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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Appellate Panel

W.C.C. No. 1301480

RECEIVED
SEP 08 2016
SC Court of Appeals

Ronnie McDonald, Employee..... Respondent,

v.

J Mac's Express, LLC, Direct Employer,

Gregg Blakely Logging, Inc., Statutory Employer Employers, and
WC Uninsured Employers Fund and Palmetto Timber Fund, Carriers, Defendants

Of which Gregg Blakely Logging, Inc. and
Palmetto Timber Fund are the Appellants.

**MOTION TO STRIKE AND/OR CORRECT
RESPONDENT'S DESIGNATION OF MATTER**

Pursuant to Rules 209 and 240, SCACR, Appellants Gregg Blakely Logging, Inc. and Palmetto Timber Fund move this Court to strike and/or correct Respondent Ronnie McDonald's Designation of Matter to be Included on Appeal ("Designation"). Respondent has designated his entire APA filing with the Commission, Designation #8, which includes 153 pages of irrelevant or duplicative material. In addition, his Designation does not contain the certification required by Rule 209(c).

Rule 209(b), SCACR, states that, "[a] party shall not include any matter in his Designation which is not relevant to the appeal." With the exception of pages 1-9, comprised of a Vocational Rehabilitation Assessment performed by Fi-Fi Jubran that

addresses Respondent's ability to perform basic math and reading functions, the next 141 pages, pages 10-150 of his APA submissions (Att. A), consist of medical and physical therapy records that have no bearing whatsoever on the issue of whether the Commission erred in awarding a lump sum payment in this case. Tellingly, Respondent does not cite or refer to these pages anywhere in his Initial Brief.¹ Appellants have not challenged on appeal the extent of Respondent's injuries or the Commission's finding that Respondent is totally and permanently disabled pursuant to S.C. Code Ann. § 42-9-10, or his entitlement to causally-related medical care. Thus, these medical records are completely irrelevant to the sole issue on appeal: whether the Commission erred and committed an abuse of discretion in awarding a lump sum payment in this case?

Furthermore, Respondent's counsel has failed to certify "that the Designation contains no matter which is irrelevant to the appeal." Rule 209(c), SCACR. As explained above, APA pages 10-150 are irrelevant to the issue of whether the Commission improperly awarded a lump sum payment.

In addition, pages 151-162 of Respondent's APA submissions contain the Single Commissioner Order filed on August 13, 2013 (Att. A), which Respondent already has designated separately as Designation #1. Respondent's designation of these 153 irrelevant or duplicative pages only serves to inflate unnecessarily the cost of this appeal.

¹ Appellants are *not* moving to strike or correct the Initial Brief of Respondent, but simply reference it here to demonstrate that pages 10-150 of his APA submissions are irrelevant to this appeal. As a result, Appellants are not requesting a stay of the briefing schedule while the Court considers this Motion; however, Appellants do request a stay of the deadline to file and serve the Record on Appeal until the Court decides this Motion.

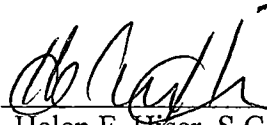
CONCLUSION

For all the reasons stated herein, this Court should strike Respondent's Designation #8, with the exception of pages 1-9 of his APA submissions, and order his counsel to certify that his Designation does not contain any material that is irrelevant to this appeal. In addition, Appellants request that the deadline to file and serve the Record on Appeal be stayed while the Court considers this Motion.

Respectfully submitted,

MCANGUS GOUDELOCK & COURIE, LLC

September 7, 2016



Helen F. Hiser, S.C. Bar No. 76124
735 Johnnie Dodds Blvd., Suite 200
P.O. Box 650007
Mount Pleasant, South Carolina 29465
(843) 576-2900

*Attorneys for Appellants Gregg Blakely Logging, Inc.
and Palmetto Timber Fund*

THE STATE OF SOUTH CAROLINA
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APPEAL FROM THE SOUTH CAROLINA
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Ronnie McDonald, Employee..... Respondent,

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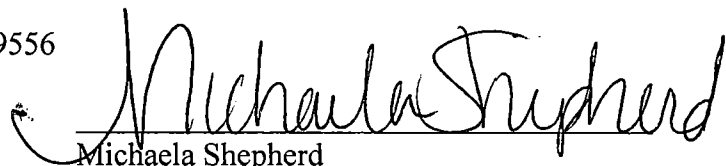
Of which Gregg Blakely Logging, Inc. and

Palmetto Timber Fund are the Appellants.

PROOF OF SERVICE

I certify that I have served the Appellants' **Motion to Strike and/or Correct Respondent's Designation of Matter** on Ronnie McDonald, by depositing a copy of it in the United States Mail, postage prepaid, on September 7, 2016, addressed to his attorney of record:

Joe Ann Calvy, Esq.
JOE ANN CALVY, LLC
P.O. Box 610
Kingstree, SC 29556



Michaela Shepherd
Legal Assistant to Helen F. Hiser
McANGUS GOUDELOCK & COURIE LLC
735 Johnnie Dodds Blvd., Suite 200
PO Box 650007
Mount Pleasant, South Carolina 29465
(843) 576-2900
Attorneys for Appellants



Reply To

HELEN F. HISER
Direct Dial: (843) 576-2930
helen.hiser@mgclaw.com

September 7, 2016

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SEP 08 2016

SC Court of Appeals

The Honorable Jenny Abbott Kitchings
South Carolina Court of Appeals
1220 Senate Street
Columbia, South Carolina 29201

RE: Ronnie McDonald vs. Gregg Blakely and Walker, Hunter & Associates, Inc.
Date of Accident: January 7, 2013
WCC File No.: 1301480
Our File No.: 2069.14007
Claim No.: 0001-0145-10-0001
Appeal Tracking No.: 2016-000480

Dear Ms. Kitchings:

Enclosed please find the original and seven (7) copies of Appellants' Motion to Strike and/or Correct Respondent's Designation of Matter, and the original and one copy of the Proof of Service in the above-referenced matter. Please file the originals and return a clocked-in copy in the self-addressed, stamped envelope. Also enclosed is our firm's check in the amount of \$25 for filing the motion.

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

Yours truly,

McAngus Goudelock & Courie, LLC

Helen F. Hiser

Enclosures

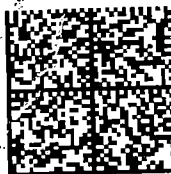
cc: Joe Ann Calvy, Esq.

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09/07/2016
From 29464

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Flat Rate Envelope

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PRIORITY MAIL 2-DAY™

Michaela Shepherd
McAngus Goudelock & Courie
735 Johnnie Dodds Blvd
Mt. Pleasant SC 29464

Delivery Date: 09/09/2016

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Honorable Jenny Abbott Kitchings
South Carolina Court of Appeals
PO Box 11629
Columbia SC 29211-1629

USPS TRACKING #



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SC Court of Appeals

Attachment A

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739 www.WCC.SC.GOV



PRE-HEARING BRIEF
WCC File
No. 1301480

Claimant's Name: Ronnie McDonald

Employer's Name: Greg Blakely/J. Mac Express

Address: [REDACTED]

Address: 589 Suttons Road

City: Kingstree 29556

State: SC

Zip:

City: Andrews

State: SC

Zip: 29510

Home Phone: () -

Work Phone: () -

Carrier: Palmetto Timber/SC Uninsured Employers' Fund

Preparer's Name: Joe Ann Calvy

Preparer's Phone #: (843) 354-9000

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

☐ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$405.47 (Per previous Order)

2. AWW: \$608.18 (Per previous Order)

Date of Injury: 01/07/13

3. Type of injury and body part(s): Bilateral hips, left leg, left knee, left ankle, right shoulder

4. Facts in controversy:

This hearing was set on the Form 50. On January 7, 2013 Claimant fractured both of his hips, tore his left ACL and fractured his left ankle in a logging accident. He has had multiple surgeries and is still left with pain to all injured members. In addition, he has continued to complain of right shoulder pain but this has been ignored. The Employer, J. Mac Express was an uninsured employer at the time. In accordance with a previous Order signed by Commissioner Barden, Greg Blakely Logging, Inc. was deemed the statutory employer. Claimant was released at MMI on December 9, 2014 by Dr. Alan at McLeod Physician Associates. Dr. Alan opined that Claimant is unable to return to his previous work as a truck driver, that he is restricted to sedentary or light physical exertion, that he will need a right hip replacement in the next 5-10 years, and he will need continued anti-inflammatories as needed for pain. Claimant saw Fi Fi Jubran for a vocational assessment. Ms. Jubran concluded that a reasonable stable market does not exist for Claimant. (See Exhibits for Order) The issues presented are a. Whether Claimant has reached maximum medical improvement and/or whether ongoing or future medical treatment will tend to lessen the period of disability b. Determination of Claimant's permanent disability to include whether Claimant is permanently and totally disabled. c. Whether Utica-Mohawk Mills vs. Orr and James v. Anne's Inc are applicable d. Whether Claimant is entitled to payment of unpaid medical bills e. Whether Claimant is entitled to payment of award in lump-sum.

5. Legal issues involved: \$42-9-10(average weekly wage & compensation rate, permanent total disability), \$42-9-20(permanent disability-loss of earning capacity) \$42-9-30 (permanent partial disability) \$42-15-60(medical treatment), \$42-9-260(temporary total disability, penalties & interest), Utica-Mohawk Mills vs. Orr, 227 S.C. 226.87 SE2d 589 (1955) and James v. Anne's Inc., 2010 WL 4184120 (2010).

6. Unusual aspects:

7. Witnesses (designate if expert):*

Claimant, Representatives of the Employer or anyone listed as a witness on the Employer's Pre-Hearing Brief(WCC F.58)

a. Exhibits: Claimant's Deposition (any other depositions taken in this case), See attached Notice of Witnesses and Written Medical Reports c. All Exhibits listed by employer in its Pre-Hearing Brief(WCC F.58)

b. Medical evidence (Indicate report pursuant to R.67-612; deposition or appearance):

See attached Notice of Witnesses and Written Medical Reports

c. Name, address, and specialty, if any, of the treating physician:

See attached Notice of Witnesses and Written Medical Reports

- d. Impairment rating(s); body part(s); physician and date of opinion:
37% RLE, 31.25% LLE, (20% right hip, 7% left knee by Dr. Alan on 05/07/14, 37% right hip, 17% left knee, 5% left ankle Dr. Alan on 06/28/13, additional 9.25% to the LLE for left thigh for femoral nerve weakness.)

12. I am amending my Form 50/51 in the following manner: _____

☒ Mediation

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

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

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

I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Susan S. Barden, Commissioner S. C. Workers' Compensation Commission, P.O. Box 1715, Columbia, S. C. 29202, on the _____ day of _____ by: ☒ first class postage ☐ certified mail ☐ personal service.

Signature: _____

Date of hearing: March 25, 2015 at 12:00 P.M.

Email: jcalvy@sc.rr.com

Time needed for hearing: 1hr

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

WCC Form # 58
Revised 7/13

58

PRE-HEARING BRIEF

STATE OF SOUTH CAROLINA

BEFORE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1301480

Ronnie McDonald,

Employee,

Claimant,

-VS-

J Mac Express, LLC/Gregg Blakely

Employers,

AND

WC Uninsured Employers Fund and
Palmetto Timber Fund,

Carriers,

Defendants.

*NOTICE OF WITNESSES AND
WRITTEN MEDICAL
REPORTS TO BE
INTRODUCED AS DIRECT
EVIDENCE ON BEHALF
OF CLAIMANT*

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION, LISA
GLOVER, ESQUIRE AND WALTER BAREFOOT, ESQUIRE

YOU ARE NOTIFIED that the Claimant, pursuant to the provisions of the South Carolina Workers' Compensation Act and Section 1-23-330 of the South Carolina Code of Laws (Cum. Supp. 1988) submit the following medical records and other documents as evidence:

	NAME OF APA # PROVIDER/OTHER(S)	DATE(S) OF RECORDS	NUMBER
1.	FI FI Jubran Vocational Specialist	08/08/14	1-9
2.	Drs. Alan and Watford McLeod Orthopaedics	02/01/13-06/23/14	10-49, 60-62

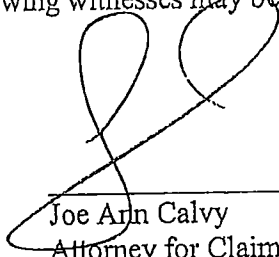
3.	Williamsburg Regional Hospital Physical Therapy	04/25/13-09/01/13	50-59,63-108
4.	McLeod Regional Medical Center	02/07/13	109-112
5.	Carolinas Rehabilitation Hospital	02/12/13	113-115
6.	Williamsburg Regional Hospital	01/07/13-01/29/13	116-150
7.	SCWCC Decision and Order	08/13/13	151-162

YOU ARE FURTHER NOTIFIED that you have the right to cross-examine or otherwise oppose this evidence and, should you desire to exercise this right, you are to promptly schedule the deposition of any provider whose records are submitted, for the purposes of cross-examination, or otherwise promptly submit opposing medical records into evidence.

YOU ARE FURTHER NOTIFIED that these records, or photocopies of the same, will be provided to the South Carolina workers' Compensation Commission for insertion in their file and for consideration as evidence on behalf of the Claimant.

YOU ARE FURTHER NOTIFIED that the following witnesses may be called on behalf of the Claimant.

1. Claimant



Joe Arn Calvy
Attorney for Claimant
P. O. Box 610
Kingstree, S. C. 29556
(843) 354-9000

March 11, 2015
Kingstree, South Carolina

STATE OF SOUTH CAROLINA

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Ronnie McDonald)
Claimant,)

CERTIFICATE OF SERVICE

vs.)

Gregg Blakely Logging, Inc., et al.)

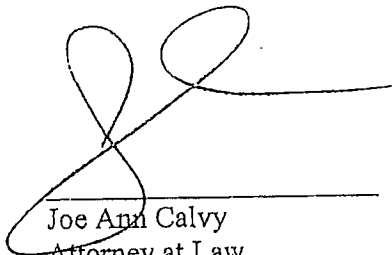
Defendant (s),)

I, Joe Ann Calvy, hereby certify that I mailed a copy of the Form 58 to Walter Barefoot, Esquire and Lisa Glover, Esquire, by placing copies of the same in the United States mail with sufficient postage attached and have served the S. C. Workers' Compensation Commission via eCase upload, this 11th day of March, 2015. The exhibits were also mailed to Mr. Barefoot and Mrs. Glover along with the Form 58

Commissioner Susan S. Barden
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, S. C. 29202-1715

Walter Barefoot, Esquire
Turner, Padget Graham & Laney, P. A.
Attorneys at Law
P. O. Box 7489
Florence, S. C. 29502

Lisa Glover, Esquire
WC Uninsured Employer's Fund
100 Executive Center Drive
Suite 101, Santee Building
Columbia, SC 29210



Joe Ann Calvy
Attorney at Law
P. O. Box 610
Kingstree, S. C. 29556
(843) 354-5504

Fi-Fi Jubran, M.A., CRC, CCM, CDMS
Rehabilitation Consultant

2 Sweet Jasmine Court
Columbia, SC 29229

Telephone: (803) 556-8357
Fax: (803) 699-0532

Claimant: Ronnie McDonald

August 8, 2014

Date of Birth: August 24, 1967

Date of Injury: January 7, 2013

SSN: [REDACTED]

Date of Evaluation: July 14, 2014

Purpose of Evaluation: Determine Whether Ronnie McDonald

VOCATIONAL REHABILITATION ASSESSMENT

INTRODUCTION:

File referred by attorney, Ms. Joe Ann Calvy for a Vocational Rehabilitation Assessment for the purpose of determining whether Mr. Ronnie McDonald is employable. Evaluation took place on July 14, 2014 at Barnes and Noble.

INJURY/MEDICAL STATUS:

On January 7, 2013, Mr. Ronnie McDonald was working as a Truck Driver for J. Macs Express. His brother was loading the truck with logs. He was swinging logs. Mr. McDonald came across the trailer and was hit with a log. It fractured his left hip. His right hip was crushed out of the socket. An ambulance took him to Williamsburg Regional where he was hospitalized for three weeks. He was sent to an inpatient facility to learn how to walk again.

On July 17, 2013, Mr. Ronnie McDonald was seen by Dr. Alan. The office note reads, "Constitutional: Patient returns for following evaluation. He had a work-related looking accident resulting in a right hip acetabular fracture which was treated operatively by my partner. He also had a proximal tibia fracture, fibula fracture with ACL tear and distal tibia fracture as well. The injuries to the left lower extremity were treated nonoperatively. His main complaint is pain and stiffness in the hip. He also complains that the leg once to give out on him with routine walking. He has been wearing a brace. He also complains of popping in the knee when he is using the clutch on his truck. He has had a trail of return to work and

Page Two
Ronnie McDonald
Vocational Rehabilitation Assessment

is not comfortable with his work duties. Assessment: Current tear of meniscus. ACL Tear. Work-related injury. Aftercare for healing traumatic fracture of hip. Treatment: 1. Current tear of meniscus: Patient continues to be symptomatic from his knee. He has had therapy and has been using a brace. At this point, I recommend arthroscopy with possible chondroplasty, partial meniscectomy, and left knee ACL reconstruction. I discussed the use of autologous versus allograft. I discussed the potential for donor site morbidity with auto graft versus potential for transmitted disease with allograft. Patient has been set up for surgery August 15, 2013 pending medical clearance."

On July 24, 2013, Mr. McDonald was seen again by Dr. Kyle Watford. The office note reads, "Constitutional: Mr. McDonald is here for follow-up. He complains of right hip pain and discomfort. He states the pain is regular and it is difficult for him to sit on hard chairs for lengthy periods of time. Assessment: Hip arthritis. Plan: Hip arthritis: We will arrange for an intraarticular injection of the right hip. He understands that this may or may not relieve his pain but is willing to give this a try. He will return to work with no restrictions. He is scheduled for left knee arthroscopy with Dr. Alan in mid-August".

On August 15, 2013, Dr. Rodney Alan performed diagnostic arthroscopy of Mr. Ronnie McDonald's left knee at McLeod Regional Medical Center. The postoperative diagnosis was: 1. Partial ACL tear, with symmetric stability on exam under anesthesia, left knee. 2. Minor raying of the posterior horn of the medial meniscus, left knee. 3. Grade 2 chondromalacia, medial femoral condyle, left knee. The operative report read, "The patient had a negative pivot shift on exam under anesthesia, with the Lachman's and drawer testing. His exam was symmetric to the contralateral side. Diagnostic arthroscopy revealed fibers intact, but the left knee ACL, grade 2 chondrodromalacia of the medial femoral condyle and minor fraying of the edges of the meniscus and posterior horn of the medial meniscus."

On August 28, 2013, Mr. McDonald was seen by Dr. Alan. The office notes read, "Constitutional: Patient returns for follow-up after left knee arthroscopy. No complaints. Assessments: 1. Surgery follow-up examination. Treatment: 1. Surgery follow-up examination. Continue physical therapy."

Page Three

Ronald McDonald

Vocational Rehabilitation Assessment

On October 9, 2013, the claimant was seen by Dr. Kyle Watford. The office notes read, "Constitutional: Patient presents to the office today for evaluations/p right acetabulum, ORIF January 2013, complaining of same right hip pain today that is intermittent in nature, ambulating well on his RLE. He complains mostly of left knee pain, underwent previous left knee arthroscopy by Dr. Alan, and has a hinge brace in place. Denies his right hip giving out, just has some pain at times mostly anterior hip. Assessment: 1. Arthritis pain, hip - 716.95 (Primary), post traumatic arthritis hip. Plan: 1. Arthritis pain, hip: Patient seen and evaluated x-rays reviewed of right hip, hardware in good alignment, fracture has healed, and post traumatic arthritis is noted."

On October 9, 2013, Mr. McDonald was also seen by Dr. Alan. The notes read, "Constitutional: Patient returns for follow-up status post left knee arthroscopy. At the time of surgery patient had partial ACL tear felt to be stable but requiring reconstruction. Patient has completed physical therapy. He wears a brace. He had a work-related injury to the knee with a log, fell on him. He also has posttraumatic arthritis of the right hip. He had an acetabular fracture. Acetabular fracture was treated surgically. Assessments: 1. Surgery follow-up examination... Treatment: 1. Surgery follow-up examination. I suspect the patient's stretch will gradually return in the left knee. Continue brace as needed. Remain out of work. Patient has follow-up with Dr. Watford for the right hip. He seemed to have responded to a steroid injection in the hip and I recommend avoiding hip replacement until the patient is older. I will see him for final visit after his follow-up with Dr. Watford for final evaluation and rating."

On January 15, 2014, Mr. McDonald was seen by Dr. Alan. His office notes read, "Patient comes in complaining of acute knee pain and swelling around the holiday time. The swelling has improved with diclofenac. He has some minimal pain at baseline in the knee. The severe pain has resolved. He does report some intermittent episodes of the knee giving out. He had a partial ACL tear that was not reconstructed. He has been using a brace. Treatment: Will order ACL brace, we will screen for gout."

On February 3, 2014, Mr. McDonald was seen by Dr. Kyle Watford. The orthopedist's notes read, "Constitutional: Patient is a 46-year-male who is well-known to me. He did have a posterior wall acetabulum fracture treated with open reduction internal fixation at over a year ago. This was something that was done a little bit sub-acute as he was 3-4 weeks out. I believe from his original injury when this was done. He is back today, having some significant pain in his right hip. He does report he had good relief from a previous intra-articular injection into his right hip many months ago. Assessments: 1. Hip arthritis- 716.95 (Primary). Posttraumatic arthrosis right hip. Plan: 1. Hip arthritis: I have ordered AP and lateral x-rays of the right hip which show some rather significant degenerative

Page Four
Ronnie McDonald
Vocational Rehabilitation Assessment

joint disease at his right hip. This is a little worse than his last films. He was supposed to see Dr. Allen today for his left knee and I do think it would be reasonable for Dr. Alan to see him to see if he thinks he is a candidate for total hip arthroplasty. I have also made sure that he understands that Dr. Almy also order an injection into his right hip."

