ORIGINAL

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE
SOUTH CAROLINA WORKERS'COMPENSATION COMMISSION
APPELLATE PANEL
Commissioner Campbell, III, Chair

RECEIVED
MAR 17 2016

APPELLATE CASE NO. 2015-002112

Lettie Spencer,..... Employee, Appellant,

v.

NHC Parklane,Employer, and Premier Group Insurance Co., Inc., Carrier.....Respondents.

RECORD ON APPEAL

VOL 2 OF 4

Clark W. McCants, III
Amy P. Shumpert
Nance, McCants & Massey
PO Box 2881
Aiken, SC 29802
(803) 649-6200 Ext. 21

Attorneys for Respondents

Andrew W. Creech
Garrett B. Johnson
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212 East Black Street
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Rock Hill, SC 29731
(803) 324-7574

Attorneys for Appellant

INDEX FOR RECORD ON APPEAL

Face is symmetric. Strength is 5/5 bilaterally throughout. DTRs are normal and symmetric throughout. Toes are downgoing. Clonus is absent. Hoffmann's sign is negative. Touch and pinprick are subjectively and slightly diminished in the left lateral thigh and superior calf compared to the right. Cerebellar function is intact with normal station, gait, finger-to-nose and heel-to-shin exams.

IMAGING STUDIES: MRI of the lumbar spine done at Chester Regional Medical Center demonstrates no significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

IMPRESSION/PLAN: Ms. Spencer presents with a very intact and relatively healthy lumbar spine that appears younger than her stated age. I have spent approximately 45 minutes with her reviewing the actual images, discussing the findings and the positive nature of those findings. I think that her symptoms are emanating from a severe lumbar strain given the mechanism of injury and her symptom complex. There is certainly no place for any neurosurgical intervention. She seemed to relieve to hear this. I think that she would best be treated with physical therapy. At the end of the session we met with the caseworker and discussed the above. She has agreed that if I order the physical therapy that the patient can be seen, monitored, and managed by Dr. Rawl with our pain department. I think this would be more appropriate than to have continuous neurosurgical surveillance. The patient may return to her current work duties with restrictions and we will make arrangements for physical therapy with a formal consultation with Dr. Rawl.

Randall G. Drye, MD
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED
RGD / MEH CNAWT: 4021

Faxed To: Patty Chambers, RN

RANDALL G. DRYE, MD
720 Rabon Rd. • Columbia, SC 29203 Phone: (803) 462-0423 Fax: (803) 462-0432
132 Sunset Court • W. Columbia, SC 29169 Phone: (803) 794-3700 Fax: (803) 794-0322

Date: 8/31/2011

PHYSICAL THERAPY ORDER

Patient Name: LETTIE SPENCER

Frequency: 3 times per week

Duration: 4 weeks

Diagnosis: LUMBAR STRAIN

Specific Orders Evaluate and Treat, Local Modalities of Heat, US, Message, Tens, E-stim as clinically indicated, Therapeutic Exercise

Precautions/ Restrictions:

Insurance Authorization:

Appt Date and Time:

*I certify that the above ordered physical therapy medically necessary

Physician: RANDALL G. DRYE, MD

Signature:

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

Spine and Neurological Surgery

Carolina Spine Center
A Program of Columbia Neurosurgical Associates

Sylvia Miller, Dir. Industrial Care Dept.
PH (803) 462-3602 Fax (803)462-3647

WORK STATUS INFORMATION

PATIENT WORK INJURY INFORMATION

LETTIE SPENCER	259746627	130062
Patient Name	Patient social security #	Chart #
NHC PARKLANE		PREMIER GROUP INS
Employer Name		Insurance Carrier
WC18202011021728	08/31/2011	07/22/2011
Case #	Date of Service	Date of Accident

Diagnosis code(s) and/or description of condition for which patient is being treated

Return to Light Work with restrictions on CONTINUE CURRENT RESTRICTIONS- Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical Demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

PHYSICAL LIMITATIONS

FOLLOW UP

Physician:RANDALL G. DRYE, MD

Signature:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

1300620

PLAN OF TREATMENT
(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN
Spencer	Lettie		1376580936	
4. PROVIDER NAME	**5. MEDICAL RECORD NO.**		**6. ONSET DATE**	**7. SOC DATE**
NHC HealthCare Parklane	4686		06/26/2011	09/07/2011
8. TYPE ☑PT ☐OT ☐SLP	**9. PRIMARY DIAGNOSIS** (Patient Medical D.X.) 847.2 SPRAIN LUMBAR REGION		**10. TREATMENT DIAGNOSIS** LATE EFFEC SPRAIN/STRAIN	**11. PAYOR** Workers Comp.

12. PLAN OF TREATMENT FUNCTIONAL GOALS

GOALS (Short Term) In 3 weeks

1. Pain - The patient will report decreased pain for lumbar area to 0 /10 (1-10 pain scale measure) by manual therapy to increase level of independence.
2. ROM: General - The patient will increase AROM of trunk forward flexion and lateral bending to only 5 inches from tip of finger to floor increase efficiency of work as a nurse.
3. Standing Balance: General - The patient will increase standingbalance with modified physical performance test to 36/36.

OUTCOME (Long Term) In 4 weeks

Pt to be able to functional as a nurse with no pain with pushing or pulling medicine carts, be able to bend to manage medicine carts

PLAN

90901 - Biofeedback training by any modality
95851 - Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
97001 - Physical Therapy Evaluation
97032 - Electrical Stimulation (constant attendance)
97033 - Iontophoresis
97035 - Ultrasound
97110 - Therapeutic Exercise - develop strength and endurance, ROM and flexibility
97124 - Massage (includes effleurage, petrissage, and/or tapotement)
97140 - Manual Therapy techniques (mobilization, manipulation, manual lymphatic drainage, manual traction, myofascial release)
G0283 - Electical Stimulation, for indications other than wound care
The resident and/or responsible party understand the proposed treatment and the expected benefit and risks if any that are associated with the plan.
The resident and/or responsible party agrees to the treatment as prescribed.
The Rehab potential is excellent.
Prognostic Indicator:
Improving medical condition.

13. ELECTRONICALLY SIGNED BY (Professional certifying POC)
Maria Visda Bozard, PT (2669) 09/07/2011

I CERTIFY THE NEED FOR THESE SERVICES UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐N/A

15. PHYSICIAN SIGNATURE

16. DATE 9-21-11

14. FREQ/DURATION (e.g. 3/Week x 4 Weeks)
3 times a week for 4 weeks

17. CERTIFICATION
FROM 09/07/2011 THROUGH 10/04/2011 ☐N/A

18. ON FILE (Print physician's name)
☑ Randall Drye

19. PRIOR HOSPITALIZATION
FROM THROUGH ☑N/A

20. INITIAL ASSESSMENT (History, medical complications, CTOP, reason for referral)

Reason for Referral: lumbar pain worst This 64 year old female presents to therapy with complaints of 8 /10 pain in lumbar area forJune 26, 2011 due to occured while pushing medicine cart. The pain impairs ability to perform difficulty with gait and lifting charts, unable to bend, difficulty sleeping, laying on back. Pain meds with Ultram have been used without resolution of pain or impact on function. Skilled therapy is necessary to improve functional abilities and pain control.

Precautions: Precautions given by neurologist,pending follow up with neurologist

PLOF: Pt works at a nurse at spring hope lane and was able to perform tasks and lift at work, until pt injury in June 2011

History: current nurse at NHC parklane spring hope lane with c/o pain lumbar area June 26 after pushing medicine cart. Pt was seen by neurologists and MRI completed, results were negative and dx with severe muscle report; DOB 11/28/1947; Female

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

1300162 R

PLAN OF TREATMENT
(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN
Spencer	Lettie		1376580936	
4. PROVIDER NAME	**5. MEDICAL RECORD NO.**		**6. ONSET DATE**	**7. SOC DATE**
NHC HealthCare Parklane	4686		06/26/2011	09/07/2011
8. TYPE ☑ PT ☐ OT ☐ SLP	**9. PRIMARY DIAGNOSIS** (Pertinent Medical D.X.) 847.2 SPRAIN LUMBAR REGION		**10. TREATMENT DIAGNOSIS** LATE EFFEC SPRAIN/STRAIN	**11. PAYOR** Workers Comp.

Medications: Anti-Hypertensives at risk for at risk for Chest pain, Cough, Depression, Dizziness, Fainting, GI disturbances, Headache, Lethargy, Lightheadedness, Nausea, Orthostatic, hypotension, Pedal edema, Possible exercise intolerance or A44Tachycardia with impact on Therapy POC of tiredness
. Hypothyroid Medications at risk for Anxiety, GI disturbances, Insomnia, Lethargy, Mood swings or Weakness with impact to Therapy POC of little to no direct effect
Narcotic Pain Medications at risk for Addiction potential, GI irritation, Liver toxicity, Mental clouding, Respiratory depression or Withdrawal risk with impact on Therapy POC of little to no direct effect.
Previous Therapy: None
Assessment: Pain gets worst at end of work day
Pain shoots down to buttock (on and off), mostly on left side.
Pt to bring in MRI report and CD for therapist to view.
DC Plans: Discharge home and return to vocational activities. Discharge home and return to community activities.
Standardized Tests: pain scale end of work day 8/10 worst on left side
Current Level of Function at SOC:

1. Pain - The patient reports a pain scale rating of 2 /10 (1-10 pain scale measure) for lumbar area.
2. ROM: General - The patient demonstrates AROM trunk forward flexion of 12 inches from tip of fingers to floor, lateral flexion to right and left 15 inches from tip of fingers to floor with complaints of discomfort and pulling on back
3. Standing Balance: General - The patient demonstrates standing balance with modified physical performance test 18/28 (2 task not done).

NHC
HEALTHCARE

130062 (2)

Randall G. Drye, MD
720 Rabon Road
Columbia, SC 29203
September 7, 2011

Dear Dr. Drye,

Thank you for referring Lettie Spencer for out patient physical therapy. She was evaluated for lumbar Sprain on sept 7, 2011, and treatment for 3xweek for 2 weeks.
Ms Spencer reports 7/10 pain on low back, muscle guarding and spasms more prominent on left side. PT POC:

1. Decrease pain to 1/10
2. Decrease muscle spams to low back
3. Increase ROM of lumbar flexion and lateral flexion

Enclosed is the eval/TOO form, please sign and return to NHC Parklane. Enclosed is a self stamped envelope.

Thank you,

Joyce Bozard, PT

mailed 7

7601 Parklane Road Columbia, SC 29223 (803) 741-9090
A National HealthCare Corporation Affiliate

5'2" 130#

NEW PATIENT INTAKE FORM

BP 120/70 HR 72 RR 16 02 96

SC PAIN ASSOCIATES

Appointment Date: 11/10/2011
Name: Spencer, Lottie
DOB: 11/28/1947 Age: 63
Referring Physician:

Please Print Legibly

Please choose one primary area of pain to discuss on the first page. There is an additional section to discuss secondary areas of pain. Where is your primary source of pain? lower back

When did your primary pain begin? June 26 2011

Was there an inciting event to your primary pain? (Car accident, fall, etc.) pushing a med cart and felt sharp pain in back

Please circle the words that describe your primary pain:

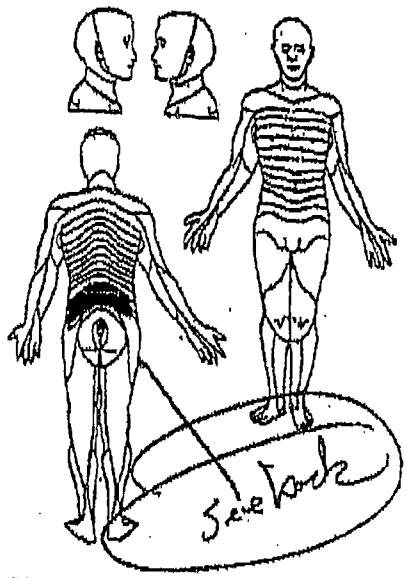
Burning	Aching	Sharp	Constant
Electric	Throbbing	Stabbing	Frequent
Prickling	Dull	Shooting	Occasional
Stinging	Cramping	Spasm	Rare
Other: nausea			

What makes your primary pain better? (medications, treatments, positioning, etc.) TENS helps

What makes your primary pain worse? crushing pills at work, running vacuum cleaner

What symptoms if any accompany your primary pain? (weakness, chest pain, shortness of breath, etc.) in (L) leg

Please shade the area of your primary pain:



Please describe below any treatments you have undergone for attempted relief of your primary pain:

PROCEDURE	DATE:	PERFORMED BY:	DID IT RELIEVE YOUR PAIN? IF SO, FOR HOW LONG?
1. Surgery			
NO			
2. Pain Procedures: Injections, radiofrequency ablation, spinal cord stimulation, intrathecal pump placement, etc.			
NO			

Please circle your average pain score for your primary pain:

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Severe Pain

Please list all current medications you are taking to treat pain, muscle spasms, anxiety and/or depression and include dosing and frequency:

N/A
Trazadone 100mg qhs
Klonopin 0.5 qds

Please provide dates for the treatments below you have participated in:

3. Physical therapy: Yes (helps some)
4. Chiropractic Manipulation:
5. Massage Therapy:
6. Acupuncture:
7. TENS: At home
8. Other:

Please list all previous medications you have taken to treat pain, muscle spasms, anxiety and/or depression and include dosing, frequency and dates the medications were taken if possible:

Ultram
Flexeril

PLEASE COMPLETE THE BACK OF THIS FORM

Do you have a secondary area of pain? If so, please discuss below:

When did the secondary pain begin? June 2011

What is the sensation of your secondary pain? (burning, sharp, etc) sharp comes and goes

What is the average pain score of your secondary pain? (1-10): 6

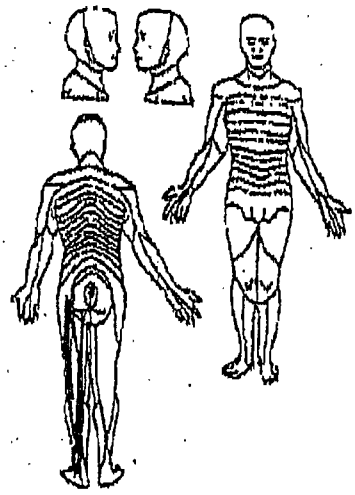
What makes your secondary pain better? NO

What makes your secondary pain worse? NO

What symptoms if any accompany your secondary pain? (weakness, chest pain, shortness of breath, etc.) NO

Do you have any other areas or conditions that cause you pain? If so please discuss below. NO

Please shade the area of your secondary pain:



PAST MEDICAL HISTORY: HTN, ↑ lipids, thyroid

ALLERGIES: Demerol, PCN, Codeine

MEDICATIONS: Please list the medications you currently take along with dosing and frequency: (other than the medications listed on page 1)

Synthroid 88mcg qam
Aldactone - qam
Novasc - qam
CA+ 600mg - qam
VitD 1000IU - qam
Crestor 20mg - 1 qhs
Protonix 40mg - qhs
Tricor 145mg - qhs

SOCIAL HISTORY:

Do you drink alcohol? If so, how much and how often? NO

Do you smoke cigarettes? If so, how much and for how many years? ½ ppd

Do you use illicit (street) drugs? If so which drug(s), how often and for how long? NO

PAST SURGICAL HISTORY: (other than listed on page 1)

FAMILY HISTORY:

Do any blood relatives suffer from chronic pain? If so, list each family member affected along with the type of pain and any diagnosis given. NO

REVIEW OF SYSTEMS:

Please circle any symptom(s) you have experienced within the last month:

CONSTITUTIONAL:	Fatigue	Fevers	Sweats	Weight loss	Weight gain	General weakness	Other:	
EYES:	Double vision	Blurry vision	Redness	Eye pain	Eye discharge/puss	Other:		
ENT/MOUTH:	Bleeding	Throat swelling	Ulcers	Lip lesions	Mouth dryness	Other:		
RESPIRATORY:	Shortness of breath	Wheezing	Chest tightness	Coughing up blood/puss	Other:			
CARDIOVASCULAR:	Chest pain	Palpitations	Passing out	Extremity swelling	Other:			
GASTROINTESTINAL:	(Nausea)	Vomiting	Heartburn	Bleeding	Constipation	Other:		
GENITOURINARY:	Incontinence	Impotence	Genital burn	Difficult urination	Discharge	Other:		
MUSCULOSKELETAL:	Cramps	(Pain)	Weakness	Joint pain	Muscle loss	Other:		
NEUROLOGICAL:	Headache	Seizures	Vertigo	Memory loss	Concentration difficulty	Other:		
PSYCHIATRIC:	Anxiety	Depression	Insomnia	Homicidal or suicidal thoughts	Other:			

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Thu, Nov 10, 2011 01:00 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 11/10/2011 11:43:16 AM
Printed on 04/13/2012 at 2:10 pm.

SUBJECTIVE:

CC: Pt complains of Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history lumbar back pain which began in June of this year. She describes this pain as 8 out of 10 on the NRS with a dull, stabbing, constant and nauseating sensation. Pain is along the lumbosacral spine with radiation in the posterior aspect of the left lower extremity to the left lateral malleolus. Crushing pills at work and utilizing a vacuum cleaner tends to exacerbate her pain while utilizing a TENS unit has alleviated this pain to some extent. She reports her pain is associated with some weakness in the left leg.

Regarding management this condition, she reports no previous surgeries or interventions in effort to control his pain symptoms. She does report participation in physical therapy with modest results. Regarding medication management, she reports previous trials of Ultram and Flexeril. She is currently on a medication regimen of Trazodone and Klonopin.

ROS:
CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Positive for nausea. Negative for vomiting, heartburn, bleeding or constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Current Medications:
Tramadol 50mg Tablet 1-2 q8h prn

OBJECTIVE:

Vitals:

Current: 11/10/2011 6:18:12 PM
Ht: 5 ft, 2 in; Wt: 130 lbs; BMI: 23.8
BP: 120/70 mm Hg; P: 72 bpm; R: 16 bpm
O2 Sat: 98 %
Pain Index: 8

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

ENT/MOUTH: No ear lesions present. Mucous membranes moist.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

[illegible] is a registered trademark of [illegible] and is used with permission.

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Thu, Nov 10, 2011 01:00 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 11/16/2011 11:43:16 AM
Printed on 04/13/2012 at 2:10 pm.

ABDOMEN: Negative for tenderness. No present masses or lesions.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.
Reflex Exam: Right bicep 3+, Right tricep 3+, Right patella 3+, Right achilles 3+, Left bicep 3+, Left tricep 3+, Left patella 3+, and Left achilles 3+.
Hoffmann's Sign: Negative bilaterally.
Clonus: None present.
Sensory Exam: No gross deficits noted.
Patrick's Test: Positive on the left side.
Fortin's Point: Positive on the left side.
Straight Leg Test: Negative bilaterally.
Tenderness to palpation: L-spine.

MUSCULOSKELETAL:
Gait: Non-antalgic.
Muscle Atrophy: None noted.
Right Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.
Left Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results: MRI of L-spine 07/22/11
Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.

ASSESSMENT:

724.6	Sacroiliac pain
338.4	Chronic pain syndrome
724.2	Low back pain

PLAN: 1. Due to the distribution of Ms. Spencer's pain as well as physical exam findings, she was scheduled for a left sacroiliac joint injection.
2. I did initiate her on Tramadol today in effort to gain better control of her breakthrough pain for the time being.
3. She will follow up in clinic in 4 weeks assess the effectiveness of the intervention and medication changes mentioned above and make additional treatment recommendations as necessary.

Sacroiliac pain

Orders:
Office/outpatient visit; new patient, level 4

CPT © 2011 American Medical Association

Patient: Spencer, Lettie L
DOB: 11/28/1947
Date of Exam: 11/21/2011

SC PAIN ASSOCIATES

Dr. Tony Owens
SC Pain Associates
Phone: (803) 457-7246
Fax: (803) 454-6544

Left Sacroiliac Joint Injection with Sedation

Indication: Back Pain
CPT code(s): 27096
ICD 9 code(s): 720.2
Pre-procedural diagnosis: Sacroiliac Pain
Post-procedural diagnosis: Sacroiliac Pain

Procedure:
1) Left Sacroiliac Joint Injection:
2) Fluoroscopy
3) IV sedation

The patient was identified in the holding room. Written informed consent was obtained including a discussion of the risks, benefits and alternatives to the procedure. An IV was placed and the patient was positioned prone on the fluoroscopic table. IV access was confirmed, monitors applied and mild IV sedation was initiated by the sedation nurse. A/P fluoroscopy with a slight oblique tilt was utilized to identify the left SI joint at its most posterior and inferior aspect. 4cc of 0.5% Lidocaine was used for skin anesthesia. Then a 22 gauge spinal needle was placed into the SI joint utilizing intermittent fluoroscopic guidance. After negative aspiration for blood or CSF, 3 cc of a solution containing 0.25% Bupivacaine and 40 mg of Kenalog was injected into the joint. The needle was removed intact and hemostasis was appreciated. Meaningful verbal contact was maintained with the patient throughout the entire procedure. The patient was allowed to recover in a monitored setting for 30 minutes prior to discharge. No complications were noted.

This document has been electronically verified and signed by Tony Owens, M.D. 11/21/2011

SOUTH CAROLINA PAIN ASSOCIATES
TONY OWENS, M.D.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 457-7246
FAX: (803) 454-6544

Monday, November 21, 2011

RE: Lettie Spencer

To Whom It May Concern,

Please excuse Ms. Spencer from work until 12/9/2011. She has a follow-up appointment scheduled with me at that time.

Sincerely,

Tony Owens, M.D.

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Fri, Dec 9, 2011 01:00 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:33 AM
Printed on 04/13/2012 at 2:10 pm.

SUBJECTIVE:

CC: Follow up Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit
1. November 2011, left sacroiliac joint injection, which decreased her pain approximate 80% for about an 18 hour period.

She is describing her pain today as 8-9 out of 10 on the NRS with an aching, dull, shooting and constant sensation. The pain is in the lumbosacral spine with radiation down the posterior aspect of the left lower extremity to the superior aspect of her left hamstring.

ROS:
CONSTITUTIONAL: Positive for weight loss and general weakness. Negative for fatigue, fever, sweats or weight gain.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Positive for nausea. Negative for vomiting, heartburn, bleeding or constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Current Medications:
Norco 6mg/325mg Tablet one po tid prn
Tramadol 50mg Tablet 1-2 q8h prn

OBJECTIVE:

Vitals:

Current: 12/9/2011 4:50:16 PM
Ht: 5 ft, 2 in
BP: 122/70 mm Hg; P: 71 bpm; R: 16 bpm
O2 Sat: 98 %
Pain Index: 9

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to ausoultation bilaterally.

CARDIOVASOULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

CPT is a registered trademark of the American Medical Association

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Fri, Dec 9, 2011 01:00 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:33 AM
Printed on 04/13/2012 at 2:10 pm.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.
Fortin's Point: Positive on the left side.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:
MRI of L-spine 07/22/11
Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:

724.6 Sacroiliac pain
338.4 Chronic pain syndrome
724.2 Low back pain

PLAN: Plan

1. Due to the short-lived benefit she received from the left sacroiliac joint injection, I scheduled her for a left L5-S2 lateral branch radiofrequency ablation.
2. She will continue her Norco as previously prescribed due to positive benefit.
3. She will follow up in clinic in 6-8 weeks to assess her response to the intervention mentioned above and to make additional treatment recommendations as necessary.

Sacroiliac pain

Orders:
Office/outpatient visit, established patient, level 3

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SOUTH CAROLINA INTERNAL MEDICINE ASSOCIATES & REHABILITATION, L.L.C.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111 • FAX: (803) 749-0050

Friday, December 09, 2011

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

Please be advised that Ms. Spencer is currently under my medical care. She will be released to return to work effective 01/14/2012.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,

~~Choose provider~~

South Carolina Internal Medicine Associates and Rehabilitation, L.L.C.

2

Patient: Spencer, Lottie L
DOB: 11/28/1947
Date of Exam: 12/20/2011

SC PAIN ASSOCIATES

Dr. Tony Owens
SC Pain Associates
Phone: (803) 457-7246
Fax: (803) 454-6544

Left L5-S2 Lateral Branch Radiofrequency ablation (SI Joint) with Sedation

Indication: Back Pain
CPT code(s): 64622 (1st level), 64640 (additional levels)
ICD 9 code(s): 724.6
Pre-procedural diagnosis:
Post-procedural diagnosis:

Procedure:
1) Left L5-S2 Lateral Branch RFA (SI Joint)
2) Fluoroscopy
3) IV sedation

The patient was identified in the holding room. Written informed consent was obtained including a discussion of the risks, benefits and alternatives to the procedure. An IV was placed and the patient was positioned prone on the fluoroscopic table. IV access was confirmed, monitors applied and mild IV sedation was initiated by the sedation nurse. The patient's lumbosacral area was prepped and draped in a sterile fashion with Betadine x 3. AP fluoroscopy was utilized to identify the junction of the sacral ala and the superior articulating process of the sacrum on the left side. The skin and subcutaneous tissues at this sight were anesthetized with 4cc of 1% Lidocaine. An 18/10/10 curved tip radiofrequency cannula was advanced towards the targeted area on the left side. Another 18/10/10 curved tip radiofrequency cannula was advanced less than a cm lateral and caudad to the first needle. Proper needle positioning was confirmed in both the AP and lateral positions. The needle stylets were then replaced with the RF ablation probes. Sensory stimulation was tested at 50 hertz and 1 volt which produced no radicular symptoms and only mimicked the patient's typical pain complaints in a localized area. Motor stimulation was tested at 2 hertz and 3 volts without extremity movement or pain. The RF probes were then removed and approximately 2 cc of a 12cc solution containing 0.25% Bupivacaine and 40mg of Kenalog was injected into each needle after negative aspiration for blood or CSF. The RF probes were then introduced into each cannula, and lesioning was performed at 80 degrees centigrade for 85 seconds between the contacts of these two needles. Under AP fluoroscopy, the needles were repositioned just 0.5 cm lateral to the S1 neurofobramen at the 8 and 10 O'clock positions. Lateral images confirmed proper placement and then 2 cc of the Bupivacaine/Kenalog solution was injected into each cannula after negative aspiration for blood or CSF. Then, The RF stylets were introduced into each needle and lesioning was performed at 80 degrees centigrade for 85 seconds between the contacts of these two needles. The same identical procedure was repeated at the S2 neuroforamen on the left side. All needles were removed intact and hemostasis was appreciated. Meaningful verbal contact was maintained with the patient throughout the entire procedure. The patient was allowed to recover in a monitored setting for 30 minutes prior to discharge. No complications were noted.

This document has been electronically verified and signed by Tony Owens, M.D. 12/20/2011

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Fri, Jan 13, 2012 08:45 am
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 04/13/2012 at 2:10 pm.

SUBJECTIVE:

CC: Follow up Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit
1. November 2011: left sacroiliac joint injection, which decreased her pain approximate 80% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period

Lettie describes her pain today as 8/10 on the NRS with a throbbing, shooting and frequent sensation. She reports the majority of her pain is actually in the lumbar spine, although she still reports tenderness along the left sacroiliac joint.

