessment

Pt tolerated all exercises well today, but fatigued quickly today. States he is not having a good day. Pt instructed on importance of continuing home exercise program.

Plan

Continue patellar mobs, scar tissue mobilization, LE strengthening focusing on quads.

Kristen Downey, PT(SC Lic: 5366)
Signed on Nov 11, 2012 19:43:02



proaxistherapy

Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 09, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 2
Cxl/Ns: 1

Employer: J. CRAWFORD LOGGING
Insured:

Cancel/No Show *Patient cancelled appointment*

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

Cancel Reasoning:

- VOID 11.5 PATIENT GOING TO SPARTANBURG. AW

Geeta Armstrong, PT(SC Lic: 6791)
Signed on Nov 09, 2012 12:37:46



proaxistherapy

Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 06, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 2
Cxl/Ns: 0

Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee

7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Daily Comments:

- Patient states exercises at home are doing well. Continues to have difficulty ambulating without crutches. C/o pain in L hip.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 06, 2012

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
-4/5
-4/5
-4/5

Left AROM

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
-4/5
+4/5
-4/5

Right AROM

0
120

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for improved toe off)
- Straight Leg Raises - 3 Way
- Terminal Knee Extension (TKE)

Exercise Activities: Isometrics:

- Quad Sets

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(for improved sit to stand)

Exercise Activities: Range of Motion:

- Box Stretch

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Manual Interventions: Joint Complex:

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 12 Minutes, Position: Flex-Abd-Ext - Lying, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Additional Detail: short arc, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 1 Cord, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 06, 2012

- Patellofemoral Joint

Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory,
Technique 1: Superior Glide, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 8 Minutes, Tx Depth: Moderate, Location: right
patella, Direction: Multidirectional, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Therapy Session Time

- Total Therapy Session Time 60 Minutes

Assessment

Presentation:

- Patient was able to tolerated the increase in exercises today. Did fatigue easily.

Plan

Daily Plan:

- Continue to progress strengthening and endurance exercises.

Geeta Armstrong, PT(SC Lic: 6791)
Signed on Nov 06, 2012 13:34:44



Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 01, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 1
Cxl/Ns: 0
Employer: J. CRAWFORD LOGGING
Insured:

Plan of Care

Diagnoses Bilateral Knee
7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

Assessment

In my professional opinion, this client requires skilled rehabilitative therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is good. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 2-3 months. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits good understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.

Evaluation Components:

- Barriers to Rehab: Infection left lower leg

Impairments Identified:

- ADL's. Balance. Endurance. Muscle Performance. Pain. Posture. Range of Motion. Work Capacity. Strength. Soft Tissue Mobility. Joint Integrity/Mobility.

Treatment Emphasis to focus on:

- Pain relief. Postural Improvements. Anthropometric Normalization. Range of Motion/Mobility Improvements. Muscle Function Improvements. Proprioception/Balance Improvements.

Problems & Goals

Problem #1 Chief Complaint: Pain: Severity at Worst: 8/10.

LTG Achieve by Dec 13, 2012. in order to tolerate rolling over in bed

Symptomatic Improvements:

- Decreasing Pain: to 4/10.

Problem #2 Range of Motion: Knee: Pre-Treatment.

- Extension
- Flexion

Left AROM

0
130

Right AROM

0
120

LTG Achieve by Nov 29, 2012. to improve ambulation

Range of Motion Improvements to: Knee:

- Flexion

Right AROM

130

Problem #3 Joint Integrity/Mobility.

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Please sign and return.

I have reviewed this Plan of Care and certify that the skilled therapy services identified are required to meet the patient's need.
Comments and/or revisions to this Plan of Care are noted below.

Comments/Revisions

Physician/NPP Signature

Date

Print Name and Credentials



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 01, 2012

LTG Achieve by Dec 31, 2012. to improve stairs

Improve patella mobility to normal without pain to improve PF mechanics and decrease pain.

Problem #4 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.

LTG Achieve by Nov 29, 2012.

Client Education:

- Independent Home Exercise/Self Care Program.

Problem #5 Questionnaires: Lower Extremity Functional Scale.

- Date: 11/01/2012
- Total Score. 11

LTG Achieve by Jan 30, 2013. to improve ADL's

Questionnaire Improvements: Lower Extremity Functional Scale: Questionnaire:

- Total Score. 50

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Active Range of Motion Activities. Client Education. Gait Training. Therapeutic Exercise. Therapeutic Activities. Soft Tissue Mobilization Techniques. Passive Range of Motion Activities. Manual Therapy Techniques.

Geeta Armstrong, PT(SC Lic: 6791)
Signed on Nov 01, 2012 12:17:53



Greenville Proaxis Therapy
727 SE Main Street
Simpsonville, SC USA 29681
Phone: (864) 454-6670
Fax: (864) 454-6675

Acct #: 0011577
Patient: **KEITH CASE**
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Geeta Armstrong
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: **Nov 01, 2012**
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 1
Cxl/Ns: 0

Employer: J. CRAWFORD LOGGING
Insured:

Initial Evaluation

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file. The patient has read and signed the Patient Rights and Consent for Treatment forms, they have been reviewed by the evaluating therapist, and are on file.

ADL / Functional Status:

- Current status:
 - Basic care: Minimal assistance required. Work status: Unable to work secondary to dysfunction.
- Premorbid status:
 - Work status: Full time / Full duty. Basic care: Independent Without Difficulty.

ADL / Functional Status: ADL's: Activities:

- | | |
|--|---|
| • Climbing | climbing up stairs with hands and knees |
| • Mobility/Transfers | Independent, requires more time |
| • Sleeping (difficulty with rolling over in bed) | Nightly disturbances |
| • Walking | Adaptive assistive levels |

Chief Complaint: Pain:

- Severity at Worst: 8/10. Current Severity: 8/10.

Client Knowledge/Awareness of:

- Home Exercise Program: Lacks appropriate program.

Mechanism of Injury: Primary Episode: Date of Injury:



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 01, 2012

- Date 08/27/2012

Mechanism of Injury:

- Primary Episode: Traumatic: Fell.

Questionnaires: Lower Extremity Functional Scale:

- Date: 11/01/2012
- Total Score: 11

Rehabilitation Expectations/Goals:

- Return to Work Activities: Unrestricted/Symptom Free. Return to Age Appropriate Activities: Unrestricted/Symptom Free.

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 2 crutches with antalgic gait on the left lower extremity greater than right. Decreased cadence. Poor quad control bilaterally.

Joint Integrity/Mobility:

- Inferior Patellar Glide
- Lateral Patellar Glide
- Medial Patellar Glide

Muscle Testing: Lower Extremity MMT:

- Hip Abduction(11/01)
- Hip Adduction
- Hip Extension
- Hip Flexion

Range of Motion: Knee: Pre-Treatment:

- Extension
- Flexion

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Left

4/5
-4/5
-4/5
-4/5

Left AROM

0
130

Right

Hypomobile/Painful
Hypomobile/Painful
Hypomobile/Painful

Right

4/5
-4/5
+4/5
-4/5

Right AROM

0
120

Left

Negative
Negative

Left

Compression Aggravates
Symptom

Right

Negative
Negative

Right

Negative
Aggravates Symptoms

Treatments

Exercise Activities: Isotonics:

- Heel Raises.
- Straight Leg Raises - 3 Way

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds,
Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing
Code: 97110.

Time Elapsed: 12 Minutes, Position: Flex-Abd-Ext - Lying, Charge
As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Isometrics:

- Quad Sets

Time Elapsed: 3 Minutes, Charge As: Therapeutic Exercise, Billing
Code: 97110.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 01, 2012

Manual Interventions: Joint Complex:

- Patellofemoral Joint

Time Elapsed: 5 Minutes, Grade: II/III, Pressure: Oscillatory,
Technique 1: Superior Glide, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Manual Interventions: Soft Tissue:

- Scar Tissue

Time Elapsed: 5 Minutes, Tx Depth: Moderate, Location: right
patella, Direction: Multidirectional, Charge As: Manual Therapy
Techniques, Billing Code: 97140.

Pt./Family Education:

- Written Home Exercise Program

Time Elapsed: 4 Minutes, Activity: Provided & Reviewed,
Description: Diagnosis Specific, Charge As: Therapeutic Exercise,
Billing Code: 97110.

Therapy Session Time

- Total Therapy Session Time 60 Minutes

Assessment

In my professional opinion, this client requires skilled rehabilitative therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is good. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 2-3 months. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits good understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.

Evaluation Components:

- Barriers to Rehab: Infection left lower leg

Impairments Identified:

- ADL's. Balance. Endurance. Muscle Performance. Pain. Posture. Range of Motion. Work Capacity. Strength. Soft Tissue Mobility. Joint Integrity/Mobility.

Treatment Emphasis to focus on:

- Pain relief. Postural Improvements. Anthropometric Normalization. Range of Motion/Mobility Improvements. Muscle Function Improvements. Proprioception/Balance Improvements.

Problems & Goals

Problem #1 Chief Complaint: Pain: Severity at Worst: 8/10.

LTG Achieve by Dec 13, 2012. in order to tolerate rolling over in bed

Symptomatic Improvements:

- Decreasing Pain: to 4/10.

Problem #2 Range of Motion: Knee: Pre-Treatment.

LTG Achieve by Nov 29, 2012. to improve ambulation

Range of Motion Improvements to: Knee:

- Flexion

Right AROM

130

Problem #3 Joint Integrity/Mobility.

LTG Achieve by Dec 31, 2012. to improve stairs

Improve patella mobility to normal without pain to improve PF mechanics and decrease pain.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Nov 01, 2012

Problem #4 Client Knowledge/Awareness of: Home Exercise Program: Lacks appropriate program.

LTG Achieve by Nov 29, 2012.

Client Education:

- Independent Home Exercise/Self Care Program.

Problem #5 Questionnaires: Lower Extremity Functional Scale.

LTG Achieve by Jan 30, 2013. to improve ADL's

Questionnaire Improvements: Lower Extremity Functional Scale: Questionnaire:

- Total Score. 50

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

Therapeutic Contents:

- Active Range of Motion Activities. Client Education. Gait Training. Therapeutic Exercise. Therapeutic Activities. Soft Tissue Mobilization Techniques. Passive Range of Motion Activities. Manual Therapy Techniques.

Geeta Armstrong, PT(SC Lic: 6791)

Signed on Nov 01, 2012 12:17:53

Regional Wound Healing Center
101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

Received Time Dec. 11, 2012 4:24PM No. 4061

December 11, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

12/06/2012 - Office Visit: MD Visit: LLE
Provider: Melissa Fritsche MD
Location of Care: Regional Wound Healing Center

Visit Type: Follow Up

History of Present Illness:

Risk Factors:

Tobacco use: never smoker

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 Inches (182.88 cm)
Weight: 247.19 pounds
BMI: 35.60
Temp: 98.7 degrees F oral
Pulse rate: 82 / minute
BP sitting: 126 / 85 (left arm)

Pt. In pain? no

Impression & Recommendations:

Problem # 1: WOUND, LEG, WITH COMPLICATION (ICD-891.1)

Assessment: Improved

Healed. Discharge with PRN follow up

Orders:

Wound - Office visit est exp prob (99213) (CPT-10605)

HBO therapy (physician supervision) (CPT-99183)

Office visit est prob foc (99212) (CPT-99212)

Problem # 2: ACUTE OSTEOMYELITIS, LOWER LEG (ICD-730.06)

December 11, 2012

Page 2

Chart Document

Regional Wound Healing Center101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655**KEITH L CASE**

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Assessment: Improved

Resolved.

Orders:

Wound - Office visit est exp prob (99213) (CPT-10505)

HBO therapy (physician supervision) (CPT-99183)

Office visit est prob foc (99212) (CPT-99212)

Patient Instructions:

1) You are being discharged from the wound healing center today. Please call if your wounds re-open, or if you develop new wounds. We are happy to see you. Once you are a patient here, you do not need a referral to return. Remember the tips you have been given to prevent wounds.

Wound Treatment**Tx Date:** 12/06/2012**ROS:** Patient arrived to unit ambulatory**Pain**

Patient has No Complaints of Pain

Measurements**Vascular****Staff Name:** Kimberly Hughes RN**Wound Description:** LLE**Dressing(s)****Appearances:** LLE: 3m 2layer**Strikethrough:** None**Open Wound****Type:** Traumatic**Location:** Left Ant LE**Grade of Ulcer:** Healed**Base Color:** pink thin skin**Wound Base:** pink thin skin**Wound Drainage:** None**Wound Surface:** Healed**Peri-Wnd Tissue:** Intact**Final Outcome:** see notes**TX Date:** 12/06/2012**Culture / Debridement Comments:****Remarks:**

Patient identified using 2 approved identifiers per red rules. Pt here for MD follow up. Dressings removed and washed with Ultradex and water. Photos and measurements taken. Meds and allergies reviewed with pt. Dr. at bedside, see MD notes. Wound care as above.

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)428-6182

Ins: UNINSURE (14)

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: Pt to follow up with MD PRN

Goal: Maintain skin integrity, prevent infection

Clinical Time: 60 minutes

.....Kimberly H Hughes RN (December 8, 2012 11:19 AM)

Electronically Signed by Melissa Fritsche MD on 12/06/2012 at 12:05 PM

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

11/29/2012 - Office Visit: CWA - LLE**Provider: Susan O. Hilsman MD****Location of Care: Regional Wound Healing Center****Vital Signs:**

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 98.6 degrees F oral
Pulse rate: 79 / minute
BP sitting: 132 / 77 (left arm)

Pt. in pain? yes
Location: LLE
Intensity: 7
Type: aching

Vitals Entered By: Connie Williamson, RN (November 29, 2012 2:03 PM)

Wound Treatment**Tx Date: 11/29/2012****ROS: Patient arrived to unit ambulatory with crutches****Pain Scale 0-10: 7****Compression Therapy Type: 3M 2 layer****Location: LLE****Measurements****Vascular****Staff Name: Connie Williamson, RN****Wound Description: CWA - Lt ant LL**

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-8182

Ins: UNINSURE (14)

Dressing(s)

Appearances: LLE - 3M 2 layer wrap

Open Wound

Type: Traumatic

Location: Lt ant LI

Grade of Ulcer: PTW

Length: CWA

Base Color: Pink

Edema: trace

Wound Base: pink

Surface Color: Pink

Wound Drainage: Serosanguinous

Amount: small

Wound Surface: Molst

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: MD visit on 12/6

TX Date: 11/29/2012

Culture / Debridement Comments:

Prim Dressing: LLE - triamcinolone cream, 3M 2 layer wrap

Remarks:

Pt identified using 2 approved Identifiers per red rules.

Dressings removed; Lt leg cleansed with ultradex and water; wound beds rinsed with normal saline
Wound care as above. Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: Pt instructed to leave wrap intact and if it is to fall down or get wet, call us and come in for dressing change prior to appointed time.

Pt. instructed to keep legs elevated and call us with any questions or concerns. Pt to return for MD visit on 12/6

Goal: wound healing; control edema; prevent infection

Clinician time: 20 min

.....Connie Williamson, RN (November 29, 2012 2:23 PM)

Electronically Signed by Susan O. Hilsman MD on 11/29/2012 at 3:07 PM

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Regional Wound Healing Center101 East Wood Street Spartanburg, SC 29303
864-580-1650 Fax: 864-560-1655**KEITH L CASE**

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

11/21/2012 - Office Visit: CWA - LLE

Provider: Melissa Fritsche MD

Location of Care: Regional Wound Healing Center

Vital Signs:Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 97.9 degrees F oral
Pulse rate: 96 / minute
Resp: 16 per minute
BP sitting: 130 / 82 (right arm)

Pt. in pain? no

Vitals Entered By: Stephanie S Webster, RN (November 21, 2012 2:01 PM)

Wound Treatment

Tx Date: 11/21/2012

ROS: Patient arrived to unit ambulatory

Pain

Patient has No Complaints of Pain

Measurements**Vascular**

Staff Name: Stephanie Webster, RN

Wound Description: LLE

Dressing(s)

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Appearances: 3M 2 layer

Open Wound

Type: Traumatic

Location: L ant LE

Grade of Ulcer: FTW

Length: drsg change

Base Color: Pink

Wound Drainage: None

Wound Surface: Healing

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: see plan

TX Date: 11/21/2012

Culture / Debridement Comments:

Prim Dressing: LLE - triamcinolone, 3M 2 layers

Remarks:

Patient identified using 2 approved Identifiers per red rules. Patient arrives for scheduled dressing change. Dressings removed and LLE washed with ultradex and water.

Wound care as above by Lynne Tate, RRT

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan - Follow up with MD 12/6/2012. Patient to continue dressing changes as ordered above. Patient instructed to call the wound center for any questions or concerns.

Goal - wound healing, prevent infection, compression therapy, manage exudate

Clinician time - 20 minutes

.....Stephanie S Webster, RN (November 21, 2012 2:04 PM)

Electronically Signed by Melissa Fritsche MD on 11/21/2012 at 2:05 PM

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

11/16/2012 - Office Visit: CWA - LLE**Provider: Melissa Fritsche MD****Location of Care: Regional Wound Healing Center****Vital Signs:**

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 98 degrees F oral
Pulse rate: 81 / minute
BP sitting: 142 / 83 (right arm)

Pt. in pain? yes
Location: knees and hips
Intensity: 7
Type: aching

Vitals Entered By: Connie Williamson, RN (November 15, 2012 11:05 AM)

Wound Treatment**Tx Date:** 11/16/2012**ROS:** Patient arrived to unit ambulatory with crutches**Pain Scale 0-10:** 7**Compression Therapy Type:** 3M 2 layer wrap**Location:** LLE**Measurements****Vascular****Staff Name:** Connie Williamson, RN**Wound Description:** CWA - LLE

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KEITH L CASE
Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

Dressing(s)

Appearances: Lt ant LL- Iodosorb gel; LLE - 3M 2 layer wrap

Open Wound

Type: Traumatic

Location: Lt ant LL

Grade of Ulcer: FTW

Length: CWA

Base Color: Red

Wound Base: Red

Surface Color: Red

Wound Drainage: Serosanguinous

Amount: small

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact with crust

Final Outcome: weekly CWA with dressing change and MD visit on 12/6

TX Date: 11/15/2012

Culture / Debridement Comments:

Prim Dressing: Lt ant LL - Iodosorb gel

Sec Dressing: LLE - triamcinolone cream, 3M 2 layer wrap

Remarks:

Pt identified using 2 approved identifiers per red rules.

Dressings removed; Lt leg cleansed with ultradex and water; wound beds rinsed with normal saline;

Wound care as above. Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: Pt instructed to leave wrap intact and if it is to fall down or get wet, call us and come in for dressing change prior to appointed time.

Pt. Instructed to keep legs elevated and call us with any questions or concerns. Pt to return for weekly CWA with dressing change and MD visit on 12/6

Goal: wound healing; prevent infection; compression therapy

Clinician time: 20 min

.....Connie Williamson, RN (November 15, 2012 11:09 AM)

Electronically Signed by Melissa Fritsche MD on 11/15/2012 at 1:05 PM

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

11/08/2012 - Office Visit: md visit- left lower ext

Provider: Melissa Fritzsche MD

Location of Care: Regional Wound Healing Center

History of Present Illness:

Mr. Case returns to the wound healing center after three weeks. He has been in wraps with Iodosorb dressing, weekly changes. He has had total of 28 days of moxifloxacin for osteo seen on MRI. He finished the moxi Monday. No ABx since then. No problems reported with ABx.

Past Medical History:

Carpal Tunnel Syndrome

Allergic Rhinitis

Crushing Injury to left leg (8/2012)

Bedside ABI's - 10/10/12

RLE - 0.9 LLE - 0.9

Past Surgical History:

Unremarkable

Social History:

Married, lives with wife. Has 6 children. GED. Works FT.

non smoker

no alcohol

no illegal drugs

Risk Factors:

Tobacco use: never smoker

Caffeine use: 2 drinks per day

Seatbelt use: 50 %

Sun Exposure: rarely

Review of Systems**General**

Denies fever, chills, and weight loss.

Derm

Denies poor wound healing and rash.

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Weight: 242.7 pounds
BMI: 34.96
Temp: 97.9 degrees F oral

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Pulse rate: 88 / minute
BP sitting: 145 / 85 (left arm)

Pt. In pain? yes
Location: left lower ext
Intensity: 8
Type: aching

Vitals Entered By: Judy F. Kelly, RN (November 8, 2012 2:09 PM)

Physical Exam

General:

well developed, well nourished, in no acute distress.

Extremities:

open wound L anterior calf is improved. no periwound erythema, probe is improved. There is no probe to bone.

Impression & Recommendations:

Problem # 1: WOUND, LEG, WITH COMPLICATION (ICD-891.1)

Assessment: Improved

3M 2 layer with iodosorb. Anticipate uncomplicated healing from now, osteo is clinically resolved based on good wound healing.

Orders:

Office visit est exp prob (99213) (CPT-99213)

Wound - Office visit est exp prob (99213) (CPT-10505)

Problem # 2: ACUTE OSTEOMYELITIS, LOWER LEG (ICD-730.06)

Assessment: Improved

28 days of moxi now with some resolution, bone coverage.