On May 7, 2014, Mr. McDonald was seen by Dr. Alan. The office notes read, "Constitutional: Patient returns for follow-up. He has a partial tear of the left ACL and has had some intermittent episodes of giving way. The right hip hurts in the groin. He had open reduction internal fixation of acetabulum fracture. His pain is 4-8/10. He takes diclofenac intermittently. Treatment: 1. Work related injury: Patient currently with hip pain however, I do not think hip replacement surgery will improve his condition at this time. I believe he will need hip replacement in the next 5-10 years. Patient continues to have occasional symptoms from the left knee. I do not think reconstruction will improve this. He should continue with an ACL brace. He will need to wear this with activities. He will need a new one every year or two when it wears out. After talking with the patient, I believe he is at maximal medical improvement. He will eventually need a right hip replacement. He will need to continue using a knee brace. He will need continued anti-inflammatories as needed for pain. Based on his description of his job duties as a logger, I do not think he will be capable of returning to this occupation. He should be capable of caring out the duties of a job that required sedentary or light physical exertion as defined by Social Security. He has 20 percent impairment to the right hip based on his work-related injury. This is based on the diagnosis-related estimate of cruciate ligament tear with mild instability based on the fifth edition of the AMA guides to see the evaluation of permanent impairment."

On May 28, 2014, Mr. McDonald was seen by Dr. Alan. The office notes read, "Constitutional: Patient returns for follow-up evaluation. He had a work-related injury affecting his right hip, left knee, and left leg. His primary complaint today is pain in the right hip. Pain is associated with stiffness. Pain is 7/10. He is wearing a brace on the left knee. He is taking diclofenac. Assessment: 1. Right hip pain. 2. ACL tear. 3. Left ankle pain. 4. Left knee pain. Treatment: 1. Work related injury: 37 percent permanent impairment to right hip, 17 percent permanent impairment to left knee, 5 percent permanent impairment left ankle. Impairment based on diagnostic related estimates in the fifth edition of the AMA guides to the evaluation of permanent impairment. 2. Others: The patient has posttraumatic arthritis of the right hip is a direct result of his work-related injury. He is too young for hip replacement. He has had surgery and the hardware is in good position and appears stable. I recommend conservative treatment for his hip. He also has an ACL tear. We are treating this in a brace, she will need to continue

using the anytime he has instability or pain in the knee. I do not recommend surgery unless he is actively engaged in pivoting-type sports or having instability symptoms with routine activities such as walking. The patient has reached maximal medical improvement. I am going to allow him a trial to return to work. I believe he will be best off if he is able to return to the work that he is trained to do. He describes driving trucks long distances. I am going to approve that with permanent restrictions. He has been instructed to return if his work demands exceed his abilities. He will need continued anti-inflammatories and Tylenol as needed. He will need a hip replacement in the future. He will need a knee replacement in the future. Hopefully, this will be after he turns 60."

CURRENT MEDICATIONS:

Mr. McDonald takes the following medications:

1. Diclofenac Sodium 75 milligrams, one tablet three times a day for pain.
2. Ultram 50 milligrams, one tablet every six hours for pain.
3. Naprosyn 500 milligrams as needed every twelve hours

Regarding side effects, Mr. McDonald indicated they make him sleepy and effect his concentration.

ACTIVITIES OF DAILY LIVING:

Mr. McDonald is married with three sons, ages 25, 22, and 7 years old. The older boys live with him and the 7-year-old comes on the weekend. His wife has worked over 20 years as a Bus Driver. He barely gets four hours of due to the pain in his leg and hip. He is unable to get in a comfortable position. He wakes up around 10am. He eats breakfast at McDonalds. He tries to cook to help his wife but does it at his pace. She usually comes home and prepares dinner. Most of the time, he eats sandwiches.

When it comes to cleaning, Mr. McDonald explained that prior to his work injury; he used to mop, vacuum, wash dishes, and help do the laundry. Since the injury, he cannot vacuum or mop though he still tries. He does wash dishes and tries to fold the laundry. His wife cleans the bathrooms. He does more according to his symptoms. His wife scolds him for overexerting himself but he feels bad when he sees her doing most the housework.

Page Six

Ronnie McDonald

Vocational Rehabilitation Assessment

Mr. McDonald used to mow the yard, trim the bushes, and perform other yard work. Even though he has a riding lawnmower, he still cannot mow the lawn. His older sons do most of the yard work now. Sometimes, he tries to pick up trash.

The claimant goes to Church once or twice a month. When he was working, he was unable to go to Church often. Now, just sitting in Church over half an hour bothers his hip. He has never been involved in Church activities. His wife participates in them. His friends visit him sometimes but not often. When asked if he eats out, he indicates he eats out once every three months.

The injured worker watches over ten hours of TV. He is usually sitting in a recliner with his legs elevated at waist level. Sometimes, he dozes off because of the medication. He does not read. He indicates his eyesight is poor and he can barely see print. Anyway, he indicates he does not read very well.

Mr. McDonald admitted he is depressed because he misses working. He wishes there was something he could do but at times, the pain is overwhelming. Counselor noticed he turned his face and wiped at his eyes. She asked him if he has crying spells. He shook his head but Counselor told him it was ok. He indicated he does cry occasionally when he is alone about "the way my life turned out". He keeps that away from his wife and family, stating they have enough to deal with him not being able to help out. It was apparent, based on his statements, that he perceived himself to be a burden on his wife and children.

EDUCATIONAL BACKGROUND:

Mr. McDonald completed the 12th grade at Winnsboro Blakely High School in 1978. He maintained a D average. He indicated he was okay in Math but barely got by in English.

He has had no further formal schooling except for brief on the job training and orientations. He has a CDL, which has expired.

TESTING RESULTS:

Mr. McDonald was administered the Wide Range Achievement Test Revision 4 (WRAT4) by this Consultant. The WRAT 4 is a screening tool that evaluates word recognition, spelling, mathematical ability, and sentence comprehension. It is used to assess the foundational skills needed for academic success. Mr. McDonald's scores were derived from age-appropriate norms and are noted below:

Page Seven
Ronnie McDonald
Vocational Rehabilitation Assessment

Subtest	Raw Score	Standard Score	Grade Equivalents
Word Reading	40	73	4.7 Grade
Sentence Comprehension	14	58	2.8 Grade
Spelling	25	64	3.0 Grade
Math Computation	30	76	4.6 Grade

Mr. McDonald's Spelling was equivalent to a 4th grade level. His Math was equivalent to a 4th grade level. The claimant's Sentence Comprehension was equivalent to nearly 3rd grade level. His Word Reading was at nearly a 5th grade level. Mr. McDonald's was felt to have given very good effort. His results are inconsistent with his educational level except this Consultant was not surprised based on her experience with the population in this rural area and the school system.

WORK HISTORY:

For one year, Mr. McDonald worked for WBT Trucking in Georgia. He drove a truck. For a year and a half, he worked for Georgetown Carrier in Georgetown, SC as a Truck Driver carrying rocks, gravel, and sand.

For three years, the claimant worked as a Truck Driver for Paisley Trucking. He carried produce and logs the majority of the time. For two years, Mr. McDonald worked for Tri-County Gin carrying cotton gin seed.

At the early age of 16, Mr. McDonald drove a school bus for three years. He then worked as a Machine Operator at AG Whaley, a wire plant. He worked as a Cook at Calabash. He also worked as a Janitor for many years.

VOCATIONAL CONCLUSIONS AND RECOMMENDATIONS:

Mr. McDonald has an excellent work history, which reflects a good work ethic. His work history consisted of work as a Truck Driver, Janitor, Machine Operator, and Bus Driver. Most of these jobs are unskilled such as Janitor and Machine Operator since they have an SVP of 2. The Truck Driver and Bus Driver are semi-skilled and have an SVP of 3, making them semi-skilled. But, there are some jobs that are classified as semi-skilled by the Dictionary of Occupational Titles which is published by the US

Page Eight
Ronnie McDonald
Vocational Rehabilitation Assessment

Department of Labor, that are unique and specific, meaning the skills gained can only be used in that industry and job and are not readily transferable to other jobs and industries. They may as well be unskilled with regards to transferable skills. Specific Vocation Preparation is defined as the amount of lapsed time require by a typical worker to acquire the information, and develop the facility for average performance in a specific job-worker situation. This training may be acquired in a school, work, military, institutional, or vocational environment. It does not include the orientation time required of a fully qualified worker to become accustomed to the special conditions of any new job. Specific vocational training includes; vocational education, apprenticeship training, in-plant training, on-the-job training, and essential experience in other jobs. Transferability of skills applies to work skills which a person has demonstrated in vocationally relevant past jobs that can be used to meet the requirements of other jobs. Transferability of skills is most probable and meaningful among jobs requiring similar skills, when similar tools and machines are utilized and when similar processes and services are involved.

The claimant's prior jobs involved heavy lifting, up to 70 pounds constantly, prolonged standing and walking, frequent stooping, kneeling, and handling. Dr. Alan has limited Mr. McDonald to sedentary work. The orthopedist responded to a letter from Attorney Joe Ann Calvy indicating that Mr. McDonald would have pain with no prolonged standing and walking.

When Mr. McDonald's significant physical limitations are considered, it is highly unlikely he will be able to find or sustain employment. Based on his physical limitation, he is not a reasonable vocational rehabilitation candidate. And because of the length of time he has been disabled and he fact he will vocational prognosis will change. Consequently, I do not believe a reasonable stable market exists or the type of services that Mr. McDonald is physically, educationally or vocationally capable of performing/sustaining.

The claimant's Reading, Spelling, and Sentence Comprehension scores suggest unskilled work. Based on his testing scores, he would not qualify for clerical type jobs. He does not have the aptitude for clerical sedentary work. He does not have basic math skills required in many manufacturing jobs. He could not do any jobs requiring Reading, Spelling, and Math skills.

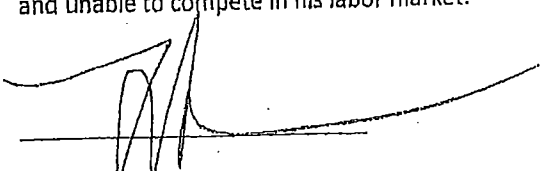
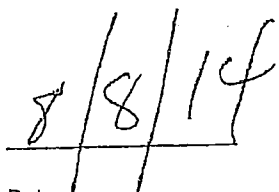
Mr. McDonald's impairments render this client unable to engage in any gainful work activity in the US Labor Force. Disability must also include the labor market in which an injured worker lives in and the likelihood of obtaining employment in that area. Mr. McDonald lives in a very rural area which has a higher unemployment rate than the rest of the United States. The textile plants have closed down years ago and lay off workers and no other businesses have replaced them due to the lack of higher education in the population that could attract potential employers.

Page Nine
Ronnie McDonald
Vocational Rehabilitation Assessment

He would not be unable to meet minimal qualifications for jobs, and could not persist at work activities for an eight hour day, over a period of weeks or months. He would need to alternate positions. He needs to be able to get up and walk around to relieve the stiffness he gets which was documented in Dr. Alan's reports. Additionally, the pain medications that he has to take cause him to be sleepy and affect his concentration.

If Mr. McDonald were to somehow find a sedentary job, which is highly unlikely, he would only earn the minimum wage of \$7.25 per hour. It would have to be a sedentary assembler job. He would have to be allowed the ability to alternate positions and get up and walk around due to the stiffness he reports. This is an accommodation that many potential employers will not make.

Taking into consideration Mr. McDonald's age of 46, his low testing scores, his limited education, and his medical restrictions; it is the professional opinion of this Consultant that Mr. McDonald is unemployable and unable to compete in his labor market.


Fifi Jubran, MA, CRC, CCM, CDMS
Rehabilitation Consultant
Date

Feb. 9. 2015 2:43PM

No. 7342 P. 2
No. 717

§ 8.5 Medical Statement Regarding Physical and Mental Abilities and Limitations for
Social Security Disability Claim

Patient: Ronnie McDonald Social Security Number: _____

Diagnoses: Right hip pain, Quadriceps weakness, neuropathy, hip
arthritis, work related injury, denervation atrophy of muscle, ACL laxity

In my medical opinion this patient has the following limitations and abilities (Circle answers):

1. Standing at one time: None 15 minutes 30 minutes 60 minutes 2 hours 4 hours
2. Sitting at one time: None 15 minutes 30 minutes 60 minutes 2 hours 4 hours
3. Hours patient can work per day: None 1 hour 2 hours 4 hours 6 hours 8 hours
Sedentary
4. Lifting on an occasional basis: None 5 pounds 10 pounds 20 pounds 50 pounds/more
5. Lifting on a frequent basis: None 5 pounds 10 pounds 20 pounds 50 pounds/more
6. Bend: Never Occasionally Frequently Constantly
7. Stoop: Never Occasionally Frequently Constantly
8. Manipulation right hand: Never Occasionally Frequently Constantly
9. Manipulation left hand: Never Occasionally Frequently Constantly
10. Raise left arm over shoulder level: Never Occasionally Frequently Constantly
11. Raise right arm over shoulder level: Never Occasionally Frequently Constantly
12. Need to elevate legs during 8 hour workday: None Occasionally Frequently Most of Time

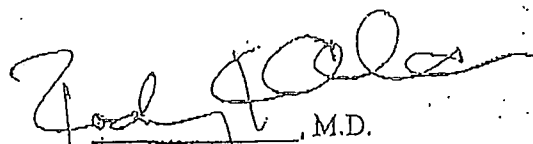
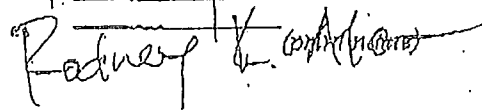
13. Psychiatric Limitations	Not Signifi- cantly In- paired	Moderately Impaired	Markedly Impaired	Extremely Impaired
a) The ability to understand, remember and carry out very short and simple instructions	☐	☐	☐	☐
b) The ability to understand, remember and carry out detailed instructions	☐	☐	☐	☐
c) The ability to maintain attention and concentration	☐	☐	☐	☐
d) The ability to work with others	☐	☐	☐	☐
e) The ability to interact appropriately with the general public	☐	☐	☐	☐
f) The ability to accept supervision	☐	☐	☐	☐
g) The ability to get along with coworkers	☐	☐	☐	☐

Comments: I do not believe this patient is capable of being
a truck driver.

Feb. 9. 2015 2:43PM

No. No. 7342 P. 3

Date: 1/30/15


Rodney L. Adams, M.D.


McLeod

Physician Associates

MCDONALD, RONNIE E

47 Y old Male, DOB: 08/24/1967

Account Number: e868929

KINGSTREE, SC-29556

Home: 843-295-5566

Guarantor: MCDONALD, RONNIE E

Insurance: WALKER, HUNTER AND ASSOC Payer

ID: PAPER

PCP: Blake H Moore, MD

Appointment Facility: McLeod Orthopaedics

12/09/2014

Progress Notes: RODNEY K. ALAN, MD

Current Medications

Unknown

- Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid

- Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN

- Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000
 diagnostic left knee arthroscopy, ACL was only partially torn
 RT HIP SURGERY DR WATFORD 2013

Family History

3 brother(s), 2 sister(s) - healthy. 3 son(s) - healthy.
 NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social HistoryTobacco 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.

Miscellaneous:

Marital status: Married, Occupation: not employed, Living with: spouse.

Drug/Alcohol:

Drugs: Denies, Alcohol: Did you have a drink containing alcohol in the past year?: No, Points: 0, Interpretation: Negative.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

Reason for Appointment

1. REVIEW NCS

History of Present IllnessConstitutional:

Patient returns for follow-up evaluation. He had a work injury. He was having persistent giving way of his knee which has a partial anterior cruciate ligament tear. On exam he was noted to have impressive quadriceps atrophy which persisted in spite of physical therapy. Nerve conduction study showed L2-3 denervation. When I talked to the patient he described having a large area of ecchymosis in the left thigh that resolved prior to presenting to our office. He was originally treated as an inpatient in Kingstree. I obtained an MRI of the lumbar spine which did not reveal pathology to explain this level of L2-3 radiculopathy. Based on the results of his nerve conduction study I suspect a blunt injury to the left thigh which has led to this L2-3 denervation.

Vital Signs

Wt 180, Ht 69, BMI 26.58, Temp 98.0.

ExaminationGeneral Examination:

Male in no distress. He has left quadriceps atrophy.
 I reviewed the results of his nerve conduction study.

Assessments

1. Right hip pain - 719.45 (Primary)
2. Quadriceps weakness - 728.87
3. Neuropathy - 355.9
4. Hip arthritis - 716.95
5. Work related injury - 959.9
6. Denervation atrophy of muscle - 356.1
7. ACL laxity - 717.9

Treatment

1. Right hip pain

Notes: Patient's right hip pain is consistent with posttraumatic arthritis. When his symptoms worsen he will need right hip replacement.

SEE ABOVE

Review of Systems
SEE ATTACHED.

2. Quadriceps weakness

Notes: The quadriceps weakness is due to L2 and 3 denervation. The only treatment for this is therapy.

3. Work related injury

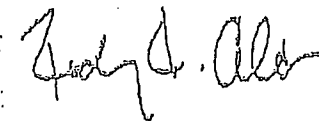
Notes: I do not believe this patient is capable of being a truck driver.

4. Others

Notes: Patient's work injuries include right hip impairment, nerve impairment to left leg, and anterior cruciate ligament injury. We will need to calculate permanent impairment. The patient has permanent physical restrictions as outlined in the note. He will need a right hip replacement in the future. He will need to use a brace for the left knee to prevent giving way episodes.

Follow Up

prn



Electronically signed by RODNEY ALAN, MD on 12/09/2014
at 03:03 PM EST

Sign off status: Completed

Addendum:

12/09/2014 03:12 PM ALAN, RODNEY K > The patient has an additional 9.25 percent impairment to the left thigh from femoral nerve weakness. This is based on table 1737 in the fifth edition of the AMA guides using the 25% multiplier from table 16-11 for resistance of muscle against gravity.

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 12/09/2014

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

Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 12/09/2014

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

McLeod
Physician Associates

MCDONALD, RONNIE E

47 Y old Male, DOB: 08/24/1967

Account Number: e868929

, KINGSTREE, SC-29556

Home: 843

Guarantor: MCDONALD, RONNIE E

Insurance: WALKER, HUNTER AND ASSOC Payer

ID: PAPER

PCP: Blake H Moore, MD

Appointment Facility: McLeod Orthopaedics

10/07/2014

Progress Notes: RODNEY K. ALAN, MD

Current Medications**Unknown**

- o Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid
- o Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN
- o Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000
diagnostic left knee arthroscopy, ACL was only partially torn
RT HIP SURGERY DR WATFORD 2013

Family History

3 brother(s), 2 sister(s) - healthy. 3 son(s) - healthy.
NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History**Tobacco Use:**

Smoking Are you a: current smoker, How many cigarettes a day do you smoke? 6-10, How often do you smoke cigarettes? every day.

Allergies

N.K.D.A.

Hospitalization/Major**Diagnostic Procedure**

SEE ABOVE

Review of Systems

SEE ATTACHED.

Reason for Appointment

1. ROUTINE FOLLOW UP: MRI/NCS REVIEW

History of Present Illness**Constitutional:**

Patient returns for followup evaluation. He is planning of pain in the right buttock. He has had a fracture of the acetabulum with pelvic fixation. He had I nerve conduction study quadriceps weakness and atrophy. Preliminary report of nerve conduction study demonstrates L4 radiculopathy.

Vital Signs

Ht 69, Temp 98.3, HR 100, BP 156/104.

Examination**General Examination:**

Male in moderate distress. Some sitting intolerance. Severe quadriceps atrophy left leg.

Assessments

1. Right hip pain - 719.45 (Primary)
2. Quadriceps weakness - 728.87
3. Neuropathy - 355.9

Treatment**1. Right hip pain**

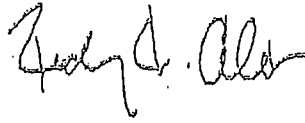
Notes: Right hip would benefit from hip replacement when symptoms are severe enough. I reviewed this with the patient. He is not an ideal age for hip replacement however if his symptoms are severe we would proceed with surgery.

2. Quadriceps weakness

Notes: Quadriceps weakness his do to L4 radiculopathy. We are awaiting the final rating of the nerve conduction study. The patient needs an MRI because the most common site of nerve root irritation is the lumbar spine.

Follow Up

6 Weeks (Reason: followup nerve conduction study report)



Electronically signed by RODNEY ALAN, MD on 10/07/2014
at 02:43 PM EDT

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 10/07/2014

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

McLeod
Physician Associates

MCDONALD, RONNIE E

47 Y old Male, DOB: 03/24/1967

Account Number: e868929

~~XXXXXXXXXX~~ KINGSTREE, SC-29556

Home: 843-XXXXXX

Guarantor: MCDONALD, RONNIE E

Insurance: WALKER, HUNTER AND ASSOC Payer

ID: PAPER

PCP: Blake H Moore, MD

Appointment Facility: McLeod Orthopaedics

08/27/2014

Progress Notes: RODNEY K. ALAN, MD

Current Medications

Taking Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid
Taking Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN
Taking Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000
diagnostic left knee arthroscopy, ACL was only partially torn
RT HIP SURGERY DR WATFORD 2013

Family History

3 brother(s), 2 sister(s) - healthy. 3 son(s) - healthy.
NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

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.

Miscellaneous:

Marital status: Married. Occupation: not employed. Living with: spouse.

Drug/Alcohol:

Drugs: Denies. Alcohol Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

Reason for Appointment

1. F/u with problems to left leg

History of Present Illness

Constitutional:

Patient returns for evaluation. He had a work-related injury to the left knee and right hip. He reports over the past few months worsening weakness and atrophy in the left quadriceps and tightness in the left hamstring with pain in the left buttock and left lower extremity. No bowel or bladder problems. He does not report radicular symptoms. He is wearing a knee brace for work related left knee ACL injury. He denies episodes of giving way only pain. He take ultram intermittently. He could not tolerated the side effects of naproxen.

Vital Signs

Wt 180, Ht 69, BMI 26.58, Temp 98.5, HR 79, BP 159/108.

Examination

General Examination:

Male in no distress. Left quadriceps has obvious atrophy. He has full range of motion of the knee. There is tightness in the hamstring area. He walks with a slight limp. There is decreased sensation in the left leg compared to the right in an L4 distribution.