ROS:
CONSTITUTIONAL: Positive for weight loss. Negative for fatigue, fever, sweats, weight gain or general weakness.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Positive for nausea and vomiting. Negative for heartburn, bleeding or constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Negative for cramps, pain, weakness, joint pain and muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Past Medical History / Family History / Social History:
... Last Reviewed on 1/13/2012 11:32:23 AM by Shealy, Lisa
Past Medical History:

Hyperlipidemia
Hypertension
Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:
... Last Reviewed on 1/13/2012 11:33:06 AM by Shealy, Lisa
Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:
... Last Reviewed on 1/13/2012 11:33:18 AM by Shealy, Lisa
None

Current Problems:
Last Reviewed on 1/13/2012 11:30:15 AM by Shealy, Lisa
Acquired hypothyroidism, other specified cause
HTN
Low back pain
Other hyperlipidemia

Allergies:

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Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Fri, Jan 13, 2012 08:45 am
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Sheely, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 04/13/2012 at 2:10 pm.

Last Reviewed on 1/13/2012 11:31:24 AM by Sheely, Lisa
Demerol HCl:
Codeine Sulfate:
Penicillins:

Current Medications:
Neurontin 300mg Capsules One qhs x 5, then two qhs x 5, then one am and two qhs x 5, then two bid x 5, then two am, one noon and two qhs x 5, then two tid thereafter
Oxycontin 10mg Tablets, Controlled Release One po BID

OBJECTIVE:

Vitals:

Current: 1/13/2012 11:34:16 AM
Ht: 5 ft, 2 in
BP: 122/72 mm Hg; P: 60 bpm; R: 16 bpm
O2 Sat: 97 %
Pain Index: 8

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:
MRI of L-spine 07/22/11
Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight dislocation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.

ASSESSMENT:

724.6	Sacroiliac pain
338.4	Chronic pain syndrome
724.2	Low back pain

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Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Fri, Jan 13, 2012 08:45 am
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 04/13/2012 at 2:10 pm.

PLAN: 1. Unfortunately Lettie did not respond as expected to the lateral branch radiofrequency ablation. I explained to her that there's no further interventional treatment to offer her at this time. I did offer to send her for a second opinion or surgical evaluation. She declined this treatment option at this time.
2. I will discontinue hydrocodone today due to lack of benefit and I initiated her on a trial of OxyContin due to the consistent nature of her pain.
3. I plan to enroll her into hydrotherapy as soon as her pain is better controlled.
4. I also initiate her on a trial of Neurontin to address what I believe is likely neuropathic pain.
5. She will follow up in clinic with me in 4 weeks for further evaluation.

Sacroiliac pain

Orders:
Office/outpatient visit; established patient, level 3

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PAIN ASSOCIATES

Tony Owens, MD
Pain Management Specialist

January 13, 2012

To whom it may concern:

Please be advised Ms Spencer is currently under my medical care. Her ability to return to work will be reassessed at her next office visit on February 10, 2012. If you have any questions or concerns please not hesitate to contact me.

Best regards,

Tony Owens, M.D.

1 Wellness Boulevard, Suite 200 • Irmo, SC 29063
Phone: (803) 457-PAIN (7246) • Fax: (803) 732-2624 • www.scpainassociates.com

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Thu, Feb 9, 2012 01:15 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM
Printed on 04/13/2012 at 2:10 pm.

SUBJECTIVE:

CC: Follow up Low back pain.

HPI: Ms. Spencer is a pleasant 63-year-old female with a history of lumbar back pain. She is currently on a medication regimen of trazodone, Klonopin, OxyContin and Neurontin. Previous medication trials include tramadol, Norco and Flexeril.

She has undergone the following interventions with the indicated benefit
1. November 2011: left sacroiliac joint injection, which decreased her pain approximate 60% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period

Lettie reports to me today that she suffered nausea which started shortly after our last visit and has progressively gotten worse. When she stopped the OxyContin and Neurontin she reports that this eased up for a few days, but now has gotten worse and she has not been able to hold down any food. She reports that the OxyContin did control her pain well, but the nausea was more than she was able to tolerate. She reports her pain today as 8/10 on the NRS with an aching and constant sensation. The pain is in the lumbosacral spine with no radiation to the lower extremities.

ROS:
CONSTITUTIONAL: Positive for fatigue, fever, sweats and weight loss. Negative for weight gain or general weakness.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Positive for nausea and vomiting. Negative for heartburn, bleeding or constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Negative for cramps, pain, weakness, joint pain and muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Positive for depression. Negative for anxiety, insomnia or homicidal or suicidal thoughts.

Past Medical History / Family History / Social History:
... Last Reviewed on 1/13/2012 11:32:23 AM by Shealy, Lisa
Past Medical History:

Hyperlipidemia
Hypertension
Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:
... Last Reviewed on 1/13/2012 11:33:08 AM by Shealy, Lisa
Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:
... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa
None

Allergies:
Last Reviewed on 1/13/2012 11:31:24 AM by Shealy, Lisa

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Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Thu, Feb 9, 2012 01:16 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Sheely, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM
Printed on 04/13/2012 at 2:10 pm.

Demerol HCl:
Codeine Sulfate:
Penicillins:

Current Medications:
Nucynta ER 50mg Tablets, Extended Release One tablet by mouth BID. May increase to two tabs BID after three days if necessary
Phenergan 25mg Suppository Insert one rectally q6hr prn nausea
Neurontin 300mg Capsules One qhs x 5, then two qhs x 5, then one am and two qhs x 5, then two bid x 5, then two am, one noon and two qhs x 5, then two tid thereafter
Oxycontin 10mg Tablets, Controlled Release One po BID

OBJECTIVE:

Vitals:

Current: 2/10/2012 12:43:31 PM
Ht: 5 ft, 2 in
BP: 118/72 mm Hg; P: 76 bpm; R: 20 bpm
O2 Sat: 96 %
Pain Index: 8

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:
MRI of L-spine 07/22/11
Impression: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:

724.6	Sacroiliac pain
338.4	Chronic pain syndrome
724.2	Low back pain

PLAN: 1. I believe Lettie initially was having a reaction to the OxyContin, but is likely now suffering from withdrawal

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Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Thu, Feb 9, 2012 01:15 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM
Printed on 04/13/2012 at 2:10 pm,

symptoms. I will discontinue her OxyContin and Neurontin and I initiated her on extended release Nucynta which I believe will help with her pain and will be less likely to cause GI distress.

2. She will also utilize Phenergan suppositories for nausea as needed,

3. She will follow up in clinic with me in four weeks for further evaluation.

Sacroiliac pain

Orders:
Office/outpatient visit; established patient, level 3

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ASSOCIATES

Tony Owens, MD
Pain Management Specialist

February 9, 2012

To whom it may concern:

Mrs. Spencer is currently under my care. I am treating and evaluating her sacroiliac pain. She is unable to return to work at this time until her next follow up appointment with me in four weeks. If you have any questions/concerns please do not hesitate to contact me.

Best regards,

Tony Owens, M.D.

1 Wellness Boulevard, Suite 200 - Irmo, SC 29063
Phone: (803) 457-PAIN (7246) - Fax: (803) 732-2624 - www.scpainassociates.com

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Wed, Mar 7, 2012 01:15 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM
Printed on 04/13/2012 at 2:10 pm.

SUBJECTIVE:

CC:
Mrs. Spencer, a pleasant 64 year old White female, returns to the office today to follow up regarding pain management.

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:
1. November 2011: Left SI injection, decreased pain approximately 80% for < 1 day.
2. December 2011: Left L5-S2 LB RFA, decreased pain for approximately 2 days

Mrs. Spencer is currently on a medication regimen of Neurontin, Nucynta ER, Trazodonen, Klonopin, and Phenergan. She reports previous medication trials of Oxycontin, Tramadol, Norco, and Flexeril.

She describes this pain as 8/10 on the NRS with a(n) aching, dull, and frequent sensation. This pain is located in the lumbosacral spine with no radiation.

ROS:
CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Negative for nausea, vomiting, heartburn bleeding and constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Past Medical History / Family History / Social History:
... Last Reviewed on 3/7/2012 1:51:54 PM by Owens, Tony L.
Past Medical History:

Hyperlipidemia
Hypertension
Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:
... Last Reviewed on 3/7/2012 1:51:55 PM by Owens, Tony L.
Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:
... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa
None

Current Problems:
Last Reviewed on 3/7/2012 1:51:48 PM by Owens, Tony L.

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Spencer, Lettie L. 11/26/1947
Office/Outpatient Visit
Visit Date: Wed, Mar 7, 2012 01:15 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM
Printed on 04/13/2012 at 2:10 pm.

Acquired hypothyroidism, other specified cause
Chronic pain syndrome
HTN
Low back pain
Other hyperlipidemia
Sacroiliac pain

Allergies:
Last Reviewed on 3/7/2012 1:51:49 PM by Owens, Tony L.
Demerol HCl:
Codeine Sulfate:
Penicillins:

Current Medications:
Last Reviewed on 3/7/2012 1:51:50 PM by Owens, Tony L.
Nucynta 50mg Tablet take one or two tablets every four to six hours as needed for pain pain
Phenergan 25mg Suppository Insert one rectally q6hr prn nausea

OBJECTIVE:

Vitals:

Current: 3/8/2012 9:10:09 AM
Ht: 5 ft, 2 in; Wt: 126 lbs; BMI: 22.8
BP: 128/72 mm Hg; P: 68 bpm; R: 16 bpm
O2 Sat: 97 %

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.
The following radiology test(s) have been performed with the indicated benefit:

7/22/2011 - MRI of Lumbar Spine: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight dislocation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

ASSESSMENT:

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Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Wed, Mar 7, 2012 01:15 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM
Printed on 04/13/2012 at 2:10 pm.

338.4 Chronic pain syndrome
724.6 Sacroiliac pain
724.2 Low back pain

PLAN:

Chronic pain syndrome
- A referral was made to Columbia Rehabilitation Clinic for hydrotherapy.
- The pain is currently reasonably controlled and no changes in management will be made today.
- Nucynta is working quite well for Ms. Spencer
- She will follow-up in clinic in 6-8 weeks for further evaluation.

Orders:
Office/outpatient visit; established patient, level 3

ADDENDUMS:

Addendum: 03/08/2012 01:40 PM -

Visit Note Faxed to:
ATTN: Pat Chambers; Number (866)440-6782

Addendum: 03/08/2012 03:16 PM -

Visit Note Faxed to:
Corvel (ATTN: Carol); Number (888)916-0958

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SOUTH CAROLINA PAIN ASSOCIATES
TONY OWENS, M.D.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 457-7246
FAX: (803) 454-6544

Wednesday, March 07, 2012

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

Please be advised that Ms. Spencer is currently under my medical care. She will be released to return to work effective APRIL 19,2012.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Tony Owens, M.D.

Spencer, Lettie L. 11/26/1947
Office/Outpatient Visit
Visit Date: Wed, Apr 18, 2012 12:05 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 06:27:16 PM
Printed on 06/06/2012 at 10:16 am.

SUBJECTIVE:

CC:
Mrs. Spencer, a pleasant 64 year old White female, returns to the office today for a follow-up visit regarding pain management.

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:
1. November 2011: Left SI injection, 80% pain relief for < 1 day
2. December 2011: Left L5-S2 LB RFA, provided pain relief for 2 days

Regarding management, she is currently on a medication regimen of Neurontin, Nucynta ER, Trazodonen, Klonopin, and Phenergan. She reports previous medication trials of Oxycontin, Tramadol, Norco, and Flexeril. No other treatment modalities are noted.

She describes her pain today as 8/10 on the NRS with a(n) aching, constant, dull, sharp, and shooting sensation. This pain is located in the lumbar spine with radiation to the posterior aspect of the left lower extremity.

ROS:
CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.
EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.
ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.
RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/puss.
CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.
GASTROINTESTINAL: Negative for nausea, vomiting, heartburn bleeding and constipation.
GENTOURIANRY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.
MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.
NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.
PSYCHIATRIC: Positive for depression. Negative for anxiety, insomnia or homicidal or suicidal thoughts.

Past Medical History / Family History / Social History:
... Last Reviewed on 4/18/2012 12:05:27 PM by James, Whitney A
Past Medical History:

Hyperlipidemia
Hypertension
Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:
... Last Reviewed on 4/18/2012 12:05:32 PM by James, Whitney A
Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:
... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa
None

Current Problems:

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SCANNED

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Wed, Apr 18, 2012 12:05 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 06:27:16 PM
Printed on 06/06/2012 at 10:16 am.

Last Reviewed on 4/18/2012 12:05:24 PM by James, Whitney A
Acquired hypothyroidism, other specified cause
HTN
Low back pain
Other hyperlipidemia

Allergies:
Last Reviewed on 4/18/2012 12:05:25 PM by James, Whitney A
Demerol HCl:
Codeine Sulfate:
Penicillins:

Current Medications:
Last Reviewed on 4/18/2012 12:05:26 PM by James, Whitney A
None

OBJECTIVE:

Vitals:

Current: 4/18/2012 1:49:36 PM
Ht: 5 ft, 2 in; Wt: 129 lbs; BMI: 23.6
BP: 142/72 mm Hg; P: 92 bpm; R: 20 bpm
O2 Sat: 98 %

Exams:
CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.

NEUROLOGICAL:
Cranial Nerves: II - XII intact.
Sensory Exam: No gross deficits noted.
Fortin's Point: Positive on the left side.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.

Lab/Test Results:
The following radiology test(s) have been performed with the indicated benefit:
7/22/2011 - MRI of Lumbar Spine: No significant pathologic findings. She has a very mild degenerative disc at L4-5 with nonpathologic bulge and slight desiccation. The disc height is however, fairly well maintained. The other discs show retention of normal fluid and position and she has no evidence of severe spondylosis, stenosis, instability or fracture.

SC Pharmacy query was evaluated today and reflected adherence to the prescribed regimen.

ASSESSMENT:

338.4 Chronic pain syndrome

SCANNED

Spencer, Lettie L. 11/28/1947
Office/Outpatient Visit
Visit Date: Wed, Apr 18, 2012 12:05 pm
Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)
Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 05:27:16 PM
Printed on 06/06/2012 at 10:16 am.

724.6 Sacroiliac pain
724.2 Low back pain

PLAN:

Chronic pain syndrome
- I continued her current medication regimen without change due to positive benefit.

- A referral was made to orthopedist for further evaluation of chronic low back pain.

Low back pain

Patient Education Handouts:
Acute Low Back Pain

ADDENDUMS:

Addendum: 04/18/2012 05:27 PM - Owens, Tony L.

Visit Note Faxed to:
CorVel; Number (866)440-6782
Premier Group Insurance (Ins. Co.); Number (866)915-0958

SCANNED

Page 000075

SOUTH CAROLINA PAIN ASSOCIATES
TONY OWENS, M.D.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 457-7246
FAX: (803) 454-6544

Wednesday, April 18, 2012

RE: Lettie Spencer
DOB: 11/28/1947

To Whom It May Concern,

Please be advised that Ms. Spencer was seen in my office today. I have ordered her to remain out of work until she sees a specialist.

If you should have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Tony Owens, M.D.
South Carolina Pain Associates

APA
6

Select Physical Therapy
154-101 Amendment Ave...
Rock Hill, SC USA 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Patient:	Leslie Spencer		
Acct #:	013-610302198	Visit Date:	Mar 12, 2012
DOB:	Nov 28, 1947	FSCI	Workers Compensation
Clinician:	Judith B. Kiser, MPT	Payor:	WC Of SC
Prim Phy:	Tony Owens	Pol/Claim#:	Not Specified
Phy Phone:	(803) 749-1111	Insured:	Not Specified
Phy Fax:	(803) 749-0050	Employer:	NHC Parklane
Sec Phy:	Not Specified	Case Mgr:	Not Specified
Inj. Date:	7/22/2011	Visit:	1
Surg. Date:	Not Specified	Cd/Ns:	0

Initial Evaluation

Diagnosis Spine 7242 LUMBAGO

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.

ADL / Functional Status:
- Premorbid status:
  - Basic care: Independant without difficulty. Work status: Full time / Full duty.
- Current status:
  - Work status: Unable to work secondary to dysfunction. Basic care: Modified independance: Requires prolonged time. can not get clothes out of washing machine, vacum, change sheets
- Occupation: LPN at skilled nursing facility

Chief Complaint:
- Pain: Aggravating Factors: Activities:
  - Standing: 20 min Walking: 60 min Sitting: < 30 min
- Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:
- 6-22-11 Pushing a med chart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Medical Management:
- Originally saw urgent care MD had x-rays and MRI and PT. Was then referred to neurosurgeon who reffered her to pain Medicine. Had injections 11-20-11, then 12-20-11 had radio frequency ablation. Medications: Prescription: Pain Medication/Analgesics.

Questionnaires: Disability Index:

Test Name	Oswestry Disability Index
Date	03/13/2012
Assessment	Initial
Percentage	50.00%

Rehabilitation Expectations/Goals:
- to get better and get stronger

Objective Examination

Muscle Testing: Lower Extremity MMT:	Left	Right
Hip Flexion	-4/5	-4/5
Knee Extension	-4/5	-4/5
Knee Flexion	+4/5	+4/5
Ankle Dorsiflexion	-5/5	-5/5

Range of Motion: Spine: Active Lumbosacral	
Extension(Bilateral - Pain Provoked)	10%
Flexion(Bilateral - Pain Provoked)	20%
Side Bending Left(Bilateral - Pain Provoked)	20%
Side Bending Right(Bilateral - Pain Provoked)	20%

Treatments

Pt./Family Education:
- Patient Education 1 — Time Elapsed: 5 Minutes, Description: benefits of aquatic therapy then progress to clinic, Charge Ad: Self Care / Home Mgt Training

Therapy Session Time

Therapy Session Start Time	12:03 PM
Therapy Session Stop Time	12:35 PM

Documented Procedural Code Summary:

Description	Code	Units	Minutes
Physical Therapy Evaluation	97001	1	n/a

SCANNED

• Self Care/Home Management Training	97535	1	5

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

- Decrease Pain. Improve Function. Increase Range of Motion. Increase Strength.

Problems & Goals

Problem #1 **Chief Complaint: Pain: Aggravating Factors: Activities: Standing: 20 min**

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 **Chief Complaint: Pain: Aggravating Factors: Activities: Sitting: < 30 min**

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 **Range of Motion: Spine: Active Lumbosacral.**

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

- Extension: 80%
- Flexion: 80%
- Side Bending Left: 80%
- Side Bending Right: 80%

Problem #4 **Muscle Testing: Lower Extremity MMT.**

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower Extremity Strength to:	Left	Right
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 8 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

- Active Assistive Range of Motion Activities. Active Range of Motion Activities. Aquatics/Pool. Client Education.

Judith E. Kisar, MPT, MPT(SC Lic: 4150)

SCANNED

Select Physical Therapy
A Select Medical company
154-101 Amendment Ave.
Rock Hill, SC USA 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Patient:	Cassie Spencer	Edit Date:	Mar 12, 2012
Acct #:	013-610302198	FSC:	Workers Compensation
DOB:	Nov 28, 1947	Payor:	WC OF SC
Clinician:	Judith E. Kiser, MPT	Pol/Claim #:	Not Specified
Prim Phy:	Tony Owens	Insured:	Not Specified
Phy Phone:	(803) 749-1111	Employer:	NHC Parklane
Phy Fax:	(803) 749-3558	Case Mgr:	Not Specified
Sec Phy:	Not Specified	Visits:	1
Inj. Date:	7/22/2011	Cvl/Ns:	0
Surg. Date:	Not Specified		

Plan of Care

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

The medical history questionnaire has been completed and signed by the patient, reviewed by the evaluating therapist, and is on file.

ADL / Functional Status:
- Premorbid status: Work status: Full time / Full duty.

Rehabilitation Expectations/Goals:
- to get better and get stronger

ADL / Functional Status:
- Current status: Work status: Unable to work secondary to dysfunction. Occupation: LPN at skilled nursing facility

Chief Complaint:
- Pain: Aggravating Factors: Activities:
  - Standing: 20 min Walking: 60 min Sitting: < 30 min
- Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:
- 6-22-11 Pushing a med chart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Questionnaires: Disability Index:

Test Name	Oswestry Disability Index
Date	03/13/2012
Assessment	Initial
Percentage	50.00%

Assessment

The patient requires skilled physical therapy to address the problems identified, and to achieve the individualized patient goals as outlined in the problems and goals section of this evaluation. Overall rehabilitation potential is good. The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:
- Decrease Pain. Improve Function. Increase Range of Motion. Increase Strength.

Problems & Goals

Problem #1 **Chief Complaint: Pain: Aggravating Factors: Activities: Standing: 20 min**

LTG Achieve by May 11, 2012.

Functional Improvements In:
- Pt able to tolerate standing for 1 hr

Problem #2 **Chief Complaint: Pain: Aggravating Factors: Activities: Sitting: < 30 min**

LTG Achieve by May 11, 2012.

Functional Improvements In:
- Pt able to tolerate sitting up to 1 hr

Problem #3 **Range of Motion: Spine: Active Lumbosacral.**

Extension(Bilateral - Pain Provoked)	10%
Flexion(Bilateral - Pain Provoked)	20%
Side Bending Left(Bilateral - Pain Provoked)	20%
Side Bending Right(Bilateral - Pain Provoked)	20%

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

Extension	80%
Flexion	80%
Side Bending Left	80%
Side Bending Right	80%

Problem #4 **Muscle Testing: Lower Extremity MMT.** Left Right

SCANNED

Acct #: 013-610702198 Visit Date: Mar 12, 2012

• Ankle Dorsiflexion	-5/5	-5/5
• Hip Flexion	-4/5	-4/5
• Knee Extension	-4/5	-4/5
• Knee Flexion	+4/5	+4/5

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements in Lower Extremity Strength to:	**Left**	**Right**
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan

Amount, Frequency and Duration:

• Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 6 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

• Active Assistive Range of Motion Activities. Active Range of Motion Activities. Aquatics/Pool. Client Education.

Judith E. Kiser, MBT, MPT(SC Lic: 4150)

Please Sign and Return

I have reviewed the Plan of Care established for skilled therapy services and certify that the services are required and that they will be provided while the patient is under my care.

Comments/Revisions

Physician Signature: [illegible] QUINN, M.D Date: 3/22/2012

SCANNED

Select Physical Therapy
154-101 Amusement Avenue
Rock Hill, SC USA 29732
Phone: (803) 366-9950
Fax: (803) 366-9960

Patient:	Lottie Spencer	Visit Date:	Apr 17, 2012
Acct #:	013-610302198	PSC:	Workers' Compensation
DOB:	Nov 28, 1947	Payor:	WC OF SC
Clinician:	Judith B. Kerr, MPT	Pol/Claim#:	Not Specified
Prim Phy:	Tony Owens	Insured:	Not Specified
Phy Phone:	(803) 487-7248	Employer:	NHC Parkland
Phy Fax:	(803) 454-4544	Case Mgr:	Not Specified
Sec Phy:	Not Specified	Visits:	11
Inj. Date:	7/22/2011	Cx/Rx:	0
Surg. Date:	Not Specified		

Re-Evaluation

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

ADL / Functional Status

- Current status:
  - Work status: Unable to work secondary to dysfunction. Basic care: Modified independence: Requires prolonged time. can not get clothes out of washing machine, vacuum, change sheets
- Occupation: LPN at skilled nursing facility

Client Complaints:

- Pain: Aggravating Factors: Activities:
  - Standing: no more than 30 min Walking: 60 min Sitting: about an hour with pain meds
- Pain: Location: Lumbosacral Area: center of low back

Daily Comments:

- Perceived Improvements: Reports that she has not noticed much difference in her symptoms yet. Usually curls up in bed the rest of the day after aquatic therapy.

Mechanism of Injury:

- 6-22-11 Pushing a med cart, had to give it a shove to get over trim at door felt immediate sharp pain in back

Medical Management:

- Originally saw urgent care MD had x-rays and MRI and PT. Was then referred to neurosurgeon who referred her to pain Medicine. Had injections 11-20-11, then 12-20-11 had radio frequency ablation. Medications: Prescription: Pain Medication/Analgesics

Questionnaires: Disability Index:

Test Name	Oswestry Disability Index
Date	04/17/2012
Assessment	Reassessment
Percentage	70.00%

Objective Examination

OBJECTIVE NOTED - 04/17/12

Muscle Testing: Lower Extremity MMT:	Mar 12, 2012 Left	Mar 12, 2012 Right	Apr 17, 2012 Left	Apr 17, 2012 Right
Hip Flexion	4/5	4/5	4/5	4/5
Knee Extension	4/5	4/5	4/5	4/5
Knee Flexion	4/5	4/5	4/5	4/5
Ankle Dorsiflexion	5/5	5/5	5/5	5/5
	-5/5	-5/5	-5/5	-5/5

Range of Motion: Spine: Active Lumbosacral:	Mar 12, 2012	Apr 17, 2012
Extension (Bilateral) - Pain Provoked	10%	20%
Flexion	20%	40%
Side Bending Left (Bilateral) - Pain Provoked	20%	50%
Side Bending Right (Bilateral) - Pain Provoked	20%	50%

Treatments

Exercise Activities Aquatics: Lower Quadrant/Trunk

Abdominal Brace (Aquatics) (This visit)	Did Not Perform: This visit
Deep Well Running (This visit)	Did Not Perform: This visit
Hip Abduction (Aquatics) (This visit)	Did Not Perform: This visit
Walking - Backward (This visit)	Did Not Perform: This visit
Walking - Forward (This visit)	Did Not Perform: This visit
Walking - Sideways (This visit)	Did Not Perform: This visit
Aquatic Activity 1 (This visit)	Did Not Perform: This visit
Aquatic Activity 2 (This visit)	Did Not Perform: This visit
Aquatic Activity 3 (This visit)	Did Not Perform: This visit

Received by CWVH Corporation 4/17/2012 8:58:31 AM Pacific Time. Page 2 of 2
Apr. 17. 2012 10:37AM Select Physical Therapy No. 7165 P. 2/5

SCANNED

* Aquatic Activity 5(This visit) Did Not Perform: This visit

Therapy Session Time

* Therapy Session Start Time 11:00 AM
* Therapy Session Stop Time 11:20 AM

Documented Procedural Code Summary:

Description	Code	Units	Minutes
* Physical Therapy Re-Evaluation	97001	1	20

Assessment

Ms Spencer has been participating in aquatic therapy for 4 weeks with fair tolerance for the activity. She reports good pain relief when she is able to unweight completely with the use of noodles, but increased pain with leg kicks and resp walking. She demonstrates decreased lumbar active ROM today, but increased in LE strength. Her Oswestry score went 20 points in the wrong direction as upon her re-evaluation from a 50% disability score to 70% disability.

The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendation/ Skilled Intervention: Required To:

* Decrease Pain. Improve Function. Increase Range of Motion. Increase Strength.