Orders:

Office visit est exp prob (99213) (CPT-99213)

Wound - Office visit est exp prob (99213) (CPT-10505)

Medications Added to Medication List This Visit:

1) Lortab 5-500 Mg Tabs (Hydrocodone-acetaminophen) 1 q 6 hours prn pain

Patient Instructions:

- 1) Return to see your doctor in 4 weeks.
- 2) Return once a week for a dressing change visit.
- 3) Do not hesitate to call if you have any questions, if there is a problem with your dressing, or if you feel that your wound is getting worse. We are always happy to hear from you.
- 4) Do not get your wraps wet, do not take a bath or shower in wraps, call us if they fall. Elevate your legs if they feel too

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864-560-1650 Fax: 864-560-1655**KEITH L CASE**

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

tight, and give us a call if that doesn't help.

Wound Treatment

Tx Date: 11/08/2012

ROS: Patient arrived to unit ambulatory using crutches

Pain Scale 0-10: 8

Pain Meds: Lortab 5- 1 qid prn pain

Measurements**Vascular**

Staff Name: Judy Kelly RN

Wound Description: left anterior lower ext

Dressing(s)

Appearances: Iodosorb gel, 3 m 2 layer wrap

Strikethrough: thru

Open Wound

Type: Traumatic

Location: left anterior lower ext

Grade of Ulcer: Healed

Length: 1.0 cm

Width: 0.9 cm

Depth: 0.2 cm

Base Color: Red

Wound Base: Red & Yellow

Wound Drainage: Serosanguinous

Amount: moderate

Tunnelling: 0.4 cm

1

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact and Moist

Final Outcome: weekly dressing changes with md visit in 4 weeks

TX Date: 11/08/2012

Culture / Debridement Comments:

Prim Dressing: Iodosorb gel, 3m 2 layer wrap

Remarks:

Pt to wound center today ambulatory using his crutches with spouse for md follow up with Dr Fritsche. Pt accompanied by Case worker- Dianna Welch, RN. Medication/allergy list updated with pt. Dressing removed and wound cleansed with ultradex and water. Wound cleansed with ultradex and water per Carol, RN. Photos and measurements taken. Dr Fritsche in to eval pt. See md notes. Wound dressed as above. Pt to follow up weekly for dressing changes with md visit in 4 weeks. Pt to call if any questions or concerns. Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: follow up as directed
goal: wound closure, infection control, compression

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)428-6182

Ins: UNINSURE (14)

clinician time: 46 minutes

.....Judy F. Kelly, RN (November 8, 2012 2:33 PM)

Electronically Signed by Melissa Fritsche MD on 11/08/2012 at 6:14 PM

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

11/01/2012 - Office Visit: CWA - LLE

Provider: Susan O. Hillsman MD

Location of Care: Regional Wound Healing Center

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 97.8 degrees F oral
Pulse rate: 107 / minute
Resp: 16 per minute
BP sitting: 138 / 75 (right arm)

Pt. In pain? no

Vitals Entered By: Lynne H Tate, RRT (November 1, 2012 2:39 PM)

Wound Treatment

Tx Date: 11/01/2012

ROS: Patient arrived to unit ambulatory

Pain

Patient has No Complaints of Pain

Compression Therapy Type: 3M 2 Layer wrap

Location: LLE

Measurements

Vascular

Staff Name: Lynne Tate, RRT

Wound Description: Left Lat LE

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Dressing(s)

Appearances: Iodosorb Gel - Left Ant LE; 3M 2 Layer wrap - LLE

Open Wound

Type: Traumatic

Location: Left Ant LE

Grade of Ulcer: FTW

Base Color: Pink

Wound Base: Pink

Wound Drainage: Serosanguinous

Amount: small

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: see plan

TX Date: 11/01/2012

Culture / Debridement Comments:

Prim Dressing: Left Ant LE - Iodosorb Gel

Sec Dressing: LLE - 3M 2 Layer wrap

Remarks:

Patient identified using 2 approved identifiers per red rules. Pt arrived to Wound Center with dressings intact. Solled dressing removed and LLE cleaned with Ultradox and water. Wounds redressed per orders above by Kim Hughes, RN. Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: Continue wound care as ordered above. Pt to return to Wound Center for MD f/u on 11/8. Pt instructed to call Wound Center for any questions or concerns.

Goal: Wound healing/closure. Prevent infection. Control edema

Total Clinician time: 20 mins

.....Lynne H Tate, RRT (November 1, 2012 2:42 PM)

Electronically Signed by Susan O. Hillsman MD on 11/01/2012 at 2:55 PM

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KEITH L CASE
Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

10/25/2012 - Office Visit: CWA---LLE
Provider: Susan O. Hilsman MD
Location of Care: Regional Wound Healing Center

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 Inches (182.88 cm)
Temp: 97.5 degrees F oral
Pulse rate: 72 / minute
Resp: 16 per minute
BP sitting: 134 / 91 (right arm)

Pt. in pain? no

Wound Treatment

Tx Date: 10/25/2012
ROS: Patient arrived to unit by wheel chair

Pain

Patient has No Complaints of Pain
Compression Therapy Type: 3M 2 layer wrap
Location: LLE

Measurements

Vascular

Staff Name: Ami Parris, RRT
Wound Description: Left anterior lower leg

Dressing(s)

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Appearances: Iodosorb gel---left anterior lower leg 3M 2 layer wrap---LLE
Strikethrough: small

Open Wound

Type: Traumatic

Location: left anterior lower leg

Grade of Ulcer: FTW

Base Color: Yellow

Wound Base: Yellow

Wound Drainage: Serosanguinous

Amount: small

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: Pt to return to wound center in 1 week for CWA.

TX Date: 10/25/2012

Culture / Debridement Comments:

Prim Dressing: Iodosorb gel---left anterior lower leg

Sec Dressing: triamcinolone cream, protective ointment with clove oil, 3M 2 layer wrap---LLE

Remarks:

CWA---Patient Identified using 2 approved Identifiers per red rules.

Pt arrived to wound center with dressings intact to his LLE. Dressings removed by Jimmy Forbis, Tech and LLE cleansed with ultradex and water. LLE redressed as ordered above. Pt to return to wound center in 1 week for CWA. Pt instructed to call wound center with any questions or concerns.

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: continue wound care as ordered above, pt to return to wound center in 1 week for CWA.

Goal: wound closure, edema control.

Total clinician time: 20 minutes.

.....Ami W. Parrls, RRT (October 25, 2012 2:53 PM)

Electronically Signed by Susan O. Hilsman MD on 10/25/2012 at 5:15 PM

Regional Wound Healing Center

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/19/2012 - Office Visit: CWA: LLE

Provider: Debra L Miller-Cox MD

Location of Care: Regional Wound Healing Center

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 97.8 degrees F oral
Pulse rate: 70 / minute
BP sitting: 158 / 92 (right arm)

Pt. In pain? no

Vitals Entered By: Kimberly H Hughes (October 19, 2012 3:56 PM)

Wound Treatment

Tx Date: 10/19/2012

ROS: Patient arrived to unit ambulatory

Pain

Patient has No Complaints of Pain

Measurements

Vascular

Staff Name: Kimberly hughes RN

Wound Description: LLE

Dressing(s)

Appearances: LLE; 3m 2layer

Regional Wound Healing Center
101 East Wood Street Spartanburg, SC 29303
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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Strikethrough: small amt

Open Wound

Type: Traumatic

Location: Left Ant LE

Grade of Ulcer: FTW

Length: CWA

Base Color: red, yellow

Wound Base: red, yellow

Wound Drainage: Serosanguinous

Amount: small

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: see notes

TX Date: 10/19/2012

Culture / Debridement Comments:

Prim Dressing: Left ant LE: Iodosorb gel

Sec Dressing: LLE: triamcinolone cream, protective oint, 3m 2layer

Remarks:

Patient Identified using 2 approved Identifiers per red rules. Pt here for CWA. Dressing removed and washed with Ultradex and water. Wounds redressed as above.

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan: Maintain wrap, return weekly for dressing changes and follow up with MD on 11/8/2012

Goal: Wound closure, prevent infection, off loading, compression therapy.

Clinical Time: 25 minutes

.....Kimberly H Hughes RN (October 19, 2012 3:58 PM)

Electronically Signed by Debra L Miller-Cox MD on 10/20/2012 at 8:12 PM

Regional Wound Healing Center

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/18/2012 - Office Visit: MD visit - L ant LE
Provider: Melissa Fritzsche MD
Location of Care: Regional Wound Healing Center

History of Present Illness:

Mr. Case returns today after one week for evaluation of chronic crush wound. He will take last avelox today. He has question of osteo on MRI. He has been in a wrap. He has tolerated ABx well. He has been in wrap. tolerated well.

Risk Factors:

Tobacco use: never smoker
Passive smoke exposure: yes
HIV high-risk behavior: no
Caffeine use: 5+ drinks per day
Alcohol use: no
Exercise: no
Seatbelt use: 0 %
Sun Exposure: frequently

Review of Systems**General**

Denies fever, chills, and weight loss.

Derm

Denies poor wound healing and rash.

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 Inches (182.88 cm)
Weight: 245 pounds
BMI: 35.28
Temp: 98.2 degrees F oral
Pulse rate: 77 / minute
Resp: 18 per minute
BP sitting: 149 / 83 (left arm)

Pt. in pain? no

Vitals Entered By: Stephanie S Webster, RN (October 18, 2012 2:39 PM)

Physical Exam

Regional Wound Healing Center
 101 East Wood Street Spartanburg, SC 29303
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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Extremities:

probe has gone from 3.4 cm to 1.2 cm

Impression & Recommendations:**Problem # 1:** ACUTE OSTEOMYELITIS, LOWER LEG (ICD-730.06)**Assessment:** Improved

Will treat with 28 days of moxl and re-evaluate. Much improvement in wound today, Iodosorb gel and continue wrap with weekly changes, RTC 3 weeks. Coag negative staph only. Will keep out of work until he does not have penetration to bone.

Orders:

Wound - Office visit est exp prob (99213) (CPT-10505)

Office visit est exp prob (99213) (CPT-99213)

Problem # 2: WOUND, LEG, WITH COMPLICATION (ICD-891.1)**Assessment:** Improved

Track much improved, still with probe to bone.

Orders:

Wound - Office visit est exp prob (99213) (CPT-10505)

Iodosorb (LOI-39121-9.03)

Office visit est exp prob (99213) (CPT-99213)

Patient Instructions:

- 1) Return to see your doctor in 3 weeks.
- 2) Do not hesitate to call if you have any questions, if there is a problem with your dressing, or if you feel that your wound is getting worse. We are always happy to hear from you.

Prescriptions:

AVELOX 400 MG TABS (MOXIFLOXACIN HCL) one tablet PO daily #20[tablet] x 0

Entered by: Stephanie S Webster, RN

Authorized by: Melissa Fritsche MD

Signed by: Stephanie S Webster, RN on 10/18/2012

Method used: Electronically to

Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1666191400056990

Wound Treatment

Regional Wound Healing Center

101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

Received Time Dec. 11, 2012 4:24PM No. 4061

December 11, 2012

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

288621

Home: (864)316-2620 Work: (864)426-5182

Ins: UNINSURE (14)

Tx Date: 10/18/2012

ROS: Patient arrived to unit ambulatory

Pain

Patient has No Complaints of Pain

Measurements

Vascular

Staff Name: Stephanie Webster, RN

Wound Description: L ant LE

Dressing(s)

Appearances: 3M 2 layer, mepilex transfer, iodoform wick

Open Wound

Type: Traumatic

Location: L ant LE

Grade of Ulcer: FTW

Length: 1.6

Width: 1.0

Depth: 0.1

Base Color: red and yellow

Wound Base: Red & Yellow

Wound Drainage: Serosanguinous

Amount: small

Tunnelling: 1.2cm @ 1 o'clock

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: Intact

Final Outcome: see plan

TX Date: 10/18/2012

Culture / Debridement Comments:

Prim Dressing: L ant LE - Iodosorb gel

Sec Dressing: LLE -3M 2 layer

Remarks:

Patient identified using 2 approved identifiers per red rules. Patient arrives for scheduled MD visit. Dressings removed and LLE washed with ultradex and water. Photos and measurements taken. Medications and allergies verified by patient. Dr. Frischoe at bedside, see MD notes. Wound care as above.

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan - Follow up with MD in 3 weeks. Patient to continue dressing changes as ordered above 1x week. Patient instructed to call the wound center for any questions or concerns. ***WOUND NOTES AND ORDERS FAXED TO PATIENT'S CASE

MANAGE, LISA WEBB, RN, FAX # 888-308-7727 -- PHONE # 888-308-6655 --- CELL # 803-968-0329

Goal - wound healing, prevent infection, compression therapy, manage exudate

Clinician time - 60 minutes

Stephanie S Webster, RN (October 18, 2012 3:09 PM)

Regional Wound Healing Center
101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

Received Time Dec. 11, 2012 4:24 PM No. 4061

December 11, 2012

Page 4

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Electronically Signed by Mollisa Fritsche MD on 10/18/2012 at 3:39 PM

Regional Wound Healing Center

101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

Page 1
Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

10/12/2012 - Office Visit: CWA - LLE

Provider: Melissa Fritzsche MD

Location of Care: Regional Wound Healing Center

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Temp: 98.4 degrees F oral
Pulse rate: 81 / minute
Resp: 18 per minute
BP sitting: 162 / 103 (left arm)

Pt. in pain? yes
Location: LLE
Intensity: 8
Type: aching

Vitals Entered By: Carol Gowan RN, (October 12, 2012 2:43 PM)

Wound Treatment

Tx Date: 10/12/2012

ROS: Patient arrived to unit ambulatory

Pain Scale 0-10: 8

Measurements

Vascular

Staff Name: Carol Gowan, RN

Wound Description: Left Anterior LE

Regional Wound Healing Center
101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

Received Time Dec. 11, 2012 4:24 PM No. 4061

December 11, 2012

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Dressing(s)

Appearances: Coban, Viscopaste, mepilex transfer, Iodoform wick
Strikethrough: small through coban

Open Wound

Type: Traumatic

Location: Left Anterior LE

Grade of Ulcer: FTW

Length: CWA only

Base Color: Unable to visualize

Surface Color: yellow / red

Wound Drainage: Serosanguinous

Amount: large

Wound Surface: Moist

Wound Odor: None

Peri-Wnd Tissue: intact w/ erythema

Final Outcome: See plan

TX Date: 10/12/2012

Culture / Debridement Comments:

Prim Dressing: L ant LE - 1/4" Iodoform wick, mepilex transfer

Sec Dressing: LLE - 3M 2 layer

Remarks:

Patient identified using 2 approved identifiers per red rules. Patient arrives at the Wound Center for scheduled dressing change. Dressings removed and LLE washed with Ultradex and water. Wound care as above.

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan - Follow-up with Dr. Fritsche on 10-18-12. Continue 2x/week dressing changes at the Wound Center. Call the Wound Center for any questions or concerns.

Goal: Prevent infection, reduce edema, compression therapy, manage exudate, pain management, wound healing/closure.

Clinician Time: 17 minutes

.....Carol Gowan RN, (October 12, 2012 2:46 PM)

Electronically Signed by Melissa Fritsche MD on 10/12/2012 at 2:58 PM

Regional Wound Healing Center

101 East Wood Street Spartanburg, SC 29303
864-560-1650 Fax: 864-560-1655

October 12, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/10/2012 - Office Visit: MD visit - LLE - ABI's

Provider: Melissa Fritsche MD

Location of Care: Regional Wound Healing Center

History of Present Illness:

Mr. Case presents new to the wound healing center. He is referred by Dr. Brewton, PCP for evaluation of poorly healing wound. I discussed this case personally with her yesterday. On August 27 he fell. A log rolled over onto his leg, he fell and hit the tractor frame. On the day he was seen and evaluated at Regional. He had stitches placed in R knee and anterior L calf. The log rolled onto him, but was not on top of him. The damage was done by tractor frame. There does not seem to be crush component in what he describes. Xrays were done, these were negative. R leg seems to be doing fine. He complains of it being stiff, and buckling some, but otherwise ambulating. He has not been back to work. He has not been back to work, wanting to get wound L healed before return.

He is not a diabetic. He does not smoke.

MRI done yesterday ? osteo. He has had a course of Keflex, and a partial course of Bactrim. Last dose of ABx was Tuesday. No cultures have been done.

Past Medical History:

Carpal Tunnel Syndrome

Allergic Rhinitis

Crushing Injury to left leg (8/2012)

Bedside ABI's - 10/10/12

RLE - 0.9 LLE - 0.9

Social History:

Married, lives with wife. Has 4 children. GED. Works FT.

Risk Factors:

Tobacco use: never smoker

Passive smoke exposure: yes

HIV high-risk behavior: no

Caffeine use: 5+ drinks per day

Alcohol use: no

Exercise: no

Seatbelt use: 0 %

Sun Exposure: frequently

Vital Signs:

Patient Profile: 41 Years Old Male

Height: 70 inches (182.88 cm)

Weight: 245 pounds

BMI: 35.28

Temp: 98.1 degrees F oral

Pulse rate: 89 / minute

Resp: 18 per minute

BP sitting: 131 / 77 (right arm)

KEITH L CASE

Male DOB: 08/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

Pt. in pain? yes
Location: LLE
Intensity: 6
Type: aching

Vitals Entered By: Stephanie S Webster, RN (October 10, 2012 9:43 AM)

L arm sitting - 130/88

Physical Exam

General:

well developed, well nourished, in no acute distress. pleasant.

Head:

normocephalic and atraumatic.

Lungs:

clear bilaterally to auscultation.

Heart:

normal S1, S2 without murmurs, rubs, gallops, or clicks.

Pulses:

2+ BLE DPs. ABIs recorded.

Extremities:

well healed X scar over R knee, no open area. BLE without deformity. open wound over L shin is with probe to bone, curette is used at bone but no bony chips are obtained. deep tissue culture is obtained. periwound is without erythema. there is no odor, no purulence, some necrotic tissue at base.

Neurologic:

no focal deficits, cranial nerves II-XII grossly intact, BLE sensation intact to light touch

Psych:

alert and cooperative; normal mood and affect; normal attention span and concentration.

Additional Exam:

10/9/12 Exam- MRI left leg with and without contrast

Technique- Multiplanar multisequence imaging is performed. 10 cc MultiHance is administered intravenously without incident.

No comparison.

Findings- There is a marker which has been placed indicating the area of the open wound. Subjacent to the marker, there is a soft tissue defect present. There is both edema and enhancement within the anteromedial subcutaneous soft tissues. This extends to the level of the anteromedial tibial cortex. Within the anteromedial tibial marrow, there is mild edema like marrow signal as well as enhancement. There are mild T1 changes associated with this as well. Signal intensity within the musculature of the left leg is normal. No peripherally enhancing fluid collections are seen to suggest abscess formation.

Impression-

1. Ulceration subjacent to the marker, indicating the clinical area of concern. There is both edema and enhancement seen within the anteromedial subcutaneous soft tissues^ these findings are compatible with cellulitis.

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

2. There is also mild edema and enhancement seen within the anteromedial marrow, immediately subjacent to the previously described area of soft tissue edema. Findings could represent early osteomyelitis at this location, though the area of marrow involvement is small, and the findings are fairly subtle, making this diagnosis less certain.

Impression & Recommendations:

Problem # 1: ACUTE OSTEOMYELITIS, LOWER LEG (ICD-730.06)

This diagnosis is uncertain, but given persistent probe to bone today we will treat as such. Beginning Avelox today empirically, will treat with culture directed antibiotics in consultation with ID. Will follow with anticipated 6 weeks of ABx, likely will be able to do PO, but will discuss culture with ID.

Orders:

Office visit new detailed (99203) (CPT-99203)

Cult bacteria no urine/blood/stool aerobic (40825)

Cult bacteria no urine/blood/stool anaerobic (CPT-87073)

Wound - Office visit est exp prob (99213) (CPT-10505)

Problem # 2: WOUND, LEG, WITH COMPLICATION (ICD-891.1)

iodoform wick and 3M 2 layer. RTC one week for re-evaluation. CWA Friday.

Orders:

Office visit new detailed (99203) (CPT-99203)

Debridement skin subcutaneous and muscle (CPT-11043)

Cult bacteria no urine/blood/stool aerobic (40825)

Cult bacteria no urine/blood/stool anaerobic (CPT-87073)

Wound - Office visit est exp prob (99213) (CPT-10505)

Problem # 3: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)

Question of how much a component crush played in this. Too late to consider HBO therapy at this point.

Orders:

Office visit new detailed (99203) (CPT-99203)

Medications Added to Medication List This Visit:

1) Avelox 400 Mg Tabs (Moxifloxacin hcl) One tablet po daily

Patient Instructions:

1) Return to see your doctor in 1 week.

2) Return twice a week for a dressing change visit.

3) Do not hesitate to call if you have any questions, if there is a problem with your dressing, or if you feel that your wound is getting worse. We are always happy to hear from you.

4) Do not get your wraps wet, do not take a bath or shower in wraps, call us if they fall. Elevate your legs if they feel too tight, and give us a call if that doesn't help.