He has regular palpable pulses.

His skin is intact without evidence of any new injury.

I reviewed the patient's prior imaging.

Assessments

1. Quadriceps weakness - 728.87 (Primary)
2. Neuropathy - 355.9

Treatment

1. Quadriceps weakness

IMAGING: MRI: Lumbar without contrast

IMAGING: NCS-EMG

Notes: Will order nerve conduction study. Current problem is work related. Also needs MRI to rule out pinched nerve.

He has so much atrophy in left quadriceps at the ACL brace is not fitting well. This may need to be adjusted or obtain a new one. We will

SEE ABOVE

Review of Systems
SEE ATTACHED.

hold on this for now while we are working up his atrophy.

Diagnostic Imaging

Imaging: Knee-LT /3 Views

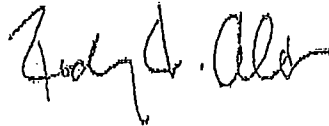
HOLLOMAN, CANDACE 08/27/2014 10:45:44 AM EDT > done
ALAN, RODNEY K 08/27/2014 11:46:51 AM EDT > Left knee 3
views demonstrates prior fibular fracture now healed and
unchanged from prior imaging.

Procedure Codes

73562 Xray exam of knee 3

Follow Up

3 Weeks (Reason: f/u MRI and NCS)



Electronically signed by RODNEY ALAN, MD on 08/27/2014
at 11:48 AM EDT

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 08/27/2014

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

Jun. 24. 2014, 12:16 PM

No. 2659 P. 1
No. 2659 P. 2

Joe Ann Calvy, LLC

ATTORNEY AT LAW

P.O. Box 610 • 209 W. Main Street • Kingstree, SC 29556

TELEPHONE: (843) 354-9000
FAX: (843) 354-5845

EMAIL: JCALVY@SC.MY.COM
PAGE: 1-800-800-9698
WWW.JOECALVY.COM

VIA FACSIMILE 843-777-7925

Monday, June 23, 2014

Att'n: Rodney Alan, MD
McLeod Orthopaedics
800 E. Cheves Street
Florence, SC 29506

Re: My Client: Ronnie McDonald
DOB: 08/24/1967
DOI: 01/07/2013

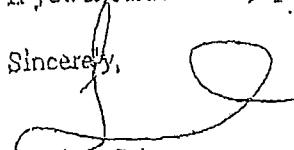
Dear Dr. Alan:

Thanks for your prompt response to the previous letter we faxed you on June 10, 2014 indicating when Mr. McDonald will need a hip replacement.

Accordingly, we ask that you please specifically indicate Mr. McDonald's functional limitations with respect to standing, sitting, and walking and what kind of problems it could cause to his hip if he exceeds those work limitations.

If you should have any questions or concerns, please contact our office for further assistance.

Sincerely,


Joe Ann Calvy
Attorney at Law

JAC/bsw

enc

cc: Ronnie McDonald

5-10 yrs
Anticipate
with pain
prolonged
standing
and
walking
Zoe

Jun. 11. 2014, 1:44 PM
Jun. 11. 2014 2:11 PM

No. 2435 P. 1
No. 2021 P. 2


Joe Ann Calvy, LLC

ATTORNEY AT LAW

P.O. Box 610 • 209 W. Mill Street • Kingstree, SC 29556

TELEPHONE: (843) 354-9000
FAX: (843) 354-5845

E-MAIL: JCALVY@SC.BR.COM
FACER: 1-800-800-9698
WWW.JOEANNCALVY.COM

VIA FACSIMILE 843-777-7925

Tuesday, June 10, 2014

Att'n: Rodney Alan, MD
McLeod Orthopaedics
800 E. Cheves Street
Florence, SC 29506

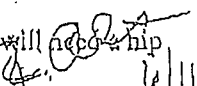
Re: My Client: Ronnie McDonald
DOB: 08/24/1967
DOI: 01/07/2013

Dear Dr. Alan:

Please indicate to a reasonable degree of medical certainty as to whether Mr. McDonald will need a hip replacement in the next 5-10 years.

Accordingly, please indicate below your opinion to the same.

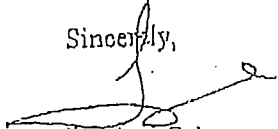
☒ Yes, to a reasonable degree of medical certainty, Mr. McDonald will need a hip replacement in the next 5-10 years.


Initials Date 6/11/14

☐ No, to a reasonable degree of medical certainty, Mr McDonald will not need a hip replacement in the next 5-10 years.

Initials Date

Sincerely,


Joe Ann Calvy
Attorney at Law

JAC/baw

McLeod
Physician Associates

MCDONALD, RONNIE E

46 Y old Male, DOB: 08/24/1967

Account Number: e868929

~~XXXXXXXXXX~~ KINGSTREE, SC-29556

Home: 843-XXXXXX

Guarantor: MCDONALD, RONNIE E

Insurance: WALKER, HUNTER AND ASSOC Payer

ID: PAPER

PCP: Blake H Moore, MD

Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

05/07/2014

Current Medications

Taking Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid

Taking Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN

Taking Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs

Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000

diagnostic left knee arthroscopy, ACL was only partially torn

Family History

NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

Tobacco Use:

Smoking Are you a: former smoker, How long has it been since you last smoked?: 1-3 months.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

SEE ABOVE

Review of Systems

SEE ATTACHED.

Reason for Appointment

1. ROUTINE 3 MONTH FOLLOW UP: RECHECK LEFT KNEE
2. XRAY RIGHT HIP AND LEFT KNEE

History of Present Illness

Constitutional:

Patient returns for followup. He had work-related injury to the right hip and left lower extremity. He has a partial tear of the left ACL and has had some intermittent episodes of giving way. The right hip hurts in the groin. He had open reduction internal fixation of acetabulum fracture. His pain is 4-8/10. He takes diclofenac intermittently.

Vital Signs

Wt 184, Ht 69, Temp 98.8, HR 76, BP 148/100, BMI 27.17.

Examination

General Examination:

Male in no acute distress. He has a slight limp to his gait. His right hip has full range of motion and movement of the right hip is not increased pain in the groin

The left knee has full range of motion. There is no effusion today. No gross instability. After carefully comparing Lachman and drawer on the right and left sides he may have slightly increased anterior laxity on the left when compared to the right.

AP and lateral right hip show stable appearance of acetabular fixation and preserved hip joints with some mild sclerosis of the acetabular dome

Left knee 3 views shows healed proximal fibular fracture otherwise normal.

Assessments

1. Work related injury - 959.9 (Primary)
2. Hip arthritis - 716.95
3. ACL tear - 844.2

Treatment

1. Work related injury

Notes: Patient currently with hip pain however I do not think hip replacement surgery will improve his condition at this time. I believe

he will need hip replacement in the next 5-10 years. Patient continues to have occasional symptoms from the left knee. I do not think reconstruction will improve this. He should continue with an ACL brace. He will need to wear this with activities. He will need a new one every year or 2 when it wears out.

After talking with the patient I believe he is at maximal medical improvement. He will eventually need a right hip replacement. He will need to continue using a knee brace. He will need continued anti-inflammatories as needed for pain. Based on his description of his job duties as a logger I do not think he will be capable of returning to this occupation. He should be capable of caring out the duties of a job that required sedentary or light physical exertion as defined by Social Security.

He has 20 percent impairment to the right hip based on his work-related injury. This is based on hip radiographic estimate based on the fifth edition of the AMA guides to the evaluation of permanent impairment.

He has a 7 percent impairment to the left knee as result of his work related left knee injury. This is based on the diagnosis-related estimate of cruciate ligament tear with mild instability based on the fifth edition of the AMA guides to the evaluation of permanent impairment.

Diagnostic Imaging

Imaging: Knee-LT /3 Views

HOLLOMAN, CANDACE 05/07/2014 11:28:19 AM EDT > done

Imaging: HIP/UNI-RT/2 VIEW MINIMUM (73510)

HOLLOMAN, CANDACE 05/07/2014 11:28:26 AM EDT > done

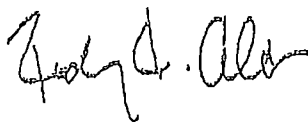
Procedure Codes

73562 Xray exam of knee 3

73510 Xray exam of hip

Follow Up

pm



Electronically signed by RODNEY ALAN, MD on 05/07/2014
at 12:30 PM EDT

Sign off status: Completed

Summary View for MCDONALD, RONNIE E

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 05/07/2014
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Summary View

Progress Notes

Provider: KYLE E. WATFORD, MD
Date: 02/03/2014

Patient: MCDONALD, RONNIE E
DOB: 08/24/1967 Age: 46 Y Sex: Male
Phone: 843-██████████
Address: ██████████, KINGSTREE, SC-29556
Pcp: Blake H Moore, MD

Subjective:

CC:

1. POSSIBLE RIGHT HIP INJECTION.

HPI:

Constitutional:

Patient is a 46-year-old male who is well-known to me. He did have a posterior wall acetabulum fracture treated with open reduction internal fixation at over a year ago. This was something that was done a little bit subacute as he was 3-4 weeks out I believe from his original injury when this was done. He is back today having some significant pain in his right hip. He does report he had good relief from a previous intra-articular injection into his right hip many months ago.

Family History:

Social History:

Medications: Diclofenac Sodium(Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid,
Ultram(TraMADol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN, Naprosyn(Naproxen) 500 mg
Tablet 1 tablet as needed every 12 hrs

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

He does have significant pain and try some rotation of his right hip. His surgical incisions are all well-healed. He is neurologically intact his right lower extremity. His pulses are 2+ bounding in his right lower extremity.

Assessment:

Assessment:

1. Hip arthritis - 716.95 (Primary)
Posttraumatic arthrosis right hip.

Plan:

1. Hip arthritis

I have ordered AP and lateral x-rays of the right hip which show some rather significant degenerative joint disease at his right hip. This is a little worse than his last films.

He was supposed to see Dr. Allen today for his left knee and I do think it would be reasonable for Dr. Allen to see him to see if he thinks he is a candidate for total hip arthroplasty. I have also make sure he understands that Dr. Almy also order an injection into his right hip.

Immunizations:

Diagnostic Imaging: HIP/UNI-RT/2 VIEW MINIMUM (73510) HOLLOMAN,CANDACE 02/03/2014 04:04:52
PM EST > done COBIA,CAROL 02/03/2014 04:12:14 PM EST > OK per Dr Watford

Labs:

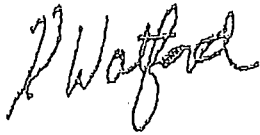
Procedure Codes: 73510 Xray exam of hip

Preventive:

Follow Up: prn

Summary View

Provider: KYLE E. WATFORD, MD
Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 02/03/2014

A handwritten signature in cursive script, appearing to read "K Watford".

Electronically signed by KYLE WATFORD , MD on 02/24/2014 at 08:41 AM EST
Sign off status: Completed

McLeod
Physician Associates

MCDONALD, RONNIE E

46 Y old Male, DOB: 08/24/1967

KINGSTREE, SC-29556

Home: 843-644-4444

Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880

PCP: Blake H Moore, MD

Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

02/03/2014

Current Medications

Diclofenac Sodium (Diclofenac Sodium
(Ophth)) 75 mg Tablet Delayed Release 1
tablet bid
Ultram (Tramadol HCl) 50 mg Tablet 1 tablet
as needed every 6 hrs PRN
Naprosyn (Naproxen) 500 mg Tablet 1 tablet
as needed every 12 hrs

Reason for Appointment

1. ROUTINE FOLLOW UP APPT TO REVIEW BLOODWORK

History of Present Illness

Constitutional:

The patient returns for followup evaluation. He had a work related locking injury. His injuries included a left knee ACL partial tear which has been treated without reconstruction, right hip fracture dislocation which has been treated with open reduction internal fixation, left ankle injury, and left proximal fibula fracture. Patient complains of intermittent pain in the right hip. The patient also complains of weak feeling in the knee if trying to drive a truck. Patient also reports some episodes of giving way of the knee on flat ground. He has not received his ACL brace yet. He most recently had a flareup of acute pain and swelling in the left knee just prior to Christmas. Blood work showed elevated serum uric acid level consistent with gout.

Examination

General Examination:

Male in no acute distress. He has a nonantalgic gait. Lachman and drawer testing are negative. He has no effusion and full range of motion of the left knee. When I take his right hip range of motion there is no crepitation and no exacerbation of pain and no instability of the hip.

Serum uric acid level reviewed elevated at 9.0.

Assessments

1. Hip arthritis - 716.95 (Primary)
2. ACL tear - 844.2
3. Gout - 274.9
4. Work related injury - 959.9

Treatment

1. Hip arthritis

The patient has posttraumatic right hip arthritis. Radiographs do not show significant bony changes and therefore recommend continued anti-inflammatories and Tylenol as needed for pain.

2. ACL tear

Patient has a partial ACL tear. On my examination in the office and under anesthesia I cannot elicit instability. I do not believe he has

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 02/03/2014
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

clinical instability to the point where ACL reconstruction would be beneficial. I recommend brace treatment only. After discussion with the patient and his wife they would like another opinion.
Referral To: Patrick Denton Orthopedic Surgery
Reason: Eval and treat

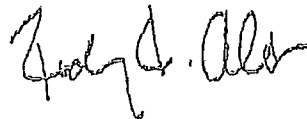
Referral To: Case Manager
Reason: please give patient ACL brace

3. Gout

Informed the patient that his uric acid level is elevated. We will refer to rheumatologist.
Referral To: Rheumatology
Reason: hyperuricemic gout, evaluate and treat

Follow Up

3 months (Reason: x-ray right hip, x-ray left knee)



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at 01:18 PM EST

Sign off status: Completed

McLeod Orthopaedics
800 E CHURCH ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 02/03/2014

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

McLeod

Physician Associates

MCDONALD, RONNIE E

46 Y old Male, DOB: 08/24/1967
KINGSTREE, SC-29556
Home: 843-444-4444

Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: Blake H Moore, MD
Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

01/15/2014

Current Medications

Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid
Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN
Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000
diagnostic left knee arthroscopy, ACL was only partially torn

Family History

NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

Tobacco Use:
Smoking Are you a: former smoker, How long has it been since you last smoked?: 1-3 months.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure
SEE ABOVE

Review of Systems

SEE ATTACHED.

Reason for Appointment

1. PROBLEM VISIT: PATIENT HAS C/O LEFT KNEE PAIN-PATIENT STATES HIS KNEE FEELS LIKE IT SLIPPING OUT OF PLACE
2. PATIENT DID NOT BRING IN MEDICATION -XRAY LEFT KNEE

History of Present Illness

Constitutional:
Patient comes in complaining of acute knee pain and swelling around the holiday time. The swelling has improved with diclofenac. He has some minimal pain at baseline in the knee. The severe pain has resolved. He does report some intermittent episodes of the knee giving out. He had a partial ACL tear that was not reconstructed. He has been using a brace.

Vital Signs

Wt 175, Ht 69, Temp 98.3, HR 75, BP 146/99, BMI 25.84.

Examination

General Examination:

Male in no distress. There is no effusion on the left knee today. He has full range of motion and no instability with Lachman and drawer testing. He has a minimally antalgic gait.

X-rays left knee 3 views shows preserved joint spaces, healed proximal fibula fracture, there is a small radiopacity seen overlying the proximal medial tibia.

Assessments

1. Knee pain - 719.46 (Primary)

Treatment

1. Knee pain

LAB: Uric Acid, Serum

Will order ACL brace, we will screen for gout.

Referral To: Case Manager

Reason: contact Brooke for functional ACL brace

Diagnostic Imaging

Knee-LT /3 Views HOLLOMAN, CANDACE 01/15/2014 10:47:45 AM
EST > done

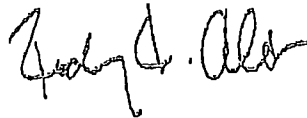
Procedure Codes

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 01/15/2014
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

73562 Xray exam of knee 3

Follow Up

2 Weeks (Reason: f/u labs)



Electronically signed by RODNEY ALAN, MD on 02/03/2014
at 03:53 PM EST

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 01/15/2014

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

Summary View

Progress Notes

Provider: KYLE E. WATFORD, MD
Date: 10/09/2013

Patient: MCDONALD, RONNIE E
DOB: 08/24/1967 Age: 46 Y Sex: Male
Phone: 843-295-1111
Address: [REDACTED] KINGSTREE, SC-29556
Pcp: Blake H Moore, MD

Subjective:

CC:

1. Hips giving out 2-3 mo f/u Same Complaint as July - given fluoro Guided Injection.

HPI:

Constitutional:
Pt presents to the office today for evaluation s/p right acetabulum ORIF January 2013, complaining of some right hip pain today that is intermittent in nature, ambulating well on his RLE. He complains mostly of Left knee pain, underwent previous left knee arthroscopy by DR Alan, has a hinge knee brace in place. Denies his Right hip giving out, just has some pain at times mostly anterior hip.

Family History:

Social History:

Medications: Diclofenac Sodium 75 mg Tablet Delayed Release 1 tablet bld, Ultram 50 mg Tablet 1 tablet as needed every 6 hrs PRN, Naprosyn 500 mg Tablet 1 tablet as needed every 12 hrs

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

Pt seen and evaluated, ambulates to room well, slight antalgic gait noted, N/V Intact RLE, + DF/PF, +EHL, 2+ pulses.
Not much pain on exam with IR/ER ROM on today's exam.

Assessment:

Assessment:

1. Arthritis pain, hip - 716.95 (Primary), post traumatic arthritis right hip

Plan:

1. Arthritis pain, hip
pt seen and evaluated, xrays reviewed of right hip, hardware in good alignment, fracture has healed, post traumatic arthritis is noted.
Continue WBAT RLE, continue diclofenac prn, return PRN basis. May need future hip injection again in future.

Immunizations:

Diagnostic Imaging: HIP/UNI-RT/2 VIEW MINIMUM (73510) HOLLOMAN, CANDACE 10/09/2013 10:50:44 AM EDT > done COBIA, CAROL 10/09/2013 10:56:55 AM EDT > OK per Dr Watford

Labs:

Procedure Codes: 73510 Xray exam of hip

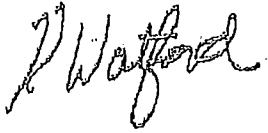
Preventive:

Follow Up: prn

Provider: KYLE E. WATFORD, MD

Summary View

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 10/09/2013

A handwritten signature in black ink, appearing to read "K Watford". The signature is written in a cursive, flowing style.

Electronically signed by KYLE WATFORD, MD on 10/14/2013 at 11:44 AM EDT
Sign off status: Completed

McLeod
Physician Associates

MCDONALD, RONNIE E

46 Y old Male, DOB: 08/24/1967
[REDACTED], KINGSTREE, SC-29556
Home: 843-[REDACTED]

Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: Blake H Moore, MD
Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

10/09/2013

Current Medications

Diclofenac Sodium 75 mg Tablet Delayed Release 1 tablet bid
Ultram 50 mg Tablet 1 tablet as needed every 6 hrs PRN
Naprosyn 500 mg Tablet 1 tablet as needed every 12 hrs
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000
ACL RECONSTRUCTION

Family History

NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

Tobacco Use:
Smoking Are you a: former smoker, How long has it been since you last smoked?: 1-3 months.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

SEE ABOVE

Review of Systems

Follow-Up Review of Systems:

no Cardiology: no Endocrinology:
no Gastroenterology: no General:
no GI/GU: no HEENT: Musculoskeletal yes.
no Neurology: no Psychology:
no Pulmonology:

Reason for Appointment

1. ROUTINE 6 WEEK F/U-FINAL CHECK LEFT KNEE ACL RECONSTRUCTION
2. PATIENT STATES NO CHANGES SINCE PRIOR VISIT

History of Present Illness

Constitutional:

Patient returns for followup status post left knee arthroscopy. At the time of surgery patient had partial ACL tear felt to be stable not requiring reconstruction. Patient is completed physical therapy. He wears a brace. He had a work-related injury to the knee with a log fell on him. He also has posttraumatic arthritis of the right hip. He had an acetabular fracture. Acetabular fracture was treated surgically.

Vital Signs

Ht 69, Temp 98.7, HR 88, BP 140/96, Pain scale 2/10.

Examination

General Examination:

Male in no distress. He walks with a limp. Left knee has no effusion and full range of motion. Lachman has a firm endpoint with symmetric laxity.

Assessments

1. Surgery follow-up examination - V67.00 (Primary)

Treatment

1. Surgery follow-up examination

I suspect the patient's stretch we will gradually return in the left knee. Continue brace as needed. Remain out of work. Patient has followup with Dr. Watford for the right hip. He seemed to have responded to a steroid injection in the hip and I recommend avoiding hip replacement until the patient is older. I will see him for final visit after his followup with Dr. Watford for final evaluation and rating.

Follow Up

4 Months (Reason: final check. Bring list of essential job duties.)

Rodney K. Alan

Electronically signed by RODNEY ALAN, MD on 10/15/2013
at 04:42 PM EDT

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVRS ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K, ALAN, MD 10/09/2013
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

McLeod
Physician Associates

MCDONALD, RONNIE E

46 Y old Male, DOB: 08/24/1967
KINGSTREE, SC-29556
Home: 843-295-5566

Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: Blake H Moore, MD
Appointment Facility: McLeod Orthopaedics

RODNEY K. ALAN, MD

08/28/2013

Current Medications

Diclofenac Sodium 75 mg Tablet Delayed
Release 1 tablet bid
Ultram 50 mg Tablet 1 tablet as needed every
6 hrs PRN
Naprosyn 500 mg Tablet 1 tablet as needed
every 12 hrs

Reason for Appointment

1. POST OP 14 DAYS

History of Present Illness

Constitutional:

Patient returns for followup after left knee arthroscopy. No
complaints.

Examination

General Examination:

Male in no distress. Effusion on the knee. Range of motion 0-100.
Quad atrophy noted. Negative Homans signs.