Problems & Goals

Problem #1 Chief Complaint: Pain: Aggravating Factors: Activities: Standing: no more than 20 min

LTG Achieve by May 11, 2012. Progress: Some progress.

Functional Improvements In:

* Pt able to tolerate standing for 1 hr

Problem #2 Chief Complaint: Pain: Aggravating Factors: Activities: Sitting: about an hour with pain meds

LTG Achieve by May 11, 2012. Progress: Excellent progress.

Functional Improvements In:

* Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spine: Active Lumbosacral.

LTG Achieve by May 11, 2012. Progress: Somewhat Hard.

Range of Motion Improvements for Active Lumbosacral:

* Flexion	80%
* Side Bending Left	80%
* Side Bending Right	80%

Problem #4 Muscle Testing: Lower Extremity MMT.

LTG Achieve by May 11, 2012. Progress: Good progress.

Musculoskeletal Improvements In: Lower Extremity Strength to:	Left	Right
* Knee Extension	5/5	5/5
* Knee Flexion	5/5	5/5

Plan

Unless otherwise directed after MD follow-up 4-18-12

Amount, Frequency and Duration:

* Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Centers:

* Aquatics/Pool

Judith E. Kiser, MPT, MPT(SC Lic 4150)

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Received by CoCyo Corporation 4/17/2012, 8:58:01 AM Pacific Time, 2058, Page 3 of 5
Apr. 17. 2012 10:58AM Spartan Physical Therapy No. 7168 P. 3/5

Select Physical Therapy
154-101 Amendment Avenue
Rock Hill, SC USA 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Patient:	**Lettie Spencer**	**Visit Date:**	**Apr 17, 2012**
Acct #:	**013-610302198**	FSC:	Workers Compensation
DOB:	Nov 28, 1947	Payor:	WC OF SC
Clinician:	Judith E. Kiser, MPT	Pol/Claim#:	Not Specified
Prim Phy:	Tony Owens	Insured:	Not Specified
Phy Phone:	(803) 457-7246	Employer:	NHC Parklane
Phy Fax:	(803) 454-6544	Case Mgr:	Not Specified
Sec Phy:	Not Specified	Visits:	11
Inj. Date:	7/22/2011	Cxl/Ns:	0
Surg. Date:	Not Specified		

Plan of Care

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction.

Questionnaires: Disability Index:

• Test Name	Oswestry Disability Index
• Date	04/17/2012
• Assessment	Reassessment
• Percentage	70.00%

Assessment

Ms Spencer has been participating in aquatic therapy for 4 weeks with fair tolerance for the activity. She reports good pain relief when she is able to unweight completely with the use of noodles, but increased pain with leg kicks and retro walking. She demonstrates decreased lumbar active ROM today, but increased in LE strength. Her Oswestry score went 20 points in the wrong direction on upon her re-evaluation from a 50% disability score to 70% disability.

The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

Recommendations: Skilled Intervention: Required To:

- Decrease Pain, Improve Function, Increase Range of Motion, Increase Strength.

Problems & Goals

Item #1 **Chief Complaint: Pain: Aggravating Factors: Activities: Standing: no more than 30 min**

LTG Achieve by May 11, 2012. Progress: Some progress.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

Problem #2 **Chief Complaint: Pain: Aggravating Factors: Activities: Sitting: about an hour with pain meds**

LTG Achieve by May 11, 2012. Progress: Excellent progress.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 **Range of Motion: Spine: Active Lumbosacral.**

• Extension (Bilateral - Pain Provoked)	20%
• Flexion	40%
• Side Bending Left (Bilateral - Pain Provoked)	50%
• Side Bending Right(Bilateral - Pain Provoked)	50%

LTG Achieve by May 11, 2012. Progress: Somewhat worse.

Range of Motion Improvements to: Active Lumbosacral:

• Extension	30%
• Flexion	80%
• Side Bending Left	80%
• Side Bending Right	80%

Problem #4 **Muscle Testing: Lower Extremity MMT.**

	Left	Right
• Ankle Dorsiflexion	-5/5	-5/5
• Hip Flexion	+4/5	+4/5
• Knee Extension	-4/5	-4/5
• Knee Flexion	-5/5	-5/5

LTG Achieve by May 11, 2012. Progress: Good progress.

Musculoskeletal Improvements In: Lower Extremity Strength to:

	Left	Right
• Hip Flexion	-5/5	-5/5

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• Knee Extension	-5/5	-5/5
• Knee Flexion	5/5	5/5

Unless otherwise directed after MD follow-up 4-18-12 *

Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

Therapeutic Contents:

- Aquatics/Pool.

Judith Kiser MPT

Judith E. Kiser, MPT, MPT(SC Lic: 4150)

Please Sign and Return

I have reviewed the Plan of Care established for skilled therapy services and certify that the services are required and that they will be provided while the patient is under my care.

Comments/Revisions

Physician Signature **Date**

SCANNED

Select Physical Therapy
154-101 Amendment Avenue
Rock Hill , SC 29732
Phone: (803) 366-9990
Fax: (803) 366-9960

Appointment list for Spencer, Lettie

Thank you for visiting Select Physical Therapy. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Thu, Mar 15, 2012	11:00 AM	Aquatics	Bragg, PTA , Rochelle	0.00
Tue, Mar 20, 2012	11:00 AM	Aquatics	Bragg, PTA , Rochelle	0.00
Thu, Mar 22, 2012	11:00 AM	Aquatics	Bragg, PTA , Rochelle	0.00
Tue, Mar 27, 2012	11:00 AM	Aquatics	Bragg, PTA , Rochelle	0.00
Thu, Mar 29, 2012	11:00 AM	Aquatics	Bragg, PTA , Rochelle	0.00
				0.00

Additional Instructions:

4 - 3 - 12 11:00
4 - 5 - 12 11:00
4 - 10 - 12 11:00
4 - 12 - 12 11:00
Thank you,
Select Physical Therapy
4 - 17 - 12 11:00

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES, P.A. (COSA)
PATIENT UPDATE AND REGISTRATION

PATIENT INFO: SSN: 259-74-6627 DOB: 11/28/1947 SEX: Female

Name: LETTIE SPENCER	PHONE Home: (407) 497-0388
Address: 2867 GREAT FALLS HWY	PHONE Cell: 803 581 2919
RICHBURG, SC 29729	PHONE Work:
EMPLOYER: NHC. Park Lane Columbia SC	

RESPONSIBLE PARTY: SSN: DOB:

Name: Self	PHONE Home:
Address:	PHONE Cell:
	PHONE Work:
EMPLOYER:	

The following questions MUST BE ANSWERED prior to seeing the physician.

What are we seeing you for today? Back pain.

1) WHEN DID THIS PROBLEM BEGIN? (date) 6-22-11

2) If accident - Check the appropriate type

Accident? ✓ YES ___ NO

___ Auto Accident ___ Other	State where accident occured: S. C
✓ Work Related Injury	Did someone else cause this injury? ___ YES ✓ NO

3) Who referred you to our office?

Referred by: Friends Notes: If referred notes are sent

4) INSURANCE INFORMATION:

Insurance to be filed 1st: BCBS

Person Insured: Lettie Spencer	Employer: Work Today
DOB: 11-28-47	Relation:

Insurance to be filed 2nd: ___

Person Insured:	Employer:
DOB:	Relation:

Calls may be made to you for reminders regarding appointments. We may also leave messages for you to contact us regarding billing questions or other information. If we are unable to reach you may we leave a message? Please INITIAL beside each that you would like us to leave messages at.

HOME ___ CELL ✓ WORK ___

VIA EMAIL ___ email address: ___

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Carolina Orthopaedic Surgery Associates, P.A.
Consent and Financial Responsibility

Thank you for choosing COSA as your healthcare provider.

MEDICAL CONSENT: The undersigned consents for treatment by the physicians and staff of Carolina Orthopaedic Surgery Associates, P.A. This treatment may include office visits, laboratory testing, x-rays, physical therapy, MRI?s or other medical treatment directly related to the patient?s care.

The undersigned understands that medicine is not an exact science and diagnosis and treatment may involve risk. The undersigned also acknowledges that no guarantees have been made as to the results of examinations and/or treatment.

FINANCIAL RESPONSIBILITY: The undersigned acknowledges full responsibility for services rendered and agrees to make a definite financial arrangement for services rendered and understands that the charges made for professional services and supplies may not be covered by health insurance and therefore they are solely responsible for payment of all uncovered services. The undersigned understands that payment is expected at the time of service for all office visits, testing, supplies and services not covered by insurance including co-pays, deductibles and co-insurance.

Patients who are not covered by insurance are required to pay a minimum deposit established by the practice. This is a deposit and not to be considered as the total for services rendered. Balances are due at the time of treatment unless other arrangements have been made.

CONTACT FROM PRACTICE/AGENTS: When you provide us with a wireless telephone or land line number you are giving us and our representatives/agents your prior express consent to call that number.

LIABILITY CLAIMS: The undersigned acknowledges that COSA does not accept third party liability as the sole means of payment for services. Payment is expected in full at the time of service unless other arrangements have been made. In the event of other medical insurance, all claim forms and subrogation forms must be completed prior to services being rendered.
The undersigned authorizes COSA to establish a said lien against any settlement, claim, judgment or verdict as a result of said claim for the full amount of services rendered and not previously paid by the patient.

The undersigned further authorizes and directs all Attorneys and Third Party Payors to pay directly to COSA any sums owing, including payments and adjustments from insurance carriers, prior to sums being distributed to the patient and within 15 days of settlement of said liability claim. COSA will, as required by contracts, refund insurance carriers for amounts previously paid on liability claims.

MEDICAL RECORDS: The undersigned authorizes COSA to release medical records, according to HIPAA guidelines, which relate to treatment rendered to insurance carriers, including workers compensation, employers and nurse case mangers for the purpose of payment of claims. This may include but is not limited to medical records, medical opinions and test results.

MEDICARE, MEDICAID, and GOVERNMENT AUTHORIZATIONS: The undersigned certifies the information given in applying for payment of services provided under TITLES XVIII and IXIX of the social Security Act is correct and request payment to be made in their behalf. The undersigned states they do not have:

-Other group/private insurance that should be filed primary and has provided COSA with all insurance information

-Has not been involved in a third party liability claim for which another party is liable and if so, has provided COSA with detailed billing information as required

The undersigned further authorizes COSA to release information about treatment to the utilization and quality control peer review organization responsible for reviewing medical care.

ASSIGNMENT OF BENEFITS: The undersigned authorizes payment of medical, surgical, and all associated charges for services provided directly to Carolina Orthopaedic Surgery Associates, P.A.

A PHOTOSTATIC COPY OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL. I/WE AGREE THIS AUTHORIZATION SHALL BE VALID FOR TWO YEARS.

Lettie Spencer
Signature Patient/Primary Insured

Signature Patient/Spouse/Guarantor

4-4-12
Date

LETTIE SPENCER Patient #: 179171-LS DOB: 11/28/1947 (64 years)

Printed with FinePrint trial version - purchase at www.fineprint.com

SCANNED

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

134 Professional Park Drive
Rock Hill, SC 29732
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
04/04/2012 02:00 PM
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 64 year old female who presents with a complaint of LUMBAR SPINE PAIN. The onset of the pain has been sudden and has been occurring in a persistent pattern for 9 months. The course has been constant. The pain is described as severe. Note for "LUMBAR SPINE PAIN": -

-CHIEF COMPLAINT: low back pain

-REFERRING PHYSICIAN: Dr Robert Bradley

-PRIMARY CARE PHYSICIAN: same

ACCOMPANIED BY: spouse

-WOULD YOU LIKE FOR THEM TO RECEIVE A COPY OF TODAY'S OFFICE NOTE? yes

Patient states she was pushing a cart at work through a doorway the wheels got caught on the carpet/tile and she felt a sharp pain in her back. Patient states she has seen the company doctor and several other doctor's for this problem. Patient states she is wanting a 2nd opinion for this problem.

Subjective Transcription

She has been an LPN at a nursing home for about four years, employed by NHC Long Term Care. She was working for this company for 9 years when in Orlando, FL, but has been working for four years in this area. On 6/26/11, she was pushing a cart at work through the doorway and the wheel got caught on the carpet or tile, and she felt a sharp pain in her back. Symptoms extend from the back into the left leg towards the calf. She denies any bowel or bladder difficulties. She tried to pursue her regular duties but eventually had to go out of work and has not been actually working since November 2011. She has been using a TENS unit. No specific light duty is available. She initially saw the company doctor and was then sent to a neurologist who felt that there is nothing really to do other than send it to a pain management program. She thus has been referred to Tony Owens, M.D., at South Carolina Pain Associates in Irmo, SC. She has been traveling back and forth from Richburg, SC near Rock Hill down to Irmo. She received ESI X 1 on 11/21/11, but this offered no relief. On 12/21/11, she apparently underwent lumbar medial branch radiofrequency blocks with no improvement. This apparently was dealing with a facet arthropathy seen on scans. Physical therapy was also initiated but this made matters worse. She is potentially released to return back to work on 4/19/12 but feels that she cannot really do this. She is extremely uncomfortable with her back difficulties, still having pain down the left leg. She cannot bend over. She cannot vacuum, use the dishwasher or do anything that requires any bending, leaning, stooping or twisting. She has been taking Nucynta 50 mg which really has not offered that much relief.

Health History Form is on the chart and reviewed with her, including medications and allergies.

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Allergies
PENNICILIAN: rash swelling
DEMEROL: rash swelling

Past Medical History
No reported breathing problems
Hypertension
Thyroid Problem
None - Liver/Kidney
None - Neurologic
None - Blood
Hysterectomy
Crowns
Dentures
Vision Problems: glasses
General Anesthesia

Family History
Myocardial Infarction: Father
Hypertension: Mother

Social History
No Drug Use
Non Drinker/No Alcohol Use
Tobacco Use: 1/2 pack per day
Living Situation: spouse
Current Work/Study Status: Full-time

Medication History
potassium 20 mq (1 daily) Active.
Magnesium Oxide (400MG Tablet 1 Oral daily) Active.
Aldactone (25MG Tablet 1 Oral daily) Active.
Norvasc (10MG Tablet 1 Oral daily) Active.
Calcium Carbonate (600MG Tablet 1 Oral daily) Active.
TraZODone HCl (100MG Tablet 1 Oral daily) Active.
KlonoPIN (0.5MG Tablet 1 Oral daily) Active.
Crestor (20MG Tablet 1 Oral daily) Active.
Tapazole (10MG Tablet 1 Oral daily) Active.
Tricor (145MG Tablet 1 Oral daily) Active.
Fish Oil Concentrate (300MG Capsule 1 Oral daily) Active.
Nucynta ER (50MG Tablet ER 12HR 1 Oral every four-six hours with food, as needed for pain) Active.

Past Surgical
Hysterectomy
Cervical Discectomy

Review of Systems
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- New Lesions and Ulcer.
HEENT: Not Present- Visual Loss, Hearing Loss, Sleep Apnea, Hoarseness, Sore Throat and Voice Changes.
Respiratory: Not Present- Cough, Difficulty Breathing, Hemoptysis and Wheezing.
Cardiovascular: Present- Hypertension. Not Present- Chest Pain, Edema, Elevated Blood Pressure and Palpitations.
Gastrointestinal: Not Present- Abdominal Pain, Change in Bowel Habits, Difficulty Swallowing and Heartburn.
Neurological: Not Present- Difficulty Speaking and Visual Changes.
Psychiatric: Not Present- Change in Sleep Pattern and Mood changes.
Endocrine: Not Present- Appetite Changes, Cold Intolerance, Excessive Thirst, Excessive Urination and Hair Changes.
Hematology: Not Present- Abnormal Bleeding and Easy Bruising.

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Page 000091
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04/04/2012 02:12 PM
Weight: 128 lb **Height:** 62 in
Body Surface Area: 1.59 m² **Body Mass Index:** 23.41 kg/m²
Pulse: 64 (Regular) **P. OX:** 95% (Room air)

Objective Transcription
Ms. Spencer is alert and conversant, oriented X 3. Vital signs are noted and recorded. She is accompanied by her husband. She obviously is severely uncomfortable and has to change positions frequently because of increasing back and left leg symptoms. There is very limited mobility at the lumbar spine. There is no specific motor, sensory or reflex deficit involving the left lower extremity with no pathologic reflexes. Peripheral pulses are normal. There is mild edema in both legs.

X-RAY: Personal review of the MR of the lumbar spine obtained at Chester Regional Medical Center on 7/22/11 did show hypertrophic facet arthropathy at the L3-4 level. At the L4-5 level, there were hypertrophic facet changes but also ligamentum thickening and a disc bulge extending into the inferior foramen at L4-5 bilaterally, with lateral recess narrowing, left greater than right. This would be consistent with symptoms.

Assessment & Plan
Unspecified Diagnosis
Current Plans:
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 04/04/2012, No Refill, Active.

Assessments Transcription
WORK INJURY 6/22/11 WITH PERSISTENT LOW BACK AND LEFT LEG RADICULAR SYMPTOMS, PROBABLY RELATED TO THE L4-5 LEVEL WITH EVIDENCE OF FORAMINAL STENOSIS AND LATERAL RECESS NARROWING LEFT GREATER THAN RIGHT.

Plan Transcription
I recommended further evaluation and treatment. She probably needs a CT myelogram to determine the extent of impingement at the L4-5 level. I increased Nucynta to 75 mg one to two every six hours as needed for pain and she hopefully would respond to perhaps a selective nerve root block prior to considering any surgical intervention. She has had Prednisone in the past and does not want to continue this. It does appear that she would be extremely limited in return back to work and would have to include sedentary work only with ability to change positions frequently. She will contact her attorney, Mr. Elrod, regarding transfer of her care so that I can evaluate her further and provide more effective treatment for this unfortunate woman.
William L. Lehman, Jr., M.D. / as 20083

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)

Electronically signed by William L. Lehman

SPENCER, LETTIE

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

134 Professional Park Drive
Rock Hill, SC 29732
Phone: 803-329-3130
Fax: 803-329-2611

Patient Name: LETTIE B SPENCER
Date of Birth: 11/28/1947
Account: 179171-LS

Date: 04/12/2012

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 04/12/2012. She was discharged at 05:22:54 PM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William L .Lehman

SCANNED

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

134 Professional Park Drive
Rock Hill, SC 29732
Phone: 803-329-3130
Fax: 803-329-2611

LETTIE B SPENCER
04/12/2012 05:20 PM
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

Assessment & Plan
Unspecified Diagnosis
Current Plans:
- Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

Electronically signed by William L .Lehman

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
09/17/2012
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 64 year old female who is in today for TEST RESULTS. Note for "TEST RESULTS": ct lumbar myelogram

Subjective Transcription

She presents for further follow up regarding her work injury of 6/22/11, with back pain and left leg radicular symptoms, MR showing hypertrophic facet arthropathy L3-4, ligamentum thickening and disc bulging at L4-5. I had suggested a CT myelogram in my note of 4/4/2012. This has finally been completed. She has been to physical therapy which only made matters worse.

Previous Health History Form is reviewed and updated from 4/4/12.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs: Temperature - 98.2. Pulse - 75. Respiration - 15. There is satisfactory range of motion of the lumbar spine, though somewhat limited in flexion. There are radicular symptoms but no definite neurologic deficit.

X-RAY: Personal review of the CT myelogram lumbar spine did show interestingly no problem whatsoever other than the L4-5 level which did show mild central stenosis. No abnormality otherwise.

Assessment & Plan

Unspecified Diagnosis

Current Plans:

- Sit Down Work Only

Low Back Pain (724.2)

Current Plans:

THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED (724.4)

Current Plans:

- REFERRAL / CONSULT (ADD COMMENTS); Routine (refer to Dr. Nandurkar for pain management/snrb left L-5)
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 09/17/2012, No Refill. Active.
- Neurontin 300MG, 1 Capsule three times daily, #60, 09/17/2012, No Refill. Active.
- Follow up in 3 - 4 weeks

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Assessments Transcription
WORK INJURY 6/22/11 WITH PERSISTENT BACK AND LEFT LEG RADICULAR SYMPTOMS.

Plan Transcription
I suggested a selective nerve root block on the left at L5 as this is the most likely nerve that is irritated from the L4-5 level. I recommended ongoing pain management, possibly by Dr. Nandurkar or someone in Charlotte. I also placed her on Neurontin 300 mg at bedtime gradually increasing to 300 mg tid. I refilled Nucynta 75 mg. Hopefully, we will be able to get her to pain management through Dr. Nandurkar which would be much more direct. I will be glad to see her back if she has any further difficulties, but will follow along to see if she receives authorization for these suggestions as outlined above.

Ms. Pat Chambers, RN, CCM, Corvel Corporation, was available after examination for clarification and facilitation of care on behalf of Ms. Spencer.

She is able to work at light duty, though such apparently is not available. Her previous pain doctor, Tony Owens, M.D. at South Carolina Pain Associates in Columbia, SC, did recommend continued protective mobility, numbness and tingling of the right arm and hand. Electrical studies were to be helpful in this regard.
William L. Lehman, Jr., M.D: / as 801_1101

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)
Pat Chambers, NCM, Corvel - fax: 866-440-6782

Electronically signed by William .Lehman MD

SCANNED
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Patient Name: LETTIE B SPENCER
Date of Birth: 11/28/1947
Account: 179171-LS

Date: 09/17/2012

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 09/17/2012. She was discharged at 08:42:01 AM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Sit Down Work Only

Work Restrictions / Additional Instructions

Follow up In 3 - 4 weeks

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William .Lehman MD

SCANNED

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
10/25/2012
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 64 year old female who presents for a recheck of Back pain.

Subjective Transcription

64 year old woman presents for further follow up regarding her work related injury which occurred on 6/12/11 when functioning as an LPN at National Health Care for approximately 3-1/2 years. I had been provided with extensive records from Columbia Neurosurgical Associates, Randall Drye, M.D. who saw her once upon referral from the company physician who saw her initially after the injury. She was referred for pain management to Tony Owens, M.D. at South Carolina Pain Associates in Columbia, SC, undergoing left sacroiliac joint injection on one occasion, radiofrequency ablation on the left at L5, S1 and S2, performed November and December 2011 with no relief. She has also undergone physical therapy which offered no relief.

She was on light duty until November 2011, but then her progressive symptoms required that she be out of work and has not been able to return to work since. She was referred for my evaluation in 9/17/2011, and she apparently paid for the appointment through her attorney since I was not the approved treating physician.

I had suggested a lumbar CT myelogram, as well as pain management through Dr. Nandurkar. The CT myelogram was finally approved and performed on 9/11/2012.

She continues to be out of work and is quite depressed, and has lost a considerable amount of weight because of the pain. She continues to have left leg pain extending to the calf, only moderately relieved by Nucynta 75 mg, as well as Neurontin 300 mg tid. She is becoming progressively more debilitated and depressed.

Previous Health History Form is reviewed and updated from 9/17/12.

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Received by CorVel Corporation 10/25/2012 20:40:14 Pacific Time, 6752, Page 2 of 4

1 >> CorVel Corporation P 2/4

2012-10-25 20:40:14 6752 1

Page 000098

Objective Transcription
Ms. Spencer is alert and conversant, obviously quite depressed and very thin. Vital signs: Temperature - 98.4, Pulse - 78, Respiration - 15. General exam is otherwise unremarkable.

At the lower back, there is extreme tenderness to palpation over the lumbar paraspinal muscles with some paraspinal tension, no active spasm, kyphosis or scoliosis.

Patrick's maneuver increases pain in the back. This does appear to be consistent with SI joint pain and Faber does appear to be positive. There is very restricted motion diffusely about the lumbar spine created by pain. Bilateral hip range of motion is normal. Neurologic function to the cranial nerves is normal. Deep tendon reflexes are normal, and there is no clonus. There are no pathologic reflexes. There is decreased touch and pin prick sensation at the left lateral thigh and superior calf as compared to the opposite side. Peripheral pulses are normal. Gait is quite slow and deliberate but is reciprocal heel to toe.

~~X-RAY: Personal review of the CT myelogram of the lumbar spine, performed at Springs Hospital 9/11/12 shows a very poor study. There was considerable extra dural injection with paraspinal contrast at the L2-3 through L4-5 levels. This study is unlikely to be completely accurate. It does demonstrate, however, that there was significant but relatively mild changes of central canal stenosis at L4-5 with pathology at 9 mm diameter at the L4-5 level.~~

Assessment & Plan
Radiculitis (729.2)
Current Plans:
- REFERRAL / CONSULT (ADD COMMENTS); Routine (refer to Dr. Nandurkar for esi ? SNRB LEFT L-5 and pain management)
- Neurontin 600MG, 1 Tablet three times daily, #90, 10/25/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 10/25/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 1 month or as needed

Assessments Transcription
WORK INJURY 6/12/11 WITH ONGOING BACK PAIN AND LEFT LEG RADICULAR SYMPTOMS, PROGRESSIVE WEIGHT LOSS AND DEPRESSION.

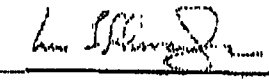
Plan Transcription
I recommended increasing Neurontin to 600 mg tid on a trial basis. I refilled Nucynta #40. Her condition appears to be deteriorating consistent and severely, to the point that I think that maybe it may be physically impossible for her to return back to her date of injury job or any suitable gainful employment. I believe it is of paramount importance to provide more effective treatment for this unfortunate woman.

I met with the case manager, Ms. Patty Chambers, RN, CCM, who thinks that Dr. Owens' rationale for the left SI joint and injection, as well as the facet blocks on the left side, may have occurred because the primary problem at that point was back pain. The leg symptoms are now seemingly more prominent, and I would recommend a trial of epidural steroid injection or selective nerve root block at the L5 level, even though the CT myelogram is not particularly useful. Pain management also appears to be appropriate.