Prescriptions:

AVELOX 400 MG TABS (MOXIFLOXACIN HCL) one tablet PO daily #10[tablet] x 0

Regional Wound Healing Center

101 East Wood Street Spartanburg, SC 29303
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October 12, 2012

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Chart Document

KEITH L CASE

Male DOB: 08/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Entered by: Stephanie S Webster, RN
Authorized by: Melissa Fritsche MD
Signed by: Stephanie S Webster, RN on 10/10/2012
Method used: Electronically to
Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)
441 N Duncan Byp Ste A
Union, SC 29379-8607
Ph: 8644276114
Fax: 8644276444

RxID: 1665484126157240

Wound Treatment

Tx Date: 10/10/2012

ROS: Patient arrived to unit ambulatory

Pain Scale 0-10: 6

Measurements**Vascular**

Staff Name: Stephanie Webster, RN

Wound Description: LLE

Dressing(s)

Appearances: ace wrap, telfa

Open Wound

Type: Traumatic

Location: L anterior LE

Grade of Ulcer: FTW

Length: 2.2

Width: 1.0

Depth: 1.0 (straight)

Base Color: yellow and red

Wound Base: yellow and red

Wound Drainage: Serosanguinous

Amount: moderate

Tunneling: 3.4cm @ 1 o'clock -- probe to bone

Wound Surface: Slough

Wound Odor: None

Peri-Wnd Tissue: Intact and Red

Final Outcome: see plan

TX Date: 10/10/2012

Culture / Debridement Comments:

Speciman sent to Lab

L ant LE

Prim Dressing: L ant LE - 1/4" Iodoform wick, mepilex transfer

Sec Dressing: LLE - Viscopaste, coban --- CHANGE TO A 3M 2 LAYER ON FRIDAY

Remarks:

Patient identified using 2 approved identifiers per red rules. Patient arrives for scheduled MD visit. Dressings removed and

-174-

KEITH L CASE

Male DOB: 06/09/1971

266621

Home: (864)318-2620 Work: (864)426-6182

Ins: UNINSURE (14)

BLE washed with ultradex and water. Photos and measurements taken. Medications and allergies verified by patient Dr. Fritsche at bedside, see MD notes. Wound care as above.

Patient educated regarding diagnosis, treatment, and other options available. Patient voiced and demonstrated understanding of these back to me and agrees with plan of care.

Plan - Follow up with MD in 1 week. Patient to return Friday for a dressing change, PLEASE PUT PATIENT IN A 3M 2 LAYER WRAP ON FRIDAY, Patient instructed to call the wound center for any questions or concerns.

Goal - wound healing, prevent infection, compression therapy, manage exudate

Clinician time - 60 MINUTES

.....Stephanie S Webster, RN (October 10, 2012 10:45 AM)

PROCEDURE NOTE:

11043 Deb skin, subcu tissue, muscle Dx: traumatic crush wound, L upper calf

After obtaining informed verbal consent the skin, subcutaneous tissue, and muscle was sharply debrided with a 10 blade and sharp curettage. Necrotic skin, subcutaneous tissue, and muscle are removed to viable bleeding tissue underneath. Sharp curettage is used against suspected bone probe, but there are no loose chips obtained, bone feels to be intact. The patient tolerated the procedure well with minimal blood loss and good hemostasis upon completion. Wound area = 6 sq cm. Wound dressed as per RN notes. Melissa Fritsche MD October 10, 2012 1:06 PM

Electronically Signed by Melissa Fritsche MD on 10/10/2012 at 1:09 PM

Pacolet Family Medicine7221 South Pine St. Pacolet, SC 29372
864-474-1528 Fax: 864-474-1049

October 26, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/09/2012 - Imaging Report: NG MRI EXTREMITY LOWER WWO CONT**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine**

Patient: KEITH L CASE

ID: HBOX 000184520

Note: All result statuses are Final unless otherwise noted.

Tests: (1) NG MRI EXTREMITY LOWER WWO CONT (25175&IMS)

! NG MRI EXTREMITY LOWER WWO CONT

"Result Below..."

RESULT: NG MRI EXTREMITY LOWER WWO CONT

Check In # 0003451295S25175

History- Open wound of the left leg

Exam- MRI left leg with and without contrast

Technique- Multiplanar multisequence imaging is performed. 10 cc
MultiHance is administered intravenously without incident.

No comparison.

Findings- There is a marker which has been placed indicating the area of the open wound. Subjacent to the marker, there is a soft tissue defect present. There is both edema and enhancement within the anteromedial subcutaneous soft tissues. This extends to the level of the anteromedial tibial cortex. Within the anteromedial tibial marrow, there is mild edema like marrow signal as well as enhancement. There are mild T1 changes associated with this as well. Signal intensity within the musculature of the left leg is normal. No peripherally enhancing fluid collections are seen to suggest abscess formation.

Impression-

1. Ulceration subjacent to the marker, indicating the clinical area of concern. There is both edema and enhancement seen within the anteromedial subcutaneous soft tissues^ these findings are compatible with cellulitis.

2. There is also mild edema and enhancement seen within the anteromedial marrow, immediately subjacent to the previously described area of soft tissue edema. Findings could represent early osteomyelitis at this location, though the area of marrow involvement a small, and the findings are fairly subtle, making this diagnosis less certain.

Transcriptionist- n/a

Reading Radiologist- JASON P KELLY MD

Releasing Radiologist- JASON P KELLY MD

Released Date Time--10/09/12 1047

Note: An exclamation mark (!) indicates a result that was not dispersed into the flowsheet.

Document Creation Date: 10/09/2012 10:47 AM

(1) Order result status: Final

Received Time: Oct. 26, 2012 3:18PM No. 3270 10/09/2012 09:33

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October 26, 2012

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Reported date-time: 10/09/2012 10:47

Referring Physician:

Ordering Physician: MARY BREWTON (B91120)

Specimen Source:

Source: HBOX

Filler Order Number: 0003451295S25175 HBOX

Lab site:

The following results were not dispersed to the flowsheet:

NG MRI EXTREMITY LOWER WWO CONT, NG MRI EXTREMITY LOWER WWO CONT, (F)

Electronically Signed by Mary Sue Brewton, DO on 10/09/2012 at 11:21 AM

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October 26, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/09/2012 - Imaging Report: NG XR ORBITS FOR FOREIGN BODY/MRI**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine**

Patient: KEITH L CASE

ID: HBOX 000184520

Note: All result statuses are Final unless otherwise noted.

Tests: (1) NG XR ORBITS FOR FOREIGN BODY/MRI (38530&IMS)

! NG XR ORBITS FOR FOREIGN BODY/MRI

"Result Below..."

RESULT: NG XR ORBITS FOR FOREIGN BODY/MRI

Check In # 0003451271S38530

3 View Screening orbit x-ray dated 10/9/2012

Reference Exam- None

Indication- Screening for MRI, possible metal in orbits

Findings- 3 images are presented. No dense foreign bodies are seen overlying the orbit shadows.

Impression- No metal seen in the orbits

Transcriptionist- n/a

Reading Radiologist- JEFFREY NEWMAN MD

Releasing Radiologist- JEFFREY NEWMAN MD

Released Date Time- 10/09/12 0911

Note: An exclamation mark (!) indicates a result that was not dispersed into the flowsheet.

Document Creation Date: 10/09/2012 9:11 AM

(1) Order result status: Final

Collection or observation date-time: 10/09/2012 08:56

Requested date-time:

Receipt date-time:

Reported date-time: 10/09/2012 09:11

Referring Physician:

Ordering Physician: MARY BREWTON (B91120)

Specimen Source:

Source: HBOX

Filler Order Number: 0003451271S38530 HBOX

Lab site:

The following results were not dispersed to the flowsheet:

NG XR ORBITS FOR FOREIGN BODY/MRI, NG XR ORBITS FOR FOREIGN BODY/MRI, (F)

Electronically Signed by Mary Sue Brewton, DO on 10/09/2012 at 9:32 AM

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October 26, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/09/2012 - Imaging Report: NG XR ORBITS FOR FOREIGN BODY/MRI**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine**

Patient: KEITH L CASE

ID: HBOX 000184520

Note: All result statuses are Final unless otherwise noted.

Tests: (1) NG XR ORBITS FOR FOREIGN BODY/MRI (38530&IMS)

! NG XR ORBITS FOR FOREIGN BODY/MRI

"Result Below..."

RESULT: NG XR ORBITS FOR FOREIGN BODY/MRI

Check In # 0003451271S38530

3 View Screening orbit x-ray dated 10/9/2012

Reference Exam- None

Indication- Screening for MRI, possible metal in orbits

Findings- 3 images are presented. No dense foreign bodies are seen overlying the orbit shadows.

Impression- No metal seen in the orbits

Transcriptionist- n/a

Reading Radiologist- JEFFREY NEWMAN MD

Releasing Radiologist- JEFFREY NEWMAN MD

Released Date Time- 10/09/12 0911

Note: An exclamation mark (!) indicates a result that was not dispersed into the flowsheet.

Document Creation Date: 10/09/2012 9:11 AM

(1) Order result status: Final
Collection or observation date-time:
Requested date-time:
Receipt date-time:
Reported date-time: 10/09/2012 09:11
Referring Physician:
Ordering Physician: MARY BREWTON (B91120)
Specimen Source:
Source: HBOX
Filler Order Number: 0003451271S38530 HBOX
Lab site:

The following results were not dispersed to the flowsheet:

NG XR ORBITS FOR FOREIGN BODY/MRI, NG XR ORBITS FOR FOREIGN BODY/MRI, (F)

Electronically Signed by Mary Sue Brewton, DO on 10/09/2012 at 9:32 AM

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864-474-1528 Fax: 864-474-1049

October 26, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/04/2012 - Office Visit: LEG Rm1

Provider: Mary Sue Brewton, DO

Location of Care: Pacolet Family Medicine

Visit Type: Follow-up Visit

CC: Sore on leg.

History of Present Illness:

Patient identified using 2 approved identifiers per red rules.

Pt is here to follow up with sore on left leg. Pt states it has gotten worse since last visit. Jamle Powell, CMA (October 4, 2012 8:43 AM)

41 yo WM presents today with his wife for follow up on his left leg wound. He says that he went to the ER the day after being seen in clinic last week due to pain. The wound was explored and he did have some drainage from it (non-purulent). He has not been taking the Bactrim because he was told to stop it by the ER and he also says that his dog ate the medicine. He is taking one percocet per day to help with pain, but also admits that the pain can become so severe that it makes his entire body sore.

Pt also notes that his left elbow is still hurting. He says it feels like someone is pinching him on his medial elbow.

Past Medical History:

Carpal Tunnel Syndrome

Allergic Rhinitis

Crushing Injury to left leg (8/2012)

Risk Factors:

Tobacco use: never smoker

Review of Systems**General**

Denies fever.

Vital Signs:

Patient Profile: 41 Years Old Male

Height: 70 inches (182.88 cm)

Weight: 240.38 pounds

BMI: 34.62

Temp: 98.8 degrees F tympanic

Pulse rate: 123 / minute

Resp: 16 per minute

Received Time Oct. 26, 2012 at 3:18PM No. 3270

Pacolet Family Medicine
7221 South Pine St. Pacolet, SC 29372
864-474-1528 Fax: 864-474-1049

October 26, 2012
Page 2
Chart Document

KEITH L CASE
Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

Vitals Entered By: Jamie Powell,CMA (October 4, 2012 8:39 AM)

Physical Exam

General:

well developed, well nourished, in no acute distress.

Head:

normocephalic and atraumatic.

Lungs:

clear bilaterally to auscultation, no distress.

Heart:

normal S1, S2 without murmurs, rubs, gallops, or clicks.

Msk:

left elbow- tender to palpation medial aspect, mild edema

Pulses:

pulses normal in all 4 extremities.

Extremities:

Full ROM of all extremities

Skin:

Left lower leg wound- 1.3cmW X 1.9cmL, pt tenderness around wound seems out of proportion with exam, serosanguinous drainage, no warmth or erythema surrounding

Psych:

depressed affect and agitated.

Impression & Recommendations:

Problem # 1: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)

Assessment: Unchanged

Will send to wound clinic for evaluation.

Question of proper hygiene measures taken with the wound. We have again instructed to use new dressings at each dressing change

Orders:

Referral (DC-99999)

MRI Unlisted (*See Code Book*)

Office visit est detailed (99214) (CPT-99214)

Problem # 2: LEG PAIN, LEFT (ICD-729.5)

Assessment: Deteriorated

Pain seems out of proportion with exam at this point. Will send for MRI to assess for sinus tracts, abscess, or osteo.

Orders:

BMP (CPT-80048)

Office visit est detailed (99214) (CPT-99214)

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864-474-1528 Fax: 864-474-1049

October 26, 2012

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Problem # 3: ELBOW PAIN, LEFT (ICD-719.42)**Assessment: New**

likely some nerve compression due to ongoing edema in this area. Will give it a few more weeks for swelling to decrease and re-evaluate.

Orders:

Office visit est detailed (99214) (CPT-99214)

Prescriptions:

PERCOCET 5-325 MG TABS (OXYCODONE-ACETAMINOPHEN) take one tab every 6 hours as needed for pain #40 x

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Print then Give to Patient

RxID: 1664961278062210

ROLLED GAUZE BANDAGE 4"X2.5YD MISC (GAUZE BANDAGES) apply over telfa and under coban wrap at dressing changes #4 rolls[Undefined] x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Electronically to

Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1664961218062210

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) Take 1 tablet by mouth every 6 hours as needed for nausea #40[tablet] x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Electronically to

Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1664961188062210

IBUPROFEN 600 MG TABS (IBUPROFEN) Take one tablet every 6 hrs as needed with food for moderate pain #90[tablet] x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Electronically to

Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1664961158262210

NEXCARE COBAN WRAP 3"X5YD MISC (ELASTIC BANDAGES & SUPPORTS) wrap over telfa pads on wounds #2 rolls[Undefined] x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Electronically to

Pacolet Family Medicine

7221 South Pine St. Pacolet, SC 29372

864-474-1528 Fax: 864-474-1049

October 26, 2012

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1664961158162210

TELFA NON-ADHERENT DRESSING 3"x4" PADS (GAUZE PADS & DRESSINGS) apply one telfa pad twice daily
#40[each] x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 10/04/2012

Method used: Electronically to

Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)

441 N Duncan Byp Ste A

Union, SC 29379-8607

Ph: 8644276114

Fax: 8644276444

RxID: 1664961158062210

.....Mary Sue Brewton, DO (October 4, 2012 9:51 AM)

Electronically Signed by Mary Sue Brewton, DO on 10/04/2012 at 9:52 AM

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October 26, 2012

Page 1

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

10/04/2012 - Lab Report: BASIC METABOLIC PANEL- WNL

Provider: Mary Sue Brewton, DO

Location of Care: Spartanburg Regional Healthcare System

Patient: KEITH L CASE

ID: LA01 000184520

Note: All result statuses are Final unless otherwise noted.

Tests: (1) BASIC METABOLIC PANEL (13500&LMC)

Order Note: No hemolysis noted

Urea Nitrogen	11 mg/dL	7-25
Sodium	138 mmol/L	133-146
Potassium	3.7 mmol/L	3.5-5.2
Chloride	108 mmol/L	100-111
Carbon Dioxide [L]	22.8 mmol/L	23.0-32.6
Glucose	84 mg/dL	70-100
Creatinine	0.91 mg/dL	0.47-1.35
Calcium	9.3 mg/dL	8.9-10.3
Bun/Creat Ratio	12	8-23

Osmolality Calculation

274 mOsm/kg 270-350

Anion Gap 11 mmol/L 6-13

Estimated GFR-African American>60 mL/min/1.73 m²Estimated GFR-Other >60 mL/min/1.73 m²

Do not use this eGFR calculation for medication dose adjustments.

The above 13 analytes were performed by SPARTANBURG REGIONAL LABORATORY

101 EAST WOOD STREET, SPARTANBURG, SC 29303

Note: An exclamation mark (!) indicates a result that was not dispersed into the flowsheet.

Document Creation Date: 10/04/2012 4:03 PM

(1) Order result status: Final

Collection or observation date-time: 10/04/2012 14:11

Requested date-time: 10/04/2012 14:11

Receipt date-time: 10/04/2012 14:11

Reported date-time: 10/04/2012 16:03

Referring Physician:

Ordering Physician: MARY BREWTON (B91120)

Specimen Source: 2&BLOOD GREEN-GEL&GREEN GEL TUBE

Source: LA01

Filler Order Number: 12278562423 LA01

Lab site: N122780152

The following non-numeric lab results were dispersed to the flowsheet even though numeric results were expected:

Estimated GFR-African American, >60

Estimated GFR-Other, >60

Electronically Signed by Mary Sue Brewton, DO on 10/04/2012 at 4:34 PM

Received Time: Oct. 26. 2012 3:18PM No. 3270

Pacolet Family Medicine

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October 26, 2012

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Pacolet Family Medicine

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

09/25/2012 - Office Visit: LEG PAIN Procedure room

Provider: Mary Sue Brewton, DO

Location of Care: Pacolet Family Medicine

Visit Type: Follow-up Visit

CC: Wound odor.

History of Present Illness:

Pt states he was hurt at work a few weeks back. His right leg is healing nicely, but he states the left leg now has a smell to it. Ask a nurse told him that he needed to be checked again for infection. Drainage is still bloody/clear on his right leg and he still does have some drainage from his left leg. Some of the scab fell off of his left leg wound. He notes an increase in pain over the last week.

He also complains of insomnia- he has difficulty falling asleep for the last 1+ weeks. He does not fall asleep until sunrise and then sleeps until about 2:30 pm. He notes that he is worried that when he reports back to work after his injury that he will get laid off. He has tried over-the-counter sleep aid with some success.

Past Medical History:

Reviewed history from 09/04/2012 and no changes required:

Carpal Tunnel Syndrome

Allergic Rhinitis

Risk Factors:

Tobacco use: never smoker

Review of Systems

General

Complains of fever.

Derm

Denies changes in color of skin.

Psych

+insomnia

Vital Signs:

Patient Profile: 41 Years Old Male

Height: 70 inches (182.88 cm)

Weight: 243.13 pounds

BMI: 35.01

Temp: 98.6- 98.3 degrees F tympanic

Pacolet Family Medicine

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

BP sitting: 130 / 94 (left arm)
Cuff size: regular

Vitals Entered By: Karen O Longshore, RT (September 25, 2012 10:31 AM)

Physical Exam

General:

well developed, well nourished, in no acute distress.

Head:

normocephalic and atraumatic.

Lungs:

clear bilaterally to auscultation, no distress.

Heart:

normal S1, S2 without murmurs, rubs, gallops, or clicks.

Msk:

left leg edema decreased from previous exam and decreased tenderness to palpation

Pulses:

pulses normal in all 4 extremities.

Skin:

right leg wound- skin well approximated and healing, scant drainage noted.

Left leg wound- 1.7cm (W) X 2.6cm (L). eschar thinner and only covering 1/2 the wound. granulation tissue present. No odor or drainage noted.

Psych:

anxious.

Impression & Recommendations:

Problem # 1: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)

Assessment: Unchanged

Wound healing well. Decrease in overall size. Granulation tissue present. Cont pressure dressings

Orders:

Office visit est detailed (99214) (CPT-99214)

Problem # 2: WOUND INFECTION (ICD-686.9)

Assessment: New

no purulent drainage on exam and no odor noted. appears to be healing well with granulation tissue. Due to patient's description of wound over the weekend and risk of infection due to wound type will start bactrim. RTO in 7-10 days for recheck. If drainage becomes purulent or fever persists, instructed to return to the office

Orders:

Office visit est detailed (99214) (CPT-99214)

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

continue percocet 5mg. Cont Ibuprofen. Rx refills. No change in strength of percocet at this visit. Increase in pain may be due to infection.

Orders:

Office visit est detailed (99214) (CPT-99214)

Problem # 4: INSOMNIA, TRANSIENT (ICD-780.52)

Assessment: New

likely assoc with increased worry about work

His updated medication list for this problem includes:

Ambien 5 Mg Tabs (Zolpidem tartrate) Take one tab at night for sleep

Orders:

Office visit est detailed (99214) (CPT-99214)

Medications Added to Medication List This Visit:

- 1) Bactrim Ds 800-160 Mg Tabs (Sulfamethoxazole-trimethoprim) Take 1 tablet by mouth twice daily for infection
- 2) Ambien 5 Mg Tabs (Zolpidem tartrate) Take one tab at night for sleep

.....Mary Sue Brewton, DO (September 25, 2012 11:17 AM)

Electronically Signed by Mary Sue Brewton, DO on 09/25/2012 at 11:18 AM

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October 26, 2012

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

09/18/2012 - Office Visit: FU ON LEG - RM 2**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine****Visit Type: Follow-up Visit****History of Present Illness:**

Patient identified using 2 approved Identifiers per red rules.