Assessments

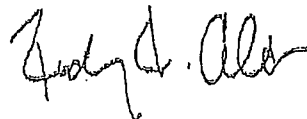
1. Surgery follow-up examination - V67.00 (Primary)

Treatment

1. Surgery follow-up examination
Continue physical therapy. Followup 6 weeks.

Follow Up

6 Weeks (Reason: final check left knee)



Electronically signed by RODNEY ALAN, MD on 08/30/2013
at 01:21 PM EDT

Sign off status: Completed

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 08/28/2013
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 08/28/2013
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Summary View for MCDONALD, RONNIE E

Page 1 of 1

Patient: MCDONALD, RONNIE E
Account Number: e868929
DOB: 08/24/1967 Age: 45 Y Sex: Male
Phone: 843-
Address:
Pcp: Blake H Moore, MD

Provider: RODNEY K. ALAN, MD
Date: 08/15/2013

Subjective:

1. Left knee ACL reconstruction.

Medications: Taking Diclofenac Sodium (Diclofenac Sodium (Ophth)) 75 mg Tablet Delayed Release 1 tablet bid, Taking Ultram (Tramadol HCl) 50 mg Tablet 1 tablet as needed every 6 hrs PRN, Taking Naprosyn (Naproxen) 500 mg Tablet 1 tablet as needed every 12 hrs.

Objective:

Assessment:

Assessment:

1. Surgery follow-up examination - V67.00 (Primary)

Plan:

1. Surgery follow-up examination

Referral To: Physical Therapy

Reason: evaluate and treat, weightbearing as tolerated, range of motion as tolerated quad strengthening hamstring strengthening

Provider: RODNEY K. ALAN, MD
Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 08/15/2013

WMC LAB
00125667451

WMC LABORATORY
555 E CHEVRES ST.
FLORENCE, SC 29501
(843) 777-2070

043 777-2071

NAME: MCDONALD, RONNIE E
MRN : 00-15-76-58

OUTPATIENT REPORT

COLLECTED: 01/15/2014 12:25

RECEIVED: 01/15/2014 12:47
CREATING PHYSICIAN: Alan, Rodney K

SPECIMEN NUMBER: W78314

TEST	RESULT	REF RANGE	UNITS
URIC ACID	9.0	H [3.5-8.5]	MG/DL

PIC
Z [Signature]
1/17/14

MRN : 00-15-76-58
ACCT NO: 000125667451
Physicians : Alan, Rodney K ,

NAME: MCDONALD, RONNIE E
DOB: 08/24/1967 SEX: M

LOC: LAB
PRINTED: 01/15/2014
17:21
END OF REPORT

EVENT REPORT COMPLETED

To: Rodney K Alan, M.D. From: Medical Records

08/19/2013 08:34:03 AM Page 1 of 2

OPERATIVE REPORT

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

DAYH149D01

NAME: McDonald, Ronnie Edward
MED. REC. NO.: 00-15-76-58
DR. DICTATING: Rodney K Alan, M.D.
DOB: 08/24/1967
PATIENT NO.: 000124548413
DATE OF SURGERY: 08/15/2013

PREOPERATIVE DIAGNOSIS: 1. ACL tear, left knee.
2. Meniscus tear, left knee.
3. Chondromalacia, left knee.

POSTOPERATIVE DIAGNOSIS: 1. Partial ACL tear, with symmetric stability on exam under anesthesia, left knee.
2. Minor raying of the posterior horn of the medial meniscus, left knee.
3. Grade 2 chondromalacia, medial femoral condyle, left knee.

PROCEDURES: 1. Diagnostic arthroscopy, left knee.
2. Exam under anesthesia, left knee.

SURGEON: Dr. Rodney Alan.

ANESTHESIA: General.

ASSISTANT: Elizabeth Burns-Boyle, certified first assistant.

FINDINGS: The patient had a negative pivot shift on exam under anesthesia, with the Lachman's and drawer testing. His exam was symmetric to the contralateral side. Diagnostic arthroscopy revealed fibers intact, but the left knee ACL, grade 2 chondromalacia of the medial femoral condyle, and minor fraying of the edges of the meniscus and posterior horn of the medial meniscus.

INDICATIONS: The patient is a middle-aged gentleman who had a logging injury and injured his left knee. This was treated non-operatively. The patient reported continued symptoms of instability. MRI showed a full-thickness ACL tear with a meniscus abnormality in the posterior horn of the medial meniscus. The patient reported symptomatic instability of the knee without even while wearing his brace. I counseled the patient on treatment options. Risks, benefits, and alternatives of arthroscopy were reviewed preoperatively, the plan was for reconstruction of the knee. After informed consent was obtained, the patient was taken to the operating room.

DESCRIPTION OF PROCEDURE: The patient was identified preoperatively. The operative site was marked. The patient is taken to the operating room. Satisfactory anesthesia was achieved by the anesthesiologist. The left lower extremity was prepped and draped in sterile fashion. After time-out and preoperative antibiotics, the procedure began. The left lower extremity was examined under anesthesia to begin the procedure, Lachman's and drawer testing was symmetric to the contralateral side. Pivot-shift exam was negative. Following this, the left lower extremity was elevated and exsanguinated. A well-padded thigh tourniquet was inflated and the procedure began. A stab incision was made just distal to the patella and just lateral to the patellar tendon. A blunt trocar was inserted towards the notch and redirected towards the suprapatellar pouch. A 4 millimeter 30-degree arthroscope was inserted and the knee was insufflated with arthroscopic irrigation solution. Routine diagnostic arthroscopy was carried out. Findings were as noted above. The posterior horn of the medial meniscus was identified and probed superiorly and inferiorly. There

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COPY FOR Rodney K Alan, M.D.

To: Rodney K Alan, M.D From: Medical Records

08/19/2013 08:34:17 AM Page 2 of 2

OPERATIVE REPORT

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves St
Florence, SC 29501-0551

DAYH149D01

NAME: McDonald, Ronnie Edward
MED REC. NO.: 00-15-76-58
DR. DICTATING: Rodney K Alan, M.D.
PATIENT NO.: 000124548413
DATE OF SURGERY: 08/15/2013

was some fraying of the edges, but no unstable meniscus tearing. The patient had some grade 2 chondromalacia of the medial femoral condyle. A shaver was used to partially shave the frayed edges. The ACL was probed in both full extension and flexion. There was no gross instability and after evaluating the ACL it was felt that the patient would not benefit from reconstruction. The lateral compartment was examined and felt to be pristine. The patellofemoral compartment was examined. There was a mild amount of grade 2 chondromalacia at the very inferior pole of the patella, and after examining all the different areas of the knee the instruments were removed. The arthroscopic irrigation solution was aspirated from the knee and the portal sites were reapproximated with nonabsorbable suture. The surgical site was dressed sterilely. All counts were correct. The patient tolerated the procedure without apparent complication, was awakened and taken to the recovery room in stable condition.

Rodney K Alan, M.D.

meq
DD: 08/15/2013 09:10 A
DT: 08/17/2013 12:07 P

Job #: 1181607
cc: Rodney K Alan, M.D.

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Page 2 of 2 COPY FOR Rodney K Alan, M.D.

Summary View

Progress Notes

Provider: KYLE E. WATFORD, MD
Date: 07/24/2013

Patient: MCDONALD, RONNIE E
DOB: 08/24/1967 Age: 45 Y Sex: Male
Phone: 843-
Address:
Pcp: Blake H Moore, MD

Subjective:

CC:

1. Hip giving out on R Side X Rays R Hip.

HPI:

Constitutional:

Mr. McDonald is here for follow up. He complains of right hip pain and discomfort. He states the pain is regular and it is difficult for him to sit on hard chairs for lengthy periods of time.

Family History:

Social History:

Medications: Diclofenac Sodium 75 mg Tablet Delayed Release 1 tablet bid, Ultram 50 mg Tablet 1 tablet as needed every 6 hrs PRN, Naprosyn 500 mg Tablet 1 tablet as needed every 12 hrs

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

Right hip pain with internal and external rotation. 2+ DP pulse. Motor and sensation intact to the right leg.

Assessment:

Assessment:

1. Hip arthritis - 716.95

Plan:

1. Hip arthritis

We will arrange for an intraarticular injection of the right hip. He understands that this may or may not relieve his pain but is willing to give this a try. He will return for a follow up visit in about 2-3 months. A work release note was given today for him to return to work with no restrictions. He is scheduled for left knee arthroscopy with Dr. Alan in mid August.

2. Others

Referral To: Radiology

Reason: Interventional radiology [Right hip Injection under fluoro with 1 cc lidocaine without epi, 1 cc 40mg/ml methylprednisolone, 1 cc kenalog 40mg/ml]

Immunizations:

Diagnostic Imaging: HIP/UNI-RT/2 VIEW MINIMUM (73510) HOLLOMAN, CANDACE 07/24/2013 09:24:41 AM EDT > done COBIA, CAROL 07/24/2013 09:25:41 AM EDT > OK per Dr Watford

Labs:

Procedure Codes: 73510 Xray exam of hip

Preventive:

Follow Up: 2 Months, 3 Months

Summary View

Provider: KYLE E. WATFORD, MD
Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 07/24/2013

A handwritten signature in black ink, appearing to read "K. Watford". The signature is stylized with a large initial "K" and a cursive "Watford".

Electronically signed by KYLE WATFORD, MD on 08/05/2013 at 01:37 PM EDT
Sign off status: Completed

McLeod

Physician Associates

MCDONALD, RONNIE E

45 Y old Male, DOB: 08/24/1967
KINGSTREE, SC-29556
Home: 843-29556

Guardian: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: Blake H Moore, MD
Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

07/17/2013

Current Medications

Diclofenac Sodium 75 mg Tablet Delayed
Release 1 tablet bid
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY
2000

Family History

NO FAMILY HX OF SICKLE CELL, RA OR
DVT.

Social History

Tobacco Use:
Smoking Are you a: former smoker, How
long has it been since you last smoked?: 1-3
months.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Follow-Up Review of Systems:
no Cardiology: no Endocrinology:
no Gastroenterology: no General:
no GI/GU: no HEENT: Musculoskeletal yes.
no Neurology: no Psychology:
no Pulmonology:

Reason for Appointment

1. PROBLEM VISIT-TORN ACL
2. PATIENT STATES THAT HE IS HAVING PAIN AND DISCOMFORT
IN HIS RIGHT HIP AND LEFT KNEE

History of Present Illness

Constitutional:
Patient returns for followup evaluation. He had a work-related
locking accident resulting in a right hip acetabular fracture which was
treated operatively by my partner. He also had a proximal tibia
fracture, fibula fracture with ACL tear and distal tibia fracture as well.
The injuries to the left lower extremity were treated nonoperatively.
His main complaint is pain and stiffness in the hip. He also complains
that the leg once to give out on him with routine walking. He has been
wearing a brace. He also complains of popping in the knee when he is
using the clutch on his truck. He has had a trial of return to work and is
not comfortable with his work duties.

Vital Signs

Wt 176, Ht 69, Temp 98.0, HR 98.6, BP 140/98, BMI 25.99, Pain scale
8-7/10, Location RIGHT HIP AND LEFT KNEE.

Examination

General Examination:

Patient in no acute distress. Alert and oriented to person, place and
time. Mood and affect normal. Judgment and insight normal for age
and circumstance.

Heart with regular rate and rhythm no peripheral edema or JVD
Lungs clear with no wheezing or labored breathing or lip pursing
Abdomen soft nontender nondistended no guarding no masses
The patient ambulates with a limp. He has decreased range of
motion of the right hip. He has pain with flexion and internal or
external rotation.

The left knee has obvious quadriceps atrophy, there is
patellofemoral crepitation with range of motion testing, the patient has
full range of motion, the patient has a positive Lachman and drawer
sign.

I reviewed the prior knee MRI.

Assessments

1. Current tear of meniscus - 836.2 (Primary)

2. ACL tear - 844.2
3. Work related injury - 959.9
4. Aftercare for healing traumatic fracture of hip - V54.13

Treatment

1. Current tear of meniscus

Patient continues to be symptomatic from his knee. He has had therapy and has been using a brace. At this point I recommend arthroscopy with possible chondroplasty, partial meniscectomy and left knee ACL reconstruction. I discussed the use of autologous versus allograft. I discussed the potential for donor site morbidity with autologous graft versus potential for transmitted disease with allograft. Patient has been set up for surgery August 15, 2013 pending medical clearance.

2. ACL tear

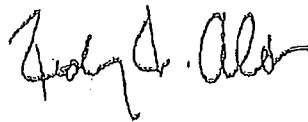
Start Ultram Tablet, 50 mg, 1 tablet as needed, Orally, every 6 hrs PRN, 30 days, 60, Refills 3
Start Naprosyn Tablet, 500 mg, 1 tablet as needed, Orally, every 12 hrs, 30 days, 60, Refills 5

3. Aftercare for healing traumatic fracture of hip

The patient continues to have hip symptoms. He is too young for hip replacement. I will have the patient see my partner to evaluate the prior surgery. Would only consider hip replacement after all other options have been exhausted.

Follow Up

left knee ACL reconstruction



Electronically signed by RODNEY ALAN, MD on 08/30/2013
at 01:17 PM EDT

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650

Patient: McDONALD, RONNIE E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 07/17/2013
Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE H DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 07/17/2013

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

McLeod

Physician Associates

MCDONALD, RONNIE E

45 Y old Male, DOB: 08/24/1967
KINGSTREE, SC-29556
Home: 843-XXXXXX

Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: UNKNOWN UNKNOWN
Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

06/28/2013

Current Medications

Neurontin 300 MG Capsule 1 capsule qhs
Diclofenac Sodium 75 mg Tablet Delayed
Release 1 tablet bid
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY
2000

Family History

NO FAMILY HX OF SICKLE CELL, RA OR
DVT.

Social History

Tobacco Use:
Smoking Are you a: former smoker, How
long has it been since you last smoked?: 1-3
months.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Follow-Up Review of Systems:
no Cardiology.. no Endocrinology..
no Gastroenterology.. no General..
no GI/GU, no HEENT.
Musculoskeletal yes, Positive for, joint
pain IN THE LEFT KNEE .
no Neurology.. no Psychology..
no Pulmonology..

Reason for Appointment

1. ROUTINE 2 MONTH FOLLOW UP: ACL TEAR LEFT KNEE
2. PATIENT HAD MRI OF THE LEFT KNEE 4/29/13
3. PATIENT STATES THAT HIS KNEE IS DOING GOOD-BUT HE IS
HAVING PAIN IN THE RIGHT HIP
4. X-RAY TIB/FIB AND PELVIS

History of Present Illness

Constitutional:

Patient returns for followup evaluation. He had a work-related
injury affecting his right hip left knee and left leg. His primary
complaint today is pain in the right hip. Pain is associated with
stiffness. Pain is 7/10. He is wearing a brace on the left knee. He is
taking diclofenac.

Vital Signs

Wt 176, Ht 69, Temp 98.0, HR 76, BP 126/78, BMI 25.99, Pain scale
2/10, Location RIGHT HIP.

Examination

General Examination:

Patient in no acute distress. Alert and oriented to person, place and
time. Mood and affect normal. Judgment and insight normal for age
and circumstance.

Right hip with well-healed incision. Mildly decreased range of
motion with pain. No gross instability. Limb lengths equal. Mildly
antalgic gait.

Left knee with normal alignment and no effusion. There is laxity
with drawer and Lachman testing.

Left ankle with swelling resolved, pain with range of motion, no
focal tenderness.

X-rays AP pelvis with daily views demonstrates stable hardware
mild central arthritis

Left tibia 2 views demonstrates healed possible fibular fracture
posttraumatic changes to the ankle joint.

Assessments

1. Right hip pain - 719.45 (Primary)
2. ACL tear - 844.2
3. Left ankle pain - 719.47
4. Left knee pain - 719.46

5. Work related injury - 959.9

Treatment

1. Work related injury

37 percent permanent impairment to right hip, 17 percent permanent impairment to left knee, 5 percent permanent impairment left ankle. Impairment based on diagnostic related estimates in the fifth edition of the AMA guides to the evaluation of permanent impairment.

2. Others

The patient has posttraumatic arthritis of the right hip is a direct result of his work-related injury. He is too young for hip replacement. The has had surgery and the hardware is in good position and appears stable. I recommend conservative treatment for his hip. He also has an ACL tear. We are treating this in a brace, she will need to continue using the brace any time he has instability or pain in the knee. I do not recommend surgery unless he is actively engaged in pivoting-type sports or having instability symptoms with routine activities such as walking.

The patient has reached maximal medical improvement. I am going to allow him a trial to return to work. I believe he will be best off if he is able to return to the work that he is trained to do. He describes driving trucks long distances. I am going to approve that with permanent restrictions. He has been instructed to return if his work demands exceed his abilities.

He will need continued anti-inflammatories and Tylenol as needed. He will need a hip replacement in the future. He will need a knee replacement in the future. Hopefully this will be after he turns 60.

Diagnostic Imaging

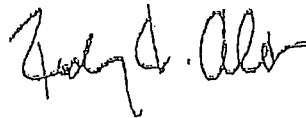
Tibia/Fibula-LT /2 View HOLLOMAN,CANDACE 06/28/2013
09:24:24 AM EDT > done, Pelvis-W /Judet Views
HOLLOMAN,CANDACE 06/28/2013 09:24:18 AM EDT > done

Procedure Codes

73590 Xray exam of lower leg
72190 Xray exam of pelvis
99455 Work related disability exam

Follow Up

prn



Electronically signed by RODNEY ALAN, MD on 06/28/2013

at 09:50 AM EDT
Sign off status: Completed

McLeod Orthopaedics
800 E CHIEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE R DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 06/28/2013

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

McLeod
Physician Associates

MCDONALD, RONNIE E

45 Y old Male, DOB: 08/24/1967
KINGSTREE, SC-29556
Home: 843-
Guarantor: MCDONALD, RONNIE E Insurance: BCBS
STATE GROUP Payer ID: SB880
PCP: UNKNOWN UNKNOWN
Appointment Facility: McLeod Orthopaedics

Progress Notes: RODNEY K. ALAN, MD

04/25/2013

Current Medications

Percocet 5-325 MG Tablet 1-2 tablet every 6 hrs
Medication List reviewed and reconciled with the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY 2000

Family History

NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

Tobacco Use:
Smoking. Are you a former smoker, How long has it been since you last smoked? 1-3 months.

Miscellaneous:
Marital status: Married. Occupation: LOGGER. Living with: spouse.

Allergies

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Follow-Up Review of Systems:
no Cardiology: no Endocrinology:
no Gastroenterology: no General:
no GI/GU. no HEENT.
Musculoskeletal yes, Positive for joint pain LEFT KNEE AND ANKLE.
no Neurology: no Psychology:
no Pulmonology:

Reason for Appointment

1. ACL TEAR PER DR. WATFORD-ASAP WITH ALAN
2. MRI 4/8/13 ON PACS

History of Present Illness

Constitutional:

MRI left knee showed ACL tear. c/o pain and left giving out left knee. Pain intermittent 9/10, associated with swelling left ankle, not relieved with rest. Taking percocet for hip.

Vital Signs

Wt 176, Ht 69, Temp 98.4, HR 83, BP 141/92, BMI 25.99.

Examination

General Examination:

Left knee benign, no effusion, medial tenderness over MFC, full ROM with pain, unstable gait, guards with lachman
MRI with ACL tear, reports suggests plateau injury, not consistent with clinical history.

Assessments

1. ACL tear - 844.2 (Primary)
2. Current tear of meniscus - 836.2
3. Work related injury - 959.9
4. Aftercare for healing traumatic fracture of hip - V54.13
5. Left lateral ankle pain - 719.47

Treatment

1. ACL tear

Start Diclofenac Sodium Tablet Delayed Release, 75 mg, 1 tablet, Orally, bid, 30 day(s), 60, Refills 3
Will need more recovery from right hip surgery prior to treatment of ACL. Will start some PT. Will get brace. Out of work.
Referral To: Physical Therapist

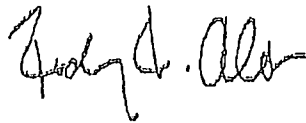
Reason: Eval and treat left knee pain, left ankle pain, ACL tear

2. Aftercare for healing traumatic fracture of hip

Start Neurontin Capsule, 300 MG, 1 capsule, Orally, qhs, 30 day(s), 30, Refills 1
Wean opioid. Neurogenic pain reliever at night.

3. Left lateral ankle pain
Diagnostic Imaging;MRI : Ankle, left TISDALE,SUSAN 04/25/2013
04:26:38 PM EDT > MRI OF LEFT ANKLE 4/29/13 @ 4:00 IN THE
TOWER ORDER FAXED LEFT MESSAGE ON VOICE MAIL AUTH
#1311580532

Follow Up
2 Months (Reason: ACL left knee)



Electronically signed by RODNEY ALAN , MD on 04/26/2013
at 09:49 AM EDT

Sign off status: Completed

McLeod Orthopaedics
800 E CHEYES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONNIE DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 04/25/2013

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

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	D.O.B.: 08/24/1967
Admission Date: 08/16/2013 15:54	Age: 46 y
Med. Record No.: 89187	Gender: Male
Visit No.: 20004419	Location: OUT
Attending Phys.: ALAN, RODNEY	Room/Bed: N/A
Allergies: No allergy history (Not reviewed)	
Scheduled: 08/29/2013 12:27	User: BURROUGHS, LIDIA M. PT
Performed: 08/29/2013 12:24	Status: Finished

Treatment Log

Total Physical Therapy Time: 60 minutes. Start time: 10:30. Stop time: 11:30.

Treatments Include:
Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units (treatment details: see ex log).
The response to the treatment was good. Additional Comments: Patient had no knee pain after treatment

Exercises

Exercise: mat exercises 2# -- supine: heel slides, SLR, hip abd/add with leg lift over foam roller, abdominal crunches, bridges, sidelying hip abd, add with bolster, prone hip ext, HS curl, sitting hip flex, LAQ x30 ea.
Exercise: standing exercises -- (B) hip flex, ext, abd x30, heel/toe raises x30, (L) LE SLR with hold x20, standing on L LE, squats 2x10, standing on L LE with two 4# dumbbells "dead lift" x20, all R/L squats, lunges x20 ea, wall sits with swiss ball.
Exercise: Leg Press Cybex - 4 1/2 pl 3x10.
Exercise: Recumbent Bike - 10 min.
Exercise: stair master -- 5min.