If she does not respond to these treatments, a trial of a spinal cord dorsal column stimulator might be considered as well. I feel strongly that such referral to Dr. Nandurkar would be essential to further treatment of this unfortunate woman and does have the propensity to lessen the current level of disability. Ultimately, it is likely that there will be sufficient residual symptoms that Ms. Spencer will require alternative work activities, ideally based on MFCE.
William L. Lehman, Jr., M.D. / as 801 1950

1 >> rVal Corporation p 3/4
2012-10-30 15:
SCANNED
Received by CorVel Corporation Pacific Time, 6782, Page 3 of 4
Page 000099

cc: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)
Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133



Electronically signed by William Lehman MD

SPENCER, LETTIE

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2012-10-30 15:15
Received by CorVel Corporation [illegible] Pacific Time, 6752, Page 4 of 4
1 >> rVel Corporation p 4/4

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Patient Name: LETTIE B SPENCER
Date of Birth: 11/28/1947
Account: 179171-LS

Date: 10/25/2012

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 10/25/2012. She was discharged at 11:39:44 AM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Sit Down Work Only

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William .Lehman MD

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Procedure Order

Ordering Site

INDIAN LAND OFFICE
6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
(803) 329-3130 x 216 Delores
Fax: (803) ~~329-2611~~ 985-4580
Report Date: 10/29/2012

Patient Information

LETTIE B SPENCER
2867 GREAT FALLS HWY
RICHBURG, SC 29729
(407) 497-0358
Gender: Female Date of Birth: 11/28/1947 SSN (last 4 digits): 6627

Patient Insurance Information

PREMIER GROUP INS (866) 414-7442
Group #NONE
Plan #WC18202011021728

[redacted]

Patty Chambers
866-440-6782

Procedures Ordered

REFERRAL / CONSULT (ADD COMMENTS)
Note: refer to Dr. Nandurkar for esi ? SNRB LEFT L-5 and pain management
Diagnosis: Radiculitis (729.2)
Ordered by: William Lehman, MD

End of Procedures Ordered

Electronically signed by William Lehman MD

LETTIE B SPENCER Patient #: 179171-LS DOB: 11/28/1947 (64 years)
Monday, October 29, 2012

1 >> rVel Corporation p 1/4
Received By CorVel Corporation 10/30/2012 12:43PM Pacific Time, 6782, Page 1 of 4
2012-10-30 15:44
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MEDICAL QUESTIONNAIRE

RE: LETTIE SPENCER

1. In your opinion "most probably and to a reasonable degree of medical certainty" has Ms. Spencer developed depression and psychological overlay- as a result of her ongoing chronic pain and inability which is the direct result from her work related back injury?

X
YES

NO

2. If the above answer is yes, do you recommend Ms. Spencer seek treatment for her depression and psychological overlay with a psychiatric professional?

X
YES

NO

William Lehman, M.D

11/19/2012
Date

NOV 2 1 2012

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
11/26/2012
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 64 year old female who is in today for TEST RESULTS. Note for "TEST RESULTS": ct lumbar myelogram

Subjective Transcription

She presents for further follow up regarding work related injury to her lower back which occurred on 6/12/11 while functioning as an LPN, National Health Care, just previously being treated by Randall Drye, M.D., Columbia Neurosurgical Associates, then Tony Owens, M.D., Pain Management at South Carolina Pain Associates, Columbia, SC. She has undergone left SI joint injection as well as RF ablation on the left at L5-S1 and S2. She has been out of work since November 2011.

She has remained quite depressed and continues to lose weight to some extent, responding to some extent to Neurontin and Nucynta. A CT myelogram has been performed as of 9/11/11, which again, was a very poor study, showing some mild central stenosis L4-5 with 9 mm diameter centrally. She has responded a little bit to Neurontin, which was increased to 600 mg tid. She continues to require Nucynta. She still has mainly back pain but occasionally does have symptoms that extend into the left calf. I had recommended a left L5 selective nerve root block versus a spinal cord stimulator, but the referral has not been authorized as yet.

Previous Health History Form is reviewed and updated from 10/25/12.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are unchanged. She still has the appearance of someone who is very depressed and chronically ill. She apparently is only taking Trazodone which is mainly used for sleep. Her weight is 109 pounds. She does have radicular symptoms extending into the left calf. There is seemingly improved straight leg raise, but with continued decreased touch and pinprick sensation on the left lateral thigh and upper portion of the left calf as compared to the opposite side. Gait remains slow, deliberate, reciprocal heel to toe.

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Assessment & Plan

Low back pain (724.2)

Current Plans:

- Neurontin 600MG, 1 Tablet three times daily, #60, 11/26/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 11/26/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 6 weeks or as needed

Chronic back pain (724.5)

Current Plans:

Stenosis of lumbosacral spine (724.02)

Current Plans:

Assessments Transcription

WORK INJURY 6/12/11 WITH ONGOING BACK AND LEFT LEG RADICULAR SYMPTOMS, MILD STENOSIS L4-5 CONSISTENT WITH SYMPTOMS, SEVERE DEPRESSIVE SYMPTOMATOLOGY.

Plan Transcription

She continues to require referral to Dr. Nandurkar requiring possible L5 selective nerve root block versus bone growth stimulator. I think she needs the decompression controlled before considering any more aggressive treatment. I continued Neurontin at 600 mg tid, and if she needs something more, such as Celexa, or otherwise. I refilled Nucynta 75 mg. I will see her back in three to four weeks for further follow up hoping that something will have happened at that point to treat her ongoing difficulties. It is obvious that she can pursue only sedentary work activity and this will likely per a work capacity for an extended period of time.
William L. Lehman, Jr., M.D. / as 801_2580

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)
Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133

Electronically signed by William .Lehman MD

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CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
02/12/2013
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 65 year old female who presents for a recheck of Back pain.

Subjective Transcription

She presents for follow up regarding selective nerve root block on the left at L5 which, amazingly, helped dramatically, though the radiofrequency facet joint ablation and left SI joint injection really offered very little response to her pain syndrome. She actually had no low back pain whatsoever for about three days. She still has difficulty driving. Her weight has stabilized to 106 pounds. She has been taking Neurontin 600 mg t.i.d. with minimal side effect. She still requires pain medication.

Previous Health History Form is reviewed and updated from 1/14/13.

Objective Transcription

Ms. Spencer is alert and conversant, oriented X 3. Vital signs are unchanged. She does appear to be much more positive. She does have a tentative appointment with a psychologist in Charlotte in the near future. She has some back pain and limited mobility and still has some radicular symptoms in the left leg without evidence of neurologic deficit.

Assessment & Plan

Radiculitis (729.2)

Current Plans:

- SELECT NERVE ROOT BLOCK L5 - LEFT (64483); Routine (#2 Dr. Nandurkar)
- Neurontin 800MG, 1 Tablet three times daily, #90, 02/12/2013, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 02/12/2013, No Refill. Active.
- Restrictions are in place until follow up appointment
- Follow up in 1 month or as needed

Assessments Transcription

WORK INJURY 6/12/11 WITH BACK PAIN/LEFT LEG RADICULAR SYMPTOMS, SIGNIFICANT THOUGH TEMPORARY RESPONSE TO LEFT L5 SELECTIVE NERVE ROOT BLOCK; REACTIVE DEPRESSION WITH SEVERE WEIGHT LOSS, SOMEWHAT IMPROVED.

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Plan Transcription
I increased Neurontin to 800 mg t.i.d. and refilled Nucynta 75 mg. Another selective nerve root block left L5 seems to be appropriate. Due to her continued difficulty with driving to Columbia and back, I think that she needs to remain out of work for an additional period of time, though I feel that she does have a reasonably good prognosis for improvement. Whether this will be sufficient for her to return back to her previous work activity is unclear, and she may require Vocational Rehabilitation.

Addendum: The case manager, Ms. Patty Chambers, RN, CCM, was available after the examination to coordinate medical care as appropriate.
William L. Lehman, Jr., M.D. / as 801_4145

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)
Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133 (MAIL)

Electronically signed by William .Lehman

SCANNED

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

LETTIE B SPENCER
04/02/2013
Patient #: 179171-LS
DOB: 11/28/1947

History of Present Illness

The patient is a 65 year old female who presents for a recheck of Back pain.

Subjective Transcription

She presents for follow up regarding her work injury of 6/12/2011 with back and left leg radicular symptoms, stating that the selective nerve root block at L5 has continued to be helpful. She had her second injection recently and basically has no further leg pain, though she still has considerable back pain. She tried increasing Neurontin, but it caused weakness, nausea and a tired feeling. She has seen a psychologist in Charlotte who has confirmed that she has a major depression. No medications were recommended specifically. She still weighs about 103 pounds and has not been able to gain. She has recently seen a family physician, Dr. Bradley, because of her progressive weakness and was found to have a low blood pressure. Her blood pressure medications were diminished. An echo was negative. The stress test has been ordered because of EKG changes, and this is going to be done in the near future by Dr. Delphia.

Health History Form is on the chart and reviewed with her, including medications and allergies.

Objective Transcription

Ms. Spencer is alert and conversant, but is obviously thin and does appear to be quite debilitated. She continues to have significant back pain with limited mobility. There are no left leg radicular symptoms currently with a negative straight leg raise and no definite neurologic deficit.

Assessment & Plan

Low back pain (724.2)

Current Plans:

- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 04/02/2013, No Refill. Active.
- Restrictions - Patient has been released w/ permanent restrictions: less than sedentary work.
- Follow up as needed

Assessments Transcription

WORK INJURY 6/12/11 WITH CHRONIC BACK PAIN, RESOLVED LEFT LEG RADICULAR SYMPTOMS STATUS POST SNRB L5 ON THE LEFT X 2, NO RESPONSE TO FACET ABLATION OR LEFT SI JOINT INJECTION; CHRONIC DEPRESSION WITH SEVERE WEIGHT LOSS.

Plan Transcription
It appears that the back condition will persist over an extended period of time, though fortunately, she no longer has any leg symptoms or evidence of radiculopathy. It is obvious that Ms. Spencer is functioning at less than a sedentary level, not only to her back difficulties requiring independent recumbency, but also a chronic pain syndrome as well as major depression. She can wean herself off of Neurontin as her leg symptoms have gone away. She does require chronic pain management as well as psychiatric medications. Dr. Nandurkar would be a good resource for the chronic pain management, but she probably needs to see a psychiatrist to get her appropriate medications for her depression, though Dr. Bradley could perhaps pursue this quite adequately.

I gave her Nucynta at her request, but would prefer that the pain patch she is asking for be provided through pain management, along with the Nucynta chronically. She does have permanent restrictions in terms of function, which have been previously described and will be permanent in nature. I don't think an FCE is going to be helpful as resulting to aggravate her back pain and she is chronically functioning at a lessened sedentary level. She appears to have reached maximum medical improvement from an orthopaedic standpoint.

Referring to the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, Ms. Spencer qualifies for a Class 1 level of impairment based on stenosis present at L4-5 with resolved radiculopathy. The default level of impairment would be 7% whole person. This is equivalent to a regional lumbar spine impairment of 9%.
William L. Lehman, Jr., M.D. / as 801_5122

c: Robert Bradley, M.D., Chester Internal Medicine, One Medical Park Drive, Bldg. 1, Ste. D, Chester, SC 29706 (fax: 803-581-0827)
Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance, Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133 (MAIL)

Electronically signed by William Lehman

CAROLINA ORTHOPAEDIC SURGERY ASSOCIATES

6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
Phone: (803) 329-3130
Fax: (803) 329-2611

Patient Name: LETTIE B SPENCER
Date of Birth: 11/28/1947
Account: 179171-LS

Date: 04/02/2013

To Whom It May Concern:

LETTIE B SPENCER was treated in our office on 04/02/2013. She was discharged at 03:22:24 PM. Please excuse LETTIE for this appointment.

Work Restrictions / Additional Instructions

Restrictions - Patient has been released w/ permanent restrictions: less than sedentary work.

If unable to accommodate restrictions patient should be out of work until next scheduled appointment.

If you have further questions regarding the patient's work status you must talk with the patient and have them contact our office. Due to HIPAA regulations we are unable to verbally confirm the appointment, work note or the work status of the patient without their signed consent unless they are covered under workers compensation.

William .Lehman

SPENCER, LETTIE

8.

Springs Memorial Hospital

Lancaster, SC 29720

RADIOLOGY REPORT

NAME			SEX	ACCOUNT NUMBER
SPENCER,LETTIE F			F	D0063345 39
ORDERING PHYSICIAN		PT. STATUS	LOCATION	MEDICAL RECORD NO.
Lehman,William L. MD		REG SDC	OPS	M0005944 70
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
Lehman,William L. MD	11/28/1947	64	09/11/2012	

EXAM# TYPE/EXAM RESULT

000748584 CT/LUMBAR SPINE WITHOUT CONTRAS

CLINICAL HISTORY: Back pain.

EXAMINATION: CT of the lumbar spine, post myelogram.

REPORT:

In this patient in which access to the CSF space was obtained fluoroscopically at the L4-L5 level, the injection in part was extradural in that there is some contrast about the paraspinal soft tissues at the L4-L5, L3-L4 and L2-L3 levels. The injection also had to breech the venous system at some time given the fact that there is some minimal contrast seen within the intrarenal collecting systems.

The field-of-view visualized from the upper endplate of T11 through the lower sacrum. Preserved vertebral body heights and alignment.

Distal cord and conus are of normal size and signal, conus ends L1.

The T11-T12 level is unremarkable.

The T12-L1 level is unremarkable.

The L1-L2 level is unremarkable.

The L2-L3 level is unremarkable.

The L3-L4 level is unremarkable.

The L4-L5 level demonstrates mild central canal stenosis related to annular disc bulging and facet arthropathy, the thecal sac triangularly shaped with the AP diameter of the spinal canal in the region of maximum pathology at about 9 mm.

The L5-S1 level is unremarkable

OCT 18 2012

IMPRESSION:

Mild acquired central canal stenosis at the L4-L5 level as described.

PAGE 1 Signed Report (CONTINUED)

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Springs Memorial Hospital

Lancaster, SC 29720

RADIOLOGY REPORT

NAME			SEX	ACCOUNT NUMBER
SPENCER, LETTIE F			F	D0063345 39
ORDERING PHYSICIAN		PT. STATUS	LOCATION	MEDICAL RECORD NO.
Lehman, William L. MD		REG SDC	OPS	M000594470
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
Lehman, William L. MD	11/28/1947	64	09/11/2012	

EXAM# TYPE/EXAM RESULT

000748584 CT/LUMBAR SPINE WITHOUT CONTRAS

<Continued>

Remaining lumbar disc space levels without significant findings.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/11/2012 **
Reported By: TOMMY L. WEAVER, MD

CC: William L. Lehman MD

Technologist: JULIE H. COX, RT(R)
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/11/2012 (1320). Batch No: 1663

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You have been diagnosed and treated by a specialist in Emergency Medical Care. These discharge instructions have been prepared for you in order that you better understand your condition, and how this condition may affect you now that you have been discharged from our emergency room. Please read these instructions carefully, and do not hesitate to call us if you have any questions.

Your emergency care provider today was: ANSARI, AMIR

Referred to:

SHEALY, K. D. MD, INTERNAL MED
Phone:(803)285-7414
1025 W. MEETING ST LANCASTER, SC 29720
LANCASTER SC 29720

Follow up in 2 days

The exam and treatment you received today has been provided on an emergency basis only. This is not a substitute for complete medical care. You, not Springs Memorial Hospital, are responsible for arranging and obtaining follow-up care with a doctor or other healthcare provider, which includes making arrangements for payment. If your problem worsens or new symptoms appear and you are unable to arrange prompt follow-up care, call or return to this emergency room.

If you had EKG's or X-rays done in the Emergency Department, they will be reviewed by a specialist. If their interpretation is different from the Emergency care provider; you or your physician will be notified.

If you had cultures done, results are usually available within 48-72 hours. If the results indicate a need for re-evaluation or change in treatment, you will be notified.

General education is provided to all patients at discharge. It is important for everyone to understand that a stroke is an EMERGENCY. Every minute counts. ACT FAST. When you get home you may refer to the the copy of the Paitent Discharge Instructions that were provided to you. Signs and Symptoms of a Stroke include sudden numbness or weakness, sudden trouble seeing, sudden confusion, sudden loss of balance or coordination or sudden severe headache. Risk factors include high blood pressure,

(3)

overweight, poor diet, physical inactivity, smoking, diabetes, excesive alcohol intake, heart disease and heredity. Call 911 immediately for sudden nubness or if weakness of a extremity is noticed. Check the time so you will know when the first symptoms appeared. Medication compliance is very important. If you are prescribed a blood thinner (such as Coumadin), take it exactly as perscribed by your doctor. Do not skip or double up the dosage without talking to your doctor. When discharged on Coumadin, it is important to follow-up with your doctor within 2 weeks for lab monitoring.

ANXIETY

ANXIETY

WHAT IS ANXIETY?
Anxiety is a vague uncomfortable feeling of fear or dread.
This can cause many different physical symptoms. These include;
- Irritability - Sleeplessness (insomnia)
- Dizziness - Headache
- Chest discomfort - Trouble breathing
- Passing out - Pounding heart beat
- Stomach pain - Nausea, vomiting or diarrhea

WHAT SHOULD I KNOW AND DO FOR ANXIETY REACTION?
- Try to identify what causes you anxiety. Common causes are:
  - Daily activities--appointments, traffic, deadlines.
  - Life changes--changes in job or children.
  - Overload--a feeling of too many responsibilities or demands on your time.
  - Helplessness--problems seem to be beyond your control.
- If possible, try to eliminate the cause of your stress.
- Reduce your stress level by:
  - Getting regular exercise. Just a 15-30 minute walk each day may help.
  - Eat a balanced diet and eat regularly. Don't be rushed when eating.
  - Get enough sleep. Rest during the day when possible. A 15-30 minute rest will make a difference.
  - Use relaxation techniques such as breathing exercises.
- Find something you enjoy and set aside 30 minutes each day for that activity.
- Try to identify how you react to stress.
- Books or tapes on anxiety and anxiety relief may be helpful.
- Consider counseling to help you understand the reasons for your anxiety.

WHEN AND WHY SHOULD I FOLLOW UP WITH THE DOCTOR?
- If your symptoms are getting worse instead of better.
- If you develop chest pain or have trouble breathing.
- If you have a severe headache not relieved by rest and/or over the counter pain medicine.
- If you have repeated fainting spells.
- If you have continued vomiting. 9905>

5

DEPRESSION

DEPRESSION

WHAT IS DEPRESSION?
Depression is a feeling of continued sadness, hopelessness or loss of interest in personal matters. There are many causes for depression: loss of a loved one, loss of a job, major illness/injury, hormonal changes (after the birth of a baby). Depression can occur at any age from childhood to the late adulthood Frequently, once the cause for depression is identified and dealt with, symptoms improve. Professional counseling can assist in dealing with depression and learning how to cope with the causes.

WHAT SHOULD I KNOW AND DO FOR DEPRESSION
- Seek assistance (physician, therapist, support groups, family, church).
- Use medications only as prescribed by your doctor.
- Maintain normal daily activities even if you don't feel up to it.

WHEN AND WHY SHOULD I FOLLOW UP WITH A DOCTOR?
- If you feel overwhelmed or consider ending your life, call for help immediately.
- If you feel the symptoms of depression returning.

Your condition may benefit from home health services.
Please ask for home health assistance or information. 0103>

(5)

SYNCOPE (FAINTING)

SYNCOPE (FAINTING)

WHAT IS SYNCOPE (FAINTING)?

It is a loss of consciousness that occurs when the blood pressure is to low to provide enough blood flow to the brain. Some of the causes are strokes, heart problems, heat exhaustion, dehydration, severe pain, internal bleeding and emotional upsets.

WHAT SHOULD I DO FOR SYNCOPE?

- Know the warning signs of fainting:
  - dizziness - vision disturbance
  - nausea - turning pale
- If you have the warning signs, lie down right away and do not get up until the symptoms pass.
- The symptoms usually go away quickly once you lie down.
- You may feel tired for several hours after a fainting spell.

WHEN AND WHY SHOULD I FOLLOW UP WITH THE DOCTOR?

- If you have another fainting spell.
- If you have an irregular or very fast heartbeat at the time of the fainting spell.
- If you have a fainting spell when you are already sitting or lying down.

SEEK IMMEDIATE MEDICAL ATTENTION IF:

- If you develop a severe headache, chest pain, abdominal or back pain with a fainting spell.

Your condition may benefit from home health services.
Please ask for home health assistance or information. 0103>

(5)

Height: 5ft. 2in.	Weight: 46.36 kg	Source:	☐ Pregnant ☐ Breastfeeding
Allergies:	penicillin-		

Note: If the ellipsis (...) is seen at the end of the list, please refer to the patient record for additional items

ADMISSION / DISCHARGE

Source ☐Patient ☐Nursing Home ☐Previous Admission ☐H&P
☐Copied from Patient's Labeled Meds ☐Patient's Pharmacy: _____
☐Other: _____ (name) ☐Patient Provided & Verified Medication List
Personal Meds: ☐Sent to Pharmacy ☐Sent home with _____ (name)

If Personal Meds Stored in Pharmacy, Obtained and Sent Home With ☐Patient or ☐Other: _____ (name)

Medication Name Dosage / Frequency / Route Patient Is Knowledgeable About Home Meds: ☐Yes ☐No	Indication For Use	Date/Time Last Taken U=Unknown T=Today Or Record Date	Continue In Hospital	Continue At Discharge	Next Dose Due At:
Aldactone 25 milligram(s) once a day oral			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
Klonopin 0.5 milligram(s) HS oral			☐ Yes ☐ No _____ (time) First Dose: @	☑ Yes ☐ No	
Norvasc 5 milligram(s) once a day oral			☐ Yes ☐ No _____ (time) First Dose: @	☑ Yes ☐ No	
Nucynta 75 milligram(s) every 6 hours oral			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
Potassium Chloride 20 milliequivalent(s) once a day oral			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
Tapazole 5 milligram(s) HS oral			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
traZODONE 50 milligram(s) once a day (at bedoral			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	
			☐ Yes ☐ No _____ (time) First Dose: @	☐ Yes ☐ No	

List New Medications to be Taken

Hospital Pharmacy Order: Compare Pre-Admission Medications with Formulary Medications. Formulary medications that are identical in form and content may be dispensed for the pre-admission medications continued in the hospital, EXCEPT, do NOT dispense substitutions for the following medications: _____

Vaccination Decision (Risk Assessment completed on admission)

☐Pneumococcal vaccine	☐Indicated	☐Not Indicated	☐Administer vaccine per protocol
☐Influenza vaccine	☐Indicated	☐Not Indicated	☐Administer vaccine per protocol

ADMISSION RECONCILIATION	DISCHARGE RECONCILIATION
Date/Time ☐ READ BACK of a: ○ Telephone ○ Verbal Order	Date/Time ☐ READ BACK of a: ○ Telephone ○ Verbal Order
Physician Name/Nurse Signature & Title	Physician Name/Nurse Signature & Title
Date/Time/Ordering Physician Signature:	Date/Time/Ordering Physician Signature:
Transcribed: Date/Time/Signature/Title:	Transcribed: Date/Time/Signature/Title:
Noted: Date/Time/Admission Nurse/Title/Initials:	Noted: Date/Time/Admission Nurse/Title/Initials:

Medication Reconciliation
Springs Memorial Hospital

NAME: SPENCER, LETTIE F DOB: 11/28/1947 AGE: 65
MR#: M000594470 PT#: D006388302 DATE IN: 6/4/2013
EDP: ANSARI, AMIR PCP: SHEALY, K. D. MD
Referral Physician SHEALY, K. D. MD

WC FAST TRACK PROCEDURE VISIT

Place of Service: Lancaster Office.
Date of Service: 01/28/2013
Referring Physician: William Lehman, MD

Ref: Ms. Lettie Spencer: Chart #: SPELE000: DOB: 11/28/1947

SUBJECTIVE:

Ms. Lettie Spencer is a 65 year old female who presents to The Piedmont Interventional Spine & Pain Center for fast track lumbar epidural injection for her work related chronic low back and left leg pain symptoms. Her pain is located in the lower back. The pain started about 2 year(s) ago after work related injury in 6/2011, and since it began the pain intensity has worsened over the last 5 month(s). Today her pain is constant with variable intensity and described as 7 out of 10 and sharp. The pain is radiating to left back of the calf. Her pain is associated with tingling in her left leg and on top of foot left. Her pain is worse while sitting and standing for a prolonged period of time. Her pain is better with rest. She denies any saddle numbness, severe weakness, fever, or extreme pain.

She states that the pain started as a result of work related injury at NHC on 06/12/2011 as a LPN. She states she was pushing a medicine cart that caught on the carpet and between slick tile where she fell. She has been out of work since November 2011. She was seen at in Columbia by neurosurgeon and pain doctor. She was treated by Dr. Owens at South Carolina Pain Associates, Columbia, SC in 2011 where she had SI joint left injections and RFA injection procedure which she states did not help. The patient states she has had extensive PT in the past which did not help the patient. She also tried the back brace and TENS unit which did not help it actually made her pain worse. The Patient indicates her pain is worse in the evening and Her pain does awaken her from sleep. She usually gets 6 hr(s) of uninterrupted sleep a night. lately her pain is getting worse and not able to do the things that she used to do before and she is getting depression. She also lost the appetite nad lost some weight. She says WC is working on that she can get mental health help. Recently she was seen by Dr. Lehman for her pain symptoms. He ordered CT myelogram and recommended left L5 SNRB. Her case manager is here with her.

The Patient denies any allergy to latex, local anesthetics, or kenalog. She denies any bleeding disorder and is not taking any blood thinning medications.

Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work retrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History:
Active:

- Aldactone (active)
- Klonopin (active)
- Neurontin (active)
- Norvasc (active)
- Nucynta 75 mg Tab (active)
- potassium acetate (active)
- Tapazole (active)
- Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

Spencer, Lettie 01/28/13 - SPELE000

Sanjay Nandurkar MD

Past Surgical History: She admits past surgical history of neck surgery, hysterectomy.
Family History: She admits a family history of hypertension associated with mother (deceased). heart disease associated with father (deceased).
Social History: She denies tobacco use, alcohol use, illegal drug use.
LMP: She is s/p hysterectomy.
Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breadth, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: BP Sitting: 115/68 HR: 72 5 ft. 2.000 in. Weight: 105 lbs. BMI: 19
Gen Appearance: Alert, oriented, appropriate, well appearing, not in distress. **Psych:** Judgement & insight intact. Looks depressed. **Skin:** No rashes/erythema noted. **HEENT:** Conjunctiva is pink, sclera is non icteric. **Lungs:** Breathing non-labored. **Heart:** No clubbing, cynosis, or edema. **Abdomen:** Abdomen non-distended. **Extremities:** No deformities, edema. Appears warm and well perfused. **Musculoskeletal:** Large joint ROM within functional limits w/o deformity. Thoracic Spine: No midline tenderness or deformity..

Lower back exam : Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy. EXCEPT there is some numbness over leg and foot along left L5 distribution.

Trigger Points: Palpation reveals no trigger point(s).

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

PRE PROCEDURE ASSESSMENT:

1. 724.4 = Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain and extensive PT including brace and TENS unit but not much help. Intely her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram and he recommended Left L5 SNRB. Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight.

INFORMED CONSENT: I have discussed the benefits, alternatives Rxs and possible risks but not limited to sepsis, hemorrhage, pain, and failure to achieve the stated goals of the procedure were all discussed, on 01/28/2013 at 10:36 AM. The Lettie Spencer expressed understanding and is agreeable to

Spencer, Lottie 01/28/13 - SPELE000

Sanjay Nandurkar MD

proceeding as planned. She denies any fever, chills, weakness or bleeding diathesis and use of blood thinners. Lottie denies allergy to IVP dye, betadine, latex, local anesthetics and steroids. An appropriate consent form was signed, indicating, Lottie Spencer understands the procedure and its possible complications, risks, and alternatives.

PROCEDURE:

Name of the patient: Lottie Spencer
Procedure: Lumbar Transforaminal Steroid Injection.
IV Started: NO.
Sedation: NO.

Lottie Spencer was transferred to the block room and placed in a prone position on table with a pillow at appropriate position. After placement of EKG and pulse ox monitors, appropriate area was prepped and draped in sterile fashion and procedure was performed in the usual manner.