Patient presents for follow up visit regarding leg injuries, he states he is still in significant amount of pain (6/10) & is unable to walk for long distances without falling. States he does not think legs are getting better.....Tara S. Rice LPN (September 18, 2012 10:01 AM)

Is still taking percocet around the clock to help control pain, and is also taking ibuprofen. The phenergan helps with the nausea assoc with the pain meds. Is up and walking more and feels weak in his legs.....Mary Sue Brewton, DO (September 18, 2012 10:59 AM)

Risk Factors:

Tobacco use: never smoker

Review of Systems**Derm**

Complaints of poor wound healing and changes in color of skin.

Vital Signs:

Patient Profile: 41 Years Old Male
Height: 70 inches (182.88 cm)
Weight: 248 pounds
BMI: 35.71
Temp: 98.8 degrees F tympanic
Pulse rate: 89 / minute
Pulse rhythm: regular
Resp: 18 per minute
BP sitting: 126 / 95 (left arm)
Cuff size: large

Vitals Entered By: Tara S. Rice LPN (September 18, 2012 9:57 AM)

Pacolet Family Medicine

7221 South Pine St. Pacolet, SC 29372

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Physical Exam**General:**

well developed, well nourished, in no acute distress.

Msk:

less tenderness to palpation upper left extremity

Pulses:

pulses normal in b/l lower extremities

Skin:

left leg wound- 2.8L X 2.4W, decrease in edema and erythema

Right knee wound- well approximated, sterl strips in place, scant clear drainage, no erythema or edema

Psych:

alert and cooperative

Impression & Recommendations:**Problem # 1: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)**

continue pressure dressings, etc later next week for recheck.

Orders:

Office visit est exp prob (99213) (CPT-99213)

Problem # 2: LEG PAIN, LEFT (ICD-729.5)

cut percocet back to 6mg

Orders:

Office visit est exp prob (99213) (CPT-99213)

Medications Added to Medication List This Visit:

1) Percocet 5-325 Mg Tabs (Oxycodone-acetaminophen) Take one tab every 6 hours as needed for pain

Prescriptions:**PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL)** Take 1 tablet by mouth every 6 hours as needed for nausea #40 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/18/2012

Method used: Print then Give to Patient

RxID: 1663584284507140

IBUPROFEN 600 MG TABS (IBUPROFEN) Take one tablet every 6 hrs as needed with food for moderate pain #90 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/18/2012

Method used: Print then Give to Patient

RxID: 1663584284057140

PERCOCET 5-325 MG TABS (OXYCODONE-ACETAMINOPHEN) take one tab every 6 hours as needed for pain #40 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/18/2012

Method used: Print then Give to Patient

received 190
Time: Oct. 26. 2012 3:18PM No. 3270

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KEITH L CASE
Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182
Ins: UNINSURE (14)

.....Mary Sue Brewton, DO (September 18, 2012 11:01 AM)

Electronically Signed by Mary Sue Brewton, DO on 09/18/2012 at 11:03 AM

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

09/12/2012 - Diagnostic Report Other: NVL Venous Duplex : Neg for DVT, pt Informed**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine**

Patient: KEITH L CASE

ID: MEDCON 000184520

Note: All result statuses are Final unless otherwise noted.

Tests: (1) NVL Venous Duplex LE Unilateral Lt (51901)

NVL Venous Duplex LE Unilateral Lt

"Result Below..."

RESULT: Vascular Lower Extremities DVT Study Procedure

Demographics

Patient Name	CASE KEITH L	Age	41 year(s)
Height		Weight	
MRN	000184520	Gender	Male
Account Number	1225600395	Race	Caucasian
Corporate ID	00091477	Accession Number	26696590HBOC
Date of Birth	06/09/1971	Room Number	*OP
Referring Physician	Simon Ifekan-shango MD	Reading Physician	Calton Cuyler
Vascular Tech	Terry Joaneth RVT, RDMS		

Procedure

Type of Study:

Veins: Lower Extremities DVT Study, NVL Venous Duplex LE Unilateral Lt.

Indications for Study: Pain, edema, discoloration.

Exam Status: STAT.

Study Location: SRMC VASCULAR LAB.

Technical Quality: Image quality is good..

Conclusions

Summary

No evidence of left lower extremity deep venous thrombosis or superficial thrombophlebitis.

Signature

Electronically signed by Calton Cuyler (Reading Physician) on
09/12/2012 07:31 PM

Pacolet Family Medicine

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Limited examination of the right common femoral vein shows normal compression and duplex signals.

Left Impression

Duplex images of the left lower extremity veins show normal compression and duplex signals. No abnormal intraluminal echogenic densities are visualized.

Velocities are measured in cm/s ; Diameters are measured in cm

Right Lower Extremities DVT Study Measurements**Right 2D Measurements**

!Location	!Visualized	!Compressibility	!Thrombosis
!Femoral	!Yes	!Yes	!

Right Doppler Measurements

!Location	!Signal	!Reflux	!Reflux (sec)
!Femoral	!Phasic	!	!

Left Lower Extremities DVT Study Measurements**Left 2D Measurements**

!Location	!Visualized	!Compressibility	!Thrombosis
!Dist External Iliac	!Yes	!Yes	!None
!Femoral	!Yes	!Yes	!None
!GSV High Thigh	!Yes	!Yes	!None
!Prox Femoral	!Yes	!Yes	!None
!Mid Femoral	!Yes	!Yes	!None
!Dist Femoral	!Yes	!Yes	!None
!Deep Femoral	!Yes	!Yes	!None
!Popliteal	!Yes	!Yes	!None
!Peroneal	!Yes	!Yes	!None
!PTV	!Yes	!Yes	!None
!Gastroc	!Yes	!Yes	!None
!SSV	!Yes	!Yes	!None
!GSV Ankle	!Yes	!Yes	!None

Left Doppler Measurements

!Location	!Signal	!Reflux	!Reflux (sec)
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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

!Femoral	!Phasic!No	!	!
!GSV High Thigh	!Phasic!No	!	!
!Prox Femoral	!Phasic!No	!	!
!Deep Femoral	!Phasic!No	!	!
!Popliteal	!Phasic!No	!	!

Billing

ICD 9 Codes

1) 729.81-Swelling of limb.

Note: An exclamation mark (!) indicates a result that was not dispersed into the flowsheet.

Document Creation Date: 09/12/2012 7:31 PM

(1) Order result status: Final

Collection or observation date-time: 09/12/2012 10:03

Requested date-time:

Receipt date-time:

Reported date-time: 09/12/2012 10:03

Referring Physician: IFEKAN-SHANGO SIMON

Ordering Physician: IFEKAN-SHANGO SIMON (S24115)

Specimen Source:

Source: MEDCON

Filler Order Number: 26696590 HBOC

Lab site:

Electronically Signed by Mary Sue Brewton, DO on 09/13/2012 at 9:47 AM

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October 26, 2012

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

09/11/2012 - Office Visit: 1 WK RT - RM 2

Provider: Mary Sue Brewton, DO

Location of Care: Pacolet Family Medicine

Visit Type: Follow-up Visit

History of Present Illness:

Patient identified using 2 approved Identifiers per red rules.

41 yo WM workman's comp patient presents for recheck and stitch removal on leg wounds. He still complains of ongoing pain. He reports that the pain has increased in his left upper leg and is described as a pulling pain in the last 3 days. The lower left leg wound is still being dressed with pressure dressings but did open some after stitch removal last week. His right leg is feeling much better but still rates pain as 6/10. He has mainly been resting in bed and using a walker. Requesting more pain and nausea medicine.

Past Medical History:

Reviewed history from 09/04/2012 and no changes required:

Carpal Tunnel Syndrome

Allergic Rhinitis

Risk Factors:

Tobacco use: never smoker

Review of Systems**General**

Denies fever,

GI

Complains of nausea.

Vital Signs:

Patient Profile: 41 Years Old Male

Height: 70 Inches (182.88 cm)

Weight: 248.25 pounds

BMI: 35.75

Temp: 98.8 degrees F tympanic

Pulse rate: 91 / minute

Pulse rhythm: regular

Resp: 18 per minute

BP sitting: 126 / 85 (left arm)

Cuff size: large

Pacolet Family Medicine

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Location: legs bilaterally
Intensity: 6

Vitals Entered By: Tara S. Rice LPN (September 11, 2012 1:03 PM)

Physical Exam**General:**

well developed, well nourished, in no acute distress.

Head:

normocephalic and atraumatic.

Msk:

left upper leg tender to palpation over medial and lateral aspects of thigh

Skin:

Right knee wound- 7 stitches removed, area cleaned with sterile water, steri-strips applied and wound dressed
Left leg wound- thick eschar, pressure dressing applied, hematoma surrounding, edema surrounding

Impression & Recommendations:**Problem # 1: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)****Assessment:** Unchanged

Stitches removed from left knee wound, steri strips applied. Both sites are healing, granulation tissue noted. Both wound dressed before patient left.

Percocet and phenergan refilled.

Orders:

Duplex study of extremity veins (mapping) UNILATERAL (CPT-93971)

Office visit est exp prob (99213) (CPT-99213)

Problem # 2: LEG PAIN, LEFT (ICD-729.5)**Assessment:** New

Pain suspicious for DVT, sent for venous duplex. Pt said they could not go today for the venous duplex and would rather go tomorrow when it is more convenient for them. Appointment scheduled for tomorrow. Pt informed of importance of keeping that appointment.

Orders:

Duplex study of extremity veins (mapping) UNILATERAL (CPT-93971)

Office visit est exp prob (99213) (CPT-99213)

Medications Added to Medication List This Visit:

1) Promethazine Hcl 25 Mg Tabs (Promethazine hcl) Take 1 tablet by mouth every 6 hours as needed for nausea

Pacolet Family Medicine

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864-474-1528 Fax: 864-474-1049

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

PROMETHAZINE HCL 25 MG TABS (PROMETHAZINE HCL) Take 1 tablet by mouth every 6 hours as needed for nausea #30 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/11/2012

Method used: Print then Give to Patient

RxID: 1662990421160050

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) take one tab every 6 hours as needed for severe pain #30 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/11/2012

Method used: Print then Give to Patient

RxID: 1662990361610050

.....Mary Sue Brewton, DO (September 11, 2012 2:01 PM)

Electronically Signed by Mary Sue Brewton, DO on 09/11/2012 at 2:14 PM

Pacolet Family Medicine
7221 South Pine St.
Pacolet, SC 29372
Phone: 864-474-1528 Fax: 864-474-1049

09/11/2012

KEITH CASE
573 GOLDMINE RD
PAULINE, SC 29374 USA

To whom it may concern,

Mr. Case is currently under our medical care and can be expected to be out of work for atleast the next 3 weeks, with hopeful return October 3, 2012. This timeframe will be re-evaluated as the date approaches.

Sincerely,

Dr. Mary Sue Brewton
Pacolet Family Medicine

Please fax to 803-798-6383

Pacolet Family Medicine7221 South Pine St. Pacolet, SC 29372
864-474-1528 Fax: 864-474-1049

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KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

09/04/2012 - Office Visit: LEG PAIN _ RM 3**Provider: Mary Sue Brewton, DO****Location of Care: Pacolet Family Medicine****Visit Type:** Acute Visit**CC:** leg pain.**History of Present Illness:**

Patient identified using 2 approved identifiers per red rules.

Patient presents for hospital follow up, / workmans comp visit

He was injured on his job as a tractor trailer driver, he injured both legs. He was treated at SRHS.

The pt is a 41 yo WM seen today for suture removal and wound follow up. On Aug. 27th pt was at work and was unloading a tractor-trailer. Was getting down off of the tractor trailer and a log started rolling. He fell down to the ground and the log fell on him. His wife took him to the hospital at Spartanburg Regional immediately after the accident. Xrays were obtained, his wounds were cleaned and sutured. He is currently taking pain medication and antibiotic provided by the ER. No drainage from wounds.

Past Medical History:

Carpal Tunnel Syndrome

Allergic Rhinitis

Risk Factors:

Tobacco use: never smoker

Review of Systems**General**

Denies fever.

Vital Signs:

Patient Profile: 41 Years Old Male

Height: 70 inches (182.88 cm)

Weight: 249.44 pounds

BMI: 35.92

Temp: 98.8 degrees F tympanic

Pulse rate: 85 / minute

Pulse rhythm: regular

Resp: 18 per minute

BP sitting: 134 / 97 (left arm)

Cuff size: large

Pacolet Family Medicine

7221 South Pine St. Pacolet, SC 29372

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Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Physical Exam**General:**

well developed, well nourished, in moderate pain/ distress.

Head:

normocephalic and atraumatic.

Skin:

Right knee laceration- crescent shaped with what looks like was a wedge lac also, sutures intact. Crescent part of lac moist and not healed yet, most proximal part of lac with 2 sutures and well healing skin

Left leg laceration- Sutures intact, eschar, erythema surrounding approximately 1cm, hematoma underneath, no warmth noted

Psych:

alert and cooperative; normal mood and affect; normal attention span and concentration.

Impression & Recommendations:**Problem # 1: CRUSHING INJURY UNSPECIFIED SITE LOWER LIMB (ICD-928.9)****Assessment: New**

Injury involving right knee and left leg. Xrays reviewed from ER. Right knee lac is a high tension area and we will wait another week to remove the remaining stitches. Left knee wound/lac has formed a scab, some erythema surrounding- p and wife were advised to watch for purulent drainage or enlarging erythema. To RTC if erythema worsens or drainage develops. Cont keflex.

Please see procedure note below.

Orders:

Office visit new expanded prob (99202) (CPT-99202)

Medications Added to Medication List This Visit:

- 1) Cephalexin 500 Mg Caps (Cephalexin) Take one capsule by mouth three times daily for 10 days
- 2) Percocet 5-325 Mg Tabs (Oxycodone-acetaminophen) Take one tablet by mouth every 6 hours as needed for pain
- 3) Percocet 10-325 Mg Tabs (Oxycodone-acetaminophen) Take one tab every 6 hours as needed for severe pain
- 4) Telfa Non-adherent Dressing 3"x4" Pads (Gauze pads & dressings) Apply one telfa pad twice daily
- 5) Nexcare Coban Wrap 3"x5yd Misc (Elastic bandages & supports) Wrap over telfa pads on wounds
- 6) Ibuprofen 600 Mg Tabs (Ibuprofen) Take one tablet every 6 hrs as needed with food for moderate pain
- 7) Promethazine Hcl 12.5 Mg Tabs (Promethazine hcl) One tab po every 4-6 hrs as needed for nausea
- 8) Rolled Gauze Bandage 4"x2.5yd Misc (Gauze bandages) Apply over telfa and under coban wrap at dressing changes

Prescriptions:

ROLLED GAUZE BANDAGE 4"x2.5YD MISC (GAUZE BANDAGES) apply over telfa and under coban wrap at dressing

Pacolet Family Medicine7221 South Pine St. Pacolet, SC 29372
864-474-1528 Fax: 864-474-1049

October 26, 2012

Page 3

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Method used: Electronically to
Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)
441 N Duncan Byp Ste A
Union, SC 29379-8607
Ph: 8644276114
Fax: 8644276444

RxID: 1662392989162330

PROMETHAZINE HCL 12.5 MG TABS (PROMETHAZINE HCL) One tab PO every 4-6 hrs as needed for nausea
#24[tablet] x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/04/2012

Method used: Electronically to
Wal-mart - Union, SC - 441 N Duncan Byp Ste* (retail)
441 N Duncan Byp Ste A
Union, SC 29379-8607
Ph: 8644276114
Fax: 8644276444

RxID: 1662392779162330

IBUPROFEN 600 MG TABS (IBUPROFEN) Take one tablet every 6 hrs as needed with food for moderate pain #60 x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/04/2012

Method used: Print then Give to Patient

RxID: 1662392600158600

NEXCARE COBAN WRAP 3"X5YD MISC (ELASTIC BANDAGES & SUPPORTS) wrap over telfa pads on wounds #2
rolls x 1

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/04/2012

Method used: Print then Give to Patient

RxID: 1662392510158600

TELF A NON-ADHERENT DRESSING 3"X4" PADS (GAUZE PADS & DRESSINGS) apply one telfa pad twice daily #40
0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/04/2012

Method used: Print then Give to Patient

RxID: 1662392450158600

PERCOCET 10-325 MG TABS (OXYCODONE-ACETAMINOPHEN) take one tab every 6 hours as needed for severe pain
#30 x 0

Entered and Authorized by: Mary Sue Brewton, DO

Signed by: Mary Sue Brewton, DO on 09/04/2012

Method used: Print then Give to Patient

RxID: 1662392420158600

Procedure Note: Left leg- 6 sutures removed in the normal fashion. Pt tolerated this well. Right knee- the 2 most
proximal sutures were removed in the normal fashion. Pt tolerated this well.....Mary Sue Brewton,
DO (September 4, 2012 4:06 PM)

Pacolet Family Medicine

7221 South Pine St. Pacolet, SC 29372
864-474-1528 Fax: 864-474-1049

October 26, 2012

Page 4

Chart Document

KEITH L CASE

Male DOB: 06/09/1971

286621

Home: (864)316-2620 Work: (864)426-6182

Ins: UNINSURE (14)

Electronically Signed by Mary Sue Brewton, DO on 09/04/2012 at 4:12 PM

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

ED RECORD

Patient: Case, Keith L
Home Address: 573 Goldmine Road
City: Pauline
State: SC Zip: 29374
Home Ph: (864) 316-2620

DOB: 6/9/1971
Age: 41 yr
Sex: M

Patient Code Alert

Insurance Companies

Insurance Company

WORKERS COMPENSATION

Acuity: 4

Mode of Disposition: Home
Condition at Dispo: Good

Pt Weight: 111.1 kg
(245 lbs)
Pt Height: 5'10" (178cm
s)

CC / Curr Imp: Follow-Up Exam Nos, Recheck

RN Triage: Hill, Gemia V R.N. (E.C.)
RN Primary: Karen R.
Provider: Lombardozzi, Christopher M.D.

Created Record: 8/29/2012 1624

Mode of Arrival: Walk-In NOS

Decision To Admit:

Dispo Summary Printed: 8/29/2012 1816

Time Left ED: 8/29/2012 1853

BMI: 35.1

BSA: 2.34 m2

PCP: Bishop, Preston M.D.

PCP Ph: 864-474-1528

Referring Phys:

Referring Phys Ph:

Consult Phys:

Consit Phys Ph:

Admit Info

Dx/Instr

Dx 1: Wound Check, Follow Up Exam

Created and Electronically Authenticated By: Lombardozzi, Christopher M.D. Created: 8/29/2012 1609 Last Entry: 1813

PHYSICIAN H&P Wound Recheck/ Suture removal

Patient seen at: 8/29/2012 1758.

PREHOSPITAL CARE: none

History not limited.

Chief Complaint: (+) Recommended recheck () Packing removal () Dressing change () Suture/Staple removal

HPI:

Treated in ED 2 days ago

For (+) laceration repair (

To the bilateral lower extremity extensive lacerations sutured two days ago by Dr. Dixon. Pt was instructed to return here for re-evaluation of wounds. Pt has no new complaints, no fever/chills, no pus, no separation of wound edges. Pt currently has (-) no complaints () fever () increased pain () increased redness () Discharge 10/18/2012

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

Other symptoms: "still hurts" out of percocet and needs another work note

ROS: < Click to add systems

SKIN(System): ()rash, ()itching, ()redness, ()swelling.

+)Except as marked, all systems above reviewed and found negative or are noted in HPI.

PMH List (See PMH Table) PSH List (See PSH Table)

+)PMH and PSH reviewed and agree with or personally modified the table above.

+)Medications and allergies in nursing notes reviewed and confirmed or modified in table.

+)Nursing chart reviewed. Available family and social history reviewed as documented in the nursing notes with supplement as needed below.

FH: ()CAD, ()DM, (+)HTN ()Other type in

SH: no tobacco, no alcohol, no drugs, lives with family.

IMMUNIZATIONS:

Status: Up To Date.

PHYSICAL EXAM:

VITAL SIGNS REVIEWED

GENERAL APPEARANCE: well nourished, alert, cooperative, no obvious discomfort.

KIN: Wound description healing wounds on bilat legs

(+) Wound healing (-) redness (+) wound edges well approximated

(-) Pus expressed

(

Created and Electronically Authenticated By: Lombardozzi, Christopher M.D. Created: 8/29/2012 1609 Last Entry: 1814

Provider Note: pt instructed to continue minimal weight bearing to avoid dehiscence of wounds

DISCHARGE - Plan of care discussed with patient or caregiver. Questions were answered. Verbal and printed instructions were provided. If prescription(s) were given, the prescribed medications were reviewed, including relevant side effects and interactions. The patient is to seek outpatient follow up as noted in the discharge instructions. They verbalized understanding and ability to comply. The patient is discharged in stable condition. They were instructed to return to the emergency department for worsening symptoms or other concerns.

Clinical Decision Support

Part

CPT II

Compliance

Entries

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
PI Acct: 1224201638
Med Rcd: 000184520

Vital Signs										
Sys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at
139	89	90	14	98%	RA	98.7 F	oral			8/29/2012 1634
			18						Disposition Vitals	8/29/2012 1859
										Hill, Garria V.R.N. (E.C.)
										Crossley, Sally R.N.