Subjective Assessment

No complaints of pain

Occurrence History for PT Treatments

Effective	Status	User
08/29/2013 12:27	Scheduled	BURROUGHS, LIDIA M. PT
08/29/2013 12:27	Finished	BURROUGHS, LIDIA M. PT

Visit No.: 20004419

Viewed/Printed on:
08/29/2013 12:27

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E
Admission Date: 08/16/2013 15:54
Med. Record No.: 89187
Visit No.: 20004419
Attending Phys.: ALAN, RODNEY
Allergies: No allergy history (Not reviewed)
D.O.B.: 08/24/1967
Age: 46 y
Gender: Male
Location: OUT
Room/Bed: N/A
Scheduled: 08/28/2013 17:43
Performed: 08/28/2013 17:33
User: GRAHAM, KIMBERLY N. PTA
Status: Finished

Treatment Log

Total Physical Therapy Time: 65 minutes. Start time: 03:00. Stop time: 04:05.

Treatments Include:
Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units.
The response to the treatment was good. Additional Comments: Pt progressing with exercises. Working on strengthening quad muscles. Continue with POC

Exercises

Exercise: mat exercises 2# - - supine: heel slides, SLR, hip abd/add with leg lift over foam roller, abdominal crunches, bridges, sidelying hip abd, add with bolster, prone hip ext, HS curl, sitting hip flex, LAQ x30 ea.
Exercise: standing exercises - - (B) hip flex, ext, abd x30, heel/toe raises x30, (L) LE SLR with hold x20, standing on L LE, squats 2x10, standing on L LE with two 4# dumbbells "dead lift" x20.
Exercise: Leg Press Cybex - 4 1/2 pl 3x10.
Exercise: Recumbent Bike - 10 min.

Subjective Assessment

Patient continue to complain about his knee "slipping" out of place causing him to loose balance.

Occurrence History for PT Treatments

Effective	Status	User
08/28/2013 17:43	Scheduled	GRAHAM, KIMBERLY N. PTA
08/28/2013 17:43	Finished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20004419

Viewed/Printed on:
08/28/2013 17:43

MCDONALD, RONALD E

Page 1 of 1

Summary View

Progress Notes

Patient: MCDONALD, RONNIE E
DOB: 08/24/1967 Age: 45 Y Sex: Male
Phone: 843-
Address:
Pcp: UNKNOWN UNKNOWN

Provider: KYLE E. WATFORD, MD
Date: 04/22/2013

Subjective:

CC:

1. MRI RESULTS.

HPI:

Constitutional:

Patient is a 45-year-old gentleman who had multiple injuries one of which was a proximal fibula fracture on the left he also had a posterior wall acetabulum fracture that was treated late on the right side. At his last visit he began having trouble with his left knee both with pain as well as giving way and this led to an MRI. He is back today for the results of his MRI.

Family History:

Social History:

Medications: OxyContin 20 MG Tablet Extended Release 12 Hour 1 tablet every 12 hrs, Lovenox 40 MG/0.4ML Solution 0.4 ml Once a day, Percocet 5-325 MG Tablet 1-2 tablet every 6 hrs

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

Patient has joint line tenderness as well as some instability of his left knee.

Assessment:

Assessment:

1. Current tear of meniscus - 836.2 (Primary)
 2. ACL tear - 844.2
- Left knee meniscus tear as well as an ACL injury.

Plan:

1. Current tear of meniscus

I have spoken with the patient regarding the fact that I do believe he would need an evaluation by someone that specializes in this injury with his left knee and that would not be myself. I will try to get him appointment with Dr. Allen in next week or so.

Immunizations:

Labs:

Preventive:

Follow Up: with Dr Alan

Provider: KYLE E. WATFORD, MD
Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 04/22/2013

Summary View

Page 2 of 2

A handwritten signature in black ink, appearing to read "K Watford". The signature is stylized with a large initial "K" and a cursive "Watford".

Electronically signed by KYLE WATFORD, MD on 04/24/2013 at 08:44 AM EDT
Sign off status: Completed

		MRI Lower Extremity Joint Without Contrast-Left Results	
Pt Name:	MCDONALD, RONNIE E	MRN:	157658
Pt ID:	100987427	Acct No:	123808743
DOB:	08/24/1967	Age/Sex:	45Y/M
Adm DTime:	04/08/2013 13:00	Atn Dr:	Watford, Kyle MD
Nurse Sta:		Rm/Bed:	
Dx:			
Alrg:	No Known Drug Allergies	Observation Dtime:	04/08/2013 14:04
Order Name:	MRI Lower Extremity Joint Without Contrast-Left	Result Status:	Corrected Result
Result Name:	MRI Lower Extremity Joint Without Contrast-Left		

5510126ORDER DR: KYLE E. WATFORD M.D.
ATTEND DR: KYLE E. WATFORD M.D.
TRANSCRIBED D/T: Apr 9 2013 9:08AM
PROCEDURE: MRI:LOWER EXT JOINT WO CON-LT / ORD #: 90018 Accession#:
5510126 CPT: 73721
ORDERED FOR: Apr 8 2013 1:28PM COMPLETED: Apr 8 2013 2:04PM
INDICATIONS/COMMENTS: LEFT KNEE MEDIAL TEAR

INDICATION: Persistent left knee pain after a fall generate 2013

COMPARISON: Left foreleg radiographs MOA 4/3/2013 and 2/1/2013 showing healing proximal fibular fracture

RESULT: Multiplanar multisequence MRI imaging of the left knee was acquired per our routine protocol on the full strength closed field MRI.

Complete ACL tear from the femoral attachment is seen with an edematous femoral attachment of the PCL. Nondepressed subchondral fracture medial tray tibial plateau posterior margin is seen. Posterior horn meniscal tears parrot-beak orientation is seen extending from the periphery toward the tibial root attachment of both medial and lateral menisci. Metallic susceptibility artifact is noted anteromedially in the proximal tibia.

Mild simple appearing joint effusion distending the suprapatellar pouch is present.

Medial and lateral collateral ligamentous complexes as well as patellar retinacular complexes are normal.

CONCLUSION: Nondepressed subchondral fracture posteriorly medial tray tibial plateau with posterior horn meniscal tears and ACL tear left knee

\E\

READING DR: NOEL PHIPPS M.D.
READING DATE: Apr 9 2013 9:14AM

MRN: 157658

Pt Name: MCDONALD, RONNIE E

Page 1 of 2

MRI Lower Extremity Joint Without Contrast-Left Results

Rm/Bed:

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ORE_0126.rpt;Version 1.00
Printed By: Crisp, Brian PA
Printed On: 22-Apr-13 09:19

P54

		<u>MRI Lower Extremity Joint Without Contrast-Left Results</u>	
Pt Name:	MCDONALD, RONNIE E	MRN:	157658
Pt ID:	100987427	Acct No:	123808743
DOB:	08/24/1967	Age/Sex:	45Y/M
Adm DTime:	04/08/2013 13:00	Atn Dr:	Watford, Kyle MD
Nurse Sta:		Rm/Bed:	
Dx:			
Alrg:	No Known Drug Allergies	Observation DTime:	04/08/2013 14:04
Order Name:	MRI Lower Extremity Joint Without Contrast-Left	Result Status:	Corrected Result
Result Name:	MRI Lower Extremity Joint Without Contrast-Left		

Final Result
 ELECTRONICALLY SIGNED BY:
 NOEL PHIPPS M.D.
 On: Apr 9 2013 9:08AM

Comments

Result Comments:

Requisition Comments:

Ordering Dr:	Watford Kyle E	Order Date/Time:	04/08/2013 13:28
		Ord#/Occurrence#:	4229583 / 6433922

MRN: 157658

Pt Name: MCDONALD, RONNIE E

Page 2 of 2

MRI Lower Extremity Joint Without Contrast-Left Results

Rm/Bed:

ORE_0126.rpt;Version 1.00

Printed By: Crisp, Brian PA

Printed On: 22-Apr-13 09:19

Progress Notes

Patient: MCDONALD, RONNIE E
DOB: 08/24/1967 Age: 45 Y Sex: Male
Phone: 000-000-0000
Address: [REDACTED], KINGSTREE, SC-29556
Pcp: UNKNOWN UNKNOWN

Provider: KYLE E. WATFORD, MD
Date: 04/03/2013

Subjective:

CC:

1. 2 mo F/U missed appt 4 Wks ago R Acetab Fx DOS 2-5-13 & L Tib fib Fx X Rays . 2. AP Pelvis Judet Views and 2 Views L tib Fib.

HPI:

Constitutional:

Patient is 8 wks postop from open reduction internal fixation of her right posterior wall acetabular fracture. His history is a little bit unique in that the surgery was performed 4-5 weeks out from his original injury and also because I was very concerned about his ability to be compliant with his nonweight bearing status at his first postoperative visit. Apparently he has an appointment and is now approximately 8 weeks out from his original injury. He sees me doing pretty well. He reports his hip still bothers him it is stiff at times. His major complaint today there is some significant pain in his left knee. He reports that his left knee seems to bother him on the medial side especially when he is weightbearing on this
Pain is reported as.

Family History:

Social History:

Medications: OxyContin 20 MG Tablet Extended Release 12 Hour 1 tablet every 12 hrs, Lovenox 40 MG/0.4ML Solution 0.4 ml Once a day, Percocet 5-325 MG Tablet 1-2 tablet every 6 hrs

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

Wound is well healed. There is no redness or drainage.
Sciatic nerve is intact. Dorsiflexion and plantar flexion of toes is intact. Sensation is grossly intact in right lower extremity.
Post tib pulse is 2+
Right knee is examined and he does have tenderness to palpation along the medial joint line. He has no evidence of any laxity to varus valgus stress.

Assessment:

Assessment:

1. Aftercare for healing traumatic fracture of hip - V54.13 (Primary)
 2. Current tear of meniscus - 836.2
- A weeks postop from open reduction internal fixation of a right posterior wall acetabular fracture
Possible left knee medial meniscus tear
Left proximal fibula fracture.

Plan:

1. Aftercare for healing traumatic fracture of hip
Xray reading-AP pelvis x-rays I have ordered show his femoral head is well reduced within his acetabulum. It appears posterior wall acetabulum fracture is healing very nicely. I also ordered AP and lateral x-rays of the left tib-fib show his proximal fibula fracture be completely healed.
Advance activity to -he can now be full activity with weightbearing as tolerated bilateral extremities.
Since he is having so much complaints with his left knee and his history of significant, I think it is reasonable to proceed with an MRI of his left knee. We will get this and see him back in a few weeks to see what the results of this are.

Summary View

I do not believe he needs his right acetabulum x-rayed anymore as this appears to be completely healed
Follow up in 4 wks results of MRI.

Immunizations:

Diagnostic Imaging: Pelvis-W /Judet Views HOLLOMAN,CANDACE 04/03/2013 03:19:20 PM EDT > done
COBIA,CAROL 04/03/2013 03:32:18 PM EDT > OK per Dr Watford, Tibia/Fibula-LT /2 View
HOLLOMAN,CANDACE 04/03/2013 03:19:47 PM EDT > done COBIA,CAROL 04/03/2013 03:32:32 PM EDT >
OK per Dr Watford

Labs:

Procedure Codes: 72190 Xray exam of pelvis, 73590 Xray exam of lower leg

Preventive:

Follow Up: 4 Weeks

Provider: KYLE E. WATFORD, MD
Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 04/03/2013



Electronically signed by KYLE WATFORD , MD on 04/05/2013 at 12:32 PM EDT
Sign off status: Completed

Summary View

Patient: MCDONALD, RONNIE E
 DOB: 08/24/1967 Age: 45 Y Sex: Male
 Phone: 000-000-0000
 Address: [REDACTED] KINGSTREE, SC-29556
 Pop: UNKNOWN UNKNOWN

Provider: KYLE E. WATFORD, MD
 Date: 02/27/2013

Subjective:

CC:

1. 1ST POST OP R Post Wall Acetab. FX DOS 2-5-13 Logging Injury 1 month Earlier.

HPI:

Constitutional:

Patient is 2 wks postop from open reduction internal fixation of a right acetabulum fracture. His history is interesting in that he was originally seen by another physician who is worth treating this nonoperatively so this was a subacute fracture that had a significant amount of marginal impaction so we operated on him about a month out from his injury and treated him with a formal open reduction internal fixation of his posterior wall fracture with elevation of the marginal impaction and bone grafting. Unfortunately he is here today with just a cane and walks in with just this and not being very compliant with his nonweightbearing status. Otherwise he seen to be doing very well and having really very little pain and other complaints.

Gyn History:

OB History:

Family History:

Social History:

Medications: Percocet 5-325 MG Tablet 1-2 # 90 q 4-6, OxyContin 20 MG Tablet Extended Release 12 Hour 1 tablet every 12 hrs, Lovenox 40 MG/0.4ML Solution 0.4 ml Once a day

Allergies:

Objective:

Past Orders:

Examination:

General Examination:

Wound is well healed. There is no redness or drainage.
 Sclatic nerve is intact. Dorsiflexion and plantar flexion of toes is intact. Sensation is grossly intact in right lower extremity
 Post tib pulse is 2+
 Patient does have some tenderness to palpation over his left proximal fibula as he has a known fibula fracture there.

Assessment:

Assessment:

1. Aftercare for healing traumatic fracture of hip - V54.13 (Primary)
 first postop from ORIF of right acetabulum.

Plan:

1. Aftercare for healing traumatic fracture of hip Start Percocet Tablet, 5-325 MG, 1-2 tablet, Orally, every 6 hrs, 90, Refills 0.
 Xray reading-I have ordered AP pelvis and Jude ABDs of his pelvis since he walks in today at only 2 weeks out from his original surgery and these actually showed that his reduction appeared to be very well maintained and his hardware appears to be in place.
 Advance activity to -I have basically electric him today on the importance of being compliant with his nonweightbearing status with his right lower extremity for another 4 weeks
 Refill pain medicine
 Follow up in 4 wks with xrays as follows AP pelvis Jude views and AP and lateral left tib-fib.
2. Others

Summary View

Immunizations:

Diagnostic Imaging: Pelvis-W /Judet Views HOLLOMAN,CANDACE 02/27/2013 09:44:07 AM EST > done
COBIA,CAROL 02/27/2013 09:52:47 AM EST > OK per Dr Watford

Labs:

Procedure Codes: 72190 Xray exam of pelvis

Preventive:

Follow Up: 4 Weeks

Provider: KYLE E. WATFORD, MD

Patient: MCDONALD, RONNIE E DOB: 08/24/1967 Date: 02/27/2013



Electronically signed by KYLE WATFORD , MD on 03/04/2013 at 11:32 AM EST
Sign off status: Completed

Physician Associates:

45 Y old Male, DOB: 08/24/1967

~~REDACTED~~, Kingstree, SC-29556

Home: 043 [REDACTED]

Guarantor: MCDONALD, RONALD E Insurance: BCBS

STATE GROUP Payer ID: SB880

PCP: Adora Matthews, MD

Appointment Facility: McLeod Orthopaedics

RODNEY K. ALAN, MD

02/01/2013

Current Medications

Enoxaparin Sodium 40 MG/0.4ML Solution
0.4 ml Once a day
Ferrous Sulfate 325 (65 Fe) MG Tablet 1
tablet Once a day
Folic Acid 1 MG Tablet as directed
Omeprazole 40 MG Capsule Delayed Release
1 capsule Once a day
Sennosides 17.2 MG Tablet as directed
Oxycodone-Acetaminophen 10-325 MG
Tablet 1 tablet as needed every 6 hrs
Medication List reviewed and reconciled with
the patient

Past Medical History

No Medical History.

Surgical History

PUNCTURE LUNGS REQUIRING SURGERY
2000

Family History

NO FAMILY HX OF SICKLE CELL, RA OR DVT.

Social History

Tobacco Use:
Smoking Are you a: former smoker, How long has it been since you last smoked? 1-3 months.

Miscellaneous:
Marital status: Married. Occupation:
LOGGER. Living with: spouse.

മുഖ്യമന്ത്രി

N.K.D.A.

Hospitalization/Major

Diagnostic Procedure

No Hospitalization History.

Review of Systems

Follow-Up Review of Systems:

no Cardiology:, no Endocrinology:,
no Gastroenterology:, no General:.,
no GI/GU. no HEENT.

Musculoskeletal yes, Positive for joint

Reason for Appointment

1. WORK IN: CAROLINA ER-MINIMALLY DISPLACED BILATERAL ACETABULAR FRACTURES INVOLVING THE LEFT HIP, RHABDOMYOLYSIS, RESOLVED , ACUTE RENAL FAILURE, RESOLVED
2. LOGGING ACCIDENT ON 1/7/13 PATIENT WAS ADMITTED TO WILLIAMSBURG REGIONAL HOSPITAL
3. PATIENT WAS TRANSFERRED TO CAROLINA'S REHAB ON 1/29/13

History of Present Illness

Constitutional:

Construction:

Patient sent over for urgent evaluation regarding left leg. Patient has had left leg pain since logging accident January 7, 2013. He crushed his left thigh with rhabdomyolysis and describes a pelvic and acetabular fracture where his right hip was popping out of place. Details an orthopedic evaluation or not available to me at this time. He reports that since he has been at a rehabilitation facility the hip has not popped out of place. He has been toe-touch weightbearing on the right and full weightbearing on the left. He was apparently seen by another orthopedic surgeon in Georgetown but did not want to go back to him. His pain is controlled with Percocet. His pain is primarily located in the left leg with some associated swelling. X-ray at Carolinas Hospital showed fracture of the proximal fibula.

Vital Signs

Wt WC, Ht 69, Temp 98.6, BP 124/77, Pain scale 4.

Examination

General Examination:

General Examination.
Patient in no acute distress. Alert and oriented to person, place and time. Mood and affect normal. Judgment and insight normal for age and circumstance.

Head normocephalic atraumatic.

Neck supple no mass no JVD.

Heart regular rate and rhythm.

Lungs breath sounds clear.

Abdomen soft nondistended no masses no guarding.

The right hip has no swelling. Mild tenderness. He is sitting with the hip flexed at 90°. There is no gross instability. It appears to be located.

pain. no Neurology. no Psychology.
no Pulmonology.

The left knee has an effusion. There is tenderness over the fibula. Compartments are soft. There swelling at the ankle. There is decreased range of motion. There regular palpable pulses.

The skin is intact in all 4 extremities, without rashes, bruising or breaks in the skin.

In all 4 extremities there is normal sensation to light touch. Deep tendon reflexes are 2+ and symmetric. There are no pathologic reflexes identified.

Circulation is intact in all 4 extremities with regular symmetric pulses, normal temperature and turgor, and no delayed capillary refill.

Radiographs left tib-fib two-view shows proximal fibula fracture. The distal portion of the ankle does not demonstrate syndesmotic widening. The patient was has what appears to be an old injury.

Assessments

1. Fibular upper end fracture - 823.01 (Primary)
2. Pelvis fracture - 808.8
3. Crush injury - 929.9

Treatment

1. Others

Patient needs CT of pelvis to determine the type of fracture. Patient needs CT of the ankle. If there is no widening of the syndesmosis the fibula fracture can be treated nonoperatively. Depending on the fracture type and the pelvis that may be treated nonoperatively also. If nonoperative treatment we will sent back to rehabilitation pending results of CTs.

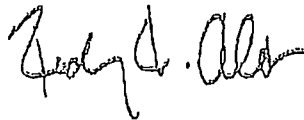
Diagnostic Imaging

Tibia/Fibula-LT /2 View HOLLOMAN, CANDACE 02/01/2013
04:37:22 PM EST > done

Procedure Codes

73590 Xray exam of lower leg

Follow Up
to hospital



Electronically signed by RODNEY ALAN, MD on 02/11/2013
at 04:35 PM EST

Sign off status: Completed

McLeod Orthopaedics
800 E CHEVES ST STE 480
FLORENCE, SC 295062650
Tel: 843-777-7900
Fax: 843-777-7925

Patient: MCDONALD, RONALD E DOB: 08/24/1967 Progress Note: RODNEY K. ALAN, MD 02/01/2013

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

Care Activity Report**Williamsburg Regional Hospital****PT Progress Note**

Name: MCDONALD, RONALD E
Admission Date: 09/01/2013 00:00
Med. Record No.: 89187
Visit No.: 20005488
Attending Phys.: ALAN, RODNEY
Allergies: No allergy history (Not reviewed)

D.O.B.: 08/24/1967
Age: 46 y
Gender: Male
Location: OUT
Room/Bed: N/A

Scheduled: 09/19/2013 11:11

User: BURROUGHS, LIDIA M. PT

Performed: 09/19/2013 10:55

Status: Finished

Overview

Patient is a 46 y old M with an admitting diagnosis of L knee pain, s/p arthroscopy Onset date is 08/15/2013. Start of care date is 08/20/2013. Level of consciousness is alert. Oriented to person, place, and time.

Subjective Assessment

"My leg still feels a little weak. I still can't squat down". Patient also c/o L knee occasionally giving away when he walks. He has no c/o pain today but some days he still experiences pain, mostly in patellar area.

Assessment

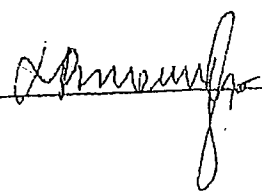
Assessment: L knee AROM is 0°- 130°. L knee strength extension 4/5, flexion 4+/5. L quad girth is still < than R. Patient favors LLE when squatting, rising from sitting to standing. Prognosis for Goal Achievement is good. Plan developed with patient. Plan of Care is agreed upon by patient. Discharge Recommendations: Return to work per Physician orders.

Functional Status and Goals
on 09/19/2013.**LONG TERM GOALS:**

- 1) AMBULATE WITH NORMAL GAIT PATTERN ON ALL SURFACES INCLUDING STAIRS, UP AND DOWNHILL. 3 WEEKS
- 2) PATIENT WILL BE ABLE TO STOOP, SQUAT, KNEEL, ETC. WITHOUT ANY DIFFICULTY WITHOUT PAIN IN L KNEE. 3 WEEKS
- 3) INCREASE L QUAD MUSCLE STRENGTH TO NORMAL. 3 WEEKS

Plan

Physical Therapy recommended 3 times a week for 3 weeks. Interventions include: exercises for endurance, flexibility, and strength.
Modalities include electric stimulation - unattended, hot or cold pack, and ultrasound/phonophoresis with 100% hydrocortisone cream.