Level: Left L5-S1.
Fluoroscopy Guidance Used: YES for guidance and localization of spinal needle.

Technique:

A oblique paraspinous approach was used with C arm fluoroscopy guidance. The injection site was infiltrated with 10 cc of 1% lidocaine mixed with sodium bicarbonate using a 1.5 inch, 25 gauge needle. A # 25 gauge spinal 3.5 inch needle was introduced under fluoroscopy guidance. The entry into the epidural space was confirmed with epidurogram after injecting 2 cc of water-soluble, nonionic contrast. A total solution containing 3 cc of PF 1% Lidocaine and Kenalog 60 mg was injected. The intravascular/intrathecal flow was not observed on injection.

Lottie tolerated the procedure well. Needle site was dressed with bacitracin ointment and sterile Band-Aid. She was taken to the post-block recovery area for further observation.

I was present during the entire procedure.

POST PROCEDURE ASSESSMENT: .
Post procedure Diagnosis: Same as above.
Post procedure pain level: 0 on a scale of 0-10. She denies any pain immediately following injection.

Purposeful response to verbal or tactile stimulation: YES

PLAN:

I have discussed the findings and pathophysiology of above diagnosis including prognosis and various treatment options including pain interventional procedures, medications, physical therapy, Psychotherapy, Spinal Cord stimulator and activity modification. She understands and agrees for the plan as below. Dr Lehman has also discussed these with her. Seems she is not a surgical candidate at present.

- Ms. Lottie Spencer has a scheduled follow up appointment with Dr. Lehman.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and no refill prescription given today. Continue klonopin, neurontin nad nyeynta.
- Advised to remain active within limit of pain.
- She was advised regarding importance of proper spine posturing, daily ROM/Ex, better sleeping habits,

stress control and relaxation techniques.
- She will benefit from psychological eval for her reactive depression.
- IF she continues to have significant pain and if she is not a surgical candiate she will be candidate for dorsal column stimulator trial for her chronic back and leg pain.
- Above plan discussed with her case manager.

FOLLOW UP: She has a follow up appointment with Dr. Lehman.

Lettie was discharged home in stable condition with driver. Post procedure instructions reviewed with patient.

PCP: Robert Bradley, MD

_____ Sanjay Nandurkar, MD

Updated on 01/28/2013 By: _____ Sanjay Nandurkar, MD

Updated on 01/28/2013 By: _____ Sanjay Nandurkar, MD

PROCEDURE NOTE

Place of Service: Lancaster Office.
Date of Service: 03/14/2013
Referring Physician: William Lehman, MD

Ref: Ms. Lettie Spencer: **Chart #:** SPELE000: **DOB:** 11/28/1947

SUBJECTIVE:

Lettie Spencer is a 65 year old female who presents to Piedmont Interventional Spine & Pain Center for a transforaminal epidural steroid injection. This is her 2nd injection of this series. Previous TF ESI helped her and pain relief is more than 80 % for 5 weeks. She states she is NPO and has a driver for return home.

Pain is located in left lower back. The pain is radiating to left leg to the calf. The pain is associated with tingling in the left leg and top of the left foot. The pain is throbbing and described as intermittent. The pain intensity ranges form 5 to 10 on scale of 0-10 and current pain intensity is 7. She denies any saddle numbness, severe weakness, or fever. The Patient denies any allergy to latex, dye, local anesthetics, or steroids. She denies any bleeding disorder and is not taking any blood thinning medications. The patient is still currently not working as this pain is a work related accident.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History: No change in meds from 01/31/2013
Past Medical History: Cardiovascular Hx: (+) hypertension. **Endocrine Hx:** (+) hyperthyroidism.
LMP: She is s/p hysterectomy.
Review of Systems: No change in review of systems.

I have reviewed the chart notes and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

PHYSICAL EXAMINATION:

Vitals: BP Sitting: 167/79 HR: 67
Constitutional: Alert, oriented, cooperative and appropriate.**CVS:** No clubbing, cynosis or edema.**RS:** Breathing non labored..
Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is milkdly positive. Left SI joint provocation tests are positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.
Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy. EXCEPT there is some numbness oover leg and foot along left L5 distribution.
CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

INFORMED CONSENT: I have disoussed the risks, benefits, alternatives of the procedure with the patient on 03/14/2013 at 11:42 AM. There are no contraindications to the procedure. Lettie Spencer expressed understanding and is agreeable to procedure and gave a written consent. She denies any fever,

chills, weakness, bleeding disorder, or use of blood thinners. She also denies allergy to IVP dye, latex, local anesthetics, and local steroids.

PROCEDURE:

Name of the patient: Lettie Spencer
Procedure: Lumbar Transforamial Steroid Injection.
IV Started: NO.
Sedation: NO.

Lettie Spencer was transferred to the block room and placed in prone position on the table with a pillow at the appropriate position. After placement of EKG and pulse ox monitors, the appropriate area was prepped and draped in sterile fashion and the procedure was performed in the usual manner.

Level: Left L5-S1.
Fluoroscopy Guidance Used: YES for guidance and localization of spinal needle.

Technique:

A oblique paraspinous approach was used with C arm fluoroscopy guidance. The injection site was infiltrated with 5 cc of 1% lidocaine mixed with sodium bicarbonate with a 1.5 inch 25 gauge needle. A # 25 gauge spinal 3.5 inch needle was introduced under fluoroscopy guidance. The entry into the epidural space was confirmed with epidurogram after injecting 2 cc of water-soluble, nonionic contrast. A total solution containing 3 cc of PF 1% Lidocaine and Kenalog 60 mg was injected. The intravascular/intrathecal flow was not observed on injection.

Lettie tolerated the procedure well. Needle site was dressed with bacitracin ointment and sterile Band-Aid. She was taken to the post-block recovery area for further observation.

I was present during the entire procedure.

ASSESSMENT:

Pre Procedure Diagnosis:
1. 724.4 =Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Post Procedure Diagnosis: Same

Pre Procedure Pain Level: As Above
Post Procedure Pain Level: 1 on a scale of 0-10.

Purposeful response to verbal or tactile stimulation: YES

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight.

She is s/p SNRB with good pain relief for 4-5 weeks.

(S)

Spencer, Lettie 03/14/13 - SPELE000 Sanjay Nandurkar MD

PLAN:

- Ms. Lettie Spencer will follow up with Dr.Lehman.
- If she continues to have pain and if she is not a surgical candidate one can consider SCS trial for her continued radicualr pain.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and no refill prescription given today
- Advised to remain active within limit of pain.

FOLLOW UP: She should follow up with Dr.Lehman.

Lettie was discharged home in stable condition with driver. Post procedure instructions reviewed with patient.

PCP: Robert Bradley, MD

_____ Sanjay Nandurkar, MD

FOLLOW UP VISIT

Place of Service: Lancaster Office.
Date of Service: 05/13/2013

Ref: Ms. Lettie Spencer: Chart #: SPELE000: DOB: 11/28/1947

SUBJECTIVE:

Ms. Lettie Spencer is a 65 year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation after procedure for her back pain symptoms. Her WC MCM is here with her today, Patty Chambers. She has seen Dr. Lehman since she was here last and he has released her. Today her pain is located in the lower back. She is s/p TFESI. The procedure helped her pain and/or function and is still helping. Her leg pain is still much better about 30%. Still continues to have lower back pain. Dr Lehman said he can not do anything more and recommonded pain maagement. The pain is radiating to back of leg to below the knee. Numbness is little better. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever, or extreme pain. Since the last visit, Lettie states her pain symptoms are better with pain medications. Dr. Lehman was writing her Nucynta 75mg #40. She says she takes about 2-3 a day. She has been out about 1 week now. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does not have medication bottles for review today.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History:

Active:

- Aldactone (active)
- Klonopin (active)
- Norvasc (active)
- Nucynta 75 mg Tab (active)
- potassium acetate (active)
- Tapazole (active)
- Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hypothyroidism.
Opioid Contract: NO.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breadth, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.
Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities,edema, or calf tenderness.Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting.

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.
Neurological: Neurological examination of the both lower extremities are normal with symmetrical sensation over all lumbosacral dermatomes, normal motor strength 5/5 in all muscle groups and symmetrical reflexes. She exhibits a negative SLR, negative Babinski's sign and there is no ankle clonus. Gait is age appropriate with good tone and no evidence of pathological muscle atrophy.Numbness is better than before.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 =Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA adn SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen pshyologist in Charlotte once but no follow up. She is not a surgical candidate.

She is s/p SNRB x 2 with good pain relief.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and will refill her Nucynta.
- She is not taking neurontin anymore as her leg pain is better.
- Advised to remain active within limit of pain.
- Will evaluate her for chronic opioid therapy at next visit. SOAPP/ORT and contract..
- Needs follos up with her psychologist for her reactive depression.
- Continue home exercise.
- Diff Rx options discussed including SCS trial. But before she needs follow up with her psychologist.

FOLLOW UP: She should return to the office for follow up OV in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:
Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Total Daily Dose QS: 3 Dispense: 60 Refills: 0 Allow Generic: Yes

Sanjay Nandurkar, MD

Sanjay Nandurkar MD
Interventional Spine Specialist

Piedmont Interventional Spine & Pain Center
Relieving Pain, Restoring Function

834 W Meeting St, Ste A
Lancaster SC 29720
Ph: (803) 289-PAIN
Fax: (803) 283-1522

Letter of Medical Necessity LumboSacral Orthosis – LSO (631)

Patient: Lettie Spencer Chart # SPELE000 Date 6/10/13 DC # ____

DURABLE MEDICAL EQUIPMENT: Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated.

HCPCS CODE: L0631 ✓ WL (small)

BILLING CODE: 1620

DIAGNOSIS:
- ☑ Low back pain (724.2)
- ☑ Muscle spasm (728.85)
- ☐ Sciatica (724.3)
- ☑ Radicular syndrome (724.4)
- ☐ Spondylolisthesis, congenital (738.4)
- ☐ Lumbar sprain/strain (847.2)
- ☐ Lumbar disc syndrome (722.73)
- ☐ Lumbar IVD degen. (722.52)
- ☐ Lumbosacral sprain/strain (846.0)
- ☐ Other (Include ICD-9 code) ____

ONSET OF DIAGNOSIS: ____

INDICATIONS AND EXPECTED BENEFITS (check those appropriate)
- ☐ Relaxation of muscle spasm
- ☐ Muscle re-education
- ☐ Reduce exacerbations of disc injury
- ☑ Improve overall clinical picture
- ☑ Significantly reduce pain
- ☐ Symptomatic relief and management of chronic pain
- ☐ Adjunctive treatment of post-traumatic acute pain
- ☑ Increase stabilization of spine/SI joint
- ☐ Increase the stability of the spondylolisthesis
- ☐ Significantly increase mobility without pain
- ☐ Other: ____

DURATION OF NEED: ☐ More than 3 months ☐ More than 6 months ☐ Up to 12-months ☑ Lifetime

Utilizing accepted standards of medical practice, the above-prescribed durable medical equipment is essential in the continuous treatment of this patient.

Medical Provider: NANDURKAR

Signature ____ Date 6/10/13

SCANNED

FOLLOW UP VISIT

Piedmont Interventional
Spine & Pain Center
834 W. Meeting St., Ste. A
Lancaster, SC 29720

Place of Service: Lancaster Office.
Date of Service: 06/10/2013

Ref: Ms. Lettie Spencer: Chart #: SPELE000: DOB: 11/28/1947

SUBJECTIVE:

Ms. Lettie Spencer is a 65 year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation and medicalton refill for her back pain symptoms. Today her pain is located in the lower back. The pain is radiating to back of leg above the knee. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever,or extreme pain. She states she saw Dr. W Brain OMalley in Charlotte who suggested Functional rehab program in Charlotte, she does not want to do this as she doesn't want to be away from her family. She talks to case maange and would consider going to Columbia if necessary, Since the last visit, Lettie states her pain symptoms are little better with pain medications. She is prescribed medications through the PISPC. She is not having any difficulty with her medications and they are effective without any side effects. Current plan of management is helping her to control pain and improve daily function. She does not have medication bottles for review today.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT.
Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work retrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History:

Active:

- Aldactone (active)
- Klonopin (active)
- Norvasc (active)
- Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)
- potassium acetate (active)
- Tapazole (active)
- Trazodone (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breadth, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.
Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities,edema, or calf tenderness.Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting..

Spencer, Lettie 06/10/13 - SPELE000 Sanjay Nandurkar MD

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 =Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen pshyologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate. She is s/p SNRB x 2 with good pain relief for some time. She still has leg and back pain. Injection did not helped much of her lower back pain.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and refill prescription given today
- Advised to remain active within limit of pain.
- SOAPP/ORT Score and Opioid Contract signed today.
- She has not decided for functional rehab at Charlotte at present.
- will order back brace- (small) for her. She tried back brace that helped her to support back and significant reduction in back pain in office.
- If she continues to have have significant pain after rehab will consider SCS trial for chronic back and leg pain. Provided she has clearance from psychologist.
- will give her SCS video.
- Discussed with patient and case manager.

FOLLOW UP: She should return to the office for follow up OV in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:
Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 60 Refills: xx Allow Generic: Yes

EXHIBIT 5

Spencer, Lettie 06/10/13 - SPELE000 Sanjay Nandurkar MD

_____ Sanjay Nandurkar, MD

Piedmont Interven.Spine Ctr.

Patient Face Sheet

6/20/2013

Patient Chart #: SPELE000
Patient Name: Lettie B. Spencer
Street 1: 2867 Great Falls Hwy
Street 2:
City: Richburg, SC 29729
Phone: (407)497-0358

D.O.B: 11/28/1947
Sex: Female
SSN: 259746627
Mar Status:
S.O.F:
Assigned Provider: Sanjay G. Nandurkar

Age: 65

Employer Name:
Street 1:
City:
Phone:

Case Information

Case Desc: LAN 06/10/2013
Last Visit: 6/10/2013
Referral: William L. Lehman MD
Guarantor Name: Lettie B. Spencer
Street 1: 2867 Great Falls Hwy
City: Richburg, SC 29729
Phone: (407)497-0358
SSN: 259746627

Diagnosis 1: 724.4
Diagnosis 2: 721.3
Diagnosis 3: 722.52
Diagnosis 4:

Ins Co #: FRE00
Insurance 1: Premier Group Insurance
Street 1: PO Box 1122
Street 2:
City: Murfreesboro, TN 37133
Phone:
Ins-Start:
End:

Insured 1 Name: Lettie B. Spencer
Street 1: 2867 Great Falls Hwy
Street 2:
Phone: (407)497-0358
D.O.B.: 11/28/1947
Policy Number:
Group Number:

Sex: Female

Ins Co #:
Insurance 2:
Street 1:
Street 2:
City:
Phone:
Ins-Start:
End:

Insured 2 Name:
Street 1:
Street 2:
City:
Phone:
D.O.B.:
Policy Number:
Group Number:

Sex:

Ins Co #:
Insurance 3:
Street 1:
Street 2:
City:
Phone:
Ins-Start:
End:

Insured 3 Name:
Street 1:
Street 2:
City:
Phone:
D.O.B.:
Policy Number:
Group Number:

Sex:

SCANNED

FOLLOW UP VISIT

Place of Service: Lancaster Office.
Date of Service: 07/11/2013

Ref: Ms. Lottie Spencer: Chart #: SPELE000: DOB: 11/28/1947

SUBJECTIVE:

Ms. Lottie Spencer is a 65 year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation for her back pain symptoms. She watched SCS video and thinks this could help her and she would like to try this. She has not rcvd her back brace yet. Today her pain is located in the lower back. The pain is radiating to back of left leg. The pain is constant with variable intensity, dull and current intensity is 7 on a scale of 0-10. She denies any severe weakness, fever,or extreme pain. Since the last visit, Lottie states her pain symptoms are the same. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does have medication bottles for review today.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT.
Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work restrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History:

Active:

- Aldactone (active)
- Klonopin (active)
- Norvasc (active)
- Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)
- potassium acetate (active)
- Tapazole (active)
- Trazodone (active)
- vibryd (active)

Past Medical History: **Cardiovascular Hx:** (+) hypertension. **Endocrine Hx:** (+) hyperthyroidism.
Opioid Contract: YES.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breadth, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs,
Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. Psych: Patient judgment and insight is good. Skin: No rashes/erythema noted. Extremities: Appears normal without any deformities,edema, or calf tenderness.Musculoskeletal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting..

SCANNED

Spencer, Lettie 07/11/13 - SPELE000

Sanjay Nandurkar MD

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 =Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.
3. 338.4 = Chronic Pain Syndrome.

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psyhologist in Charlotte once and he recommonded for inhouse rehab. She is not a surgical candidate.She is s/p SNRB x 2 with good pain relief for some time. She still has leg and back pain.

- Ms. Lettie Spencer will be scheduled in 4 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and no refill prescripiton given today
- Advised to remain active within limit of pain.
- SOAPP/ORT Score and Opioid Contract signed today.
- Her back brace is approved per her case manage who is present here. Back Brace given
- Will recommond SCS trail for her pain control. Before that will order psych eval for pre trial psych eval.
- SCS trial discussed in detail.

FOLLOW UP: She should return to the office for follow up OV in 4 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

SCANNED

Spencer, Lettie 07/11/13 - SPELE000

Sanjay Nandurkar MD

Prescriptions:
Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 75 Refills: XXX Allow
Generic: Yes

_____ Sanjay Nandurkar, MD

Updated on 07/11/2013 By: _____ Sanjay Nandurkar, MD

Updated on 07/11/2013 By: _____ Sanjay Nandurkar, MD

SCANNED

FOLLOW UP VISIT

Place of Service: Lancaster Office.
Date of Service: 08/08/2013

Ref: Ms. Lettie Spencer: Chart #: SPELE000: DOB: 11/28/1947

SUBJECTIVE:

Ms. Lettie Spencer is a 65 year old female who presents to Piedmont Interventional Spine & Pain Center for follow-up evaluation for her back pain symptoms. Today her pain is located in the lower back. The pain is radiating to back of leg. The pain is constant with variable intensity, dull and current intensity is 7-8 on a scale of 0-10. She denies any severe weakness, fever,or extreme pain. Since the last visit, Lettie states her pain symptoms are better with pain medications. Her back brace is helping her pain, esp. when riding in a car. She is not prescribed medications through the PISPC. Current plan of management is helping her to control pain and improve daily function. She does have medication bottles for review today. She has been approved for comprehensive rehab in Charlotte.
Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work retrictions: Sit down work only and no driving.

She filled SOAPP/ORT questionnaire on 06/10/2013 and score is 3/1. She is low risk for COT.
Occupational History: She is working as LPN at National Health Care. She has been out of work since November 2011. Dr. Lehman has her under work retrictions: Sit down work only and no driving.

Allergies: She admits allergies to demerol resulting in rash, penicillin resulting in rash.
Medication History:

Active:

- Trazodone (active)
- Norvasc (active)
- Tapazole (active)
- Klonopin (active)
- potassium acetate (active)
- Aldactone (active)
- vibryd (active)
- Nucynta 75 mg Tab (One by mouth every 8-12 hours) (active)

Past Medical History: Cardiovascular Hx: (+) hypertension. Endocrine Hx: (+) hyperthyroidism.
Opioid Contract: YES.

I have reviewed the chart notes, and I am aware of the family/social history. Since the last evaluation her medical history has not changed.

Review of Systems: Denies any fever, vertigo, dizziness, ear symptoms, chest pain, bilat leg edema, shortness of breadth, abdominal pain, hematuria, face swelling, blood in stool, seizures, bleeding problems, heat/cold intolerance, or suicidal ideation. Admits back pain.

PHYSICAL EXAMINATION:

Vitals: Afebrile and Stable Vital signs.
Constitutional: Patient appears alert, appropriate, cooperative, pleasant, in no apparent distress. **Psych:** Patient judgment and insight is good. **Skin:** No rashes/erythema noted. **Extremities:** Appears normal

without any deformities,edema, or calf tenderness.Musculoskelstal: Musculoskeletal exam of major joints reveals functional range of motion, no abnormal muscle tone and no obvious wasting..

Back exam: Lower back exam reveals tenderness over left L4/5 and L5/S1 lumbar midline and lumbar paraspinal muscle area and tenderness over left SI joint area. There is significant restriction of lumbar ROM with extension and flexion. Left SLR test is mildly positive. Left SI joint provocation tests are mildly positive.. She is able to stand tiptoe & on heel. Waddell signs are positive 0/5.

Neurological: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes.

Trigger Point: Palpation reveals no trigger points.

CT scan lumbar spine report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis.

ASSESSMENT/PLAN:

1. 724.4 =Radicular Syndrome, Lower limbs (Lumb/Thor).
2. 722.52 = Degenerative Lumbar Disc Disease and 721.3 = Lumbar Spondylosis.
3. 338.4 = Chronic Pain Syndrome.

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psyhyologist in Charlotte once and he recommended for inhouse rehab. She is not a surgical candidate.

She has been approved for comprehensive rehab at charlotte.

- Ms. Lettie Spencer will be scheduled in 8 week(s) for office visit.
- Patient assessed for efficacy of current medication regimen, Continue current medication(s) and refill prescription given today
- Advised to remain active within limit of pain.
- Will see her after rehab program.

FOLLOW UP: She should return to the office for follow up OV in 8 week(s) or sooner if the condition worsens, changes, and/or if any concerns.

Prescriptions:
Nucynta Dosage: 75 mg Tab Sig: One by mouth every 8-12 hours Dispense: 75 Refills: XXX Allow Generic: Yes

Spencer, Lottie 08/08/13 - SPELE000 Sanjay Nandurkar MD

Sanjay Nandurkar, MD

Progress Notes

Patient: Spencer, Lettie B
DOB: 11/28/1947 **Age:** 65 Y **Sex:** Female
Phone: 805-581-2919
Address: 2867 Great Falls Hwy, Richburg, SC-29729

Provider: Sanjay G Nandurkar, MD
Date: 10/10/2013

Subjective:

CC:
1. Back pain.

HPI:
Pain Management:
Pain located over lower back. The pain intensity has remained same since last visit. The pain quality is described as dull , aching . The severity of the pain is 3/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS , lying down . Patient does not c/o sever weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, TENS unit, back brace.
She has finished chronic pain rehab center at Charlotte. And she is doing overall better. She is also using TENS units every day. She is feeling less depressed and able to manage her pain with medications and TENS.
Medication Follow Up:
Patient is prescribed medications through the PISPC. Patient is not having difficulty with medications. The medications are effective without any side effects. Patient states not getting pain medications from other physicians.Daily function is better with pain medications. No abberant pain behaviour noted. Driving is not affected. She does not have bottles review. Dr. Carlton at Rehab center prescribed last and this months prescription for Nucynta.

ROS:
*:
Patient c/o back pain.
Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.
Opiod Management:
Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.
Psychology:
Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Medical History: Hyperthyroidism, Hypertension.

Family History:

Social History:
Tobacco Use: Tobacco Use/Smoking Are you a current smoker.
Social History: Social Hx: alcohol use(Denies) illegal drug use(Denies) tobacco use(Denies) .

Medications: Viibryd , Nucynta 75 mg Tab One by mouth every 8-12 hours , Tapazole 100 mg HS , Klonopin 1 mg HS , trazodone , Norvasc , Aldactone , Potassium Acetate , Medication List reviewed and reconciled with the patient

Allergies: Penicillin: rash: Allergy, Demerol: rash: Allergy, Codeine Phosphate.

Objective:

Vitals: HR 68 /min, BP 154/89 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index.

Examination:
Exam:
GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive

function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT conjuctivie is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lwoer back and left SI joint area. SLR is mildly positive., NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes. .

Diagnostic Results: :

* MRI Lumbar Spine: ..

Assessment:

Assessment:

1. Thoracic or lumbosacral neuritis or radiculitis, unspecified - 724.4 (Primary)
2. Degeneration of lumbar or lumbosacral intervertebral disc - 722.52
3. Chronic pain syndrome - 338.4

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen pshyologist in Charlotte once and he recommonded for inhouse rehab. She is not a surgical candidate.

She has finished rehab program at Charlotte and doing overall better. Her strength is better, posture is better. She is feeeling less depressed. Using TENS unit. She thinks her pain is managable with pain meds and TENS unit..

Plan:

1. Chronic pain syndrome

\# She do not need pain meds today.

Immunizations:

Therapeutic Injections:

Labs:

Preventive:

\# long term prognosis discussed.

Follow Up: 4/8 weeks (Reason: Med Refill)

Provider: Sanjay G Nandurkar, MD

Patient: Spencer, Lettie B **DOB:** 11/28/1947 **Date:** 10/10/2013

Piedmont Interventional Spine & Pain Center
Relieving Pain, Restoring Function

Spencer, Lettie B

66 Y old Female, DOB: 11/28/1947
2867 Great Falls Hwy, Richburg, SC-29729
Home: 803-581-2919
Guarantor: Spencer, Lettie B Insurance: Premier Group
Ins Payer ID: PAPER
Referring: William L Lehman, MD
Appointment Facility: Piedmont Interventional Spine Pain

12/09/2013 Progress Notes: Sanjay G Nandurkar, MD

Current Medications
Nucynta 75 MG Tablet 1 tablet 2-3 times day
Vibryd
Tapazole 100 mg HS
Klonopin 1 mg HS
trazodone
Norvasc
Aldactone
Potassium Acetate
Medication List reviewed and reconciled with the patient

Past Medical History
Hyperthyroidism
Hypertension

Surgical History
hysterectomy
neck surgery

Social History
Tobacco Use:
Tobacco Use/Smoking Are you a current smoker, How often do you smoke cigarettes? every day, How many cigarettes a day do you smoke? 6-10, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, Are you interested in quitting? Not ready to quit.
Social History:
Social Hx: alcohol use(Denies) illegal drug use(Denies) tobacco use(Denies) .

Allergies
Penicillin: rash: Allergy
Demerol: rash: Allergy
Codeine Phosphate

Review of Systems
S
Patient c/o back pain.
Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.
Opiod Management:

Reason for Appointment
1. Back pain

History of Present Illness
Pain Management::
Pain located over lower back. The pain intensity has worsened since last visit. She state this is due to her having a cold, when she coughs it makes her pain worse. The pain quality is described as dull . The severity of the pain is 5/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS , lying down . Patient does not c/o sever weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit, she states it is not helping as much as it was before.
She thinks she is more depressed when pain is worse. Her TENS units is not working properly. One side does not work.
Medication Management::
Patient is prescribed medications through the PISPC: Yes. Patient is not having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes.

Vital Signs
HR 83 /min, BP 144/80 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index, Pain scale 6 1-10.

Examination
Exam::
GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT conjuctivia is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lwoer back and left SI joint area. SLR is mildly positive..
NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes. .

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis. .

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a 65 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psyhyologist in Charlotte once and he recommended for inhouse rehab; She is not a surgical candidate.
She has finished rehab program at Charlotte and doing overall better. Her strength is better, posture is better. She is feeeling less depressed. Using TENS unit.
She thinks her pain is getting worse gradually as TENS unit is not working properly.