Home Medications			
Arrival Medication	Indication	Last Dose	Comments
Keflex			
Percocet 10/325			
Neprosyn			

Allergies	
Allergic Substance	Reaction
NKDA	

Input & Output			
Fluid Type	Intake	Output	I/O Time
No Entries			

PMH	
Condition	
none	

PSH	
Procedure	
none	

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

Orders

Order	Sched D/T	Comp D/T	Provider Sig
-------	-----------	----------	--------------

10 Entries

Orders (Meds)

Order	Sched D/T	Infusion Started	Administered D
-------	-----------	------------------	----------------

TIMI Scale

Criteria	Present
----------	---------

Age >= 65	
= 3 CAD risk factors	
Known coronary stenosis >= 50%	
Aspirin use in past 7 days	
Angina episodes in prior 24 hours	
Obtained serum cardiac markers	
ST deviation >= 0.5mm on admission ECG	
===== TOTAL TIMI Score	
===== Mortality/Schemit RISK	
===== Date/Time Performed	
===== User Name	

Pneumonia Scale

Pneumonia Criteria	Present	Points
--------------------	---------	--------

Age		+10
Male		-10
Living Home Resident		+10
Neoplastic Disease History		+30
Chronic Disease		+20
Congestive Heart Failure		+10
Renovascular disease		+10
Renal Disease		+10
Altered Mental Status		+20
Respiratory Rate > 29/min		+20
Systolic Blood Pressure < 90 mm Hg		+20
Temperature < 95F or > 103.8F		

PRINTED BY: JH241657

DATE 10/18/2012

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

Pneumonia Scale (continued)		
Pneumonia Criteria	Present	Points
Pulse > 124 beats/min		+10
pH < 7.35		+20
BUN > 29mg/dl		+20
Sodium < 130 mmol/liter		+20
Glucose > 250mg/dL		+10
Hematocrit < 30%		+10
Oxygen saturation < 90%		+10
Pleural Effusion on X-ray		+10
===== TOTAL Score		
===== MORTALITY RISK		
===== Performed on		
===== User Name		

NIH Stroke Scale											
LOC	Questions Comman	Gaze	Visual Fi	Paresis	RA Motor	LA Motor	RL Motor	LL Motor	Ataxia	Sensory	Language Dysarthria Exti
No Entries											

Procedures			
Procedure	Performed By	Quantity Entered	Billing No.
No Entries			

Created and Electronically Authenticated By: Hill, Germa V R.N. (EC) Created: 8/29/2012 1632 Last Entry: 1633

NURSING TRIAGE (Adult)

HPI: recheck of stitches to bilateral LE.

PREHOSPITAL CARE:

Support System: lives w family or significant other.

Special Considerations: None Identified.

LEARNING BARRIERS: None Identified.

TRIAGE DATA:

History obtained from: patient

Tetanus: immunization status:.

LMP:

PHYSICAL EXAM:

AIRWAY: oral, (-)obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: (adult) - well nourished, alert, oriented X 3, no acute distress, no obvious -207-

discomfort.

PRINTED BY: JH24657

DATE 10/18/20

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

SKIN: warm, dry, good color, no rash.

— NURSING INTERVENTION: None

Created and Electronically Authenticated By: Revis, Karen, R.N. (E.C.) Created: 8/29/2012 1719 Last Entry: 1721

Clinical Note: pt seen in EC x 2 days ago for bilateral leg injuries after falling from a truck, pt with sutures to rt knee and left lower leg, sts was instructed to return today for recheck, pt ambulating with aid of walker, dressing removed, bloody drainage noted to gauze, left lower leg wound, clean without redness or swelling.

Redness noted to rt knee wound. Pt sts had x-rays taken 2 days ago in EC

ASSESS SKIN Assessment performed at 8/29/2012 1718.

— PMH List (See PMH Table) PSH List (See PSH Table)

— SH: no alcohol, drug usage

— PHYSICAL EXAM:

AIRWAY: (+)patent, (-)obstructed.

BREATHING: no breathing compromise. (-)accessory muscle use, good air exchange bilateral.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

MENTAL STATUS: speech clear, oriented X 3, normal affect, responds appropriately to questions, alert, cooperative.

SKIN: Symptoms began 2days ago good color, dry, warm, no rash, no lesions, (-)itching

mpaired Skin Integrity:

— EXPOSURE: Clothing removed, Hospital gown provided, Family at bedside.

— SAFETY: Call light at bedside, Use of call bell explained to patient. Side rails raised for patient safety.

— FALLS ASSESSMENT ADULT:

FALL HISTORY: No history of falling 0

SECONDARY DIAGNOSIS: No secondary diagnosis 0

IV ACCESS: No IV Access 0

AMBULATORY AID: Nonelbed rest/nurse assist 0

GAIT: Gait Normal bed rest or wheelchair 0

MENTAL STATUS: Oriented to own ability 0

— FALL RISK SCORE: Low Risk (0-44).

— Plan of Care to Decrease Fall Risk: Low Risk Interventions include - ()Oriented to room, ()Instruct to call for help/call bell within reach, ()Family/caregiver at bedside, ()Bed in low position, ()Bed/stretcher brakes on, ()Bec rails up.

Created and Electronically Authenticated By: Stevenson, Donna (E.S.T.) Created: 8/29/2012 1756 Last Entry: 1757

Clinical Note: Pt given water at this time

Created and Electronically Authenticated By: Stevenson, Donna (E.S.T.) Created: 8/29/2012 1832 Last Entry: 1833

Clinical Note: Pt wounds cleaned, xeroform, telfa, gauze and cling applied to bilateral wounds

Created and Electronically Authenticated By: Crossley, Sally R.N. Created: 8/29/2012 1859 Last Entry: 1859

Clinical Note:

SP DISCHARGE with Prescription(s) - Plan of care discussed with patient. Patient discharged with printed instructions. Prescriptions given to patient. Reviewed prescribed medications with patient; including potential interactions with other substances. Patient verbalized understanding and ability to comply.

The following items were received by the patient on discharge:

(+)Discharge/Dx

(+)Diagnostic specific discharge instructions

(+)Medication Reconciliation Form

(+)Follow up plans

(+)A list of major procedures or test done in EC.

Prescription/Rx

Rx: 1: Percocet Tablets 5/325mg (oxycodone/acetaminophen)

Dose/Conc:

-208-Freq/Rle: 1 tablet by mouth every 6 hrs as needed for pain

Disp: #30 (thirty) tablets

Refill: zero

Do Not Substitute: 10/18/2012

Patient: Case, Keith L
Arrival (HIS): 8/29/2012 1624
Pt Acct: 1224201638
Med Rcd: 000184520

Disposition

Follow-up 1: Bishop, Preston M.D.
Follow-up 1 Date: 7 days

F/U MD Ph: 864-474-1528
F/U MD Fax: 864-474-1049

Other Instr: return here or see your doctor in 1 week for recheck and suture removal

May return to work/school: 10 Days

Signatures

Electronically Authenticated Lombardozzi, Christopher M.D. 8/29/2012 1816

Electronically Authenticated Crossley, Sally R.N. 8/29/2012 1859

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Spartanburg Regional

Spartanburg Regional Emergency Center

101 East Wood Street, Spartanburg, SC 29303 == (864) 560-6000

Patient: Case, Keith L

Arrival: 8/29/2012 1624

Pt Acct: 1224201638

Med Rcd: 000184520

Disposition Summary (for discharged patient; English)

Patient: Case, Keith L

Home Address: 573 Goldmine Road

City: Pauline

SC

29374

DOB: 6/9/1971

Age: 41yr

Home Ph: (864) 316-2620

Arrival: 8/29/2012 1624

RN Triage: Hill, Gemia V R.N. (E.C.)

Provider: Lombardozzi, Christopher M.D.

Disposition: Home

RN Primary: Karen R.

PCP: Bishop, Preston M.D.

PCP Ph: 864-474-1528

Triage Impression: Recheck

Dx 1: Wound Check, Follow Up Exam

Rx 1: Percocet Tablets 5/325mg (oxycodone/acetaminophen)

1 tablet by mouth every 6 hrs as needed for pain

1/30 (thirty) tablets

Disposition

Follow-up 1: Bishop, Preston M.D.

Pacquet Family Medicine

7221 South Pine St

Pacquet

Sc

29372

F/U MD Ph: 864-474-1528

F/U MD Fax: 864-474-1049

Follow-up 1 Date: 7 days

Other Instructions: return here or see your doctor in 1 week for recheck and suture removal

MY SIGNATURE BELOW INDICATES:

☐ I have received a transition record upon discharge.

☐ I understand that I have had emergency treatment and that I may be released before all of my medical problems are known or treated.

☐ I have received and understood the instructions regarding my current condition.

☐ I will arrange follow-up care as instructed above.

☐ I acknowledge receipt of the written instructions as outlined on this and any previous page(s).

☐ I will read and review these instructions.

☐ I understand the hospital and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this admission. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

x Sharon Case
Patient (or Legal Guardian)

Relationship to patient Wife

x Sally Crosby
Signature Staff (Witness) Signature

1224201638 000-184520
CASE, KEITH L DOB 06/09/71
ADM: PHYSICIANS, ED
ADM DATE/TIME: 08/29/12 1624





Spartanburg Regional

101 East Wood Street
Spartanburg, SC 29303
Phone: 864-560-8131
Fax: 864-560-6716

Report Status: Finalized



Vascular Lower Extremities DVT Study Procedure

Demographics

Patient Name	CASE KEITH L	Age	41 year(s)
Height		Weight	
MRN	000184520	Gender	Male
Account Number	1225800395	Race	Caucasian
Corporate ID	00091477	Accession Number	26696590HBOC
Date of Birth	06/09/1971	Room Number	*OP
Referring Physician	Simon Ifekan-shango MD	Reading Physician	Calton Cuyler
Vascular Tech	Terry Joaneth RVT, RDMS		

Procedure

Type of Study:

Veins: Lower Extremities DVT Study, NVL Venous Duplex LE Unilateral Lt.

Indications for Study: Pain, edema, discoloration.

Exam Status: STAT.

Study Location: SRMG VASCULAR LAB.

Technical Quality: Image quality is good..

Conclusions

Summary

No evidence of left lower extremity deep venous thrombosis or superficial thrombophlebitis.

Signature

Electronically signed by Calton Cuyler(Reading Physician) on 09/12/2012 07:31 PM

Technical Comments

Right Impression

Limited examination of the right common femoral vein shows normal compression and duplex signals.

Left Impression

Duplex images of the left lower extremity veins show normal compression and duplex signals. No abnormal intraluminal echogenic densities are visualized.

Velocities are measured in cm/s ; Diameters are measured in cm

Right 2D Measurements

Vein	Visualized	Compressibility	Thrombosis
Femoral	Yes	Yes	

Right Doppler Measurements

Vein	Flow	Reflex	Ref x / Sec
Femoral	Phasic		

Patient Name: CASE KEITH L

MRN: 00091477

Date of study: 09/12/2012 10:03 AM

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Page: 1 of 2

PRINTED BY: JH24657

DATE

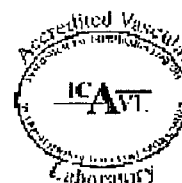
-211-
10/18/2012



Spartanburg Regional

101 East Wood Street
Spartanburg, SC 29303
Phone: 864-560-8131
Fax: 864-560-6716

Report Status: Finalized



Left Lower Extremity Doppler Study Measurements

Left 2D Measurements

Location	Visualized	Compressibility	Flow (cm/s)
Dist External Iliac	Yes	Yes	None
Femoral	Yes	Yes	None
GSV High Thigh	Yes	Yes	None
Prox Femoral	Yes	Yes	None
Mid Femoral	Yes	Yes	None
Dist Femoral	Yes	Yes	None
Deep Femoral	Yes	Yes	None
Popliteal	Yes	Yes	None
Peroneal	Yes	Yes	None
PTV	Yes	Yes	None
Gastroc	Yes	Yes	None
SSV	Yes	Yes	None
GSV Ankle	Yes	Yes	None

Left Doppler Measurements

Location	Stasis	Reflex	Reflex (cm/s)
Dist External Iliac	Phasic	No	
Femoral	Phasic	No	
GSV High Thigh	Phasic	No	
Prox Femoral	Phasic	No	
Deep Femoral	Phasic	No	
Popliteal	Phasic	No	

ICD 9 Codes

- 729.81-Swelling of limb.

Patient Name: CASE KEITH L

MRN: 00091477

Date of study: 09/12/2012 10:03 AM

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Page: 2 of 2

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove

NAME: CASE,KEITH L
ORDERING PHYSICIAN: BREWTON,MARY SUE
LOC: OPT DOB: 06/09/71
Pt. Type:OPT NORTH GROVE MRI

UNIT #: 000184520
CI#: 3451295
AN#:S1227901012

FINAL

Exam

25175 NG MRI EXTREMITY LOWER WWO CONTDate: 10/09/12 0905
73720 Ord Diag: 729.5-PAIN IN LIMB

History: Open wound of the left leg

Exam: MRI left leg with and without contrast

Technique: Multiplanar multisequence imaging is performed. 10 cc
MultiHance is administered intravenously without incident.

No comparison.

Findings: There is a marker which has been placed indicating the area of the open wound. Subjacent to the marker, there is a soft tissue defect present. There is both edema and enhancement within the anteromedial subcutaneous soft tissues. This extends to the level of the anteromedial tibial cortex. Within the anteromedial tibial marrow, there is mild edema like marrow signal as well as enhancement. There are mild T1 changes associated with this as well. Signal intensity within the musculature of the left leg is normal. No peripherally enhancing fluid collections are seen to suggest abscess formation.

Impression:

1. Ulceration subjacent to the marker, indicating the clinical area of concern. There is both edema and enhancement seen within the anteromedial subcutaneous soft tissues; these findings are compatible with cellulitis.
2. There is also mild edema and enhancement seen within the anteromedial marrow, immediately subjacent to the previously described area of soft tissue edema. Findings could represent early

Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove

NAME: CASE,KEITH L

UNIT #: 000184520

ORDERING PHYSICIAN: BREWTON,MARY SUE

CI#: 3451295

LOC: OPT

DOB: 06/09/71

AN#:S1227901012

Pt. Type:OPT

NORTH GROVE MRI

Checkin-Exam Code Summary
3451295-25175

osteomyelitis at this location, though the area of marrow involvement
a small, and the findings are fairly subtle, making this diagnosis
less certain.

Transcriptionist- n/a

Reading Radiologist- JASON P KELLY MD

Releasing Radiologist- JASON P KELLY MD

Released Date Time- 10/09/12 1047

Page 2

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove

NAME: CASE,KEITH L
ORDERING PHYSICIAN: BREWTON,MARY SUE
LOC: OPT DOB: 06/09/71
Pt. Type:OPT NORTH GROVE MRI

UNIT #: 000184520
CI#: 3451271
AN#:S1227901012

FINAL

Exam

38530 NG XR ORBITS FOR FOREIGN BODY/MRI Date: 10/09/12 0853

70030

Ord Diag: V80.2-SCREENING-EYE COND NEC

3 View Screening orbit x-ray dated 10/9/2012

Reference Exam: None

Indication: Screening for MRI, possible metal in orbits

Findings: 3 images are presented. No dense foreign bodies are seen overlying the orbit shadows.

Impression: No metal seen in the orbits

Transcriptionist- n/a

Reading Radiologist- JEFFREY NEWMAN MD

Releasing Radiologist- JEFFREY NEWMAN MD

Released Date Time- 10/09/12 0911

Page 1

SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report
North Grove

NAME: CASE,KEITH L
ORDERING PHYSICIAN: BREWTON,MARY SUE
LOC: OPT DOB: 06/09/71
Pt. Type:OPT NORTH GROVE MRI

UNIT #: 000184520
CI#: 3451271
AN#:S1227901012

FINAL

Exam

38530 NG XR ORBITS FOR FOREIGN BODY/MRI Date: 10/09/12 0853
70030 Ord Diag: V80.2-SCREENING-EYE COND NEC

3 View Screening orbit x-ray dated 10/9/2012

Reference Exam: None

Indication: Screening for MRI, possible metal in orbits

Findings: 3 images are presented. No dense foreign bodies are seen
overlying the orbit shadows.

Impression: No metal seen in the orbits

Transcriptionist- n/a
Reading Radiologist- JEFFREY NEWMAN MD
Releasing Radiologist- JEFFREY NEWMAN MD
Released Date Time- 10/09/12 0911

Page 1

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

ED RECORD

Patient: Case, Keith L
Home Address: 573 Goldmine Road

City: Pauline
State: SC Zip: 29374
Home Ph: (864) 316-2620

DOB: 6/9/1971
Age: 41yr
Sex: M

Patient Code Alert:

Insurance Companies

Insurance Company

WORKERS COMPENSATION

Acuity: 3

Mode of Disposition: Home
Condition at Dispo: Stable

Pt Weight: 111.1 kg
(245 lbs)
Pt Height: 5'10" (178cm
s)

CC / Curr Imp: Observ-Accident Nec, Laceration(Complex)

RN Triage: Mull, Steven, R.N. (E.C.)
RN Primary: Angie F
H Provider: Dixon, Byron D M.D. (E.C.)

Created Record: 8/27/2012 1103
Mode of Arrival: Wheelchair
Decision To Admit:
Dispo Summary Printed: 8/27/2012 1805
Time Left ED: 8/27/2012 1823
BMI: 35.1
BSA: 2.34 m2

PCP: Bishop, Preston M.D.
PCP Ph: 864-474-1528
Referring Phys:
Referring Phys Ph:
Consult Phys:
Onst Phys Ph:

Admit Info

Dx/Instr

Dx 1: Laceration, Leg, Complicated

Created and Electronically Authenticated By: Dixon, Byron D M.D. Created: 8/27/2012 1458 Last Entry: 1502

PHYSICIAN H&P General Medical

Patient seen at: Patient seen. (+) Upon arrival to room.

PREHOSPITAL CARE:

History not limited.

Chief Complaint:

HPI: 41 yo male presents with bilateral leg pain and left elbow pain after falling off of a truck earlier today, no loc, no head injury

CONTEXT: at work

QUALITY: sharp

LOCATION: bilateral lower extremities and left elbow

TIMING: sudden

SEVERITY: moderate

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DATE

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10/18/20

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

MODIFIERS: none

ASSOCIATED SYMPTOMS: none

— ROS:

) Unable to obtain full ROS due to non ros reason

ONST(System): (-)fever, ()chills, ()fatigue ()headache.

NT(System): (-)sore throat, ()nasal drainage, ()congestion

RES(System): (-)blurry vision, ()pain, ()drainage, ()eye redness.

V(System): (-)palpitations, ()chest pain.

ESP(System): (-)cough, ()wheezing, ()SOB.

(System): (-)abdominal pain, ()nausea, ()vomiting, ()diarrhea, ()black/bloody stools.

J(System): (-)difficulty urinating, ()frequency (urinary).

S(System): (-)back pain, (+)joint pain, (+)leg pain, ()swelling feet.

IN(System): ()rash, ()itching, ()hives, ()abscess, ()redness.

EURO(System): ()difficulty walking, ()difficulty with speech, ()confusion, ()numbness, ()weakness.

MPH(System): ()swollen lymph nodes

DO(System): ()polyuria, ()polydipsia.

YCH(System): ()anxiety, ()depression.

) Except as marked, all systems above reviewed and found negative or are noted in HPI.

— PMH List (See PMH Table) PSH List (See PSH Table)

) PMH and PSH reviewed and agree with or personally modified the table above.

) Medications and allergies in nursing notes reviewed and confirmed or modified in table.

) Nursing chart reviewed. Available family and social history reviewed as documented in the nursing notes with supplement as needed below.

— FH: (-)CAD, ()DM, ()HTN

— SH: nonsmoker

— IMMUNIZATIONS: tetanus UTD

— PHYSICAL EXAM:

) VITAL SIGNS REVIEWED

GENERAL APPEARANCE: well nourished, alert, cooperative, no obvious discomfort.

EAD:

YES: conjunctiva clear PERRL, EOMI

ARS:

OSE:

THROAT: no airway obstruction

CK: supple.

ESPIRATORY: (-)respiratory distress, good air exchange bilateral, no wheezing, no rhonchi, no rales.

VS: normal rhythm, normal rate, (-)friction rub, no murmur.

BDOMEN/GI: (-)rebound, (-)guarding, soft, normal BS, no abd tenderness, no abd masses, (-)distended.

ECTAL:

KIN: no rash, dry, warm, good color, no abrasions/lacerations.

XTREMITIES: right knee with large stellate laceration over anterior surface, left tib/fib with laceration/swelling, left elbow with tenderness and abrasion

ACK:

EURO: (-)facial droop, motor intact, sensory intact

ENTAL STATUS: oriented X 3, responds appropriately to questions, speech clear.

ENTALS(female):

ENTALS(male):

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DATE

10/18/2012

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

PSYCH: normal affect.

CLINICAL DECISION TOOLS:

DATA REVIEWED:

() EKG interpreted by ED Physician See Pyramis.