THERAPIST SIGNATURE:  DATE: 9/19/13

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE.

PHYSICIAN SIGNATURE: _____ DATE: _____

Visit No.: 20005488
Viewed/Printed on:
09/19/2013 11:11

MCDONALD, RONALD E

Page 1 of 2

Visit No.: 20005488

MCDONALD, RONALD E

Occurrence History for PT Progress Note

<i>Effective</i>	<i>Status</i>	<i>User</i>
09/19/2013 11:11	Scheduled	BURROUGHS, LIDIA M. PT
09/19/2013 11:11	Finished	BURROUGHS, LIDIA M. PT

Visit No.: 20005488

MCDONALD, RONALD E

Viewed/Printed on:
09/19/2013 11:11

Page 2 of 2

Care Activity Report**Williamsburg Regional Hospital****PT Treatments**

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00		Age: 46 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20005488		Location: OUT
Attending Phys.: ALAN, RODNEY		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		

Scheduled: 09/19/2013 10:54	User: BURROUGHS, LIDIA M. PT
Performed: 09/19/2013 08:45	Status: Finished

Treatment Log

Total Physical Therapy Time: 65 minutes. Start time: 09:30. Stop time: 10:35.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units (treatment details: see ex log).
The response to the treatment was good. Additional Comments: see progress report for current status and new goals

Exercises

Exercise: Recumbent Bike - 10min.
Exercise: BOSU - - side to side weight shifting, single leg mini squats.
Exercise: Knee Ext Cybex - 1 1/2 plates 3x10.
Exercise: cross trainer - - 10 min.
Exercise: sit to stand - - from 10" step 2x10.
Exercise: "mountain climber" - - with hands on 8" step 2x10.
Exercise: Wall sits - - 10x5 sec/ hold.
Exercise: 8" stepper - - closed chain exercises.
Exercise: Single leg balance - - ball toss at trampoline fwd and lat x30 ea.

Subjective Assessment

"My leg still feels a little weak, I still can't squat down"

Occurrence History for PT Treatments

Effective	Status	User
09/19/2013 10:54	Scheduled	BURROUGHS, LIDIA M. PT
09/19/2013 10:54	Finished	BURROUGHS, LIDIA M. PT

MCDONALD, RONALD E

Visit No.: 20005488

Page 1 of 1

Viewed/Printed on:
09/19/2013 10:55

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00		Age: 46 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20005488		Location: OUT
Attending Phys.: ALAN, RODNEY		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		
Scheduled: 09/18/2013 11:36	User: GRAHAM, KIMBERLY N. PTA	
Performed: 09/18/2013 10:43	Status: Finished	

Treatment Log

Total Physical Therapy Time: 70 minutes. Start time: 09:30. Stop time: 10:40.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 65 minutes totaling 4 units.
The response to the treatment was good. Additional Comments: Tol exercises well. Decrease swelling in left knee today. Will reassess next visit

Exercises

Exercise: Leg Curl Cybex - 45# 3x10.
Exercise: Leg Press Cybex - 5pl 3x10.
Exercise: Knee Ext Cybex - 1 1/2 plates 3x10.
Exercise: Mat therex 2 1/2# - - strengthening and stretching for LLE in supine, sidelying, prone x30.
Exercise: Recumbent Bike - x10 min.
Exercise: II bars - - (B) hip flexion, ext, abd x30, (L) SLR with hold for quad strengthening, lunges, squats, heel-toe raises.
Exercise: Wall sits - - 10x5 sec/ hold.
Exercise: 6" stepper - - fwd step up x20, lat step up x20.
Exercise: Single leg balance - - ball toss at trampoline fwd and lat x30 ea.

Subjective Assessment

Pt complained of pain in right hip. Stated that he fell out of the bed this morning. No pains in left knee

Occurrence History for PT Treatments

Effective	Status	User
09/18/2013 11:36	Scheduled	GRAHAM, KIMBERLY N. PTA
09/18/2013 11:36	Finished	GRAHAM, KIMBERLY N. PTA

MCDONALD, RONALD E

Visit No.: 20005488

Page 1 of 1

Viewed/Printed on:
09/18/2013 11:36

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00	Age: 46 y
Med. Record No.: 89187	Gender: Male
Visit No.: 20005488	Location: OUT
Attending Phys.: ALAN, RODNEY	Room/Bed: N/A
Allergies: No allergy history (Not reviewed)	
Scheduled: 09/17/2013 13:37	User: GRAHAM, KIMBERLY N. PTA
Performed: 09/17/2013 12:11	Status: Finished

Treatment Log

Total Physical Therapy Time: 65 minutes. Start time: 10:00. Stop time: 11:05.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units.

The response to the treatment was good. Additional Comments: Tol exercises well. More swelling in knee today than usual. Still have a lot of play in knee as well.

Exercises

Exercise: Leg Curl Cybex - 45# 3x10.

Exercise: Leg Press Cybex - 5pl 3x10.

Exercise: Closed Chain - 6" stepper: fwd step up x20, lat step up x20, backward step up x20, squat and lift x20, heel-toe raises x30, (B) hip flex, abd x30, (L) SLR for quad strengthening 10x10 sec/hold, lunges x20, squats x20.

Exercise: Mat therex 2 1/2# - - strengthening and stretching for LLE in supine, sidelying, prone x30.

Exercise: cross trainer - - HELD.

Subjective Assessment

Pt reported increase pain and stiffness in left knee. Stated that he rode to Charleston yesterday and he helped his cousin hitched a car to bring home. "I'm still getting over my cold also"

PAIN:

Pain with activity: 7. Pain at rest: 7.

Occurrence History for PT Treatments

Effective	Status	User
09/17/2013 13:37	Scheduled	GRAHAM, KIMBERLY N. PTA
09/17/2013 13:37	Finished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20005488

Viewed/Printed on:
09/17/2013 13:38

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report**Williamsburg Regional Hospital****PT Treatments**

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00		Age: 46 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20005488		Location: OUT
Attending Phys.: ALAN, RODNEY		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		

Scheduled: 09/13/2013 16:27	User: GRAHAM, KIMBERLY N. PTA
Performed: 09/13/2013 16:28	Status: Finished

Treatment Log

. No treatment completed: Patient cancelled

Occurrence History for PT Treatments

Effective	Status	User
09/13/2013 16:27	Scheduled	GRAHAM, KIMBERLY N. PTA
09/13/2013 16:27	Finished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20005488

Viewed/Printed on:
09/13/2013 16:27

MCDONALD, RONALD E

Page 1 of 1

Activity Report**Williamsburg Regional Hospital****PT Treatments**

Name: MCDONALD, RONALD E	
Admission Date: 09/01/2013 00:00	D.O.B.: 08/24/1967
Med. Record No.: 89187	Age: 46 y
Visit No.: 20005488	Gender: Male
Attending Phys.: ALAN, RODNEY	Location: OUT
Allergies: No allergy history (Not reviewed)	Room/Bed: N/A

Scheduled: 09/11/2013 17:14	User: GRAHAM, KIMBERLY N. PTA
Performed: 09/11/2013 17:12	Status: Finished

Treatment Log

No treatment completed: Patient cancelled Comments: Pt called and stated that he is sick with a cold

Occurrence History for PT Treatments

Effective	Status	User
09/11/2013 17:14	Scheduled	GRAHAM, KIMBERLY N. PTA
09/11/2013 17:14	Finished	GRAHAM, KIMBERLY N. PTA

MCDONALD, RONALD E

Visit No.: 20005488

Page 1 of 1

Viewed/Printed on:
09/11/2013 17:14

Care Activity Report**Williamsburg Regional Hospital****PT Treatments**

Name: MCDONALD, RONALD E	
Admission Date: 09/01/2013 00:00	D.O.B.: 08/24/1967
Med. Record No.: 89187	Age: 46 y
Visit No.: 20005488	Gender: Male
Attending Phys.: ALAN, RODNEY	Location: OUT
Allergies: No allergy history (Not reviewed)	Room/Bed: N/A

Scheduled: 09/09/2013 17:04	User: SINGH, GITHA PT
Performed: 09/09/2013 17:03	Status: Finished

Subjective Assessment
PI cancelled treatment today

Occurrence History for PT Treatments

Effective	Status	User
09/09/2013 17:04	Scheduled	SINGH, GITHA PT
09/09/2013 17:04	Finished	SINGH, GITHA PT

Visit No.: 20005488

MCDONALD, RONALD E

Viewed/Printed on:
09/09/2013 17:04

Page 1 of 1

are Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	
Admission Date: 09/01/2013 00:00	D.O.B.: 08/24/1967
Med. Record No.: 89187	Age: 46 y
Visit No.: 20005488	Gender: Male
Attending Phys.: ALAN, RODNEY	Location: OUT
Allergies: No allergy history (Not reviewed)	Room/Bed: N/A
Scheduled: 09/06/2013 11:07	User: GRAHAM, KIMBERLY N. PTA
Performed: 09/06/2013 10:27	Status: Finished

Treatment Log

Total Physical Therapy Time: 65 minutes. Start time: 10:00. Stop time: 11:05.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units.

The response to the treatment was good. Additional Comments: Tol exercises well. Decrease discomfort with exercises continue with POC

Exercises

Exercise: Recumbent Bike - HELD.

Exercise: Leg Press Cybex - 5pl 3x10.

Exercise: Closed Chain -- 6" stepper: fwd step up x20, lat step up x20, squat and lift x20, heel-toe raises x30, (B) hip flex, abd x30, (L) SLR for quad strengthening 10x5 sec/hold, lunges x20, squats x20, wall sits with ball x10.

Exercise: Mat therex 2 1/2# -- strengthening and stretching for LLE in supine, sidelying, prone, and plank x30.

Exercise: cross trainer -- x 10 min.

Exercise: Leg Curl Cybex - 40# 3x10.

Subjective Assessment

Pt complained of pain in left knee and right hip. Stated that riding to Florence and sitting in "bucket seats" wasn't comfortable for him

Occurrence History for PT Treatments

Effective	Status	User
09/06/2013 11:07	Scheduled	GRAHAM, KIMBERLY N. PTA
09/06/2013 11:07	Finished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20005488

Viewed/Printed on:
09/06/2013 11:07

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00		Age: 46 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20005488		Location: OUT
Attending Phys.: ALAN, RODNEY		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		
Scheduled: 09/04/2013 13:07	User: BURROUGHS, LIDIA M. PT	
Performed: 09/04/2013 10:31	Status: Finished	

Treatment Log

Total Physical Therapy Time: 60 minutes. Start time: 10:25. Stop time: 11:25.

Treatments include:
Therapeutic Exercise (CPT Code - 97110) totaling 4 units (treatment details: see ex log).
The response to the treatment was good. Additional Comments: Improved ability to balance on L LE alone, patient progressing well.
cont.

Exercises

Exercise: Recumbent Bike - x10 min.
Exercise: Leg Press Cybex - 5pl 3x10.
Exercise: Closed Chain - 6" stepper: fwd step up x20, lat step up x20, squat and lift x20, heel-toe raises x30, (B) hip flex, abd x30,
(L) SLR for quad strengthening 10x5 sec/hold, lunges x20, squats x20, wall sits with ball x10.
Exercise: Mat therex 2 1/2# - - strengthening and stretching for LLE in supine, sidelying, prone, and plank x30.
Exercise: cross trainer - - x 5 min.
Exercise: Leg Curl Cybex - 40# 3x10.

Subjective Assessment

"It's sore mostly in the knee cap area"

PAIN:

Location: L knee. Pain with activity: 2.

Occurrence History for PT Treatments

Effective	Status	User
09/04/2013 13:07	Scheduled	BURROUGHS, LIDIA M. PT
09/04/2013 13:07	Finished	BURROUGHS, LIDIA M. PT

Visit No.: 20005488

Viewed/Printed on:
09/04/2013 13:07

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	D.O.B.: 08/24/1967
Admission Date: 09/01/2013 00:00	Age: 46 y
Med. Record No.: 89187	Gender: Male
Visit No.: 20005488	Location: OUT
Attending Phys.: ALAN, RODNEY	Room/Bed: N/A
Allergies: No allergy history (Not reviewed)	
Scheduled: 09/03/2013 16:29	User: GRAHAM, KIMBERLY N. PTA
Performed: 09/03/2013 16:15	Status: Finished

Treatment Log

Total Physical Therapy Time: 60 minutes. Start time: 14:00. Stop time: 15:00.

Treatments Include:
Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totalling 4 units.
The response to the treatment was good. Additional Comments: Tol exercises well. Reported decrease stiffness after treatment.
Continue with POC

Exercises

Exercise: Recumbent Bike - x10 min.
Exercise: Leg Press Cybex - 4 1/2 3x10.
Exercise: Close Chained -- 6" stepper: fwd step up x20, lat step up x20, squat and lift x20, heel-toe raises x30, (B) hip flex, abd x30, (L) SLR for quad strengthening 10x5 sec/hold, lunges x20, squats x20, wall sits with tball x10.
Exercise: Mat therex 2 1/2# -- strengthening for LLE in supine, sidelying, prone, and sitting x30.
Exercise: Stair master -- x 5 min.

Subjective Assessment

Pt complained of soreness and stiffness left knee.

PAIN:

Location: left knee. Pain with activity: 6. Pain at rest: 6.

Occurrence History for PT Treatments

Effective	Status	User
09/03/2013 16:29	Scheduled	GRAHAM, KIMBERLY N. PTA
09/03/2013 16:29	Finished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20005488

Viewed/Printed on:
09/03/2013 16:29

MCDONALD, RONALD E

Page 1 of 1

P73

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	D.O.B.: 08/24/1967
Admission Date: 08/16/2013 15:54	Age: 46 y
Med. Record No.: 89187	Gender: Male
Visit No.: 20004419	Location: OUT
Attending Phys.: ALAN, RODNEY	Room/Bed: N/A
Allergies: No allergy history (Not reviewed)	
Scheduled: 08/26/2013 12:08	User: BURROUGHS, LIDIA M. PT
Performed: 08/26/2013 11:56	Status: Finished

Treatment Log

Total Physical Therapy Time: 56 minutes. Start time: 11:00.

Treatments Include:
Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units (treatment details see ex log).
The response to the treatment was good. Additional Comments: Patient did well with weight bearing, balance exercises in single leg stance

Exercises

Exercise: mat exercises - - supine with 2# weight, heel slides, SLR, hip abd/add with leg lift over foam roller, abdominal crunches, bridges, sidelying hip abd, add with bolster, prone hip ext, HS curl, sitting hip flex, LAQ x30 ea.
Exercise: standing exercises - - side to side, front to back weight shifting, heel/toe raises, L LE SLR, standing on L LE, R leg ext/flex with forward/back trunk movements for weight bearing and proprioception, squats at stall bars 2x10, standing on L LE with two 4# dumbbells "dead lift".
Exercise: Leg Press Cybex - 4 pl 3x10.
Exercise: Recumbent Bike - 10 min.

Subjective Assessment

Patient complained that his knee continued to "slip" out of place causing him to loose balance.

PAIN:

Pain with activity: 2.

Occurrence History for PT Treatments

Effective	Status	User
08/26/2013 12:08	Scheduled	BURROUGHS, LIDIA M. PT
08/26/2013 12:08	Finished	BURROUGHS, LIDIA M. PT

Visit No.: 20004419

Viewed/Printed on:
08/26/2013 12:08

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E	
Admission Date: 08/16/2013 15:54	D.O.B.: 08/24/1967
Med. Record No.: 89187	Age: 45 y
Visit No.: 20004419	Gender: Male
Attending Phys.: ALAN, RODNEY	Location: OUT
Allergies: No allergy history (Not reviewed)	Room/Bed: N/A
Scheduled: 08/23/2013 17:19	User: GRAHAM, KIMBERLY N. PTA
Performed: 08/23/2013 15:11	Status: Finished

Treatment Log

Total Physical Therapy Time: 60 minutes. Start time: 03:00. Stop time: 04:00.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totalling 4 units.

The response to the treatment was good. Additional Comments: Good tol with exercises. No complaints of pain or discomfort after treatment. Continue with POC

Exercises

Exercise: mat exercises -- supine, heel slides, SLR, hip abd/add with leg lift over foam roller, abdominal crunches/ core strengthening with 5# ball, bridges, sidelying hip abd, add with bolster, prone hip ext, HS curl, sitting hip flex, LAQ x30 ea.
 Exercise: standing exercises -- side to side, front to back weight shifting, heel/toe raises, L LE SLR, standing on L LE, R leg ext/flex with forward/back trunk movements for weight bearing and proprioception, squats at stall bars 2x10.
 Exercise: Leg Press Cybex - 4 pl 3x10.
 Exercise: Recumbent Bike - 10 min.

Subjective Assessment

"My knee feels stiff"

Occurrence History for PT Treatments

Effective	Status	User
08/23/2013 17:20	Finished	GRAHAM, KIMBERLY N. PTA
08/23/2013 17:19	Scheduled	GRAHAM, KIMBERLY N. PTA
08/23/2013 17:19	Unfinished	GRAHAM, KIMBERLY N. PTA

Visit No.: 20004419

MCDONALD, RONALD E

Viewed/Printed on:
08/23/2013 17:20

Page 1 of 1

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 08/16/2013 15:54		Age: 45 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20004419		Location: OUT
Attending Phys.: ALAN, RODNEY		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		
Scheduled: 08/21/2013 16:00	User: BURROUGHS, LIDIA M. PT	
Performed: 08/21/2013 14:41	Status: Finished	

Treatment Log

Total Physical Therapy Time: 41 minutes. Start time: 14:00. Stop time: 15:10.

Treatments include:
Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 1 unit (treatment details: SEE EX LOG).
The response to the treatment was good.

Exercises

Exercise: mat exercises - - supine, heel slides, SLR, hip abd/add with leg lift over foam roller, abdominal crunches/ core strengthening with 5# ball.
Exercise: standing exercises - - side to side, front to back weight shifting, heel/toe raises, L LE SLR, standing on L LE, R leg ext/flex with forward/back trunk movements for weight bearing and proprioception, squats at stall bars 2x10.
Exercise: Leg Press Cybex - 4 pt 3x10.
Exercise: Recumbent Bike - 10 min.

Subjective Assessment

"My knee feels stiff"

Occurrence History for PT Treatments

Effective	Status	User
08/21/2013 16:00	Scheduled	BURROUGHS, LIDIA M. PT
08/21/2013 16:00	Finished	BURROUGHS, LIDIA M. PT

Visit No.: 20004419

Viewed/Printed on:
08/21/2013 16:00

MCDONALD, RONALD E

Page 1 of 1

Care Activity Report**Williamsburg Regional Hospital****PT Evaluation**

Name: **MCDONALD, RONALD E**
Admission Date: **08/16/2013 15:54**
Med. Record No.: **89187**
Visit No.: **20004419**
Attending Phys.: **ALAN, RODNEY**
Allergies: **No allergy history (Not reviewed)**

D.O.B.: **08/24/1967**
Age: **45 y**
Gender: **Male**
Location: **OUT**
Room/Bed: **N/A**

Scheduled: **08/20/2013 14:39**
Performed: **08/20/2013 10:50**

User: **BURROUGHS, LIDIA M. PT**
Status: **Finished**

Overview

Patient is a 45 y old M with an admitting diagnosis of L knee pain s/p arthroscopy History of Present Illness: Patient injured on the job in January of this year, sustained multiple trauma to B LE. Among other problems he was diagnosed with L ALC tear. He had outpatient therapy and returned to work, however had a lot of difficulty operating a clutch. On 8/15 he underwent arthroscopic knee surgery and now is referred back to PT for L knee rehab. Onset date is 08/15/2013. Start of care date is 08/20/2013. Level of consciousness is alert. Oriented to person, place, and time. Patient's Personal Goal: Regularly use off LLE in order to return to work.. ADL/Functional Limitations/Difficulties: squatting, standing, unable to work, up/down stairs, and walking.

Past Medical and Surgical History

Medical History: Additional Medical History Comments: hx of hip FX with surgical repair.

Precautions/Isolations

No isolation or special precautions required at this time.

Education Needs and Planning

Patient does not have any barriers to learning. Patient's preferred learning methods include demonstration with return demonstration. Patient does not have cultural restrictions. Patient does not have religious restrictions. Patient's health education needs include continuing care, and rehab services.

Subjective Assessment

Patient complains of L knee pain, uses ice at home, wears L knee immobilizer for ambulation

PAIN:

Location: L knee. Pain with activity: 6. Pain at rest: 4.

Objective Assessment**BED MOBILITY:**

Patient has the following bed mobility: supine to sit Patient currently shows complete independence with bed mobility. sit to supine Patient currently shows complete independence with bed mobility. rolling right Patient currently shows complete independence with bed mobility. rolling left Patient currently shows complete independence with bed mobility.

GAIT:

Current gait assist level is complete independence using L knee immobilizer Weight Bearing Status: weight bearing as tolerated left lower extremity.

ENDURANCE:

Patient shows good endurance. **APPEARANCE/POSTURE:**
normal posture.

TRANSFERS

Current transfer from sitting to standing assist level is complete independence.

EDEMA: mild edema L knee joint area

BALANCE:

Current balance standing static is normal with good dynamic. Current balance sitting static is normal with normal dynamic.

LE ROM and Strength

HIP Right hip is within functional limits. Left hip is within functional limits.

MCDONALD, RONALD E

Visit No.: 20004419

Page 1 of 3

Viewed/Printed on:
08/20/2013 14:40

Visit No.: 20004419

KNEE Right knee is within functional limits.

FLEXION:

(Right Side) AROM 135°;

(Left Side) Strength 3/5; AROM 0°; Supine position Test Position;

EXTENSION:

(Left Side) Strength 3/5; AROM 105°; Supine position Test Position;

ANKLE Right ankle is within functional limits. Left ankle is within functional limits.

Knee

OTHER SPECIAL TESTS: tenderness present anterior L knee.