Treatment

1. Chronic pain syndrome

she needs new TENS unit so all 4 pads are working.
we have discussed SCS trial per her request but will wait till her TENS unit is fixed and see how she si doing.

2. Others

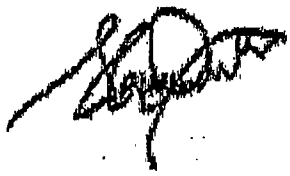
Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours, 30 days, 90, Refills 0
Start Gabapentin Capsule, 300 MG, 1 capsule, Orally, Three times a day, 30 day(s), 90, Refills 1
Will increase her nucynta to 3 times a day.

Preventive Medicine

remain active within limit of pain. Adv to continue home stretching exercise,, # Narcotic precautions discussed, # long term prognosis and diff Rx options discussed. Patient understands., # Chronic pain syndrome and depression discussed. Need for mental health support discussed.

Follow Up

2 Months (Reason: Follow Up)



Electronically signed by Sanjay Nandurkar , MD on 02/07/2014 at 02:06 PM EST

Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 297206851
Tel: 803-289-7246
Fax: 803-285-1622

Patient: Spencer, Lottie B DOB: 11/28/1947 Progress Note: Sanjay G Nandurkar, MD 12/09/2013

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

Piedmont Interventional Spine & Pain Center
Relieving Pain, Restoring Function

Spencer, Lettie B
66 Y old Female, DOB: 11/28/1947
2867 Great Falls Hwy, Richburg, SC-29729
Home: 803-581-2919
Guarantor: Spencer, Lettie B Insurance: Premier Group
Ins Payer ID: PAPER
Referring: William L Lehrman, MD
Appointment Facility: Piedmont Interventional Spine Pain

02/06/2014

Sanjay G Nandurkar, MD

Current Medications
Vibryd
Trazonic 100 mg HS
Klonopin 1 mg HS
trazodone
Norvasc
Aldactone
Potassium Acetate
Gabapentin 300 MG Capsule 1 capsule Three times a day
Nucynta 75 MG Tablet 1 tablet every 8 hours
Medication List reviewed and reconciled with the patient

Past Medical History
Hyperthyroidism
Hypertension

Surgical History
hysterectomy
neck surgery

Allergies
Penicillin: rash: Allergy
Demerol: rash: Allergy
Codeine Phosphate

Review of Systems
S:
Patient c/o back pain.
Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.
Opiod Management:
Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.
Psychology:
Patient denies stressors, substance

Reason for Appointment
1. Back pain

History of Present Illness
Pain Management::
Pain located over lower back. The pain intensity has remained the same. The pain quality is described as aching , stabbing , squeezing . The severity of the pain is 6/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at the end of the day. The pain is aggravated by standing. The pain is better with TENS , lying down . Patient does not c/o sever weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit. She is wearing that today.

She thinks she is more depressed when pain is worse. Her TENS units is working properly. She says her lawyer is trying to close her WC case. - SN.

Medication Management::
Patient is prescribed medications through the PISPC: Yes. Patient is not having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: Yes, Pill count is consistant.
Opioid Monitoring::
* SOAPP/ORT Questionnaire Score: 3/1., Mild risk for COT, Opioid Contract: Yes, PDQ Score: 02/24/2014 No change form initial visit. Today 115/150. (severe disability).

Vital Signs
HR 94 /min, BP 130/67 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index, Pain scale 6 1-10.

Examination
Exam::
GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT conjuctivia is pink. LUNGS: no

abuse, suicidal thoughts, depressed mood.

wheezing, breathing non-labored. LOWER BACK: Tenderness over left lwoer back and left SI joint area. SLR is mildly positive., paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT. Lum extension is almost 0.. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes..

Diagnostic Results::

* MRI Lumbar Spine: report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis..

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a 66 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate.

She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

1. Chronic pain syndrome

will add zanaflex for her muscle spasms.

2. Others

Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours(valid 2-6-14), 30 days, 90, Refills 0.0

Refill Gabapentin Capsule, 300 MG, 1 capsule, Orally, Three times a day, 30 day(s), 90, Refills 5

Start Zanaflex Capsule, 4 MG, 1 capsule as needed, Orally, 2-3 times day, 30 days, 90, Refills 1

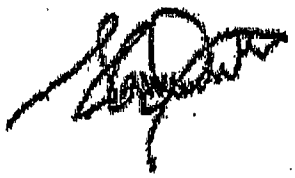
Preventive Medicine

remain active within limit of pain. Adv to continue home stretching exercise,, # Narcotic precautions discussed, # long term prognosis and diff Rx options discussed. Patient understands., # Continue home exercise as shown and discussed.

She has reached MMI as far as pain symptoms are concerned. and will do impairment rating for her.

Follow Up

4/8 weeks (Reason: Follow Up)



Electronically signed by Sanjay Nandurkar , MD on 02/26/2014 at 05:27 AM EST

Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 29720625
Tel: 803-289-7246
Fax: 803-285-1522

Patient: Spencer, Lettie B DOB: 11/28/1947 Progress Note: Sanjay G Nandurkar, MD 02/06/2014

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

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

Physician's Statement

Claimant's Name: Letitia Spencer
Physician's Name: Sanjay Nandurkar, M.D.
Practice/Clinic: Piedmont Interventional Spine & Pain Care
Preparer's Name:
Phone: (___) ___ - ____

Employer's Name: National Health Care
Insurance Carrier: Premier Group Insurance
SCWCC File No: 1120778

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

Date of Injury or Illness: June 22

Date of first office visit: 1/28/13 Date of last visit: 2/6/14

Diagnosis or nature of injury or illness: Lumbar DDD, lumbar radiculopathy, chronic pain s

Body part(s) injured: lowback Body part(s) affected: left leg (radiculopathy)

Date of **Maximum Medical Improvement:** 2/6/14

Based on the **AMA Guidelines**, the claimant has sustained a ____% **medical impairment** to ____ injured body part(s) and a 12 % **medical impairment** to lower back other affected body part(s).

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

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

✓ The claimant is **unable to return to work** at his or her current employment.
less than sedentary capacity

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

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

✓ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:
pain management, periodic spinal injection, medications, physical therapy, spinal cord stimulator

Treating Physician 2/9/14 **Date**

9/07

Piedmont Interventional Spine & Pain Center

Spencer, Lettie B

66 Y old Female, DOB: 11/28/1947
2867 Great Falls Hwy, Richburg, SC-29729
Home: 803-581-2919
Guarantor: Spencer, Lettie B Insurance: Premier Group
Ins Payer ID: PAPER
Referring: William L Lehman, MD
Appointment Facility: Piedmont Interventional Spine Pain

04/08/2014

Progress Note: Sanjay G Nandurkar, MD

Current Medications
Viibryd
Tapazole 100 mg HS
Klonopin 1 mg HS
trazodone
Norvasc
Aldactone
Potassium Acetate
Gabapentin 300 MG Capsule 1 capsule Three times a day
Zanaflex 4 MG Capsule 1 capsule as needed q-8 times day
Nucynta 75 MG Tablet 1 tablet every 8 hours

Past Medical History
Hyperthyroidism
Hypertension

Allergies
Penicillin: rash: Allergy
Demerol: rash: Allergy
Codeine Phosphate

Review of Systems
:
Patient c/o back pain.
Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.
Opiod Management:
Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.
Psychology:
Patient denies stressors, substance abuse, suicidal thoughts, depressed mood.

Reason for Appointment
1. Back pain

History of Present Illness
Pain Management::
Pain located over lower back. The pain intensity has remained the same. The pain quality is described as aching , stabbing , squeezing . The severity of the pain is 6/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at night. The pain is aggravated by standing. The pain is better with TENS , lying down . Patient does not c/o sever weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit. She is wearing that today.
-ahm She thinks she is more depressed when pain is worse. Her TENS units is working properly. She says her lawyer is trying to close her WC case.
Medication Management::
Patient is prescribed medications through the PISPC: **Yes.** Patient is not having difficulty with medications: **No.** The medications are effective without any side effects. **Yes.** Pt denies getting pain meds from other sources: **Yes.** ADLs are improved with medications: **Yes.** Aberrant behaviour noted: **No.** Driving ability is affected: **No.** Medication bottle is available: **Yes, Pill count is consistant, Patient has taken narcotic pain meds on 4/8/14, Patient is taking her/his pain meds daily .**
Opioid Monitoring::
* SOAPP- R Questionnaire Score: 3/1., Mild risk for COT, Opioid Contract: Yes, PDQ Score: 02/24/2014 No change form initial visit. Today 115/150. (severe disability).

Vital Signs
HR 67 /min, BP 130/55 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index, Pain scale 6 1-10.

Examination
Exam::
GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no

ROA 289

rashes/erythema noted. HEENT conjuctivia is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lwoer back and left SI joint area. SLR is mildly positive., paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT. Lum extension is almost o.. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes. .
Diagnostic Results::
* MRI Lumbar Spine: report dated 09/12/2012 reviewed. Impression: L4-5 DDD/facet arthritis with mild canal stenosis. , InHouse UDS: 04/08/2014 Positive for -, BZO, TCA, Negative for-, OXY, OPI/MOR, THC, COC, MET, AMP, MDMA, BAR, MTD, PCP. This was sent to the lab for confirmation.

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3
5. Drug Monitoring Encounter - V58.83

Ms. Lettie Spencer is a 66 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate.
She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

1. Drug Monitoring Encounter
LAB: * Urine Screen IH

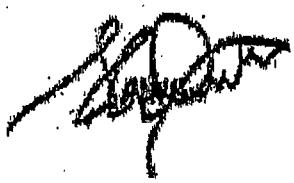
2. Others
Refill Zanaflex Capsule, 4 MG, 1 capsule as needed, Orally, 2-3 times day, 30 days, 90, Refills 1
Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours (valid 4/9/14), 30 days, 90, Refills 0.0

Preventive Medicine

remain active within limit of pain. Adv to continue home stretching exercise,, # Narcotic precautions discussed. # Remain active within limit of pain., # long term prognosis and diff Rx options discussed. Patient understands.

Follow Up

4/8 weeks (Reason: Follow Up)



Electronically signed by Sanjay Nandurkar , MD on 04/08/2014 at 12:26 PM EDT

Sign off status: Completed

Piedmont Interventional Spine Pain
834 West Meeting Street Ste A
Lancaster, SC 297206251
Tel: 803-289-7246
Fax: 803-285-1522

Patient: Spencer, Lettie B DOB: 11/28/1947 Progress Note: Sanjay G Nandurkar, MD 04/08/2014

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

Piedmont Interventional Spine & Pain Center
"Relieving Pain, Restoring Function"

Spencer, Lettie B
66 Y old Female, DOB: 11/28/1947
Account Number: 10356
2867 Great Falls Hwy, Richburg, SC-29729
Home: 803-581-2919
Guarantor: Spencer, Lettie B Insurance: Premier Group
Ins Payer ID: PAPER
Referring: William L Lehman, MD
Appointment Facility: Piedmont Interventional Spine Pain

06/05/2014

Sanjay G Nandurkar, MD

Current Medications

Taking Viibryd
Taking Taparole 100 mg HS
Taking Klonopin 1 mg HS
Taking trazodone
Taking Norvasc
Taking Aldactone
Taking Potassium Acetate
Taking Gabapentin 300 MG Capsule 1 capsule Three times a day
Taking Zanaflex 4 MG Capsule 1 capsule as needed 2-3 times day
Taking Nucynta 75 MG Tablet 1 tablet every 8 hours (valid 5/9/14)
Medication List reviewed and reconciled with the patient

Past Medical History

Hyperthyroidism
Hypertension

Allergies

Penicillin: rash: Allergy
Demerol: rash: Allergy
Codeine Phosphate

Review of Systems

:

Patient c/o back pain.

Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, night sweats, sleep disturbance, weight change, weight loss.

Opiod Management:

Patient denies breathing difficulty, sedation/sleepy feeling, itching, constipation, nausea/vomiting, hallucination/weird dreams, blurred vision, peripheral edema, use of recreational drugs. Patient admits functional pain relief.

Psychology:

Patient denies stressors, substance

Reason for Appointment

1. WC Back pain

History of Present Illness

Pain Management::

Pain located over lower back. The pain intensity has gradually worsened since last visit. She has now some bladder isuues and her pain is getting worse. She is seeing Dr Magura for that.. The pain quality is described as aching , stabbing , squeezing . The severity of the pain is 7/10 average. Pain is constant. The pain is radiating left calf. The pain is associated with weakness in left leg, muscle spasms, muscle cramps. The pain is worse at night. The pain is aggravated by standing. The pain is better with TENS , lying down . Patient does not c/o sever weakness, extreme pain, fever. Current management includes: Nucynta and membrane stabilizers, home exercise program, back brace, TENS unit.

-jm.

Medication Management::

Patient is prescribed medications through the PISPC: Yes. Patient is having difficulty with medications: No. The medications are effective without any side effects. Yes. Pt denies getting pain meds from other sources: Yes. ADLs are improved with medications: Yes. Aberrant behaviour noted: No. Driving ability is affected: No. Medication bottle is available: **Yes Last UDS is consistent done on: 4/8/14.**

Opioid Monitoring::

* SOAPP- R Questionnaire Score: 3/1., Mild risk for COT, Opioid Contract: Yes.

Vital Signs

HR 70 /min, BP 80/62 mm Hg, Ht 62 in, Wt 107 lbs, BMI 19.57 Index.

Examination

Exam::

GENERAL APPEARANCE: alert, pleasant, well nourished, in no acute distress. PSYCH: cognitive function intact, cooperative with exam, good eye contact, judgement and insight good. SKIN: no rashes/erythema noted. HEENT conjuctivia is pink. LUNGS: no wheezing, breathing non-labored. LOWER BACK: Tenderness over left lwoer back and left SI joint area. SLR is mildly positive., paraspinal muscle spasm on the LEFT, paraspinal muscle spasm on the RIGHT.

abuse, suicidal thoughts, depressed mood.

Lum extension is almost 0.. NEUROLOGIC: Quick neuro exam reveals muscle strength is functional with normal muscle tone. Sensation grossly intact and symmetrical in all dermatomes..

Diagnostic Results:

* MRI Lumbar Spine: report dated 09/12/2012 reviewed.
Impression: L4-5 DDD/facet arthritis with mild canal stenosis..

Assessments

1. lumbosacral Radiculopathy - 724.4 (Primary)
2. Lumbar DDD/Bulge - 722.52
3. Chronic pain syndrome - 338.4
4. Lumbosacral spondylosis - 721.3

Ms. Lettie Spencer is a 66 year old female with work related injury on 06/12/2011 has worsening lower back and left leg pain. Seen by neurosurgeon and pain doctor in 2011 in Columbia and has injections for mostly left side axial low back pain (RFA and SI joint) and extensive PT including brace and TENS unit but not much help. lately her pain is radiating to left leg with some numbness. Seen by Dr Lehman, had CT myelogram Her continued pain is affecting her daily life and she has developed reactive depression and lost some weight. She has seen psychologist in Charlotte once and he recommended for in house rehab. She is not a surgical candidate.
She has finished rehab program at Charlotte and doing overall better. She is feeling less depressed. Using TENS unit.

Treatment

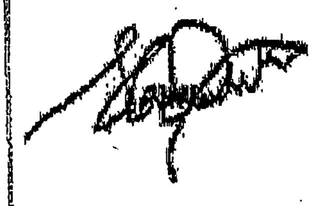
1. Chronic pain syndrome
Refill Nucynta Tablet, 75 MG, 1 tablet, Orally, every 8 hours (valid 6/10/14), 30 days, 90, Refills 00
Refill Zanaflex Tablet, 4 MG, 1 tablet as needed, Orally, 3 times a day, 30 days, 90 Tablet, Refills 1

Preventive Medicine

*Counseling: *Fall Risk Screening Fall Risk Assessment: No falls in the past year. *Smoking: Patient counselled on the dangers of tobacco use and urged to quit. 06/05/2014. *Social: alcohol and drugs: # Narcotic precautions discussed., exercise: Discussed the benefits of regular back stretching and exercise. *Communication to patient: Chronic Pain # Narcotic precautions discussed. # Remain active within limit of pain., # long term prognosis and diff Rx options discussed. Patient understands..

Follow Up

4/8 weeks (Reason: Med Refill)



Electronically signed by Sanjay Nandurkar , MD on 06/05/2014 at 11:34 AM EDT

Sign off status: Completed

Piedmont Interventional Spine Pain
834 W MEETING ST
LANCASTER, SC 29720-6220
Tel: 803-289-7246
Fax 803-285-1522

Patient: Spencer, Lettie B DOB: 11/28/1947 Progress Note: Sanjay G Nandurkar, MD 06/05/2014

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

INITIAL PSYCHOLOGICAL EVALUATION

PATIENT: Lettie Spencer
CHART #: 12615
DATE: 3-7-2013

This 65-year-old woman was seen for a psychological evaluation and recommendations regarding treatment. She reported promptly for her appointment and remained cooperative throughout. Her affect was dulled, her mood depressed. She was fully oriented.

Medical records were reviewed at the completion of Ms. Spencer's psychological evaluation. These included office notes from Carolina Occupational Healthcare, neurosurgical evaluation by Richard Dyer, M.D., progress notes by Tony Owens, M.D., physical therapy notes from Select Physical Therapy, office records from William Lehman, M.D., and a deposition of Dr. Lehman.

HISTORY:

Ms. Spencer reports that her present difficulties began secondary to an industrial injury which occurred on June 22, 2011, while employed by NHC. Ms. Spencer indicates that she was injured while pushing a medication cart, when the wheels became caught on a strip on the floor. As she pushed to free the cart, she experienced the immediate onset of low back and left leg pain. Ms. Spencer was seen at Carolina Occupational Healthcare by Dr. Thomas Motyka. She was diagnosed with a lumbar strain and possible radiculopathy. She was provided medication and referred to physical therapy. When her symptoms persisted, an MRI was obtained, which revealed mild degenerative disc disease of the lumbar spine, most prominent at L4-5. Ms. Spencer was referred to Randall G. Drye, M.D., for neurosurgical evaluation. Dr. Drye saw Ms. Spencer on 8-31-2011. Dr. Drye reviewed Ms. Spencer's MRI. He indicated that Ms. Spencer was not a candidate for neurosurgical intervention. Dr. Drye recommended additional physical therapy and pain management. Ms. Spencer was seen for pain management by Tony Owens, M.D. Dr. Owens provided a left sacroiliac joint injection, which provided transient relief. Dr. Owens then performed lateral branch radiofrequency ablation, which did not provide significant relief. Medication management was initiated. Ms. Spencer was referred for orthopedic evaluation to William Lehman, M.D. Dr. Lehman recommended a selective nerve root block, which resulted in improvement of Ms. Spencer's left leg pain. Dr. Lehman also recommended that Ms. Spencer undergo a lumbar CT myelogram and pain management through Dr. Nandurkar. He also noted that Ms. Spencer had become depressed and had lost a considerable amount of weight because of pain. The CT myelogram showed mild stenosis at L4-5. Dr. Lehman believed that Ms. Spencer would benefit from repeat selective nerve root blocks.

At the present time, Ms. Spencer complains of left low back and leg pain. She also reports significant weight loss and depression. Ms. Spencer describes her pain as constant, although she notes that her left leg pain has improved with the selective nerve root blocks. Her pain is increased by walking, standing, sitting and riding in the car. Her pain is decreased by staying in the bed and curling into a fetal position. Present medications include Nucynta 75 mg b.i.d.,

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trazodone 100 mg h.s., Klonopin 0.5 mg h.s., Norvasc 10 mg (discontinued) and Neurontin 800 mg t.i.d. Ms. Spencer indicates that she had unsuccessful trials of OxyContin and Cymbalta, which were discontinued due to side effects. Ms. Spencer described her pain on a scale from 0 to 10 as 8 today, with an average pain of 8 and a range of 0-10. She noted that her pain is often a 0 when she wakes up and increases during the first two hours of the day.

SOCIAL:

Ms. Spencer is married and lives with her husband of seven years. She has two children, ages 47 and 49. At the time of her injury, she was employed as a nurse on the dementia unit of NHC, which is a long-term care center. She had worked in this capacity for 13 years at the time of her injury. She expressed interest in returning to work as soon as she is able to do so.

Ms. Spencer reports profound limitation of her function. She estimates she is capable of 1-2 hours of productive activity per day. She estimates that she is in bed for 18 or more hours a day. She is capable of 15-20 minutes of sustained activity. She is able to walk around her home and do light housekeeping. Educationally, Ms. Spencer completed a GED and training to obtain her LPN. She has 30 years' experience in nursing.

EMOTIONAL/COGNITIVE:

Ms. Spencer describes herself as depressed secondary to her chronic pain and associated dysfunction. She indicates that she is no longer active. She struggles with persistent, severe pain. She can no longer do many of the things that she once enjoyed. She has experienced a loss of interest and has become apathetic. She has become increasingly isolated and withdrawn.

Ms. Spencer denied suicidal ideation. She did comment that she has frequently thought that it may be better if she were no longer living. She denied previous psychiatric history or family history of psychiatric illness. She denied increased irritability. Ms. Spencer experiences an episodic sleep disorder involving early and middle insomnia. She receives an average of six hours' sleep per night. Her appetite is decreased. She has lost 35 lbs since her injury. She now weighs 102 lbs. Ms. Spencer indicates that her husband has been variably supportive. She does note that her son stays with her to provide support.

Ms. Spencer complained of the moderate diminution of short-term memory and concentration. She is using compensatory strategies. She attributed her diminished cognitive function to her degree of dysfunction. No specific deficits in cognitive function were noted during the course of today's evaluation.

With regard to substance use, Ms. Spencer drinks one cup of coffee per day. She does not use alcohol. She smokes one-half package of cigarettes per day. She has smoked for 40 years and indicates that she has no interest in quitting.

Ms. Spencer was asked about her goals and expectations for treatment. She indicated she would like to achieve the following:

1. Be less depressed.
2. Improve her motivation.
3. Increase her function and activity.
4. Be less isolated.

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IMPRESSIONS AND RECOMMENDATIONS:

Ms. Spencer is suffering from a major depressive disorder and a pain disorder associated with psychological factors and general medical condition secondary to her industrial injury of 6-22-2011. Thus far, Ms. Spencer's chronic low back and leg pain has been unresponsive to physical therapy, medication management and interventional pain management. With the exception of a recent selective nerve root block, Ms. Spencer's pain has been refractory to treatment thus far. Ms. Spencer has demonstrated a pattern of progressive dysfunction, with her now spending 18-20 hours a day in bed. This has further contributed to a decline in her overall physical status and a worsening of her depression.

At this juncture, Ms. Spencer would benefit from a course of psychotherapy to assist her in reducing her depression and developing more effective strategies for management of her chronic pain. Given the degree of decline in Ms. Spencer's overall function, she will likely require a more comprehensive pain rehabilitation program to achieve substantive improvement in her overall level of function, allowing her to return to gainful employment.

In response to Mr. McCants' inquiries, Ms. Spencer's current depression is the direct consequence of her low back pain associated with her industrial injury of 6-22-2011. Ms. Spencer has not reached maximum medical improvement from a psychological perspective. Whether Ms. Spencer has sustained permanent impairment psychologically will depend upon her response to treatment. Treatment recommendations were mentioned above. At this juncture, I do not believe that Ms. Spencer would be successful in returning to work, given her depression and degree of physical decline.

A conference was held following today's evaluation with Ms. Spencer and Patti Chambers, R.N., Ms. Spencer's medical case manager. Diagnostic impressions and treatment recommendations were discussed.

Thank you for the opportunity to evaluate this pleasant woman. If I can be of further assistance in her care, please do not hesitate to contact me.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh

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2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 6-3-2013

Ms. Spencer was seen in psychological follow-up today. She reports little change in her status since her last visit. Ms. Spencer was scheduled for today's appointment to discuss treatment options. At the time of her independent psychological evaluation, it was suggested that Ms. Spencer would benefit from participation in a pain rehabilitation program. Dr. Nandurkar, Ms. Spencer's pain management specialist, concurred with this recommendation.

Ms. Spencer indicates she was able to drive to today's appointment, but did so with difficulty. She describes her pain as 9 today on a scale from 0 to 10, with an average pain of 8. She continues to spend most of her time at home. She estimates she is active for 2-3 hours per day. Present medications include Nucynta 75 mg b.i.d., trazodone 100 mg h.s., Klonopin 0.1 mg h.s., Norvasc 5 mg q.d. and Neurontin, recently discontinued secondary to positive response from recent nerve root blocks.

The pain rehabilitation program was discussed at length with Ms. Spencer today. The relevance of the program for her, given her ongoing pain and limited function, was emphasized. Ms. Spencer does not believe that she would be able to tolerate the pain rehabilitation program at this time. She indicated that she believed that with prescription of antidepressant medication by her primary care physician, she could gradually improve her overall level of function. Ms. Spencer was encouraged to discuss potential referral for psychological counseling with her primary physician, as well.

Ms. Spencer continues to require a multifaceted approach to her pain, dysfunction and depression. I continue to believe that the most efficient form of treatment for her would be participation in a rehabilitation-focused pain management program. She was encouraged to discuss this option with Dr. Nandurkar and her primary care physician. Ms. Spencer may be more receptive to additional rehabilitation once her depression is under better control.

Thank you for the opportunity to participate in Ms. Spencer's care. If I can be of further assistance, please do not hesitate to contact me.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh

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INITIAL PHYSICAL THERAPY EVALUATION

PATIENT: Lettie Spencer
CHART#: 12615
DATE: 8-16-2013
DOB: 11-28-1947

SUBJECTIVE:

Patient reports that on June 22, 2011, she was pushing a medication cart while working, and the wheels became caught on a strip on the floor. She states she did not fall but felt a pain in her back. She reports constant lumbar pain that worsens throughout the day. She states that she has mainly left lumbar pain and left lower extremity pain, which she says radiates. She states that the longer she is up, the worse the pain gets. She denies having any paresthesias, but she states that she does have weakness in both lower extremities. She states the pain increases when riding in a car and that she has lost 35 lbs since the injury. She reports that her pain is increased when she stands for 30 minutes or more or sits for 30 minutes or more, and her pain is decreased when she lies on her side with a pillow between her knees or uses pain medication. She reports that nerve blocks have helped with her left lower extremity pain and that she occasionally uses a TENS unit to help with pain. Pain level currently is 7/10. At its worst it is a 10/10 and at its best a 7/10. She reports the pain delays her ability to fall asleep and interrupts her sleep at night, occasionally, but that she gets 6-8 hours of sleep per night.

Prior Functional Level: She worked as an LPN at NHC Parklane in the dementia care unit. She reports working 40 or more hours per week. She states that she has worked there for 13 years at regular duty. Her premorbid avocational interests included gardening, watching movies and going to historical places.