COUNSELING:

Created and Electronically Authenticated By: Dixon, Byron D M.D. Created: 8/27/2012 1500 Last Entry: 1802

Provider Note:

41 yo with multiple lacerations after falling off of a truck

xr right knee with sunrise view

xr left tib/fib/left knee

xr left elbow

morphine

zofran

int

dx: fall from truck

dx: contusion multiple

dx: laceration multiple

tetanus provided

analgesia

LACERATION REPAIR (COMPLEX) - 8/27/2012 1737

Verbal consent was obtained. All sutured wound(s) were prepped and draped in usual fashion with saline

Anesthetized with 2% lidocaine with epi

Cleaned with copious sterile saline irrigation.

Exploration of wound(s) in a bloodless field visually and by palpation did not identify foreign body.

0 FB(s) removed

Wounds did not overlie tendon.

(n/a) With full range of motion, tendon involvement was not identified. (n/a) Tendon visualized in bloodless field

(n/a) Pain with tension on tendon

Laceration #1:

3cm stellate laceration on right knee.

Skin closed with 4-0 prolene simple sutures x numerous

(n/a). 0 internal suture using vicryl

Wound well approximated without tension

Repair complexity increased due to:

(+) multiple flaps aligned (+) Undermined for repair () Wound debrided (+) Wound margins revised

() vermilion border aligned () galea repaired () muscle repaired () fascia repaired () other complex repair

type in

Wound was appropriately dressed, wound care instructions reviewed, and anticipatory guidance provided for suture removal.

Factors complicating wound healing discussed with patient including:

() Contamination (+) Crush injury () Underlying structure injured (+) wound over joint () other complicating factor type in

LACERATION # 2 REPAIR -

2.5cm linear laceration on left leg.

Skin closed with 3-0 prolene simple sutures x numerous

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

Results Reviewed by ED Provider:

(R KNEE (3 VIEWS) L or R: LEFT L,
(R LEG (TIBIA-FIBULA) (2 VIEWS) L or R: LEFT L,
(R ELBOW (MIN 3 VIEWS) L or R: LEFT L,
(R KNEE INCLUDING PATELLA VIEW L or R: RIGHT R,

Treated and Electronically Authenticated By: Dixon, Byron D M.D. Created: 8/27/2012 1801 Last Entry: 1803

Provider Note:

DISCHARGE - Plan of care discussed with patient or caregiver. Questions were answered. Verbal and printed instructions were provided. If prescription(s) were given, the prescribed medications were reviewed, including relevant side effects and interactions. The patient is to seek outpatient follow up as noted in the discharge instructions. They verbalized understanding and ability to comply. The patient is discharged in stable condition. They were instructed to return to the emergency department for worsening symptoms or other concerns.

rounds explored, I do not see evidence of joint capsule involvement, will place pt on abx as a precaution, will have pt return in two days for a wound recheck

Clinical Decision Support

Alert CPT II Compliance

0 Entries

Vital Signs

ys	Dia	Pulse	Resp	SAT	O2 Delivered	Temp (F)	Route	Pain Scale	Comment	Taken at	User Name
2	77	104	16	100%	RA	98.5 F	oral			8/27/2012 1111	Mull, Steven, R.N. (E.C.)
5	110	53	10	98%	RA					8/27/2012 1459	Mason, Betty K (E.S.T.)
2	73	85	18	98%	RA					8/27/2012 1602	Mason, Betty K (E.S.T.)
2	84	105	18	97%	RA				Disposition Vitals	8/27/2012 1823	Foster, Angela G.R.N. (E.C.)

Home Medications

Arrival Medication Indication Last Dose Comments

10

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

Allergies	
Allergic Substance	Reaction
NKDA	

Input & Output			
Fluid Type	Intake	Output	I/O Time
No Entries			

PMH	
Condition	
none	

PSH	
Procedure	
none	

Orders			
Order	Sched D/T	Comp D/T	Provider Sig
CANCELED (outside ED) 1524 - XR KNEE (3 VIEWS) L_or_R: RIGHT_R,	8/27/2012 1459	8/27/2012 1524	Dixon, Byron D M.D. 8/27/2012 1458
XR KNEE (3 VIEWS) L_or_R: LEFT_L,	8/27/2012 1459	8/27/2012 1617	Dixon, Byron D M.D. 8/27/2012 1458
XR LEG (T BIA-FIBULA) (2 VIEWS) L_or_R: LEFT_L,	8/27/2012 1459	8/27/2012 1617	Dixon, Byron D M.D. 8/27/2012 1458
XR ELBOW (MIN 3 VIEWS) L_or_R: LEFT_L,	8/27/2012 1459	8/27/2012 1617	Dixon, Byron D M.D. 8/27/2012 1458
INT	8/27/2012 1458	8/27/2012 1503	Dixon, Byron D M.D. 8/27/2012 1458
XR KNEE INCLUDING PATELLA VIEW L_or_R: RIGHT_R,	8/27/2012 1523	8/27/2012 1617	Dixon, Byron D M.D. 8/27/2012 1523

Orders (Meds)			
Order	Sched D/T	Infusion Started	Administered D
MORPHINE SULFATE . IV 4mg IV once - Gave 4mg	8/27/2012 1459		

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

Orders (Meds) (continued)

Order	Sched D/T	Infusion Started	Administered D
OFRAN . IV (ondansetron hcl) 4mg (2mL of 4mg/2mL) IV once - Gave 4mg	8/27/2012 1459		8/27/2012 1509
ETANUS TOXOID (ADSORBED) IM 5 units (0.5mL of 5 unit/0.5mL) IM once; (Fixed) - Gave 5 units	8/27/2012 1459		8/27/2012 1512

TIMI Scale

Criteria	Present
Age >= 65	
> 3 CAD risk factors	
Known coronary stenosis >= 50%	
Aspirin use in past 7 days	
Angina episodes in prior 24 hours	
Obtained serum cardiac markers	
ST deviation >= 0.5mm on admission ECG	
===== TOTAL TIMI Score	
===== Mortality/Ischemia RISK	
===== Date/Time Performed	
===== User Name	

Pneumonia Scale

Pneumonia Criteria	Present	Points
Age		+1/year
Male		-10
Living Home Resident		+10
Opportunistic Disease History		+30
Immunosuppressive Disease		+20
Congestive Heart Failure		+10
Chronic Pulmonary Disease		+10
Renal Disease		+10
Altered Mental Status		+20
Respiratory Rate > 29/min		+20
Systolic Blood Pressure < 90 mm Hg		+20
Temperature < 95F or > 103.8F		+15
SpO2 < 92% on 2L/min		+10
WBC < 7.35		+30
IN > 29mg/dL		+20
BUN < 130 mmol/L		+20
Glucose > 280mg/dL		+10
Hematocrit < 30%		+10
Oxygen saturation < 90%		+10
Pleural Effusion on X-ray		+10
===== 222 TOTAL Score		
===== MORTALITY RISK		

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Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

Pneumonia Scale (continued)

Pneumonia Criteria	Present	Points
===== Performed on		
===== User Name		

NIH Stroke Scale

LOC	Questions	Command	Gaze	Visual	Fl	Paresis	RA Motor	LA Motor	RL Motor	LL Motor	Ataxia	Sensory	Language	Dysarthria	Extl
No Entries															

Procedures

Procedure	Performed By	Quantity Entered	Billing No.
Lac, Complex 1.1 CM-2.5 CM Scalp/P		8/27/2012 1759	373041050
Lac, Complex 1.1 CM-2.5 CM Scalp/P		8/27/2012 1802	373041050

Created and Electronically Authenticated By: Mull, Steven, R.N. (E.C.) Created: 8/27/2012 1108 Last Entry: 1110

NURSING TRIAGE (Adult)

HPI:

Fall - pt states fell from truck and injured both legs; lacerations noted

PREHOSPITAL CARE:

Support System: lives w family or significant other.

Special Considerations: None Identified.

LEARNING BARRIERS: None Identified.

> TRIAGE DATA:

History obtained from: patient

Tetanus: immunization status:.

LMP:

PHYSICAL EXAM:

AIRWAY: oral, (-) obstructed.

BREATHING: no breathing compromise.

CIRCULATION: no circulatory compromise, capillary refill <2 seconds.

GENERAL APPEARANCE: (adult) - well nourished, alert, oriented X 3, no acute distress, no obvious discomfort.

SKIN: warm, dry, good color, no rash.

> NURSING INTERVENTION: None

Created and Electronically Authenticated By: Foster, Angela G.R.N. (E.C.) Created: 8/27/2012 1446 Last Entry: 1744

Clinical Note:

ASSESS MUSCULOSKELETAL: Assessment performed at 8/27/2012 1447.

PMH List (See PMH Table) PSH List (See PSH Table)

SH: no alcohol, drug usage

PHYSICAL EXAM:

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10/18/20

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

AIRWAY: (+)patent, (-)obstructed.
BREATHING: no breathing compromise. (-)accessory muscle use, good air exchange bilateral.
CIRCULATION: no circulatory compromise, capillary refill <2 seconds.
MENTAL STATUS: speech clear, oriented X 3, normal affect, responds appropriately to questions, alert, cooperative.
MUSCULOSKELETAL: Onset 6hrs ago while working. (-)deformity. (-)distal neuro deficits. (-)altered sensation. Pt states was on truck and fell approx 10 feet. Pt with superficial abrasion to left lateral thigh, and left elbow with bruise. Open wound right knee. wound to left calf with swelling around area.Drsqs that were applied at pt's work removed to assess wounds.
EXTREMITIES: good pulses all extremities. moderate-severe tenderness in the lower extremities. mild edema to left calf.
— **EXPOSURE:** Clothing removed, Hospital gown provided, Family at bedside.
— **SAFETY:** Call light at bedside, Use of call bell explained to patient. Side rails raised for patient safety.
— **FALLS ASSESSMENT ADULT:**
FALL HISTORY: No history of falling 0
SECONDARY DIAGNOSIS: No secondary diagnosis 0
IV ACCESS: No IV Access 0
AMBULATORY AID: None/bed rest/nurse assist 0
GAIT: Gait Normal bed rest or wheelchair 0
MENTAL STATUS: Oriented to own ability 0
— **FALL RISK SCORE:** Low Risk (0-44).
— **Plan of Care to Decrease Fall Risk:** Low Risk Interventions include - (+)Oriented to room, (+)Instruct to all for help/call bell within reach. (+)Family/caregiver at bedside. (+)Bed in low position. (+)Bed/stretcher raises on. ()Bed rails up.

reated and Electronically Authenticated By: Foster , Angela G.R.N. (E.C.) Created: 8/27/2012 1503 Last Entry: 1503

Order(s) performed by "Task":

INT

Order Notes:

ALINE-LOCK INSERTED - 8/27/2012 1503 18ga right antecubital following 1 attempt(s) with labs drawn. 0mL normal saline flush. Patient tolerated procedure well.

reated and Electronically Authenticated By: Foster , Angela G.R.N. (E.C.) Created: 8/27/2012 1509 Last Entry: 1509

Orders Performed by Nurse:

MORPHINE SULFATE . IV 4mg IV once - Gave 4mg. Verified: 2 patient IDs and allergies. IV Med Site: antecubital right, Given At: 8/27/2012 1509

ZOFRAN . IV (ondansetron hcl) 4mg (2mL of 4mg/2mL) IV once - Gave 4mg, Verified: 2 patient IDs and allergies, IV Med Site: antecubital right, Given At: 8/27/2012 1509

reated and Electronically Authenticated By: Foster , Angela G.R.N. (E.C.) Created: 8/27/2012 1512 Last Entry: 1512

Orders Performed by Nurse:

TETANUS TOXOID (ADSORBED) IM 5 units (0.5mL of 5 unit/0.5mL) IM once; (Faxed) - Gave 5 units, Verified: 2 patient IDs and allergies, IM Site: deltoid right, Vis Form Complete: Yes completed prior to administration. Manufacturer: Sanofi Pasteur. Lot#: U4068AA. Expiration Date: 02/10/2014. Given At: 8/27/2012 1512

reated and Electronically Authenticated By: Foster , Angela G.R.N. (E.C.) Created: 8/27/2012 1742 Last Entry: 1811

Clinical Note: Dr Dixon at bedside to suture lacs to BLE. Assisted by Angie, RN and Kathy, EST. Neosporin and Pressure drsqs applied. pt able to move toes on both extremities without difficulty. good DP and PT. Jles palpated in BLE.

reated and Electronically Authenticated By: Foster , Angela G.R.N. (E.C.) Created: 8/27/2012 1822 Last Entry: 1822

Clinical Note:

SP DISCHARGE AND IV DC WITH PRESCRIPTION(S) - IV discontinued, catheter intact, dressing applied. Plan of care discussed with patient. Patient discharged with printed instructions. Prescriptions given to patient. Reviewed prescribed medications with patient; including potential interactions with other substances. Patient verbalized understanding and ability to comply.

The following items were received by the patient on discharge:

(+)Discharge/Dx

(+)Diagnostic specific discharge instructions

(+)Medication Reconciliation Form

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Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

- (+) Follow up plans
- (+) A list of major procedures or test done in EC.

Wellsoft: Interface Created: 8/27/2012 1617 Last Entry: 1617

Patient: CASE, KEITH L ; Date/Time: 8/27/2012 1537 ; 10000087753

----- ER KNEE (3 VIEWS) -----

Read By: JOHN F PARROTTJRMD

Report: History- Log fell on leg. Pain.

Report:

Report: Left leg AP and lateral views

Report:

Report: Findings- AP and lateral views of the left tibia and fibula

Report: demonstrate no displaced fracture or significant malalignment. Soft

Report: tissue swelling is present along the anterior tibia.

Report:

Report: Impression- Soft tissue swelling. No displaced fracture.

Report:

Report: Right knee series

Report:

Report: Findings- AP, oblique and lateral views demonstrate no displaced

Report: fracture or significant malalignment. A patellar view is included.

Report:

Report: Impression- No acute findings.

Report:

Report: Left elbow series

Report:

Report: Findings- Lateral, oblique and AP images demonstrate no displaced

Report: fracture, joint effusion or dislocation.

Report:

Report: Impression- No acute findings.

Report:

Report: Left knee series-

Report:

Report: Findings- AP, oblique and lateral views demonstrate no displaced

Report: fracture or significant malalignment. Small patellar osteophytes are

Report: present.

Report:

Report: Impression- No acute findings.

Report:

Report: Transcriptionist- n/a

Report: Reading Radiologist- JOHN F PARROTTJR MD

Report: Releasing Radiologist- JOHN F PARROTTJR MD

Report: Released Date Time- 08/27/12 1617

Report:

Released By: JOHN F PARROTTJRMD

Wellsoft: Interface Created: 8/27/2012 1617 Last Entry: 1617

Patient: CASE, KEITH L ; Date/Time: 8/27/2012 1522 ; 10000087754

----- ER LEG (TIBIA-FIBULA) (2 VIEWS) -----

Read By: JOHN F PARROTTJRMD

Report: History- Log fell on leg. Pain.

Report:

Report: Left leg AP and lateral views

Report:

PRINTED BY: JH24657

DATE

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
P1 Acct: 1224000741
Med Rcd: 000184520

Report: Findings- AP and lateral views of the left tibia and fibula
Report: demonstrate no displaced fracture or significant malalignment. Soft
Report: tissue swelling is present along the anterior tibia.
Report:
Report: Impression- Soft tissue swelling. No displaced fracture.
Report:
Report: Right knee series
Report:
Report: Findings- AP, oblique and lateral views demonstrate no displaced
Report: fracture or significant malalignment. A patellar view is included.
Report:
Report: Impression- No acute findings.
Report:
Report: Left elbow series
Report:
Report: Findings- Lateral, oblique and AP images demonstrate no displaced
Report: fracture, joint effusion or dislocation.
Report:
Report: Impression- No acute findings.
Report:
Report: Left knee series-
Report:
Report: Findings- AP, oblique and lateral views demonstrate no displaced
Report: fracture or significant malalignment. Small patellar osteophytes are
Report: present.
Report:
Report: Impression- No acute findings.
Report:
Report: Transcriptionist- n/a
Report: Reading Radiologist- JOHN F PARROTTJR MD
Report: Releasing Radiologist- JOHN F PARROTTJR MD
Report: Released Date Time- 08/27/12 1617
Report:
Report: Released By: JOHN F PARROTTJRMD
Report: Interface Created: 8/27/2012 1617 Last Entry: 1617
Report: Patient: CASE, KEITH L ; Date/Time: 8/27/2012 1543 ; 10000087755
Report: ----- ER ELBOW (MIN 3 VIEWS) -----
Report: Read By: JOHN F PARROTTJRMD
Report: History- Log fell on leg. Pain.
Report:
Report: Left leg AP and lateral views
Report:
Report: Findings- AP and lateral views of the left tibia and fibula
Report: demonstrate no displaced fracture or significant malalignment. Soft
Report: tissue swelling is present along the anterior tibia.
Report:
Report: Impression- Soft tissue swelling. No displaced fracture.
Report:
Report: Right knee series
Report:
Report: Findings- AP, oblique and lateral views demonstrate no displaced
Report: fracture or significant malalignment. A patellar view is included.
Report:
Report: Impression- No acute findings.
Report: 226-
Report: Left elbow series

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
Pt Acct: 1224000741
Med Rcd: 000184520

Report:
Report: Findings- Lateral, oblique and AP images demonstrate no displaced
Report: fracture, joint effusion or dislocation.
Report:
Report: Impression- No acute findings.
Report:
Report: Left knee series-
Report:
Report: Findings- AP, oblique and lateral views demonstrate no displaced
Report: fracture or significant malalignment. Small patellar osteophytes are
Report: present.
Report:
Report: Impression- No acute findings.
Report:
Report: Transcriptionist- n/a
Report: Reading Radiologist- JOHN F PARROTTJR MD
Report: Releasing Radiologist- JOHN F PARROTTJR MD
Report: Released Date Time- 08/27/12 1617
Report:
Released By: JOHN F PARROTTJRMD

Wellsol: Interface Created: 8/27/2012 1617 Last Entry: 1617

Patient: CASE, KEITH L ; Date/Time: 8/27/2012 1527 ; 10000087768

----- ER KNEE INCLUDING PATELLA VIEW -----

Read By: JOHN F PARROTTJRMD

Report: History- Leg fell on leg. Pain.

Report:

Report: Left leg AP and lateral views

Report:

Report: Findings- AP and lateral views of the left tibia and fibula

Report: demonstrate no displaced fracture or significant malalignment. Soft

Report: tissue swelling is present along the anterior tibia.

Report:

Report: Impression- Soft tissue swelling. No displaced fracture.

Report:

Report: Right knee series

Report:

Report: Findings- AP, oblique and lateral views demonstrate no displaced

Report: fracture or significant malalignment. A patellar view is included.

Report:

Report: Impression- No acute findings.

Report:

Report: Left elbow series

Report:

Report: Findings- Lateral, oblique and AP images demonstrate no displaced

Report: fracture, joint effusion or dislocation.

Report:

Report: Impression- No acute findings.

Report:

Report: Left knee series-

Report:

Report: Findings- AP, oblique and lateral views demonstrate no displaced

Report: fracture or significant malalignment. Small patellar osteophytes are

Report: present.

Report:

Report: Impression- No acute findings.

Report:

PRINTED BY: JH24657

DATE

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10/18/20

Patient: Case, Keith L
Arrival (HIS): 8/27/2012 1103
P1 Acct: 1224000741
Med Rcd: 000184520

Report: Transcriptionist- n/a
Report: Reading Radiologist- JOHN F PARROTTJR MD
Report: Releasing Radiologist- JOHN F PARROTTJR MD
Report: Released Date Time- 08/27/12 1617
Report:
Released By: JOHN F PARROTTJRMD

Description / Rx

Rx 1: Keflex Capsules (cephalexin)
Dose/Conc: 500mg/capsule
Freq/Rte: 1 capsule by mouth 3 times a day for 10 days
Disp: #30 capsules Refill: 0 Do Not Substitute:

Rx 2: Percocet Tablets 5/325mg (oxycodone/acetaminophen)
Dose/Conc:
Freq/Rte: 1-2 tablets by mouth every 6 hrs as needed for pain
Disp: #15 (fifteen) tablets Refill: zero Do Not Substitute:

Rx 3: Naprosyn Tablets (naproxen)
Dose/Conc: 500mg/tablet
Freq/Rte: 1 tablet by mouth 2 times a day as needed
Disp: #28 tablets Refill: 0 Do Not Substitute:

position

Follow-up 1: ER F/U MD Ph:
Follow-up 1 Date: 2 days for wound F/U MD Fax:
recheck
Other Instr: return to ER in 2 days for a wound recheck, return sooner if new or worsening
symptoms
by return to work/school: 4 Days

Signatures

Electronically Authenticated Dixon, Byron D M.D. 8/27/2012 1805

Electronically Authenticated Foster, Angela G R.N. (E.C.) 8/27/2012 1823



Spartanburg Regional

Spartanburg Regional Emergency Center

101 East Wood Street, Spartanburg, SC 29303 == (864) 560-6000

Patient: Case, Keith L

Arrival: 8/27/2012 1103

Pt Acct: 1224000741

Med Rcd: 000184520

Disposition Summary (for discharged patient; English)

Patient: Case, Keith L

Home Address: 573 Goldmine Road

City: Pauline

SC

29374

DOB: 6/9/1971

Age: 41yr

Home Ph: (864) 316-2620

Arrival: 8/27/2012 1103

RN Triage: Mull, Steven, R.N. (E.C.)