Assessment

Assessment: Patient is s/p arthroscopic knee surgery. He presents with decreased AROM of L knee, decreased muscle strength L LE. Gait currently with L knee immobilizer, antalgic with decreased weight bearing on L LE. PT will focus on restoring full AROM, normal muscle strength, normal functional mobility to allow patient return to work without any limitations. Prognosis for Goal Achievement is good. Plan developed with patient. Plan of Care is agreed upon by patient. Discharge Recommendations: Return to work per Physician orders.

Functional Status and Goals

on 08/20/2013.

SHORT TERM GOALS:

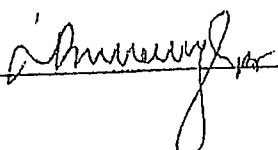
- 1) ACHIEVE FULL AROM LLE = RLE. 2 WEEKS
- 2) PATIENT WILL BE FAMILIAR WITH hep. 2 WEEKS

LONG TERM GOALS:

- 1) AMBULATE WITH NORMAL GAIT PATTERN ON ALL SURFACES INCLUDING STAIRS. 4 WEEKS
- 2) PATIENT WILL BE ABLE TO STOOP, SQUAT, KNEEL, ETC. WITHOUT ANY DIFFICULTY WITHOUT PAIN IN L KNEE, 4 WEEKS

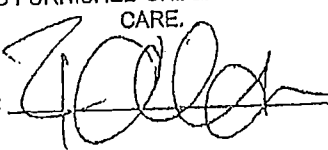
Plan

Physical Therapy recommended 3 times a week for 4 weeks. Interventions include: exercises for range of motion, and strength, neuro reeducation.
Modalities include electric stimulatn - unattended, hot or cold pack, and ultrasound/phonophoresis with 100% hydrocortisone cream.

THERAPIST SIGNATURE: 

DATE: 8/20/13

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE.

PHYSICIAN SIGNATURE: 

DATE: 8/29/13

Treatment Log

Total Physical Therapy Time: 60 minutes. Start time: 10:50. Stop time: 11:50.

Treatments include:

Initial Evaluation (CPT Code - 97001) performed for 15 minutes totaling 1 unit.

Therapeutic Exercise (CPT Code - 97110) performed for 45 minutes totaling 3 units (treatment details: see ex log).

The response to the treatment was good.

Exercises

MCDONALD, RONALD E

Visit No.: 20004419

Page 2 of 3

Viewed/Printed on:
08/20/2013 14:40

P78

Visit No.: 20004419

Exercise: mat exercises -- supine, heel slides, SLR, hip abd/add with leg lift over foam roller, side lying hip abd, hip add, prone SLR 3X10 EA.

Exercise: standing exercises -- side to side, front to back weight shifting, heel/toe raises, L LE SLR, standing on L LE, R leg ext/flex with forward/back trunk movements for weight bearing and proprioception.

Exercise: Leg Press Cybex - 4 pl 3x10.

Exercise: Recumbent Bike - 10 min.

Occurrence History for PT Evaluation

Effective**Status****User**

08/20/2013 14:39
08/20/2013 14:39

Scheduled
Finished

BURROUGHS, LIDIA M. PT
BURROUGHS, LIDIA M. PT

2013-08-16 15:12

LLING

7777023 ✓

8433552488 P 2/2
Page 2 of 4

REFERRAL

RODNEY K. ALAN, MD
Orthopedic Surgery
McLeod Orthopaedics
800 E CHEVES ST STE 480, FLORENCE, SC-295063650
Tel: 843-777-7900 Fax: 843-777-7925

RONNIE E McDONALD
08/24/1967

Reason For Referral:

Authorization No:

Authorization Type:

Reason:

evaluate and treat, weightbearing as tolerated, range of motion as tolerated quad strengthening
hamstring strengthening

Diagnosis:

V67.00 - Surgery follow-up examination

Procedures:

0

Visits Allowed:

V (VISIT)

Unit Type:

08/16/2013

Start Date:

08/16/2014

End Date:

Notes:

Clinical Notes:

July 4. Alan

*Left Knee Pain
(Arthroscopy 8/16/13)*
SCANNED

2013-08-16 15:12

LLING

7777023

8433552488 P 1/2
L 08/16/13

REFERRAL

RODNEY K. ALAN, MD
Orthopaedic Surgery
McLeod Orthopaedics
800 E CHEVES ST STE 480, FLORENCE, SC 295062650
Tel: 843-777-7900 Fax: 843-777-7925

RONNIE E McDONALD
08/24/1967

Date: 08/16/2013

Patient Information:

Patient Name: RONNIE E McDONALD
Patient DOB: 08/24/1967
Patient Insurance: BCBS STATE GROUP
Patient Subscriber No: ZCS37333841
Patient Address: [REDACTED], KINGSTREE, SC, US 29556
Patient Phone: 843-882-5400

Insurance Information

Subscriber Name: McDONALD, RONNIE E
Subscriber DOB: 08/24/1967
Subscriber Group No:
Subscriber Address: [REDACTED], KINGSTREE, SC, US 29556
Subscriber Phone: 843-882-5400

Referral From Information:

Provider Name: RODNEY K. ALAN, MD
Provider ID Number: 202939692
Provider UPIN: 892176
Provider NPI: 1568499572
Provider Facility: McLeod Orthopaedics
Provider Specialty: Orthopaedic Surgery
Address1: 800 E CHEVES ST STE 480
Address2:
City, State, Zip: FLORENCE, SC, 295062650
Phone: 843-777-7900
Fax: 843-777-7925

Kingstree Hospital

*8/20/13 @
11:00*

Referral To Information:

Provider Name:
Provider ID Number:
Provider UPIN:
Provider NPI:
Provider Facility:
Provider Specialty: Physical Therapy
Address1:
Address2:
City, State, Zip: . .
Phone:
Appt. Date/Time: 01/01/1901 00:00:00 A
Fax:

Facility Tax ID
Number:

Care Activity Report

Williamsburg Regional Hospital

PT Discharge

Name: MCDONALD, RONALD E	D.O.B.: 08/24/1967
Admission Date: 06/12/2013 09:37	Age: 45 y
Med. Record No.: 89187	Gender: Male
Visit No.: 20000060	Location: OUT
Attending Phys.: Doctor, Doctor	Room/Bed: N/A
Allergies: No allergy history (Not reviewed)	

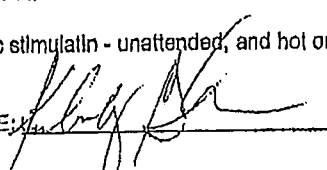
Scheduled: 06/17/2013 13:48	User: GRAHAM, KIMBERLY N.
Performed: 06/17/2013 12:04	Status: Queued for Cosign

Discharge

Prior Functional Status: PT PRESENTED TO THERAPY WITH LEFT KNEE AND ANKLE PAIN. VPR 6-8/10. DECREASE STRENGTH IN (L)LE. PT AMBULATE FULL WBING WITH AID OF DON JOY BRACE. MILD ANTALGIA on 04/30/2013. Discharge: FXNAL GOALS ACHIEVED. PT IS SUPPOSE TO BE SCHEDULED FOR SURGICAL ACL REPAIR. PT IS TO CONTINUE WITH HEP UNTIL HE SEES MD..
Met expected outcome. Reason for discharge: treatment goals met. Follow-up Plan: Follow-up with Physician.

LONG TERM GOALS:

- 1) ACHIEVE FULL AROM LLE = RLE. Goal met. Comments: AROM WNL.
 - 2) ACHIEVE GRADE OF 4+/5 STRENGTH LLE. Goal partially met. Comments: QUAD STRENGTH 4/5, HS STRENGTH WNL.
 - 3) AMBULATE WITH NORMAL GAIT PATTERN. Goal met. Comments: ANTALGIA PRESENT WITH FATIGUE AND SORENESS.
 - 4) ACHIEVE GOOD STANDING DYNAMIC BALANCE. Goal met. Comments: ABLE TO STAND ON LEFT SINGLE LEG >15 SEC WITHOUT PAIN AND LOB. Interventions include: exercises for endurance, range of motion, and strength, gait training, and manual therapy.
- Modalities include electric stimulatn - unattended, and hot or cold pack.

THERAPIST SIGNATURE:  DATE: 6/17/13

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE.

PHYSICIAN SIGNATURE: _____ DATE: _____

Occurrence History for PT Discharge

Effective	Status	User
06/17/2013 13:48	Scheduled	GRAHAM, KIMBERLY N.
06/17/2013 13:48	Queued for Cosign	GRAHAM, KIMBERLY N.

Visit No.: 20000060

MCDONALD, RONALD E

Viewed/Printed on:
06/17/2013 14:05

Page 1 of 1

Care Activity Report**Williamsburg Regional Hospital****PT Treatments**

Name: MCDONALD, RONALD E	
Admission Date: 06/12/2013 09:37	D.O.B.: 08/24/1967
Med. Record No.: 89187	Age: 45 y
Visit No.: 20000060	Gender: Male
Attending Phys.: Doctor, Doctor	Location: OUT
Allergies: No allergy history (Not reviewed)	Room/Bed: N/A

Scheduled: 06/17/2013 11:09	User: GRAHAM, KIMBERLY N.
Performed: 06/17/2013 09:45	Status: Queued for Cosign

Treatment Log

Total Physical Therapy Time: 70 minutes. Start time: 09:30. Stop time: 10:40.

Treatments include:

Therapeutic Exercise (CPT Code - 97110) performed for 60 minutes totaling 4 units.

The response to the treatment was good. Patient is discharged. Additional Comments: Good tol with exercises. Fxnal goals achieved. See D/C summary

Exercises

Exercise: stairmaster -- 8min.

Exercise: Leg Curl Cybex - 45# 3x10.

Exercise: Leg Press Cybex - 5 plates.

Exercise: standing exercises -- SLR 2X20, single leg toe raises x20, lunges 2x15, squats 2x15, step up on 8"step front/side x30ea, step down squats x20, squat and lift x20, on bosu squats x20, on reverse bosu lat shifting x30, standing on LLE ball toss/catch for balance/proprioception x30.

Exercise: Crosstrainer x10 min -

Subjective Assessment

Patient has no complaints today, no pain.

Occurrence History for PT Treatments

Effective	Status	User
06/17/2013 11:54	Queued for Cosign	GRAHAM, KIMBERLY N.
06/17/2013 11:09	Scheduled	GRAHAM, KIMBERLY N.
06/17/2013 11:09	Unfinished	GRAHAM, KIMBERLY N.

Visit No.: 20000060

MCDONALD, RONALD E

Viewed/Printed on:
06/17/2013 13:48

Page 1 of 1

CHART COPY

Routine For:
Created By: Kimberly Graham

Nov 22, 2011

HIP / KNEE - 77 Functional Quadriceps: Sit to Stand

Sit on edge of chair, feet flat on floor. Stand upright, extending knees fully.

Repeat 10 times per set.
Do 2 sets per session.
Do 2 sessions per day.



HIP / KNEE - 79 Deep Squat

Stand with feet shoulder width apart and squat deeply, head and chest up.

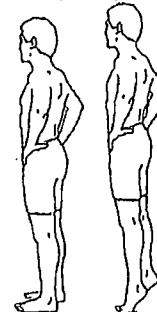
Repeat 10 times per set.
Do 2 sets per session.
Do 2 sessions per day.



ANKLE / FOOT - 20 Heel Raise: Bilateral (Standing)

Rise on balls of feet.

Repeat 10 times per set.
Do 2 sets per session.
Do 2 sessions per day.



ANKLE / FOOT - 22 Toe Raise (Standing)

Rock back on heels.

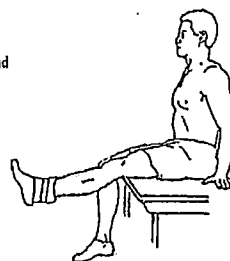
Repeat 10 times per set.
Do 2 sets per session.
Do 2 sessions per day.



HIP / KNEE - 76 Knee Extension (Sitting)

Place pound weight on left ankle and straighten knee fully, lower slowly.

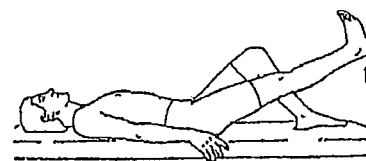
Repeat 10 times per set.
Do 2 sets per session.
Do 2 sessions per day.



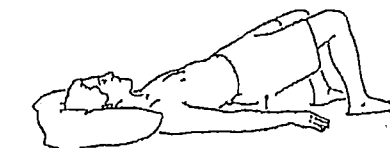
HIP / KNEE - 17 Strengthening: Straight Leg Raise (Phase 1)

Tighten muscles on front of right thigh, then lift leg inches from surface, keeping knee locked.

Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

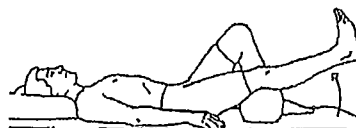


TRUNK STABILITY - 9 Bridging



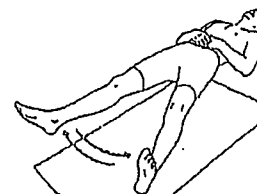
Slowly raise buttocks from floor, keeping stomach tight.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

HIP / KNEE - 23 Strengthening: Terminal Knee Extension (Supine)



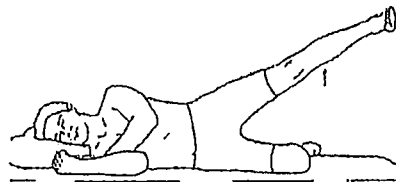
With right knee over bolster, straighten knee by tightening muscles on top of thigh. Keep bottom of knee on bolster.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

HIP / KNEE - 50 Hip Abduction / Adduction: with Extended Knee (Supine)



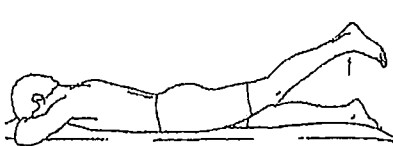
Bring right leg out to side and return. Keep knee straight.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

HIP / KNEE - 21 Strengthening: Hip Abduction (Side-Lying)



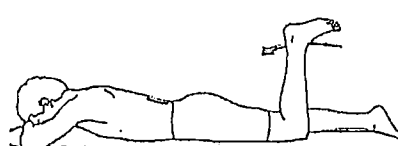
Tighten muscles on front of right thigh, then lift leg inches from surface, keeping knee locked.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

HIP / KNEE - 20 Strengthening: Hip Extension (Prone)



Tighten muscles on front of left thigh, then lift leg inches from surface, keeping knee locked.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

HIP / KNEE - 8 Self-Mobilization: Knee Flexion (Prone)



Bring right heel toward buttocks as close as possible. Hold seconds. Relax.
Repeat 10 times per set. Do 2 sets per session.
Do 2 sessions per day.

Care Activity Report

Williamsburg Regional Hospital

PT Treatments

Name: MCDONALD, RONALD E		D.O.B.: 08/24/1967
Admission Date: 06/12/2013 09:37		Age: 45 y
Med. Record No.: 89187		Gender: Male
Visit No.: 20000060		Location: OUT
Attending Phys.: Doctor, Doctor		Room/Bed: N/A
Allergies: No allergy history (Not reviewed)		
Scheduled: 06/14/2013 09:03	User: BURROUGHS, LIDIA M. PT	
Performed: 06/14/2013 08:47	Status: Finished	

Treatment Log

Total Physical Therapy Time: 75 minutes. Start time: 08:40. Stop time: 09:55.

Treatments Include:

Therapeutic Exercise (CPT Code - 97110) performed for 65 minutes totaling 4 units (treatment details: Anticipated D/C after next visit. Patient will follow up with referring physician. He is supposed to be scheduled for surgical ACL repair.).
The response to the treatment was good.

Exercises

Exercise: stairmaster - - 8min.
Exercise: Leg Curl Cybex - 45# 3x10.
Exercise: Leg Press Cybex - 5 plates.
Exercise: standing exercises - - SLR 2X20, single leg toe raises x20, lunges 2x15, squats 2x15, step up on 8" step front/side x30ea, standing on LLE ball toss/catch for balance/proprioception x20.
Exercise: mat exercises - - LLE strengthening with 2# weight, core strength in supine, side lying, prone and planks..
Exercise: stationary bike x6min - - Interval training with varied RPM.

Subjective Assessment

Patient has no complaints today, no pain.

Occurrence History for PT Treatments

Effective	Status	User
06/14/2013 10:01	Finished	BURROUGHS, LIDIA M. PT
06/14/2013 09:15	Unfinished	BURROUGHS, LIDIA M. PT
06/14/2013 09:03	Scheduled	BURROUGHS, LIDIA M. PT
06/14/2013 09:03	Unfinished	BURROUGHS, LIDIA M. PT

Visit No.: 20000060

MCDONALD, RONALD E

Viewed/Printed on:
06/14/2013 13:20

Page 1 of 1

**Williamsburg Regional Hospital
Outpatient Rehabilitation Services**

Progress Note Summary

500m

Patient Name: Donald McDonald Date: 6/12/13

Treatment # 16 Treatment Approved 18 Total # Tx 16 Report Due 186

Areas to be treated: (L) knee - Anterior MD Appointment _____

SUBJECTIVE: Pain level before treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)

4 - (R) knee stiffness and discomfort. No
if knee pain.

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____

- | | |
|-------------------|----------|
| 1. <u>IV (GI)</u> | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Standing S/L flex 2x20, mild leg heel raises x 20, old hip abduct
x 20, lunges x 20, closed chain ex on 8" step x 30 reps
one, OAPR, leg press 5x12, cross-training x 10!
Moif ex 0 24, right (L) knee strength - improve, old injury
response 3x10 ex, low strength ex, knee med leg with 15

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one) 4

- | | | |
|-------------------------------------|------------|-----------|
| Patient tolerated treatment well | <u>Yes</u> | <u>No</u> |
| Goals discussed with patient/family | <u>Yes</u> | <u>No</u> |
| Patient is compliant | <u>Yes</u> | <u>No</u> |
| New adaptive equipment needed | <u>Yes</u> | <u>No</u> |
| Patient's goals appropriate | <u>Yes</u> | <u>No</u> |

Phased into my personal life after treatment.

Skin assessment performed before treatment Intact Sensory deficit

Comments: _____

Skin assessment performed after treatment Intact Color

Comments: _____ Not Applicable ✓

PLAN/GOALS:

- Patient progressing toward goals Yes No
Continue treatment Yes No
Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk
Re-evaluation performed: Yes No
Awaiting MD orders: Yes No

- Refer to other discipline: Yes No
Family participation: Yes No
Patient understood all exs: Yes No
Discharge planning: Yes No
Home program: Yes No
(If yes, please see education form.)

Debra M. M... (Therapist)

(Therapist Asst)

Outpatient Rehabilitation Service

Progress Note Summary

Patient Name: Ronald McDonald Date: 6/10/13

Treatment # 15 Treatment Approved 18 Total # Tx 15 Report Due 18h

Areas to be treated: (2) knee - Anterior MD Appointment _____

SUBJECTIVE: Pain level before treatment (0) 1 2 3 4 5 6 7 8 9 10 (circle one)
"My (R) knee is sore today, no d/o swelling"

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
 Cold Pack 20 minutes (no charge) to: _____
 1. IV (62 ml) 4. _____
 2. _____ 5. _____
 3. _____ 6. _____
 Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Static knee x 6 min, slowly SWR 2x 15 sec squats 2x 15
MBR - 10 p.s.s. SWR 3x 15, Med x 24 0 supine, to do
very quick prone: (2) 5 strength, core strengthening
(2) 10 fast pleated on 511 day - (2) leg lift x 30 511 day -
step up for straddle x 20, single heel heel ball

OBJECTIVE/ASSESSMENT: Pain level after treatment (0) 1 2 3 4 5 6 7 8 9 10 (circle one) bike
 Patient tolerated treatment well Yes No
 Goals discussed with patient/family Yes No
 Patient is compliant Yes No
 New adaptive equipment needed Yes No
 Patient's goals appropriate Yes No
x 6' - interval

Continuity of muscle strengthening / conditioning
(2) for pre-op ACL repairs

Skin assessment performed before treatment Intact Sensory deficit
 Comments: _____
 Skin assessment performed after treatment Intact Color
 Comments: _____ Not Applicable ✓

PLAN/GOALS:

Patient progressing toward goals Yes No Refer to other discipline: Yes No
 Continue treatment Yes No Family participation: Yes No
 Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk Patient understood all exs: Yes No
 Re-evaluation performed: Yes No Discharge planning: Yes No
 Awaiting MD orders: Yes No Home program: Yes No
 (If yes, please see education form.)

Lidie R. Rump (Therapist)
 _____ (Therapist Asst)

Progress Note Summary

"I'm sure and sure" of it's success @ Kree / @ Kp

	Yes	No	X Not Applicable
Call bell given to patient with instruction on use			

STAIRS max knee x 5 sec at 1/4 hr heel pul down x 30, Alt lower x 20 side step gear x 20, with knees bent air squats x 30, side leg gear struts x 20. His circle 30, crotch to penis 5 1/2 pl 30 sec, rest there = 12 sec
Dinner shopping - sitting 1 hour 15 min / row x 30

Patent's goals appropriate

Tot have these well, it's serious in knee pt no change in
Hypertension + in RUC

Comments: _____ Not Applicable

(If yes, please see education form.)

(Therapist Asst)

Williamsburg Regional Hospital
Outpatient Rehabilitation Services

Progress Note/Summary

Patient Name: Ronald McDonald Date: 6/4/13
Treatment # 13 Treatment Approved 18 Total # Tx 13 Report Due 6/8
Areas to be treated: (C) Neck - A.C.L. MD Appointment

SUBJECTIVE: Pain level before treatment (0) 1 2 3 4 5 6 7 8 9 10 (circle one)

I don't have any pain today

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____
1. Feet (60) 4. _____
2. _____ 5. _____
3. _____ 6. _____
Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Start Mastic x 5 min Standby: 5 min x 30 HS and x 30
head/neck x 30 off machine at 15 sec
up to feet 6 ft dumbbells at 6 min
in 15 sec at 15 min at 15 min
at 15 min at 15 min at 15 min

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 (2) 3 4 5 6 7 8 9 10 (circle one)

Patient tolerated treatment well Yes No
Goals discussed with patient/family Yes No
Patient is compliant Yes No
New adaptive equipment needed Yes No
Patient's goals appropriate Yes No

At 15 min

Skin assessment performed before treatment Intact Sensory deficit
Comments: _____
Skin assessment performed after treatment Intact Color _____
Comments: _____ Not Applicable

PLAN/GOALS:

Patient progressing toward goals Yes No
Continue treatment Yes No
Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk
Re-evaluation performed: Yes No
Awaiting MD orders: Yes No

Refer to other discipline: Yes No
Family participation: Yes No
Patient understood all exs: Yes No
Discharge planning: Yes No
Home program: Yes No
(If yes, please see education form.)