Current Functional Level: She reports that she is sometimes in the bed for 18 or more hours per day. She states that she lives in a one-level home with three steps to enter, that her grandson helps her and that she her son and her grandson live with her. She states her grandson mows the lawn, vacuums, shampoos the carpet, and helps with cooking, dishwashing and bathing her dogs. She states that she is married, but her husband is a long-distance truck driver and is at the home infrequently.

Patient's Goals: Her goals include wanting to return to work.

PAST MEDICAL/PAST SURGICAL HISTORY:

1. Lumbar strain, 6-22-2011.
2. Lumbar spondylosis with L4-L5 disc protrusion.
3. Depression.
4. Hypertension.
5. Hyperthyroidism.

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OBJECTIVE:

Observation: The patient is a right-hand dominant female who presents with a lumbar-flexed posture. She frequently changes positions throughout the evaluation, including getting down into a crouching position on one knee on the floor. She is wearing a TLSO. She requires increasing time to complete any transitional movements.

Active Range of Motion:

Lumbar:	Flexion	40% with pain
	Extension	40% with pain
	Right lateral flexion	50% with pain
	Left lateral flexion	40% with pain

Strength:

Lumbar:	Flexion	4-/5
	Extension	3+/5 with pain
	Right lateral flexion	3+/5 with pain
	Left lateral flexion	3+/5 with pain

Reflexes: 2+ and symmetrical in bilateral patellar tendons.

Palpation: Patient has severely decreased muscular extensibility with palpation of paraspinals L2-L3, L3-L4, L4-L5 and L5-S1. Patient has guarding with attempts to perform any palpation and reports moderate tenderness. Sensation is intact to light touch in lumbar region and bilateral lower extremities.

Balance: Single-limb stance on the right is 6 seconds and on the left is 5 seconds. She is unable to heel- and toe-walk any distances without loss of balance.

Special Testing: SLR testing presents with hamstring tightness in bilateral lower extremities.

ASSESSMENT:

Patient is a right-hand-dominant female who sustained a work-related injury. She is a good candidate for the functional restoration program. She presents with the following deficits:

- Increased pain
- Decreased endurance
- Decreased lumbar active range of motion
- Decreased lumbar strength
- Decreased lower extremity strength
- Postural abnormality
- Poor body mechanics
- Balance abnormality
- Decreased positional tolerances
- Gait abnormality

GOALS (To Be Met in 20 Days):

1. Patient to report a reduction in verbal and physical indicators of pain.
2. Patient to complete 30 minutes of aerobic activity without breaks for improved endurance and ease with daily activities.

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3. Patient to perform activities to increase lumbar active range of motion to within functional limits for improved mobility with lifting, carrying and pushing/pulling 10 lbs or more.
4. Patient to perform activities to increase lumbar strength to within functional limits for improved stability with reaching, carrying and pushing/pulling 10 lbs or more.
5. Patient to perform activities to increase bilateral lower extremity strength to within functional limits for improved stability with ambulation, balance and transitional movements.
6. Patient to perform activities to increase core strength, to include proper transversus abdominus activation, for improved stability with reaching, carrying and pushing/pulling 10 lbs or more.
7. Patient to maintain neutral spine positioning and demonstrate proper body mechanics with lifting, carrying and pushing/pulling daily activities and transitional movements.
8. Patient to demonstrate improved positional tolerances: sitting for 60 minutes, standing for 30 minutes and walking for 20-30 minutes.
9. Patient to ambulate community distances over even/uneven surfaces without VCs for proper gait pattern and normal cadence.
10. Patient to perform dynamic standing balance activities without loss of balance for safety with navigation over even/uneven and inclining/declining surfaces.
11. Patient to be independent with her home exercise program and flare-up management program.

PLAN:

Patient to begin the 20-day functional restoration program, with emphasis on return to independence with daily functional activities and gainful employment, utilizing the goals as listed above.

Electronically Signed by:

Dee Payne, P.T., M.S.

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INITIAL PHYSICAL MEDICINE AND REHABILITATION EVALUATION

PATIENT: Lettie Spencer
CHART #: 12615
DATE: 8-16-2013

HISTORY OF PRESENT ILLNESS:

Ms. Spencer is a 65-year-old right-handed female referred for a physical therapy and pain management evaluation. She says her problem started on June 22, 2011, when she was pushing a med cart. She said that it got stuck, and when she had to push a little harder, she felt a sharp pain in her back. She says she has been out of work now for almost two years. She says the pain has persisted. She describes her pain as throbbing, and she rates it a 6. The pain is in her lower back in the midportion. Occasionally, she gets a sharp, shooting pain down her left buttock and thigh. This is usually brief, but it does occur on a daily basis. She says the left leg feels weak. It does not feel numb. She denies any bowel or bladder incontinence. She says that standing or sitting for long periods of time, 30 minutes or more, makes it worse. She says it feels better for her to bend forward. She says she developed depression after her injury due to her pain and dysfunction. She said she never had depression before. She denies any thoughts of suicide, but she says she is often tearful. She says she has tried numerous injections and procedures, and only one of them helped, but it was temporary and only lasted about three days. She says the pain gets worse as the day progresses. She says that riding in a car makes it worse. She says the pain is severe, and it comes and goes. She says she does not normally change the way she washes or dresses herself, even though it causes some pain. She said she can lift only very light weights. She says pain prevents her from walking long distances. She says pain prevents her from sitting for more than an hour. She says pain prevents her from standing for more than half an hour. She says she gets pain in bed, but it does not prevent her from sleeping well. She says pain prevents her from participating in more energetic activities. She said she can perform most of her job and homemaking duties, but pain prevents her from performing more physically stressful activities.

REVIEW OF MEDICAL RECORDS:

Extensive records are included, and these are reviewed. A cover letter to Dr. O'Malley is reviewed from Attorney McCants. Dr. O'Malley's psychological evaluation is reviewed. He saw her on 3-7-2013 and noted she was suffering from a major depressive disorder and a pain disorder associated with psychological factors and a general medical condition secondary to her industrial injury. He recommended psychotherapy. He also felt she would require a more comprehensive pain rehabilitation program. He felt that her depression was a direct consequence of her low back pain. A deposition of William Lehman, M.D., is reviewed from January 9, 2013. His treatment of Ms. Spencer was discussed. Her imaging studies were reviewed. Work restrictions were reviewed. Dr. Lehman recommended an epidural steroid injection. They also discussed a spinal cord stimulator in the deposition. Dr. Lehman did not feel that she was a surgical candidate. The spinal cord stimulator implant was discussed. Dr. Lehman also noted that Ms. Spencer was depressed. It was noted that Dr. Dyer did not feel that she was a surgical candidate. Dr. Lehman also said that he felt Ms. Spencer was capable of performing sit-down work only. It was hoped that if she could get back to some type of work, it would help her both

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physically and emotionally. Dr. Lehman did think she would have some permanent impairment. He discussed a possible rating of 5-8% of the whole person. Dr. Lehman did feel that the accident aggravated her degenerative conditions or cause her back pain or radicular symptoms. He also felt that the chronic pain at least contributed to her depression. He felt that it would be beneficial for her to be evaluated by a psychiatric professional to treat her depression. A CT myelogram report dated 9-11-2012 is reviewed. The L4-5 level was noted to show mild central canal stenosis related to annular disc bulging and facet arthropathy, with an AP diameter of the spinal canal of 9 mm at the area of maximum pathology. Notes are reviewed from Springs Memorial Hospital, where the myelogram was performed. Notes are reviewed from Dr. Lehman. She was given Nucynta for pain. He reviewed her work restrictions. He recommended a nerve block. He gave her a trial of Neurontin. It was noted that she had lost a lot of weight. Her Neurontin was increased. A trial of a spinal cord dorsal column stimulator was discussed, as well. Physical therapy notes are reviewed. Notes are reviewed from Dr. Owens with South Carolina Pain Associates. She tried OxyContin. She tried hydrocodone. She had a sacroiliac joint injection, but it was noted that the benefit was short-lived. Notes are reviewed from Dr. Drye, who saw her on 8-31-2011. He is with Columbia Neurosurgical Associates. He noted that her spine appeared very intact and relatively healthy and appeared younger than her stated age. He felt that she had a severe lumbar strain. He did not feel that she was a surgical candidate. He recommended physical therapy. An MRI on 7-22-2011 showed mild degenerative disc disease of the lumbar spine, most prominent at L4-5. There was a broad-based disc bulge at L4-5. It was noted that there was a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing, left greater than right. She had some hypertrophic facet change and ligamentum flavum thickening. A TENS unit was recommended. Notes are reviewed from Carolina Occupational Healthcare. She tried tramadol. She had physical therapy. She was referred to orthopedics. She also tried cyclobenzaprine. She also tried a steroid taper. I also reviewed cover letters and notes from Dr. O'Malley.

CURRENT MEDICATIONS: Nucynta 75 mg every 8 hours p.r.n. pain, usually 2-3 per day; she says this is helpful. She is on potassium 20 mEq per day, Norvasc 5 mg q.a.m., Aldactone 25 mg q.a.m., Viibryd 40 mg once a day, which she says she has been on for two months and has been helpful, trazodone 100 mg at bedtime, Tapazole 10 mg q.h.s. and Klonopin 1 mg at bedtime.

ALLERGIES: Penicillin, codeine and Demerol.

PAST MEDICAL HISTORY: She reports a history of bronchitis and hypertension and a history of a hiatal hernia. She also has a history of hyperparathyroidism.

SOCIAL HISTORY: She lives in Richburg, South Carolina with her spouse, her son and her grandson. She worked as a nurse. She does not drink alcohol. She denies the use of illegal drugs. She denies any history of alcohol abuse or substance abuse. She reports an eighth grade education but says she has a GED. She smokes half a pack of cigarettes per day.

FAMILY HISTORY: Positive for cancer in her brother and stroke in her mother. Her mother and father had heart disease.

REVIEW OF SYSTEMS: Negative for exertional chest pains or palpitations. She said she had some changes in her heartbeat and underwent a cardiac evaluation, but it was negative and she does not have any cardiac restrictions. She reports that she lost about 30 lbs but has recently gained about 7 lbs. She attributes it to a loss of appetite after her injury.

PHYSICAL EXAMINATION

This is a pleasant lady with a very flat affect. Her weight is 107 lbs. Her blood pressure is 130/88. Her heart has a regular rate and rhythm. Her lungs are clear. There are no carotid bruits. She has good cervical range of motion. She sits with a markedly forward flexed posture. At times, she is

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bent over so far that her spine is parallel to the ground. She is able to extend to neutral while seated and while standing. She has mild lumbar tenderness in the paraspinals, more on the left than on the right, but is not tender over the spine. There is no SI tenderness. Straight leg raising is negative for radicular pain. Patrick's test slightly increases her pain. Her reflexes are 2+ and symmetrical. Her sensation is intact to light touch, pinprick, vibration and temperature. Her strength tests 5/5 throughout. Her gait is slightly slow and mildly antalgic. There is slight guarding with her movements. Her respirations are normal. Her speech is fluent.

IMPRESSION:

1. Lumbar strain, 6-22-2011.
2. Lumbar spondylosis with L4-5 disc protrusion.
3. Depression.
4. History of hypertension.
5. Hyperthyroidism.

PLAN:

I discussed Ms. Spencer's case with Dee Payne, P.T., and Brian O'Malley, Ph.D. We then held a conference with Ms. Spencer and her case manager, Patti Chambers, R.N. We recommended a comprehensive pain rehabilitation program. We reviewed with her realistic expectations and goals. The emphasis will be on functional restoration and appropriate pain management strategies. We also talked about the role that depression can play in chronic pain. She is going to continue to get her medications from her treating physician. She was told to call if she has any further questions or concerns.

Electronically Signed by:

T. Kern Carlton, M.D., F.A.A.P.M. &R.
Medical Director

TKC:dsh

cc: William Lehman, M.D. – Fax: (803) 329-2611

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Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 1
Date:8-20-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed cued controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Psychology of Physical Symptoms: The nature of the interaction between physiological and psychological functioning was the focus of this group lecture. Issues addressed included the process by which decreased mental, physical and social activity lead to increased attention to somatic concerns, an exacerbation of perceived physical symptoms and heightened emotional distress. Common forms of patient resistance to the notion of managing pain via mental, physical and social distracters were discussed.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

☐ Rounds
☐ Team Conference
☐ Individual Psychotherapy

Comments:

Electronically Signed by:

W. Brian O'Malley, Ph.D.

ıily Progress Note

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Name: Lettie Spencer	MRN: 12615	Tx Day: 1	Date: 8/20/2013
DOB: 11/28/1947	Age At Visit: 65	Sex: F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
Mrs. Spencer began program orientation today. She viewed the lumbar stabilization video and began initial program instruction. She completed the MMPI. Began initial instruction on postural correction with emphasis on limiting lumbar flexion posture and B scapular protraction. DP

Patient began bike activity and demonstrated forward flexed position. She was requested to try to maintain more upright posture to decrease the strain on her back. She stated that it "hurts my tailbone". We added a pillow to her seat, which helped minimally. Following this activity she is noted to perform a full squat and then into a half kneel for approximately 10 seconds. She then arose to standing independently. While patient is standing and talking with the therapist, she is noted to assume a forward flexed position in her trunk. /rh

Patient states that at home, she sits in a recliner, which is the most comfortable position for her. When riding in the car or when sitting any other chair, she sits on a pillow. /rh

Prior to Relaxation class, pt stated: "I need to lie down." She was encouraged to participate in class and use ice as needed. She stated that she would try to complete the class, but refused ice, stating that it has not been beneficial. Pt reported continued lumbar pain after class and was taken to a treatment room at 3:10 and assumed a left sidelying position with a pillow between her knees. Upon assessment at 3:30, she stated she was beginning to feel better. At 3:45, she said that being able to stay in that position for that time was helpful and returned to the PT gym. She appeared more lucid after the session and began to write down the activities she had forgotten to document in the midst of the flare-up. DP

Physical Therapy - Goal: Improve Physical Condition

Bicycle
utes: 9 **MPH:** **Distance:**

Balance Training
Minutes: 2 **Balance Type** Dynamic **Position:** Standing **Notes:** toe taps on steps

Standing
Minutes: 15 **Notes:** Name/MRN/Pegboard

Physical Therapy - Goal: Improve Functional Status

Patient Education: Dynamic Lumbar Stabilization Video

Pain Behavior: Occasional nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

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Name: Patricia "Dawne" Johnson **MRN:** 12837 **Tx Day:** **Date:** 8/20/2013
DOB: 09/23/1968 **Age At Visit:** 44 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** Absent

Notes

Physical Therapy - Goal: Improve Physical Condition

Physical Therapy - Goal: Improve Functional Status

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

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Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 1
Date: 8-20-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. I oriented her to the program. I reviewed with her treatment plans and goals. We discussed the policies and procedures of the facility. Her affect is brighter. She appears motivated. I told her to notify the therapists if she has difficulty with any of her activities. We will also pace her activities carefully. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note

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Name: Lettie Spencer	**MRN:** 12815	**Tx Day:** 2	**Date:** 8/21/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
Patient states that she is feeling a little better this morning. She states that mornings are always better, though. She is reminded to always communicate with the therapists if any of her activities provoke increased symptoms. /rh

Pt. attempted to participate in core stabilization class but was unable to secondary to increased lumbar pain. Pt. was observed lying on R side with pillow between her knees for the remainder of class./ms

Additional instruction given for balance activities. Pt. began both forward tandem walking and side stepping 3 times. Noted increased difficulty and LOB when performing forward tandem walking between the two mat tables. Pt. stated it was much easier performing side-stepping leading with R LE. Pt. reported afterwards she began experiencing increased low back pain./ms

Patient is noted to be standing in a forward flexed position while performing standing upper body exercises. When asked, she stated that her pain was becoming severe. She was requested to perform her exercises in sitting if that would help manage her pain. She stated that sitting was too uncomfortable as well. She is requested to assume a side lying position and begin with clam shells and UE stretching. We also discussed pacing so that she can get through the day without flaring up her symptoms. Ice pack is recommended to patient but she states that she cannot tolerate ice. /rh

Initial instruction provided for individual exercises. Pt. has just finished lecture and had asked if she would be able to perform the exercises in standing. Pt. was reminded to vary her positioning if possible during the day. Pt. was able to maintain upright posture initially but later was observed in forward flexed posture. Exercises were modified and were completed in side lying. Pt. was appreciative and reported relief/ms

Pt. stated while completing side-lying arm circles that she was having difficulty allowing her back muscle to relax. Pt. unsure as to why she is experiencing the increased muscle tension/ms

Pt observed during various times during the day assuming a crouched position, with her knees up to her chest. Pt. reports that she "could sit like this all day." Pt. reported during lecture she sat in the chair with her knees up to her chest as this is very comfortable/ms

Pt instructed on postural correction to help eliminate scapular protraction and lumbar flexion posture. She was given tactile cues to minimize B UT elevation and superior positioning of B scapulae. Will add a postural segment to the pt's schedule. DP

Patient stated at the end of the day that she felt better than yesterday and realizes that pacing and practicing flare up management activities really do help. /rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Required Verbal Cueing, Initial Instruction - 3 exercises completed

Walking
Minutes: 15 **Distance:**

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:**

Standing
Minutes: 14 **Notes:** Pegboard
Minutes: 10 **Notes:** Couplings

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wand Overhead			3 x 3 sec
Wall Clips		6	
Kneeling		5:30	
Pulleys		6	

BTE	Attachment Description	Position	Height	Torque
Min	122	Sitting	21	3.0
6/6/6				

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman PT
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
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VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 3
DATE: 8-22-2013

VOCATIONAL GROUP:

The focus of the vocational group today was exploring tips that will lead to being hired. A video was viewed by the group that offered advice from actual employers on what job seekers can do before, during, and after job interviews to enhance hiring opportunities. A group discussion followed the video.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

CONFIDENTIAL

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 3	**Date:** 8/22/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes
BP @ 8:30 am 132/74 mm Hg

Patient states that on the drive in today, her driver had to put on the brakes suddenly and she was thrust forward. She reports increased back pain today. She is demonstrating a more forward flexed posture in standing and walking./rh

Rounds completed with pt and program team. She is demonstrating good effort with initial program activities despite mechanical and postural indicators of pain. She states the incident with the driver as listed above has caused increased lumbar pain. Pt was taken to a treatment room and given ice for her lumbar region x 20 minutes. She states that the ice was beneficial in helping to decrease her lumbar pain exacerbation. Will continue to work on the goals of postural correction, proper bed positioning, body mechanics training and gradual increases in endurance activity duration. DP

Initial instructions began with weight training activities. Pt. required frequent rest breaks to change positions and stretch out lumbar back. Attempted exercises in seated and standing position but pt. continues to experience "lightening like" muscle spasm and pain. Pt. attempted to correct forward flexed posture but only was able to maintain neutral spine for approximately 5 seconds before resuming forward flexion. LE exercises with theraband were initiated with frequent rest breaks required for positional changes/ms

Patient is noted to be standing with a flexed forward position. She states that she has not been able to do her side-lying exercises today and her pain is still severe from this morning. She is requested to lie in sidelying for the last session of the day. Patient is also requested to bring her TENS unit tomorrow. She states that the TENS really does help her pain./rh

Patient participates in tai chi exercises in side lying position./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

Walking
Minutes: 30 **Distance:**

Weight Training: Required Verbal Cueing for initial instruction: 3 exercises completed - 1lb free weight; red theraband

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wall chain		6	
Pulley		7	
Kneeling Tall		6	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman PT
	☐	Sue Payne, P.T., M.S.

		Sue Payne, P.T., M.S.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 3
Date: 8-22-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Team rounds were held today. We reviewed team conference treatment plans and goals. We discussed medical, psychological, physical therapy and vocational issues. Lettie is off to a good start. Her effort is excellent. She participates well in the groups and lectures and in the gym. We discussed a flare-up plan. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 4	**Date:** 8/23/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes
BP @ 8:39 am 140/66 mm Hg

Patient states that her back is still flared up from yesterday's ride to the clinic. She brings her TENS unit in today. She states that it does not give her a "deep enough" current to provide relief. We used one of the clinic TENS today, and she reported greater pain alleviation. we used 2 channel, 4 electrode placement, amplitude to patient tolerance. /rh

TUG Test: 22:60 seconds

Pt was taken to a treatment room twice today (2:00-2:20, 3:25-3:55) per c/o lumbar pain flare-ups to use ice on the lumbar region in a left sidelying position with a pillow between her knees. She reported pain relief after utilization both times. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Spinal Stabilization: 25 min. supine, standing

Weight Training: Required Verbal Cueing for additional instruction - 6 exercises completed - 1lb free weight, yellow theraband

dalities
nutes: **Modality:** **Placement:** **Position:**

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:** beginner level activities

Standing
Minutes: 15/5 **Notes:** standing, walking, pegboard

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wand Overhead	3		30 second hold
Kneeling Tall		6	

BTE

Min	Attachment Description	Position	Height	Torque
6	122/UBE	Sitting	212.0	

Pain Behavior: Frequent verbal, and nonverbal, mechanical or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
	☐	Rayanne Hitzeman, PT

		Rayanne Hitzeman PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 4
Date:8-23-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed cued controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Learning and Pain Behavior: Principles of learning theory were presented and explained in this group discussion, with applications to pain behavior and pain management. Principles of reinforcement, extinction and punishment, as well as schedules of reinforcement, were presented in order to demonstrate the ways in which behavior is shaped by the environment and the responses of others around us. We discussed the ways in which this can lead to shaping and increasing pain behavior, but also how knowledge of these principles can allow patients to alter their environments so as to facilitate improved functional behavior while diminishing pain behaviors.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

W. Brian O'Malley, Ph.D.

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 4
Date: 8-23-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is feeling fairly fatigued and tired, but she says she can tell that she is getting stronger. She says that, yesterday, when she was driven to the clinic, the driver had to slam on the brakes and it jerked her back. She says that she thinks this aggravated her back pain, but she thinks she will be fine. She applied ice. She does feel that she is having a little more back pain from this incident, but there is no change neurologically. There is no spasm. Her effort has been excellent. She participates well in the groups and lectures. We will continue with our plan of care. I encouraged her to follow her exercise regimen over the weekend.

Electronically Signed by:

T. Kern Carlton, III, MD

...ily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 5	**Date:** 8/26/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program

Attendance Full Day

Notes
BP @ 8:34 135/65 mm Hg

Verbal cueing given for proper performance of wand over head activities. Pt was observed performing AAROM shoulder flexion multiple times. Pt. was instructed to utilize a timer and attempt to hold the wand for 30 seconds and then relax and repeat as previously completed. /ms

Dr. Carlton states he wants the BTE maneuvers discontinued per pt's c/o cervical and L UT pain exacerbation. The activity was taken off the board. DP

Pt c/o lumbar pain and requested a TENS unit. The electrodes were placed as listed below. DP

Functional lifting tasks initiated with pt. requiring cueing for maintaining upright posture as repetitions progressed. Pt. also noted to demonstrate slight lurch to the right while completing level lifting and 1 hand carry with pt. stating she was getting tired./ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: 3 exercise completed

Spinal Stabilization: 25 min. supine, standing, sidelying

...ight Training: Demonstrated Good Technique. 2 exercises completed 1lb free weight

Modalities
Minutes: PRN **Modality:** TENS, 4 electrodes, Modulated Mode, 4 electrodes **Placement:** Lumbar **Position:** Various

Balance Training
Minutes: 3 mins **Balance Type** Dynamic **Position:** Standing **Notes:** red disc
Minutes: 6x **Balance Type** Dynamic **Position:** Standing **Notes:** tandem gait on blue foam beam
Minutes: 6x **Balance Type** Dynamic **Position:** Standing **Notes:** side stepping on blue foam beam
Minutes: 6x **Balance Type** Dynamic **Position:** Standing **Notes:** tandem gait
Minutes: 10x **Balance Type** Dynamic **Position:** Standing **Notes:** toe touch on step

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	3	3
1 Hand Carry	3	3
Push/Pull Cart	25	2

Circuit

Exercise	Up & Down	Minutes	Description
Wand Overhead	3		30 second hold
Wall Clips		6	
Kneeling Tall		6.5	
Pulleys		7	

BTE

Attachment Description	Position	Height	Torque
122/UBE	Sitting	21	3.0

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Kim Dunn, PT	☐	
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 5
Date:8-26-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed cued controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Resistance/Interpersonal Influence: This group lecture was designed to educate patients about the concept of resistance to change and to improve their receptivity to treatment and rehabilitation. Issues pertaining to perceptions of expertise, trustworthiness and similarity as they relate to patient experiences with healthcare providers, resultant compliance with treatment and treatment outcomes were addressed.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

W. Brian O'Malley, Ph.D.

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 5
Date: 8-26-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She said she had an uneventful weekend. She has been working on the BTE and says it is making her wrist and shoulder a little bit sore, so I told her to discontinue this. I also discussed this with her physical therapist. She says she is trying to cut back on the Nucynta, and did so over the weekend. Mentally, she says, she is better, and it is helping her to be around other people. She says she is having fatigue, especially at the end of the day, and I explained to her that this is normal but to let us know if she has any problems with any of the activities. There is no change neurologically in her exam. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 6	**Date:** 8/27/2019
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
BP @ 8:34 am 136/68 mm Hg

Patient introduced to "position of comfort" (i.e. supine with hips and knees in 90 degrees) which patient reported is comfortable for her back. She is begun on calf presses, hip rolls, pelvic tilts, and AAROM for bilateral shoulders using dowel. She demonstrated good technique with no increased discomfort. She is advised to assume this position every day in order to unweight her spine and perform spine stabilization in a more appropriate postion. She is agreeable./rh

Pt observed pulling a chair across the room while performing retro-ambulation. She was told that a staff member could move the chair instead. She then said: "I can handle it. This gives me a chance to work on my backwards walking." She was able to complete the activity with SPV, no LOB. DP

Pt. stated during lunch that she feels much better after assuming supine 90/90 position with B LE supported on green physioball. Pt. is shocked that it made her back feel this good. Pt. reports she is going to purchase one this weekend/ms

Pt. commended for remembering to utilize the green physioball during core stabilization. Pt. usually completes the class in side-lying. Pt. was able to complete most exercises with small modification/ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

'nal Stabilization: 25 min. supine, standing

Balance Training
Minutes: 25 **Balance Type** Dynamic **Position:** Standing **Notes:** beginner/intermediate level activity

Standing
Minutes: 15/5 **Notes:** standing/walking/pegs

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities			Wand, 2 x 30 sec
Wall Clips		6	
Wand overhead	2		30 second hold
Tall Kneeling		6:43	

Pain Behavior: Occasional nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT

Marisa T. Sheppard, LPTA ☐ Marisa T. Sheppard, LPTA

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 8-27-2013

Ms. Spencer was seen in individual psychotherapy today. She indicates that she is adjusting well to the functional restoration program. She indicates that the activities involved in the program have been challenging, but she believes that she is doing better overall.

Ms. Spencer had questions about her current pain medication. She is taking Nucynta ER 75 mg. She was encouraged to discuss her questions and concerns with Dr. Carlton. An overall goal of reducing her medication intake was discussed with her.