Provider: Dixon, Byron D M.D.

Disposition: Home

RN Primary: Angie F

PCP: Bishop, Preston M.D.

PCP Ph: 864-474-1528

Triage Impression: Laceration, Complex

Dx 1: Laceration, Leg, Complicated

Rx 1: Keflex Capsules (cephalexin)

500mg/capsule

1 capsule by mouth 3 times a day for 10 days

#30 capsules

Rx 2: Percocet Tablets 5/325mg (oxycodone/acetaminophen)

1-2 tablets by mouth every 6 hrs as needed for pain

#15 (fifteen) tablets

Rx 3: Naprosyn Tablets (naproxen)

500mg/tablet

1 tablet by mouth 2 times a day as needed

#28 tablets

Disposition

Follow-up 1: ER

FU MD Ph: _____

FU MD Fax: _____

Follow-up 1 Date: 2 days for wound recheck

Other Instr: return to ER in 2 days for a wound recheck, return sooner if new or worsening symptoms

May return to work/school: 4 Days

MY SIGNATURE BELOW INDICATES:

☒ I have received a transition record upon discharge.

☒ I understand that I have had emergency treatment and that I may be released before all of my medical problems are known or treated.

☒ I have received and understood the instructions regarding my current condition.

☒ I will arrange follow-up care as instructed above.

☒ I acknowledge receipt of the written instructions as outlined on this and any previous page(s).

☒ I will read and review these instructions.

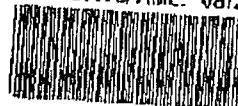
☒ I understand the hospital and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this admission. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

x Keith Case
Patient (or Legal Guardian)

Relationship to patient _____

x Angie F
Signature Staff (Witness) Signature

1224000741 000-184520
CASE: KEITH L DOB 06/09/71
ADM: PHYSICIANS, ED
ADM DATE/TIME: 08/27/12 1103



SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASE, KEITH L
ORDERING PHYSICIAN: DIXON, BYRON
LOC: EM2-EM64-A
Pt. Type: ER
DOB: 06/09/71
EMERG DEPT

UNIT #: 000184520
CI#: 3418552
AN#: S1224000741

FINAL

Exam

10150 ER LEG (TIBIA-FIBULA) (2 VIEWS)*L Date: 08/27/12 1459
73590 Ord Diag: left tib fib pain with lacerat

10160 ER KNEE INCLUDING PATELLA VIEW*R Date: 08/27/12 1459
73564 Ord Diag: laceration contusion

10068 ER ELBOW (MIN 3 VIEWS)*L Date: 08/27/12 1459
73080 Ord Diag: contusion left elbow pain

10146 ER KNEE (3 VIEWS)*L Date: 08/27/12 1459
73562 Ord Diag: left knee pain

History: Log fell on leg. Pain.

Left leg AP and lateral views

Findings: AP and lateral views of the left tibia and fibula demonstrate no displaced fracture or significant malalignment. Soft tissue swelling is present along the anterior tibia.

Impression: Soft tissue swelling. No displaced fracture.

Right knee series

Findings: AP, oblique and lateral views demonstrate no displaced fracture or significant malalignment. A patellar view is included.

Impression: No acute findings.

Left elbow series

Page 1

SPARTANBURG REGIONAL HEALTHCARE SYSTEM
SPARTANBURG REGIONAL MEDICAL CENTER
Radiology Report

NAME: CASE, KEITH L
ORDERING PHYSICIAN: DIXON, BYRON
LOC: EM2-EM64-A DOB: 06/09/71
Pt. Type: ER EMERG DEPT

UNIT #: 000184520
CI#: 3418552
AN#: S1224000741

Checkin-Exam Code Summary
3418552-10150, 3418580-10160, 3418553-10068, 3418554-10146

Findings: Lateral, oblique and AP images demonstrate no displaced fracture, joint effusion or dislocation.

Impression: No acute findings.

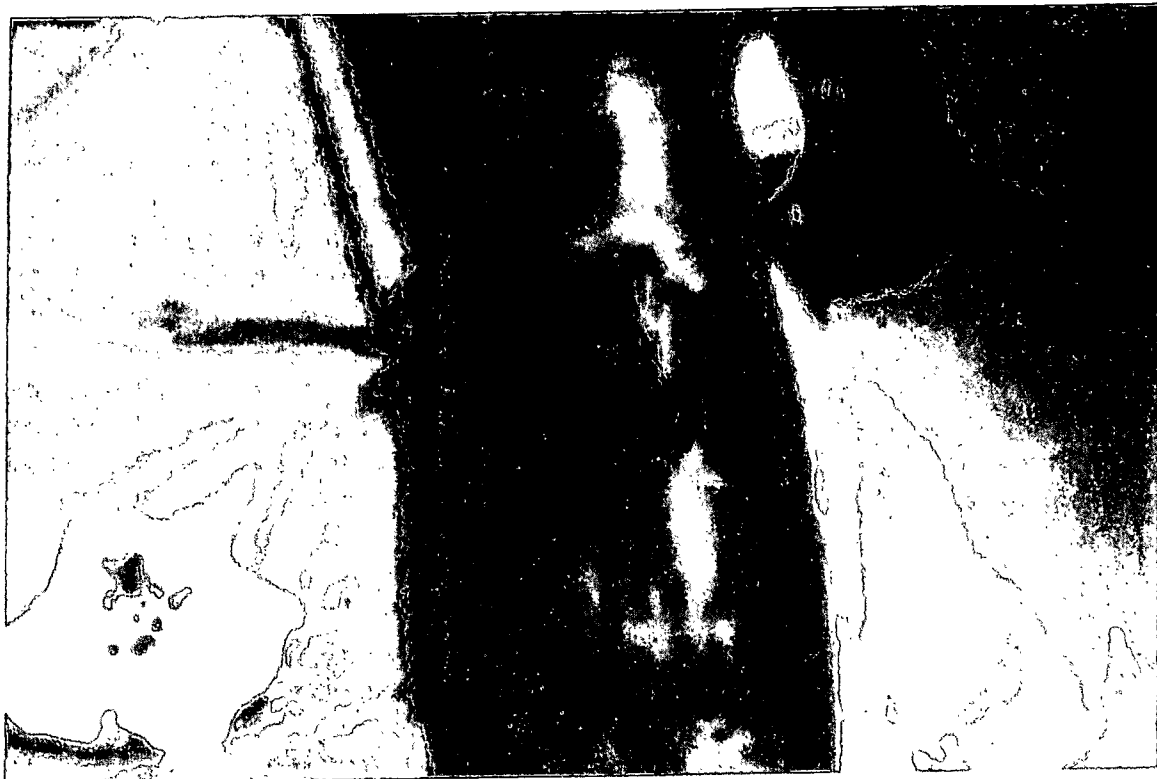
Left knee series:

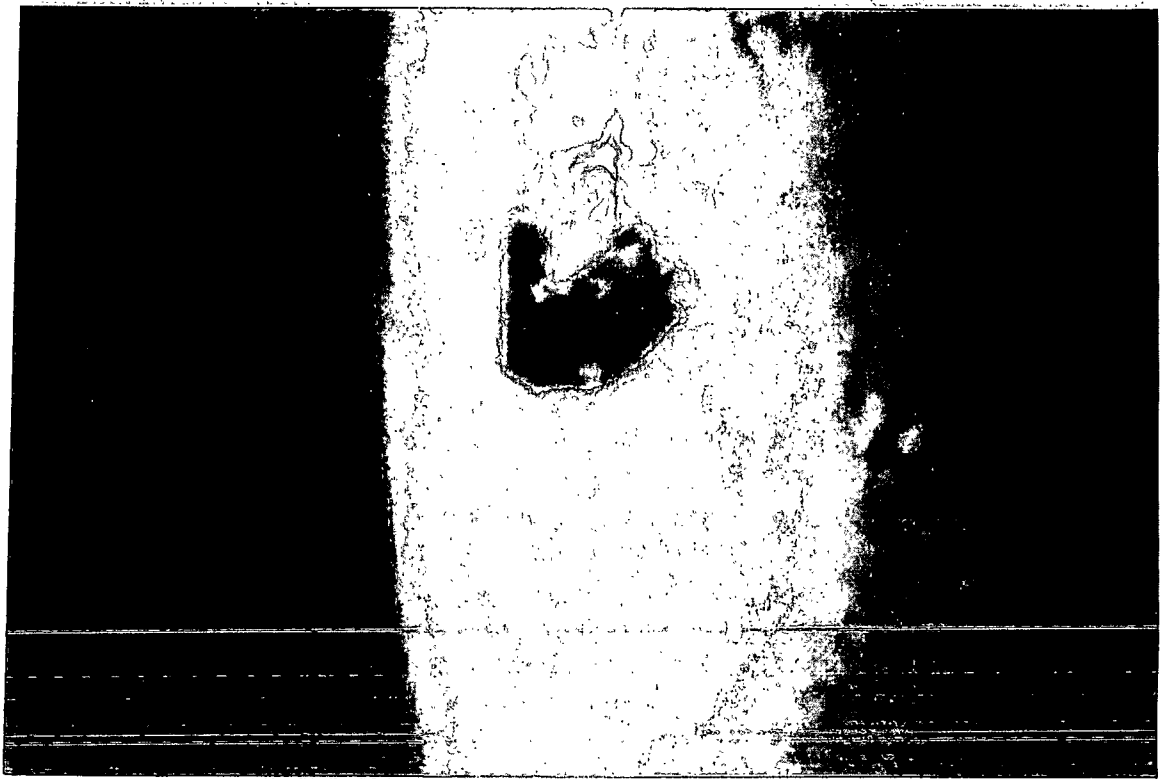
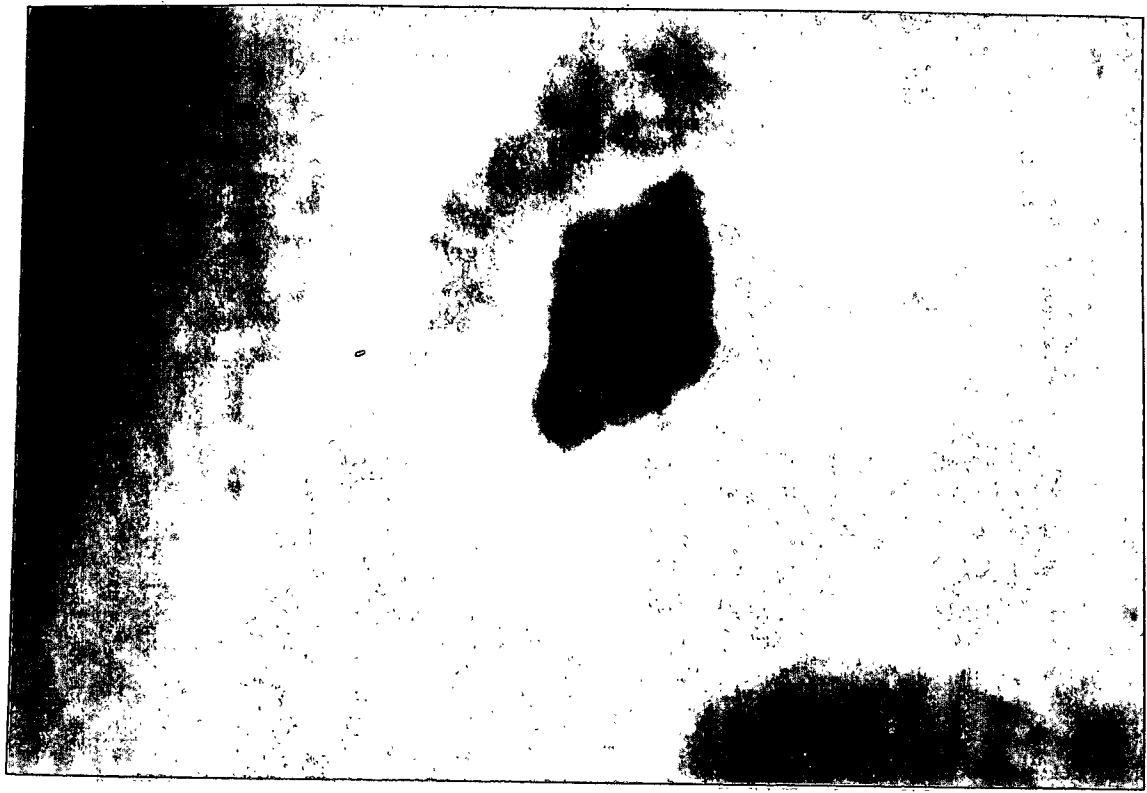
Findings: AP, oblique and lateral views demonstrate no displaced fracture or significant malalignment. Small patellar osteophytes are present.

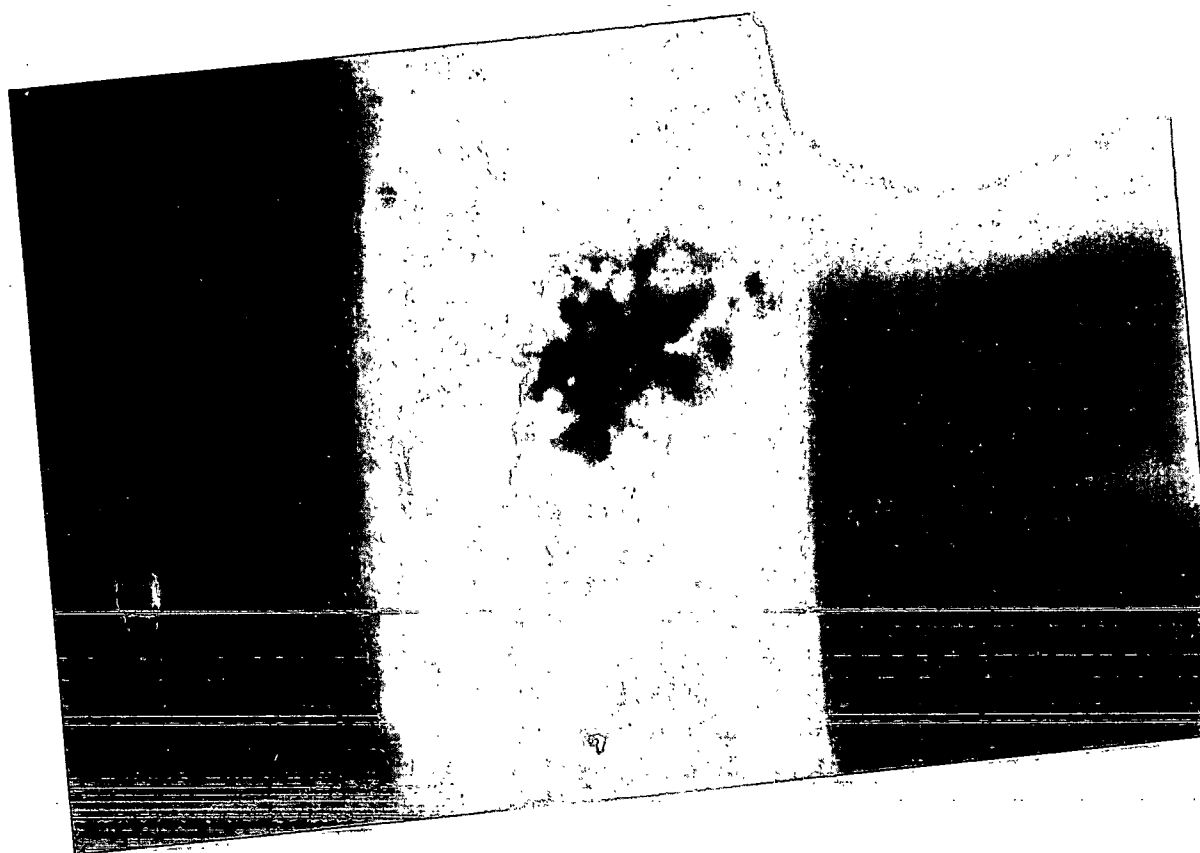
Impression: No acute findings.

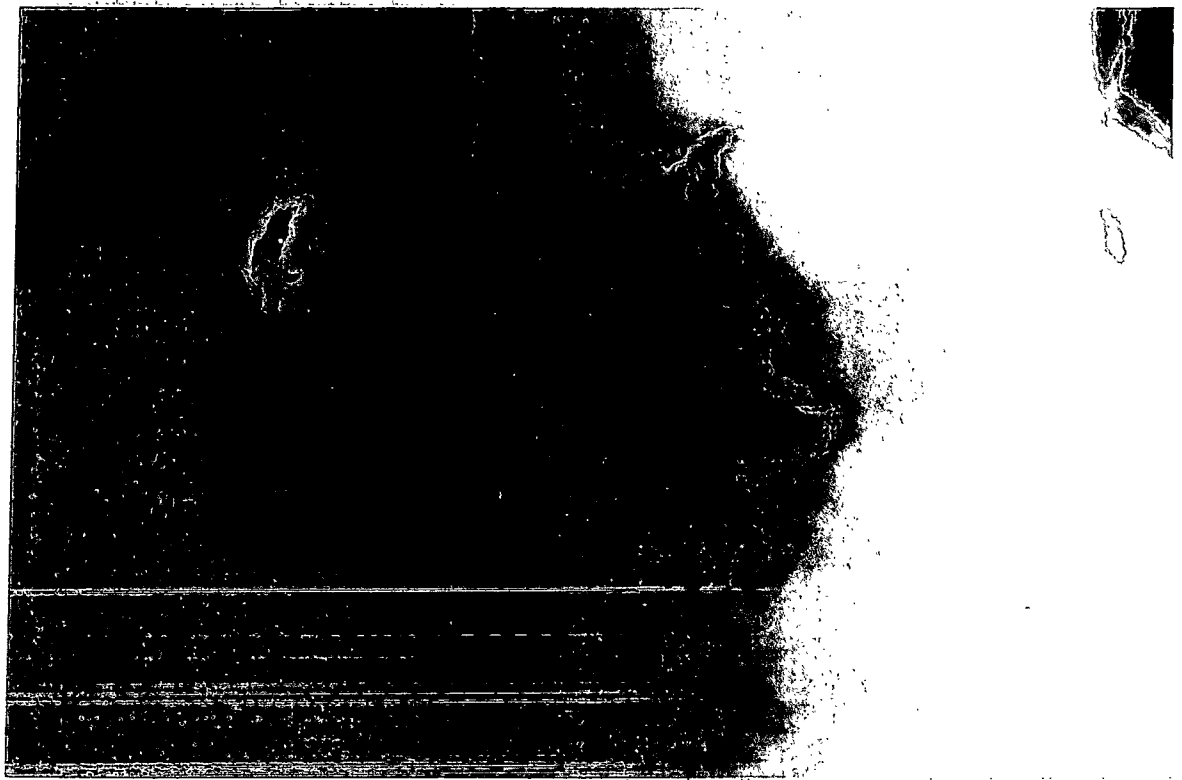
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Reading Radiologist- JOHN F PARROTTJR MD
Releasing Radiologist- JOHN F PARROTTJR MD
Released Date Time- 08/27/12 1617