Ms. Spencer has demonstrated a brightening of her mood and affect. Her participation in groups has been excellent.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh

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INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 6
Date: 8-27-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is doing better today. I reexamined her, and there is no change neurologically. She says the ice helps her at the end of the day; that is when she has more of her pain. She does have some diffuse lumbar tenderness but no palpable spasm. I talked to her about her thyroid problems, and she said her TSH level was normal about two weeks ago. She is not doing the BTE today, and her shoulder and wrist are better. She cut back a little bit on the Nucynta over the weekend. She said usually, however, she needs 3 a day. She says she takes the trazodone and the Klonopin for her restless leg syndrome. She says that when she flexes forward, she feels some improvement in her back, but she also gets the same effect when she flexes her hips. We reviewed her mechanics and talked about the importance of proper body mechanics. We will continue with our plan of treatment.

Electronically Signed by:

T. Kern Carlton, III, MD

THE REHAB CENTER
INCORPORATED

VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 7
DATE: 8-28-2013

VOCATIONAL GROUP:

The focus of the vocational group today was skill identification. We discussed how individuals often limit their perception of skills to job specific or job content skills. I explained the concept of transferable skills and demonstrated ways to identify them.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 7 **Date:** 8/28/2013

DOB: 11/28/1947 **Age At Visit:** 65 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
BP @ 8:32 am 132/70 mm Hg

Pt continues to be willing to add new activities without increased c/o. She is slow but deliberate in her actions. She was able to perform/ progress her spinal stabilization exercises today in supine with a large physioball, perform her bridging without increased pain sx noted.

Pt. observed completing balance activities demonstrating improved upright posture when completing tandem walking. Pt. utilized two fingers touching the wall for balance. No LOB noted. Pt. movements are slow and she continues to require numerous rest breaks for lumbar stretching/ms

Functional lifting activities with emphasis on body mechanics was progressed as listed below. Level lifting was increased to 4 lbs without c/o increased pain. She exhibited lumbar extension when beginning 1-hand carry and level lifting. Inconsistent heel to toe excursion was displayed with 1-hand carry maneuvers with cueing required for proper B LE initial contact sequencing. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

'vidual Exercises: Demonstrated Good Technique. Pt completed 7 exercises

Spinal Stabilization: 25 min. supine

Walking
Minutes: 15 **Distance:**

Weight Training: Performed 1 exercises

Balance Training
Minutes: 15 **Balance** Type Dynamic **Position:** Standing **Notes:** beginner level activities

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	2
1 Hand Carry	3	2/2
Push Cart	30	2

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	5x		
Wall Clips		6:30	
Kneeling Half		6:30	

Added stair climbing today with no problems noted and a step over pattern.

Patient Education: Postural Reeducation

Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Kim Dunn, PT	☐	
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 8	**Date:** 8/29/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
Patient states that she went to bed last night at 7:30 but didn't fall asleep until 11:00. She states that her back was bothering her , and she feels that that the TENS unit was "irritating" her back. She declines TENS during morning session. However, following lunch, she requested therapist to apply TENS. TENS applied, 2 channel, 4 electrode placement to LB, amplitude to patient tolerance. /rh

BP @ 8:40 am 132/74 mm Hg

Pt. c/o of increased low back pain this morning. Pt. requested PTA to examine her back for palpable muscle spasm as the pt. stated she felt like her muscles were tight and "jumping." Examined pt. back and noted palpable spasm but increased tightness in lumbar region. Pt. was required to begin circuit activities which were modified and pt. performed supine individual exercises focusing on lumbar stretches as well as physioball exercises with hips/knees in 90 degrees while lying on a ice pack/ms

Patient participated in 25 min. standing tai chi./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 8 exercises completed

Spinal Stabilization: 25 min. supine, standing

Walking
Minutes: 15 **Distance:**

Balance Training
Minutes: 15 **Balance Type** Dynamic **Position:** Standing **Notes:** beginner level activities

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Wall Clips		6	
Kneeling Tall		6	

Pain Behavior: Occasional verbal, and nonverbal, mechanical or postural indications of pain.

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 8
Date: 8-29-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says that she has been having more pain today. She said she did some stair climbing yesterday in the gym and thinks this may have aggravated her symptoms. She has not had any neurological changes, and on exam there is no neurological change. She does have a little more tenderness. She has tried ice. She has been using her TENS unit. She is also taking her pain medicine. She requested an injection, and after obtaining informed consent and prepping the area with alcohol, I injected 30 mg of Toradol IM, which she tolerated well. I reviewed with her a flare-up plan, and we will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 9	**Date:** 8/30/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
Patient states that the Tordol injection she received yesterday afternoon was helpful. She states "I went to bed at 7:30 last night and slept well". She states that she having some difficulty "getting started" this morning. She states that she can use the TENS unit only on a limited basis./rh

Patient arrives to the clinic wearing a back brace. She states that she wears it for the ride to the clinic in the morning because riding in a car really increases her back pain./rh

BP @ 8:41 am 130/64 mm Hg

Pt reports feeling "tired" today; Pt asked for asst to apply "pain patch" just given to her by Dr. Carlton. Pt spending much of am walking in gym w ice pack to low back. Pt shortened wt trng due to c/o "cramping" L lower leg; requested to "walk'. / JB

Pt states: "I am physically exhausted." Discussed flare-up management with the pt. She refused TENS utilization, stating that it sometimes irritates her muscles, but is using ice. She says that nothing is really helping with her pain and that she "is just tired." Dr. Carlton was notified. DP

Per Dr. Carlton's request, STM performed on patient. We concentrated on low back, L piriformis. Patient tolerated only sidelying position at first, but we transitioned to prone on 2 pillows, and she tolerated that position for 5 minutes. Gentle LP traction and L LE long axis traction performed with patient in prone. Following session, patient stated "this is how I feel in the morning...more upright and less pain." Discussed with patient how her forward flexed posture in standing and walking tend to put strain on her spine and create the tightness in her back muscles secondary to an anterior center of gravity. We discussed trying to assume a prone on pillows position once per day. She is reeable./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: 6 exercises completed

Weight Training: 1 exercise completed - 1lb free weight

Balance Training
Minutes: 10 **Balance Type** Dynamic **Position:** Standing **Notes:** beginner level activities

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	3/3
1 Hand Carry	4	2
Push	35	3

Push - 13.2

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT

Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Jo Anne Baucom, LPTA	☐	Jo Anne Baucom, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 9
Date: 8-30-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says she is completely exhausted. She said the injection helped her, and she slept well last night. She is not sure if she is coming down with an upper respiratory infection, but she says she has had a little bit of congestion and cough. She is afebrile. She says she has been having some spasms. I did reexamine her, and she is tender in her paraspinals. I talked to her about different approaches for the spasms. She requested a prescription for a muscle relaxant. We did not have any samples of a muscle relaxant, so I gave her a sample of a Lidoderm patch and instructed her in the appropriate application of this. We will also consider a trial of cyclobenzaprine if the spasms persist.

Electronically Signed by:

T. Kern Carlton, III, MD

Daily Progress Note

THE REHAB CENTER INCORPORATED

Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 10 **Date:** 9/3/2013

DOB: 11/28/1947 **Age At Visit:** 65 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
Pt. reported that she experienced increased low back pain on Saturday. Pt. stated she didn't get much done at home on Saturday but was able to complete some light grocery shopping on Monday/ms

BP @ 8:30 am 125/65 mm Hg

Patient stated that the soft tissue mobilization on Friday was helpful for her. She states that she also tried lying prone over 2 pillows, as we discussed on Friday. She is walking more upright during morning session today./rh

Patient asked to try TM activity. As patient was ready to go on break, deferred activity./MP

Instructed pt. on use of TM. Pt. was reminded to hold onto either set of handlebars. Pt. tolerated approximately 10 seconds of the TM at .5 mph reporting that this was too fast for her to walk without increased low back pain. Pt. is observed demonstrating decreased B LE step length. Pt. dismounted the TM and stride length increased./ms

TENS application to lumbosacral area with 2 channels. Amplitude to patient tolerance./MP

Noted lumbar flexion and posterior pelvic tilt with pull/pull activity. Patient cued to hold spinal neutral./MP

Patient reported of cramps in calf after balance activity on balance beam. Also noted labored gait and stair climbing. Patient was asked to perform therapeutic exercises on the mat./MP

ysical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 6 exercises completed

Spinal Stabilization: 25 min. supine, side lying, standing

Weight Training: 3 exercises completed.

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:** beginner level activities. Progressed with less UE support during exercises.

Standing
Minutes: 10 **Notes:**

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	4	3
1 Hand Carry	?	5/R
Push/Pull Sled	35	5

Circuit

Exercise	Up & Down	Minutes	Description
Stair Climbing	2		
Overhead Activities		2:30	
Kneeling Tall		6	

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Kim Dunn, P.T.	☐	Kim Dunn, P.T.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 10
Date: 9-3-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. I called in some cyclobenzaprine for her over the weekend, and she did get this prescription and did start taking it. Her movements are more fluid. She still has an antalgic gait. She did get some manual therapy on Friday. She is using the TENS unit. We will continue with our plan of treatment.

Electronically Signed by:

T. Kern Carlton, III, MD

ılly Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer MRN: 12615 Tx Day: Date: 9/4/2013
DOB: 11/28/1947 Age At Visit: 65 Sex: F

Type of Program: Comprehensive Rehabilitation Program Attendance Absent

Notes

Physical Therapy - Goal: Improve Physical Condition

Physical Therapy - Goal: Improve Functional Status

Signatory Name	primaryFlag	Signature
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Kim Dunn, P.T.	☐	Kim Dunn, P.T.

THE REHAB CENTER
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VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 11
DATE: 9-5-2013

VOCATIONAL GROUP:

The focus of the vocational group today was developing effective resumes, cover letters and thank-you notes. We also reviewed the utilization of electronic resumes.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: No verbal or nonverbal pain behavior exhibited.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

Daily Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 11 **Date:** 9/5/2013

DOB: 11/28/1947 **Age At Visit:** 65 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
BP @ 8:50 am 120/70 mm Hg

Patient is noted to arrive to the clinic today at 7:50 a.m. When asked about her transportation, she stated that her driver still arrived at her house approximately 6:00 a.m. but she told him that she is not going to come out of her house until 6:30 a.m./rh

Patient states that her back was flared up yesterday and she was unable to come in to the clinic. She states that she performed a higher level balance activity on the foam beam Tuesday afternoon, and by Tuesday night, her pain had increased. She is requested to assume her position of comfort (i.e. lying supine with legs propped up on the physioball). She also used ice pack and TENS and states that her back pain somewhat abated./rh

Rounds completed today with patient and program team. She reports frustration that she missed yesterday. She states that the soft tissue work was helpful the other day and allowed her to stand up more erect. We discussed her flare up management routine. She states that ice and TENS are helpful, as well as the sidelying position and supine with physioball position./rh

It is noted that patient is walking with more upright posture. When it is brought to her attention, she states "I am thinking about you said and I am trying to correct" (my forward flexed posture)./rh

Pt reported after morning warm-up that she does not want to perform Tandem walking on the blue balance beam. States this is what she believes aggravated her symptoms yesterday. Reported she has no increase in symptoms when performing side-stepping on the beam. Pt. was advised her schedule would be modified accordingly this morning so that should would be able to utilize an ice pack and assume a position of comfort. Pt. was agreeable/ms

. eported decreased in low back pain after strapping an ice pack to her low back/ms

Performed STM and LP distraction with patient prone on 2 pillows. She stated that the traction "felt really good". Following the session, KT taping was applied to LB, 2 horiz. strips at 80% stretch. Patient stated that she felt mitigation of her discomfort./rh

Patient participated in 25 min. standing tai chi./rh

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 4 exercises completed

Spinal Stabilization: 25 min. supine

Walking
Minutes: 20 **Distance:**

Weight Training: Demonstrated Good Technique. 5 exercises completed 1lb free weight

Modalities
Minutes: PRN **Modality:** Cold Pack **Placement:** Lumbar **Position:** Various

Balance Training
Minutes: 5 **Balance Type** Dynamic **Position:** Standing **Notes:** marching in place

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
'ing Tall		5	

Name: Lettie Spencer MRN: 12615 Tx Day: 11 Date: 9/5/2013
): 11/28/1947 Age At Visit: 65 Sex: F

Patient Education: Vocational Lecture

Pain Behavior: Frequent verbal, and nonverbal, mechanical or postural indications of pain.

Met With: Sabrena

Signatory Name	primaryFlag	Signature
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Kim Dunn, P.T.	☐	

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Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 11
Date: 9-5-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Team rounds were held today. We reviewed team conference treatment plans and goals. We discussed medical, psychological, physical therapy and vocational issues. Lettie was absent yesterday due to an increase in her back pain. Initially it was reported that she was sick, but she said her back pain flared up. She is better now. She says the TENS unit helps her. She says the cyclobenzaprine helps. She says she is getting Boost drinks to increase her caloric intake. We will continue with our plan of treatment.

Electronically Signed by:

T. Kem Carlton, III, MD

ılly Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer	**MRN:** 12615	**Tx Day:** 12	**Date:** 9/6/2013
DOB: 11/28/1947	**Age At Visit:** 65	**Sex:** F	

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
BP @ 8:46 am 106/64 mm Hg

Pt requested a TENS unit due to increased Sx and still was unable to perform the morning activities. She stopped throughout the am and stretched. /KD

TENS adjusted to allow increased wave width. Patient reported greater comfort./rh

Pt. continues to report relief from utilizing the TENS unit. Pt. continues to sign one out of the clinic and bring back each day. Pt. reports that if she was unable to utilize a TENS unit this morning she would be spending the day lying on the mat table. Pt. is observed ambulating at smoother cadence demonstrating improved upright posture./ms

Pt reports she can see improvement this week in posture and is concentrating on maintaining upright posture and increasing cadence when walking. Pt states she is "going to get back to being fast walker one of these days"./JB

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. Pt performed 2 exercisee and stopped due to increased pain. Pt able to complete 10 exercises later.

'nal Stabilization: 25 min. side-lying, supine

Weight Training: Pt performed 3 exercises w good technique.

Physical Therapy - Goal: Improve Functional Status

Circuit

Exercise	Up & Down	Minutes	Description
Overhead Activities	3x10		stick overhead
Overhead Activities		6	wall chain
Kneeling Tall		6	

Signatory Name	primaryFlag	Signature
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Kim Dunn, P.T.	☐	
	☐	

Mamta Patel, P.T.	☐	Mamta Patel, P.T.

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INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 12
Date: 9-6-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She says that she is doing better. She says that her flare-up does seem to be gradually resolving. The physical therapists have started some Physio Taping, and hopefully this will be beneficial to her. I stressed to her the importance of following her exercise regimen over the weekend and also talked to her about the importance of increasing her caloric intake. She says the TENS unit has been very helpful. She says she has tried them in the past and they were not beneficial, but the unit that she is using now is helpful. I told her we would prescribe this for her if it continues to be beneficial. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

THE REHAB CENTER
INCORPORATED

VOCATIONAL GROUP NOTE

NAME: Lettie Spencer
CHART #: 12615
DAY OF TREATMENT: 13
DATE: 9-9-2013

VOCATIONAL GROUP:

The focus of the vocational group today was exploring tips that will lead to being hired. A video was viewed by the group that offered advice from actual employers on what job seekers can do before, during, and after job interviews to enhance hiring opportunities. A group discussion followed the video.

Sitting Tolerance: Sat through session without any pain behavior exhibited.

Participation: Patient interacted consistently and appropriately and integrated material.

Pain Behavior: Occasional nonverbal, mechanical or postural indications of pain.

Comments: N/A

Electronically Signed By:

Sabrena Bagby, M. Ed., C.R.C., C.C.M.
Vocational Specialist

ılly Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 13 **Date:** 9/9/2013
DOB: 11/28/1947 **Age At Visit:** 65 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** Full Day

Notes
BP @ 6:37 am 144/72 mm Hg

Pt. observed ambulating in the gym demonstrating improved upright posture with relaxed shoulder and equal B heel toe gait pattern. Pt. was commended for her effort and focusing on her body mechanics/ms

Patient reports that she had a good weekend. Her back pain is at baseline./MP

Noted improved upright posture, observe patient periodically in a deep squat position to stretch her lumbar spine for pain relief./MP

Pt was instructed on treadmill ambulation today. She completed 10 minutes at 0.5 mph with occasional cueing required for consistent B LE initial contact. No dyspnea was present with ambulation. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 15 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill
utes: 10 **MPH:** 0.5 **Distance:**

Walking
Minutes: 20 **Distance:**

Weight Training: Demonstrated Good Technique: 3 exercises completed, 1 lb free weight

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:**

Standing
Minutes: 10 **Notes:** Patient was walking during standing time

Physical Therapy - Goal: Improve Functional Status

Circuit Exercise	**Up & Down**	**Minutes**	**Description**
Overhead Activities			Wand, 2 x 10 sec
Wall Chain		6:30	
Kneeling Tall		7	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.

Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 13
Date: 9-9-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ **Rounds**
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in good spirits. She says she is feeling much better. She rates her pain level a 6. She says the TENS unit is giving her great relief. She said she would like to have one to use at home, and I wrote a prescription for her. I talked to her about the importance of improving her caloric intake. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

ılly Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer | **MRN:** 12615 | **Tx Day:** 14 | **Date:** 9/10/2013

DOB: 11/28/1947 | **Age At Visit:** 65 | **Sex:** F

Type of Program: Comprehensive Rehabilitation Program | **Attendance** Full Day

Notes
BP @ 8:48 am 122/68 mm Hg

Patient reports that her pain is manageable but she is taking more medicine. She reports that the progress she sees is increased strength in her LE, improved posture, increased speed of walking and the way she is walking. "I can feel muscle" in the calf./MP

Patient reported that she performed 10 minute on the TM, but she was very tired after the activity./MP

Pt initiates and completes her tasks efficiently but is observed occasionally in a crouched position 4-5 times per day, which she states is pain relieving position. Will continue to focus on finding neutral positions of comfort for lumbar pain reduction. DP

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique. 18 exercises completed

Treadmill
Minutes: 10 **MPH:** 0.6 **Distance:** 0.08
Minutes: 15 **MPH:** **Distance:**

ıking
Minutes: 15 **Distance:**

Weight Training: Demonstrated Good Technique: 5 exercises completed, 1 lb free weight

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:**

Standing
Minutes: 10 **Notes:** dynamic-walking

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	5	3
1 Hand Carry	5	R
1 Hand Carry	2.5	L
2 Hand Carry	5	2
Push Cart	35	3

Circuit

Exercise	Up & Down	Minutes	Description
Kneeling Tall		5	

Pain Behavior: Occasional verbal, and nonverbal, mechanical or postural indications of pain.

Signatory Name | primaryFlag | Signature

Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA
Mamta Patel, P.T.	☐	Mamta Patel, P.T.

THE REHAB CENTER

2610 E. Seventh Street
Charlotte, NC 28204

PSYCHOLOGY PROGRESS NOTE

CLIENT: Lettie Spencer
CHART #: 12615
DATE: 9-10-2013

Ms. Spencer was seen in individual psychotherapy today. Ms. Spencer describes herself as exhausted. She recognizes that the physical demands of her functional restoration program exceed that which she was accustomed to before beginning the program. Ms. Spencer indicates that she has lost 1½ lbs since beginning the program.

Ms. Spencer does note that she has experienced improvement in her posture and gait. She describes her legs as stronger. She also notes that her attitude has improved. Ms. Spencer was encouraged to persist with her present efforts.

Electronically Signed by:

W. Brian O'Malley, Ph.D.
Psychologist

WBO:dsh

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 14
Date:9-10-2013

Type of Program		Attendance	
☒	Comprehensive Rehabilitation Program	☒ Full Day	☐ Absent
☐	Work Hardening Program	☐ Half Day	☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed cued controlled breathing. Appeared visibly relaxed.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Beliefs and Emotion: This group lecture introduced patients to the basic tenets of cognitive-behavioral therapy, and specifically to the notion that emotions are a product of thoughts and judgments which are themselves shaped by beliefs acquired from a variety of influences over the lifespan. We discussed some of the sources of these beliefs and pointed out that some of these are adaptive, while others are maladaptive, and that they can vary greatly in accuracy. It was noted that many of these beliefs are not fully conscious, but underlie emotional responses, and can be modified upon recognition of these and their maladaptive nature when this is the case. Applications to living with chronic pain were noted, and patients also had the opportunity to review handouts on common irrational beliefs and assessment measures used to identify these.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted moderately, but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name:Lettie Spencer
Chart No: 12615
Days Tx: 14
Date: 9-10-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

MEDICINE

GOAL: To educate patients on the mechanism of injury, causes of chronic pain, diagnosis and management of chronic pain and general preventive health guidelines.

☒ Rounds
☐ Team Conference
☐ Patient Education

Comments: Lettie is seen on rounds today. She is in fairly good spirits. She rates her pain level a 6. She says the TENS unit is helping her a great deal. Her gait looks better. I talked to her at length about her weight and her caloric intake. Her weight today is 106.6 lbs. I stressed to her the importance of increasing her calories. I reexamined her, and there is no change neurologically. We will continue with our plan of care.

Electronically Signed by:

T. Kern Carlton, III, MD

..aily Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer | **MRN:** 12615 | **Tx Day:** 15 | **Date:** 9/11/2013
DOB: 11/28/1947 | **Age At Visit:** 65 | **Sex:** F

Type of Program: Comprehensive Rehabilitation Program | **Attendance** Full Day

Notes
BP @ 8:55am 136/76 mm Hg

Patient is demonstrating consistently more upright posture. She states that her back pain persists unabated. She states that when she uses the TENS, she notes that her posture does improve./rh

B distal ILS kinesiotaping was performed at 15% tension, distal to proximal, to provide for muscle inhibition. DP

Pacing of activities continues to be slow with the pt. requiring numerous standing rest breaks to allow for stretching of lumbar region. Pt. tolerated a 5 lb increase in weight for pushing/pulling of the cart. Pt. stated she did not notice the increase in weight until she began pulling the shopping cart. Pt. continues to demonstrate improved upright posture/ms

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises: Demonstrated Good Technique: 8 exercises completed

Spinal Stabilization: 25 min. supine, standing

Treadmill
Minutes: 12 **MPH:** 0.6 **Distance:** 0.08

Walking
Minutes: 10 **Distance:**

Modalities
Minutes: PRN **Modality:** Tens, 2 channels, 4 electrodes **Placement:** lumbar **Position:** various
Minutes: **Modality:** **Placement:** **Position:**

Balance Training
Minutes: 20 **Balance Type** Dynamic **Position:** Standing **Notes:**

Standing
Minutes: 10 **Notes:**

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
1 Hand Carry	5	3R
1 Hand Carry	2.5	2L
Push Cart	40"	2
Pull Cart	40"	1

Push - 13.2
Pull - 14.8

Pain Behavior: Occasional verbal, and nonverbal, mechanical or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA

THE REHAB CENTER
INCORPORATED

Daily Progress Note

Name: Lettie Spencer
Chart No: 12615
Days Tx: 15
Date:9-11-2013

Type of Program
☒ Comprehensive Rehabilitation Program
☐ Work Hardening Program

Attendance
☒ Full Day ☐ Absent
☐ Half Day ☐ Other

PSYCHOLOGY

GOAL: Improved emotional status with decreased distress and improved sleep.

☒ Relaxation: Progressive Muscle Relaxation was utilized, followed by cued controlled breathing.

GOAL: Integrate Positive Coping Self-Statements and Coping Strategies to Address Pain-Related Beliefs

☒ Trade Secrets: This was a process-oriented group which provided patients with the opportunity to discuss topics of their choosing. Questions pertaining to the week's didactic lectures were answered as well as issues specific to patients' treatment.

Sitting Tolerance:	Sat through session without any pain behavior exhibited.
Participation:	Patient interacted minimally but appeared to integrate material, at least moderately.
Pain Behavior	No verbal or nonverbal pain behavior exhibited.

Electronically Signed by:

Darcy Alexander, Ph.D.

ally Progress Note

THE REHAB CENTER
INCORPORATED

Name: Lettie Spencer **MRN:** 12615 **Tx Day:** 16 **Date:** 9/12/2013

DOB: 11/28/1947 **Age At Visit:** 65 **Sex:** F

Type of Program: Comprehensive Rehabilitation Program **Attendance** 8:10am-4:00pm

Notes
BP @ 8:35 am 138/72 mm Hg

Patient states that her transportation was late this morning./rh

Rounds were completed with patient and the rehab team. She is commended on her excellent effort and participation in the program. She is using pain management techniques appropriately. She has progressed with her strength, posture and gait. Balance activity was modified due to flareup last week but have initiated uneven surface as this is an important goal for patient.Her fatigue continues to be an issue. She is encouraged to increase awareness of her nutrition. Her program has been modified to allow mat exercise during the day. An extension of the program is recommended for her as she has shown good progress but needs to improve her balance, endurance, strength and functional gait./MP

Patient requested removal of taping on her back, stating that it felt like it was making her back "spasm". /rh

Patient requested TENS unit at 11:00. She was excited that she was able to wait that long before asking for the TENS. Patient also requested the taping in formation of 1st application. KT taping applied to LB, 2 horizontal strips a 60% stretch. /rh

Pt. observed completing functional lifting task demonstrating improved upright posture, increased energy and requiring less breaks for stretching her back. Pt tolerated a increased in weight up to 6lbs while also increasing her reps. by 1 with certain lifts. Pt. observed demonstrating improved control when turning the cart around to pull it in the gym. Pt. was able to complete 2 laps pulling 40lbs in the cart without taking a rest beak/ms

exhibits improved gait fluidity, including increased B UE swing, with ambulation in the afternoon and improved neutral spine positioning.

Physical Therapy - Goal: Improve Physical Condition

Flexibility / ROM: Performed morning warm-up

Individual Exercises:7 exercises performed

Spinal Stabilization:25 min. standing

Treadmill
Minutes: 11:03 **MPH:** .6 **Distance:** .09

Weight Training:3 exercises performed

Standing
Minutes: 15 **Notes:**

Physical Therapy - Goal: Improve Functional Status

Functional Lifting

Exercise	Pounds	Repetitions
Level Lift	6	4
1 Hand Carry	6	3R
1 Hand Carry	3	3L
Push Cart	40	3
Pull Cart	40	2

Circuit

Name: Lettie Spencer MRN: 12615 Tx Day: 16 Date: 9/12/2013

B: 11/28/1947 Age At Visit: 65 Sex: F

Exercise	Up & Down	Minutes	Description
Overhead Activities		2x10 sec	

Pain Behavior: Frequent nonverbal, mechanical, or postural indications of pain.

Signatory Name	primaryFlag	Signature
Dee Payne, P.T., M.S.	☐	Dee Payne, P.T., M.S.
Mamta Patel, P.T.	☐	Mamta Patel, P.T.
Rayanne Hitzeman, P.T.	☐	Rayanne Hitzeman, PT
Marisa T. Sheppard, LPTA	☐	Marisa T. Sheppard, LPTA