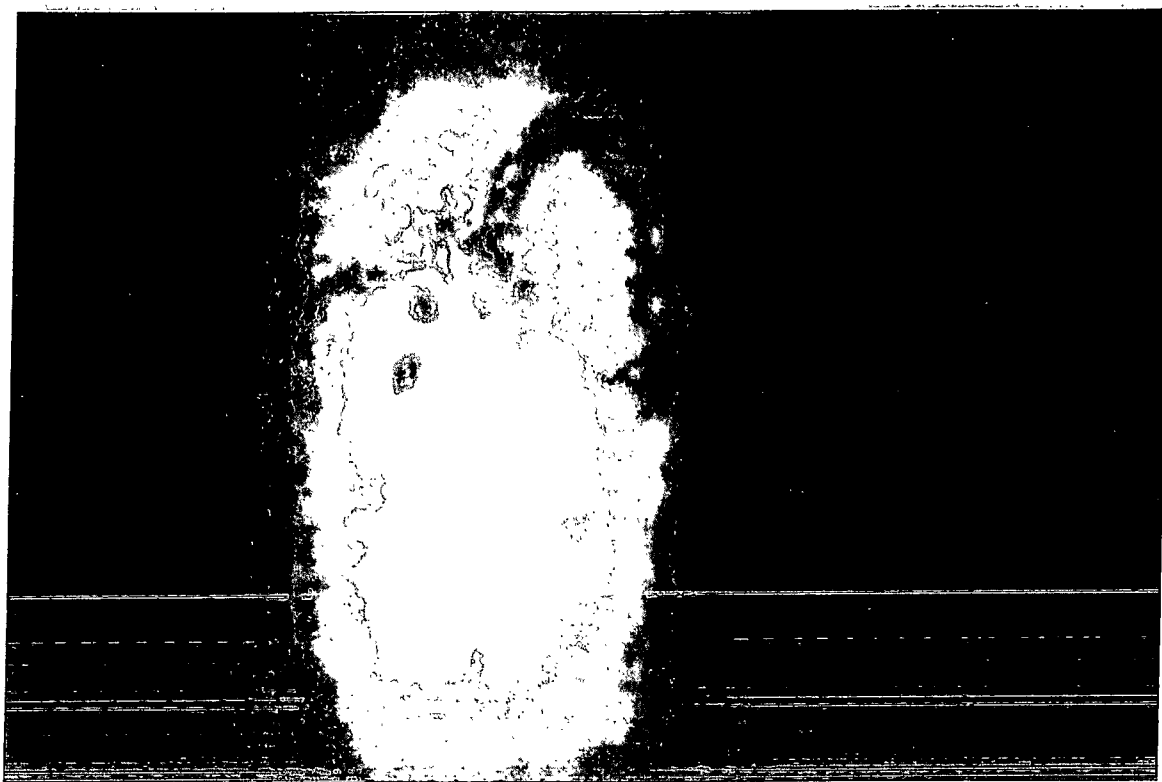
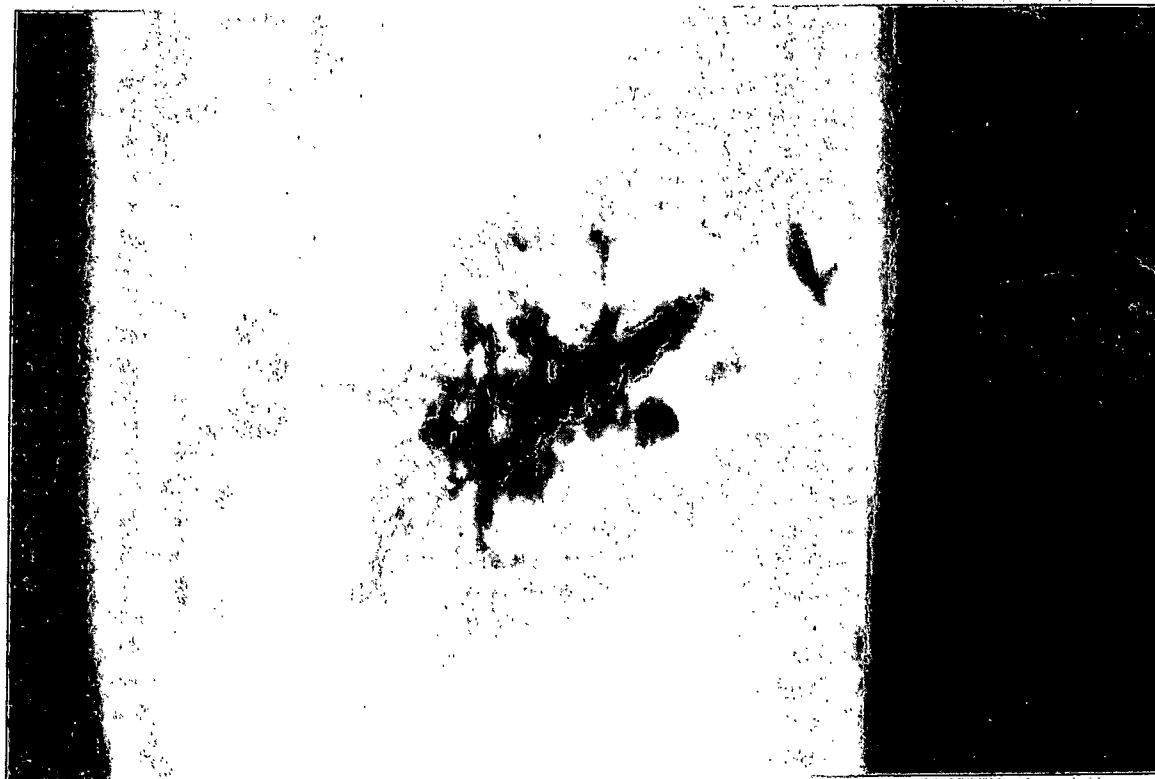
Page 2

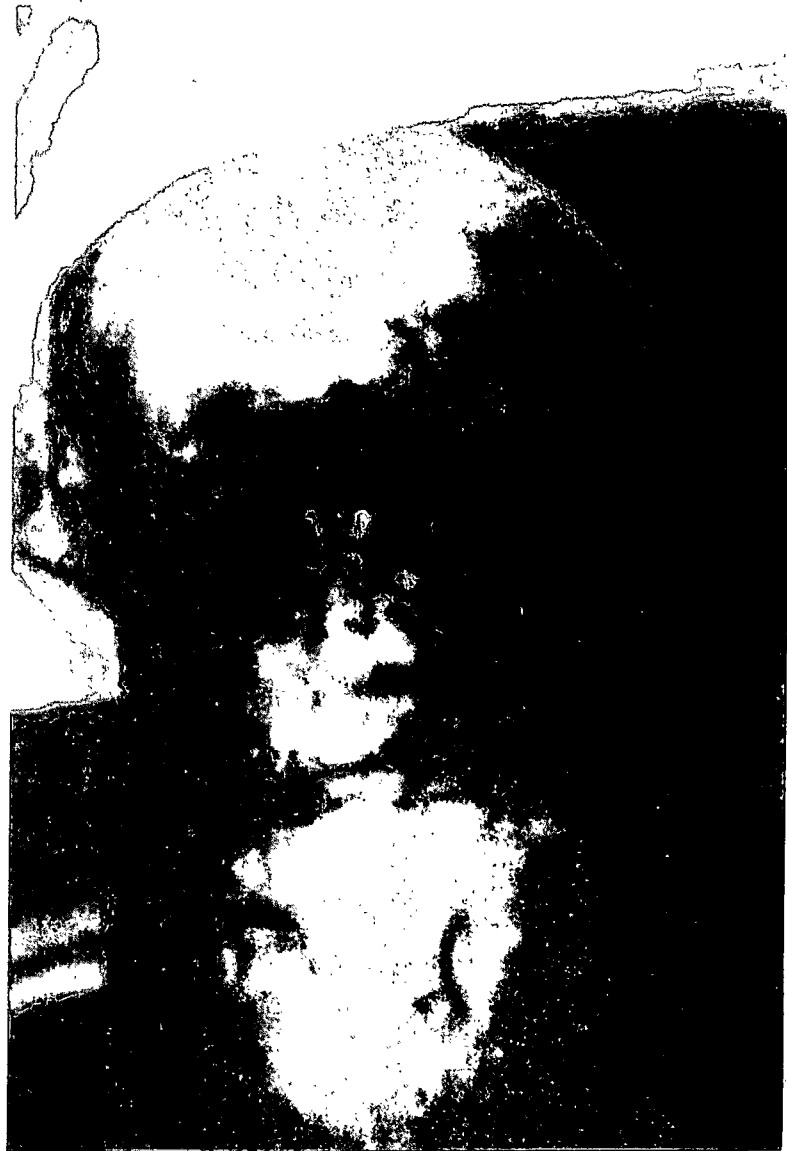














proaxistherapy

Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: KEITH CASE
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: Jan 21, 2013
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 18
Cxl/Ns: 6
Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing
- Mobility/Transfers
- Sleeping.(difficulty with rolling over in bed)
- Walking.

climbing up stairs with hands and knees
Independent, requires more time
Nightly disturbances
Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 7/10. Current Severity: 6/10.

Daily Comments:

- Pt states his knees are hurting more today. States that his back is still hurting as well and he feels that his back is the most painful body part at this time.

Questionnaires: Lower Extremity Functional Scale:

- Date: 01/21/2013
- Total Score: 15

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 1 crutch with antalgic gait on the left lower extremity greater than right.

Muscle Testing: Lower Extremity MMT:

- Hip Abduction

Left
+4/5

Right
+4/5



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Jan 21, 2013

• Hip Adduction	4/5	4/5
• Hip Extension	+4/5	+4/5
• Hip Flexion	4/5	4/5
Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:	Left	Right
• Lachman's	Negative	Negative
• Posterior Drawer	Negative	Negative
Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:	Left	Right
• Apley's Compression	Negative	Negative
• Patellar Grind Test		Negative

Treatments

Exercise Activities: Isotonics:

- Heel Raises.(for reaching into high cabinets)

- Straight Leg Raises-Abduction

- Terminal Knee Extension (TKE)

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

- Shuttle, Unilat Squat

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Exercise Activities: Dynamic Training: C-K-C Activity:

- Lunges-Forward

- Lunges-Side Step

- Step Ups: Forward(retrain for stair climbing)

- Wall Squats,

- Closed Kinetic Chain 1(This visit)

Exercise Activities: Dynamic Training: Balance/Proprioception:

- Single Leg Balance

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Additional Detail: on foam pad, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, FES/Biofeedback Assisted: on foam pad, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Weight - Pounds: 5 Pounds, Repetitions: 10, Sets: 3, Additional Detail: Standing with green band, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 5 Minutes, Resistance: 4 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 1 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Additional Detail: with blue band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 4 Minutes, Additional Detail: with blue band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.

Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Additional Detail: with foam pad, Charge As: Therapeutic Activities, Billing Code: 97530.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Did Not Perform: This visit

Time Elapsed: 4 Minutes, Additional Detail: Airplanes, Charge As: Neuromuscular Reeducation, Billing Code: 97112.



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Acct #: 0011577
Patient: KEITH CASE

Visit Date: Jan 21, 2013

- Balance/Proprioception 1

Time Elapsed: 4 Minutes, Description: Toy soldiers, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Exercise Activities: Stabilization Training: Supine Position:

- Bridging(for core stability)

Time Elapsed: 4 Minutes, Charge As: Therapeutic Activities, Billing Code: 97530.

Therapy Session Time

- Total Therapy Session Time 59 Minutes

Assessment

Pt able to perform all exercises without report of knee pain today. Pt still reporting back pain with exercises, however has no problem performing these exercises. Pt had decreased LEFS score today from 19 4 weeks ago to 15 today. Spoke with Lisa Webb, pt's worker's compensation case manager regarding these findings as patient has shown minimal improvement with functional outcome measurements since his initial evaluation.

Plan

Continue LE strengthening, core strengthening, balance retraining

Kristen Downey, PT(SC Lic: 5366)
Signed on Jan 21, 2013 20:13:48



proaxistherapy

Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
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Acct #: 0011577
Patient: KEITH CASE
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Note Date: Mar 08, 2013
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 6

Employer: J. CRAWFORD LOGGING
Insured:

Addendum to Daily Note from Jan 21, 2013

Diagnoses Bilateral Kneec 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

During pt's visit, pt was standing and therapists bent down to put sport cord strap around his right foot. Pt lost his balance, but caught himself, then stumbled backwards and landed in a squat position. Pt did not hit his head, did not injure himself. Pt stated he was fine. Pt was able to get himself up off the floor without any assistance from therapist. No injuries, scrapes or bruises noted. Patient has been able to perform single leg exercises in the clinic without loss of balance in sessions prior to this one, however pt will be asked to sit down in future visits to put strap on leg.

Kristen Downey, PT(SC Lic: 5366)
Signed on Mar 08, 2013 13:30:39



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Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: KEITH CASE
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Visit Date: Jan 23, 2013
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 6
Employer: J. CRAWFORD LOGGING
Insured:

Daily Note

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor, Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping (difficulty with rolling over in bed) Nightly disturbances
- Walking Adaptive assistive levels

Chief Complaint: Pain:

- Severity at Worst: 7/10. Current Severity: 6/10.

Daily Comments:

- Pt states his knees are hurting today, right knee is hurting worse than left. Pt states pain is about the same as it has been. Pt's wife pulled me aside and states that pt fell in his yard yesterday while a land surveyor was there. She states his right knee gave away and he fell onto his right knee in his yard and could not get up without the help of the land surveyor. Pt's wife states the patient did not want to tell me but she feels that I need to know.

Questionnaires: Lower Extremity Functional Scale:

- Date: 01/21/2013
- Total Score: 15

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern: Ambulates with 1 crutch with antalgic gait on the left lower extremity greater than right.



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Jun 23, 2013

Muscle Testing: Lower Extremity MMT:

- Hip Abduction
- Hip Adduction
- Hip Extension
- Hip Flexion

Left

+4/5
4/5
+4/5
4/5

Right

+4/5
4/5
+4/5
4/5

Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:

- Lachman's
- Posterior Drawer

Left

Negative
Negative

Right

Negative
Negative

Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:

- Apley's Compression
- Patellar Grind Test

Left

Negative

Right

Negative
Negative

Treatments

Exercise Activities: Isotonics:

- Heel Raises,(for reaching into high cabinets)

Time Elapsed: 4 Minutes, Weight - Pounds: Body Weight Pounds, Repetitions: 10, Sets: 3, Additional Detail: on foam pad, Charge As: Therapeutic Activities, Billing Code: 97530.

- Straight Leg Raises-Abduction

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: Standing, FES/Biofeedback Assisted: on foam pad, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Machines/Weights:

- Shuttle, Bilat Squat(strength for squatting)

Time Elapsed: 5 Minutes, Resistance: 4 Cords, Platform: Stable, Charge As: Therapeutic Activities, Billing Code: 97530.

- Shuttle, Unilat Squat

Time Elapsed: 5 Minutes, Resistance: 2 Cords, Platform: Stable, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Aerobic Conditioning:

- Recumbent Bicycle(10 minutes)

Time Elapsed: 1 Minutes, Level: 2, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: C-K-C Activity:

- Lunges-Forward

Time Elapsed: 4 Minutes, Additional Detail: with blue band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Lunges-Side Step

Time Elapsed: 4 Minutes, Additional Detail: with blue band around ankles, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Step Ups: Forward

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Additional Detail: with foam pad, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Wall Squats.

Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

Exercise Activities: Dynamic Training: Balance/Proprioception:

- Single Leg Balance

Time Elapsed: 4 Minutes, Additional Detail: Airplanes, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

- Balance/Proprioception 1

Time Elapsed: 4 Minutes, Description: Toy soldiers, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

Exercise Activities: Stabilization Training: Supine Position:



Acct #: 0011577
Patient: KEITH CASE

Visit Date: Jun 23, 2013

- Bridging(for core stability)

Time Elapsed: 4 Minutes, Charge As: Therapeutic Activities, Billing Code: 97530.

Therapy Session Time

- Total Therapy Session Time 58 Minutes

Assessment

Pt reported increased knee pain bilaterally, right greater than left, during all exercises today. Pt has shown minimal improvement with functional outcome measures and with objective measures in the last 4 weeks. Spoke with pt's case manager Lisa Webb and she states to hold PT until pt returns to see Dr Folk.

Plan

Hold PT at this time until pt goes back to see Dr Folk on 2/7/13 per Lisa Webb, WC case manager

Kristen Downey, PT(SC Lic: 5366)
Signed on Jan 23, 2013 11:34:53



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Greenville Proaxis Therapy
333 S. Pine St
Spartanburg, SC USA 29302
Phone: (864) 515-7580
Fax: (864) 515-7581

Acct #: 0011577
Patient: KEITH CASE
DOB: Jun 09, 1971
Physician: JASON W. FOLK
Phys Fax: (864) 454-7415
Physician: Not Specified
Clinician: Kristen Downey
FSC: Workers Compensation
Case Mgr: LISA WEBB
Payor: WORKERS COMP
Pol/Claim#: 0001-0858-12-0002

Note Date: Mar 08, 2013
Phys Phone: (864) 454-7422
SSN: XXX-XX-XXXX
Inj. Date: Aug 27, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 6
Employer: J. CRAWFORD LOGGING
Insured:

Discharge Summary

Diagnoses Bilateral Knee 7177 CHONDROMALACIA PATELLAE
72887 MUSCLE WEAKNESS-GENERAL
71946 JOINT PAIN-L/LEG

General Information

History of Injury:

- Aug 27, Patient is a 41 year old male log rolled over and hit left knee, patient hit the tractor grate. When he hit the tractor. Months later had an MRI on left leg and found an infection in the lower left leg. Found the infection on the left leg in Oct

Occupation:

- Truck driver

Reason for Referral:

- Eval and treat B knees for PF pain

Systems Review:

- X-ray knees, and MRI Left leg

Subjective Examination

ADL / Functional Status: ADL's: Activities:

- Climbing climbing up stairs with hands and knees
- Mobility/Transfers Independent, requires more time
- Sleeping, (difficulty with rolling over in bed) Nightly disturbances
- Walking Adaptive assistive levels

ADL / Functional Status:

- Current status: Work status: Pt not working at this time

Chief Complaint: Pain:

- Severity at Worst: 7/10. Current Severity: 6/10.

Questionnaires: Lower Extremity Functional Scale:

- Date: 01/21/2013
- Total Score: 15

Objective Examination

Gait/Locomotion:

- Abnormal Gait Pattern; Ambulates with 1 crutch with antalgic gait on the left lower extremity greater than right.

	Nov 01, 2012		Jan 23, 2013	
Muscle Testing: Lower Extremity MMT:	Left	Right	Left	Right
• Hip Abduction	4/5	4/5	+4/5	+4/5



Acct #: 0011577
Patient: KEITH CASE

Note Date: Mar 08, 2013

• Hip Adduction	-4/5	-4/5	4/5	4/5
• Hip Extension	-4/5	+4/5	+4/5	+4/5
• Hip Flexion	-4/5	-4/5	4/5	4/5
Special Tests: Knee: Musculoskeletal: Ligamentous/Capsular:	Left		Right	
• Lachman's	Negative		Negative	
• Posterior Drawer	Negative		Negative	
Special Tests: Knee: Musculoskeletal: Meniscal/Patellofemoral:	Left		Right	
• Apley's Compression	Negative		Negative	
• Patellar Grind Test			Negative	

Assessment

Pt was put on hold by worker's comp case manager until he returned to see Dr Folk in February. Had a discussion with pt on 1/21/13 regarding the fact that he has made minimal progress with functional outcomes and has actually regressed with functional outcome measure compared to previous measure, which made pt upset. Pt's case manager called and states pt is being referred by Dr Folk to see another doctor for complaints of back pain. Will discharge pt from physical therapy due to lack of progress at this time.

Problems & Goals

Problem #1 Chief Complaint: Pain: Severity at Worst: 7/10.

Goal Abandoned Mar 08, 2013. Pt put on hold per worker's comp case manager

Symptomatic Improvements:

- Decreasing Pain: to 4/10.

Problem #2 Muscle Testing: Lower Extremity MMT.

Goal Abandoned Mar 08, 2013. Pt put on hold per worker's comp case manager

Pt will have bilateral LE strength of 5-/5 to return to stairclimbing without restriction

Problem #3 Questionnaires: Lower Extremity Functional Scale.

Goal Abandoned Mar 08, 2013. Pt put on hold per worker's comp case manager

Questionnaire Improvements: Lower Extremity Functional Scale: Questionnaire:

- Total Score. 50

Plan

Discharge from Physical Therapy.

Discharge due to:

- Progress has plateaued.

Kristen Downey, PT(SC Lic: 5366)

Signed on Mar 08, 2013 13:57:33



SOUTH CAROLINA DIAGNOSTIC IMAGING

Piedmont Imaging
684 N. Pine St Spartanburg, SC 29303
p: (864) 542-0033 f: (864) 542-0025

PATIENT: CASE, KEITH
DOB: 06/09/1971
MRN: 918362
PHONE: 864-426-8592 (Home)
PHYSICIAN: ROBIN IVEY, DC
EXAM DATE: 04/17/2014

EXAM: MR-Cervical Spine Without Contrast

REASON FOR EXAM: Cervical pain and radiculopathy

ADDITIONAL HISTORY: Pain.

TECHNIQUE: Multiplanar, multisequence images of the cervical spine without contrast.

COMPARISON: None.

CONTRAST: None.

FINDINGS:

Cerebellum, brainstem and cord are normal.

Vertebrae: Vertebral bodies are grossly normal in height and alignment, and signal characteristics. There is no evidence of fracture or contusion. The paraspinal muscles are normal. No strain or hematoma.

C2-C3: Normal.

C3-C4: Normal.

C4-C5: Mild loss of disc height and signal and posterior disc-osteophyte complex efface the anterior thecal sac and mildly impinges upon the cord creating mild central stenosis. The neural foramina are patent.

C5-C6: Moderate loss disc height and signal. There is 1-2 mm posterior disc-osteophyte complex effacing the anterior thecal sac and minimally impinging upon the cord. More focal right central to foraminal disc protrusion compounding the central stenosis and effacing the neural foramen. This is best seen sequence S105, image 6. It is also seen sequence S102, image 6.

C6-C7: Minimal loss of disc height and signal. Focal annular zone of high signal but no focal disc protrusion. No central stenosis or foraminal narrowing.

C7-T1: Normal.

IMPRESSION:

1. Mild central stenosis C4-5 and C5-6 secondary to degenerative disc disease.
2. Small focal right central to foraminal disc protrusion C5-6 creating mild

PATIENT: CASE, KEITH
DOB: 06/09/1971
EXAM: MR-Cervical Spine Without Contrast
EXAM DATE: 04/17/2014

central stenosis and moderate right foraminal narrowing.

William Smith, MD

WSS/dla

DD: 04/17/2014 01:44 P

DT: 04/17/2014 02:04 P

Accession#: 08-1827754 VS#: 11842692 CS#: 776015

CC:

Electronically Signed and Reviewed by William Smith, MD 04/17/2014 11:07 P