Debra Brown (Therapist)

Debra Brown (Therapist Asst)

**Williamsburg Regional Hospital
Outpatient Rehabilitation Services**

Progress Note/Summary

Patient Name: Ronald McDonald Date: 6/3/13

Treatment # 12 Treatment Approved 18 Total # Tx 12 Report Due 18

Areas to be treated: (L) UK MD Appointment _____

SUBJECTIVE: Pain level before treatment 0 1 2 (3) 4 5 6 7 8 9 10 (circle one)

My knee hurts a little & day

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____

Cold Pack 20 minutes (no charge) to: _____

- | | |
|------------------------|----------|
| 1. <u>for IV (60')</u> | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Metes & 24 output - (L) UK 3 times weekly in supine, hold
unmy only break x 30 sec shoulder, knees, hips
hold - for metes x 30 sec, ankle for metes 5/10 x 10
Wk x 6 (intervals), stand Metes 20 sec / 1 min
SLK x 8 sec

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 (2) 3 4 5 6 7 8 9 10 (circle one)

Patient tolerated treatment well	<u>Yes</u>	<u>No</u>
Goals discussed with patient/family	<u>Yes</u>	<u>No</u>
Patient is compliant	<u>Yes</u>	<u>No</u>
New adaptive equipment needed	<u>Yes</u>	<u>No</u>
Patient's goals appropriate	<u>Yes</u>	<u>No</u>

Skin assessment performed before treatment Intact Sensory deficit

Comments: _____

Skin assessment performed after treatment Intact Color

Comments: _____ Not Applicable ✓

PLAN/GOALS:

Patient progressing toward goals Yes No

Continue treatment Yes No

Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk

Re-evaluation performed: Yes No

Awaiting MD orders: Yes No

Refer to other discipline: Yes No

Family participation: Yes No

Patient understood all exs: Yes No

Discharge planning: Yes No

Home program: Yes No

(If yes, please see education form.)

Didie Burroughs (Therapist)

(Therapist Asst)

Williamsburg Regional Hospital
Outpatient Rehabilitation Services

Progress Note/Summary

Patient Name: Ronald McDonald Date: 5/25/13

Treatment # 11 Treatment Approved 18 Total # Tx 18 Report Due 18

Areas to be treated: (D) LE MD Appointment 6/28

SUBJECTIVE: Pain level before treatment 0 1 2 3 4 (5) 6 7 8 9 10 (circle one)
pt reported 7 sharp stabbing today in symphysis

MODALITIES:

Moist Heat 20 minutes (no charge) to:
Cold Pack 20 minutes (no charge) to:
1. SV x 60 sec
2. _____
3. _____
4. _____
5. _____
6. _____
Call bell given to patient with instruction on use Yes No X Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Quad set x 12 my wall sit 10 x 5" high, cycle leg press 5' x 1' 7-15
Side step squats 10 x 1' 1/2" high x 2' 1/2" wide, heel raise 15 x 1' 1/2" high, heel raise 15 x 1' 1/2" high
2' 1/2" high for 10 sec, sit on floor 15 x 1' 1/2" high x 2' 1/2" wide, heel raise 15 x 1' 1/2" high

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)

Patient tolerated treatment well Yes No
Goals discussed with patient/family Yes No
Patient is compliant Yes No
New adaptive equipment needed Yes No
Patient's goals appropriate Yes No

Good pt with some weakness in legs with squats / leg press as much as
now, no pain reported in pt at rest & POC

Skin assessment performed before treatment Intact Sensory deficit

Comments: _____

Skin assessment performed after treatment Intact Color

Comments: _____ Not Applicable X

PLAN/GOALS:

Patient progressing toward goals Yes No
Continue treatment Yes No
Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk
Re-evaluation performed: Yes No
Awaiting MD orders: Yes No

Refer to other discipline: Yes No
Family participation: Yes No
Patient understood all exs: Yes No
Discharge planning: Yes No
Home program: Yes No
(If yes, please see education form.)

31/13 - PTNS

[Signature] (Therapist)
[Signature] (Therapist Asst)

Progress Note Summary (PROGRESS REPORT)

Date: 5/27/13
Report Due: 18th

Report Due 187

① U_B

No of parts today

Moist Heat 20 minutes (no charge) to:
Cold Pack 20 minutes (no charge) to:

1. _____
2. _____
3. _____
4. _____
- Call bell given to patient with _____

Call bell given to patient with instruction on use ☐ Yes ☐ No ☐ Not Applicable

see exercise sheet in chart

[illegible]

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10

PROGRESS TOWARD GOALS

1. Aumerskill kon $\text{E}^{\text{L}} \text{L}^{\text{L}}$
2. A dicker hft muske
3. Aumerskill kon $\text{E}^{\text{L}} \text{L}^{\text{L}}$
4. A dicker sand, spezialpoly

1. Met
2. pt continues to work on
unwinding depression
3. Met out of the walk present
4. Met

Goals still appropriate? YES

Skin assessment performed before treatment _____ YES _____ NO

Skin assessment performed before treatment _____ Intact _____
 Comments: _____
 Skin assessment performed after treatment _____ Sensory deficit _____
 Comments: _____

Skin assessment performed after treatment _____ Sensory deficit _____
 Comments: _____ Intact _____ Color _____

PLAN/GOALS: Patient progressing toward _____ Color _____ Not Applicable

Patient progressing toward goals Yes Yes No
 Continue treatment Yes Yes No
 Frequency Yes Yes No

Frequency: 5x/wk 1x/wk Yes No Yes No

Re-evaluation performed: 3x/wk ~~2x/wk~~ ~~4x/wk~~ ~~5x/wk~~

Awaiting MD orders: Yes No Yes No

(If yes, please see education form) Yes ☐ No ☒

Education (cont.)

Family participation: Yes Refer to other discipline: Yes No

Family participation: Yes ~~No~~

Patient understood all exs: Yes ~~No~~
Discharge: Yes ~~No~~

Discharge planning: _____
Home program: _____

Would program: Yes No

(Therapist)

(Therapist Asst)

Williamsburg Regional Hospital
Outpatient Rehabilitation Services

Progress Note Summary

Patient Name: Ronald McDonald Date: 5/22/13

Treatment # 9 Treatment Approved 18 Total # Tx 9 Report Due 10/1

Areas to be treated: (c) cure MD Appointment: _____

SUBJECTIVE: Pain level before treatment 0 1 2 (3) 4 5 6 7 8 9 10 (circle one)

~ If I were not back my my boyfriend me
more from my cute

MODALITES:

Moist Heat 20 minutes (no charge) to: _____

Cold Pack 20 minutes (no charge) to:

1. IV (60) 4.

2. _____

5. _____

3. _____ 6. _____

Call bell given to patient with instruction on use	Yes	No	☒ Not Applicable
--	-----	----	--

THERAPEUTIC EXERCISES: see exercise sheet in chart .

(W5) - Overhang x 10' APES - Deep press 5" pipe 3x10, wall w/bs x 5 sec
x 10' step up on 16" steps x 2, front & back sides, neck & face needs
stairing 8 ft x 20' H's under x 20'. Motor fare over (C) W5
spring down 3/4" - 1/2" - repair - hole deep end from 8 x 10

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)

Patient tolerated treatment well ☒ Yes ☐ No

	Yes	No
Goals discussed with patient/family	☒	☐

Patient is compliant ☒ Yes ☐ No

New adaptive equipment needed ☒ Yes ☐ No

Patient's goals appropriate	Yes	No
-----------------------------	-----	----

It did not show where it is

Skin assessment performed before treatment	Intact	Sensory deficit

Comments:

Skin assessment performed after treatment _____ Intact _____ Color _____

Comments: _____ Not Applicable

PLAN/GOALS:

Patient progressing toward goals / Yes No

Continue treatment ☒ Yes ☐ No

Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk

Re-evaluation performed: ☒ Yes ☐ No

Awaiting MD orders: Yes No ☒

Refer to other discipline: ☐ Yes ☒ No

Family participation: ☐ Yes ☒ No

Patient understood all exs: Yes No

Discharge planning: ☒ Yes ☐ No

Home program: ☐ Yes ☒ No

(If yes, please see education form.)

Lelle Brunn (Therapist)

(Therapist Asst)

Progress Note Summary

SUBJECTIVE: Pain level before treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)
 2.5 - other today, 3 - never in the past year

THERAPEUTIC EXERCISES: see exercise sheet in chart.
 Cross hiker x 6' CRK - leg press 5' x 10, steadily 5' x 10
 sled x 200 lbs 2x10, steadily 15 cranks x 30, marks 20 x 3
 back nbs x 5 sec hold x 10 Metabolic 24 weeks (1) 15 strength
 burning with burny and movie 3x10, steady (2) 10 x 10 (2)
 10. 10 - hand nbs x 30, some of 5-11' x 20, 1 hand push

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)

Patient tolerated treatment well	☒ Yes	☐ No
Goals discussed with patient/family	☒ Yes	☐ No
Patient is compliant	☒ Yes	☐ No
New adaptive equipment needed	☒ Yes	☐ No
Patient's goals appropriate	☒ Yes	☐ No

Skin assessment performed before treatment _____ Intact _____ Sensory deficit _____

Comments:	Intact	Color
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Comments: _____
 Skin assessment performed after treatment _____ Intact _____ Color _____ Not Applicable ☒
 Comments: _____

Patient progressing toward goals ☒ Yes ☐ No
 Continue treatment ☒ Yes ☐ No
 Frequency: ☐ 5x/wk ☐ 4x/wk ☒ 3x/wk ☐ 2x/wk ☐ 1x/wk
 Re-evaluation performed: ☒ Yes ☐ No
 Awaiting MD orders: ☐ Yes ☒ No

Refer to other discipline: Yes No
 Family participation: Yes No
 Patient understood all exs: Yes No
 Discharge planning: Yes No
 Home program: Yes No
 (If yes, please see education form.)

Lidia Brumwell (Therapist)

(Therapist Asst)

Williamsburg Regional Hospital
Outpatient Rehabilitation Services

Progress Note Summary

Patient Name: Ronald M. DORR Date: 5/15/13
Treatment # 7 Treatment Approved 18 Total # Tx 7 Report Due 106
Areas to be treated: (1) knee MD Appointment _____

SUBJECTIVE: Pain level before treatment 0 1 (2) 3 4 5 6 7 8 9 10 (circle one)

"My knee has felt numb I tried to run, after that
I started limping down."

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____
1. Ex IV (60') 4. _____
2. _____ 5. _____
3. _____ 6. _____
Call bell given to patient with instruction on use Yes No ✓ Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

(Ansi - forward x 6' slowly 8/12 legs abd x 2 to leg Mat ex
2x/week 4-day 5/12 hopper by circles x 25) Shuntlet
hip 3x10, from 1st work 2nd work 3x10,
5th 5 legs ext (1) by 5/12 3rd hold 10, slowly 1st work
leg 1st x 30 1st 5/12 1st 1st 1st 1st 1st 1st 1st 1st 1st 1st

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one) (1) 1st 1st 1st 1st 1st 1st 1st 1st 1st 1st
Patient tolerated treatment well ✓ Yes ✓ No
Goals discussed with patient/family ✓ Yes ✓ No
Patient is compliant ✓ Yes ✓ No
New adaptive equipment needed ✓ Yes ✓ No
Patient's goals appropriate ✓ Yes ✓ No
forward, 1st
x 2 to
well 1st x 5
x 10

Pl said his knee felt good after Rx. Cont

Skin assessment performed before treatment _____ Intact _____ Sensory deficit _____
Comments: _____
Skin assessment performed after treatment _____ Intact _____ Color _____
Comments: _____ Not Applicable ✓

PLAN/GOALS:

Patient progressing toward goals ✓ Yes ✓ No
Continue treatment ✓ Yes ✓ No
Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk
Re-evaluation performed: ✓ Yes ✓ No
Awaiting MD orders: ✓ Yes ✓ No
Refer to other discipline: ✓ Yes ✓ No
Family participation: ✓ Yes ✓ No
Patient understood all exs: ✓ Yes ✓ No
Discharge planning: ✓ Yes ✓ No
Home program: ✓ Yes ✓ No
(If yes, please see education form.)

6/17/13 - PTGP

Michelle Bunnell (Therapist)
_____ (Therapist Asst)

**Williamsburg Regional Hospital
Outpatient Rehabilitation Services**

Progress Note/Summary

Patient Name: Ronald McDonald Date: 5/13/13

Treatment # 12 Treatment Approved 18 Total # Tx 62 Report Due 10th

Areas to be treated: C knee MD Appointment _____

SUBJECTIVE: Pain level before treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)
patient stated slight pain in knee stated that he tried to run a little

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____
1. 2x x knee 4. _____
2. _____ 5. _____
3. _____ 6. _____
Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart
Rice x 10 min, 1/4 hrs (2x) v/r/t/ahd x 30, Hdr/lue rec'd x 30
6" skipper fwd step up back and step up, shoulder step down x 30
2x 13 x 30 cycle knee ext 2x H's ext 40 ft, by 1/2 hr 1 3x 15
not there 2nd 1/4 hr (2x) step up, 1/2 hr 1 3x 15

OBJECTIVE/ASSESSMENT: Pain level after treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)
Patient tolerated treatment well Yes No
Goals discussed with patient/family Yes No
Patient is compliant Yes No
New adaptive equipment needed Yes No
Patient's goals appropriate Yes No

at home therapy will be continued & attempt to run
patient pt to find if more rehabbing needed further notice
from MD

Skin assessment performed before treatment Intact Sensory deficit
Comments: _____
Skin assessment performed after treatment Intact Color _____
Comments: _____ Not Applicable

PLAN/GOALS:

Patient progressing toward goals Yes No
Continue treatment Yes No
Frequency: 5x/wk 4x/wk 3x/wk 2x/wk 1x/wk
Re-evaluation performed: Yes No
Awaiting MD orders: Yes No
Refer to other discipline: Yes No
Family participation: Yes No
Patient understood all exs: Yes No
Discharge planning: Yes No
Home program: Yes No
(If yes, please see education form.)

(Therapist)
Therapist

(Therapist Asst)

Progress Note Summary

Treatment # 5 Treatment Approved 18 Total # Tx 5 Report Due 10/1

SUBJECTIVE: Pain level before treatment (0) 1 2 3 4 5 6 7 8 9 10 (circle one)
pt. s/o it pain (0) the patient that the was up and right in jaw
and pain (0) knee

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____

1. Sw V 53m 4. _____
2. _____ 5. _____
3. _____ 6. _____
Call bell given to patient with instruction on use ☐ Yes ☐ No ☒ Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Bike 40 mins 11 hrs (20) Rep w/ 4 x 1/2 hr x 30, Hail 1000 (1412) x 30

2.5" step up (mid step up, straddle step up x 20, lat c 30 R (L) (E) step up

sitting isupress 15c pouse x 30, cgt x 4 press 4 1/2 p 30

Patient tolerated treatment well	☒ Yes	☐ No
Goals discussed with patient/family	☒ Yes	☐ No
Patient is compliant	☒ Yes	☐ No
New adaptive equipment needed	☒ Yes	☐ No
Patient's goals appropriate	☒ Yes	☐ No

Patient's goals appropriate ✓ Yes
 Not a true short-term goal. want to C/P to pass C/P Hg, 4/10/11, 12/11
 to use MUP, C/P for pain control for C/P Hg

Skin assessment performed before treatment _____ Intact _____ Sensory deficit _____

Comments: _____

Skin assessment performed after treatment _____ Intact _____ Color _____ Not Applicable ☒

Comments: _____

PLAN/GOALS:

Patient progressing toward goals ☒ Yes ☐ No

Continue treatment ☒ Yes ☐ No

Frequency: ☐ 5x/wk ☐ 4x/wk ☒ 3x/wk ☐ 2x/wk ☐ 1x/wk

Re-evaluation performed: ☐ Yes ☒ No

Awaiting MD orders: ☐ Yes ☒ No

Refer to other discipline: Yes No
 Family participation: Yes No
 Patient understood all exs: Yes No
 Discharge planning: Yes No
 Home program: Yes No
 (If yes, please see education form.)

(Therapist)

(Therapist Asst)

Progress Note Summary

of Reported Activity of "Little Soldiers"

**Williamsburg Regional Hospital
Outpatient Rehabilitation Services**

Progress Note/Summary

Patient Name: Ronald McDonald Date: 5/06/13

Treatment # 3 Treatment Approved 18 Total # Tx 3 Report Due 10th

Areas to be treated: Right knee (ankle) MD Appointment _____

SUBJECTIVE: Pain level before treatment 0 1 2 3 4 5 6 7 8 9 10 (circle one)
At 4/10 R knee pain started that knee is feeling better
still swelling in the ankle

MODALITIES:

Moist Heat 20 minutes (no charge) to: _____
Cold Pack 20 minutes (no charge) to: _____
1. Exerciser 4. _____
2. _____ 5. _____
3. _____ 6. _____
Call bell given to patient with instruction on use Yes No Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

At 4/10, 10/10, 11/10, 12/10, 1/11, 2/11, 3/11, 4/11, 5/11, 6/11, 7/11, 8/11, 9/11, 10/11, 11/11, 12/11, 1/12, 2/12, 3/12, 4/12, 5/12, 6/12, 7/12, 8/12, 9/12, 10/12, 11/12, 12/12, 1/13, 2/13, 3/13, 4/13, 5/13, 6/13, 7/13, 8/13, 9/13, 10/13, 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14, 7/14, 8/14, 9/14, 10/14, 11/14, 12/14, 1/15, 2/15, 3/15, 4/15, 5/15, 6/15, 7/15, 8/15, 9/15, 10/15, 11/15, 12/15, 1/16, 2/16, 3/16, 4/16, 5/16, 6/16, 7/16, 8/16, 9/16, 10/16, 11/16, 12/16, 1/17, 2/17, 3/17, 4/17, 5/17, 6/17, 7/17, 8/17, 9/17, 10/17, 11/17, 12/17, 1/18, 2/18, 3/18, 4/18, 5/18, 6/18, 7/18, 8/18, 9/18, 10/18, 11/18, 12/18, 1/19, 2/19, 3/19, 4/19, 5/19, 6/19, 7/19, 8/19, 9/19, 10/19, 11/19, 12/19, 1/20, 2/20, 3/20, 4/20, 5/20, 6/20, 7/20, 8/20, 9/20, 10/20, 11/20, 12/20, 1/21, 2/21, 3/21, 4/21, 5/21, 6/21, 7/21, 8/21, 9/21, 10/21, 11/21, 12/21, 1/22, 2/22, 3/22, 4/22, 5/22, 6/22, 7/22, 8/22, 9/22, 10/22, 11/22, 12/22, 1/23, 2/23, 3/23, 4/23, 5/23, 6/23, 7/23, 8/23, 9/23, 10/23, 11/23, 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Progress Note Summary

4/10 (A) Grain C movement.

3. Call bell given to patient with instruction on use Yes No ☒ Not Applicable

THERAPEUTIC EXERCISES: see exercise sheet in chart

Long sit: hamstring stretch 2x30 sec; hip add stretch 2x30 sec; hip flex stretch 2x30 sec; supine: post-pelvic tilt 5x30 sec; alt heel slides x20; bridge x20; upper ab. wrk x20; double leg curl x20; LIT x20; side L hip add 1.5# (2) LE x20; supine SLR x30; prone hip ext knee flex x30; shift ankle strength x20 each

added core muscle strength to exercise program 20 backache noted in knee/hip
exercises. Pt is educated in spine stabilization & exercises for hip/knee

Skin assessment performed after treatment Intra Color Not Applicable
 Comments: _____

(If yes, please see education form.)

(Therapist Asst)

WILLIAMSBURG REGIONAL HOSPITAL OUTPATIENT REHAB
PHYSICAL THERAPY EVALUATION

McDONALD, RONALD E

DOB: 08/24/67

Sex: M Race: B 45
ALAN, RODNEY

PATIENT: Ronald E. McDonald DOB: 8/24/67 SEX: M DATE: 4/30/13
DIAGNOSIS: (L) knee & ankle pain PHYSICIAN: Dr. Rodney Alan
ONSET DATE: 4/25/13 MECHANISM OF INJURY: lost on work injury
MEDICAL HISTORY: Feb 7th January 2013 - logging accident at work. suffered Fr (R) hip spr
DEIT: All parts of knee, (L) ankle sprain.
CONTRAINDICATIONS/PRECAUTIONS: Ø MEDICATIONS: see list
OCCUPATION: Truck driver

1. SUBJECTIVE: Difficulty walking + maintaining balance, at → stride
& pain; unable to stand 5-10 minutes
unable to return to work at this stage.

2. TEST RESULTS: Ø available

3. BEHAVIOR: appropriate COGNITION: Approx 3

4. PREVIOUS REHAB: Hosp. stay Feb 2013 ± rehab.

5. PRIOR FUNCTIONAL STATUS: Fully (I) in all activities prior to work injury.

6. PAIN (VPR): 5-6/10 - certain in front of (L) knee & pain
heights in (L) ankle controlling feeling

7. POSTURAL DEVIATIONS: Dorsal knee brace used 1 week ago set at 0°-125°.

8. ROM: 0°-135° (R) knee flexion (L) ankle ROM w/ brace = (R) for DF/PF
0°-122° (L) knee flexion heights in Inv/EV motion

9. STRENGTH: (L) Quads Gr 4-5 ; (L) Hamstrings Gr 4-5 ; (L) ankle DF/PF Gr 4-5
(L) ankle Inv/EV Gr 5-5 ; (L) Hip Gr 4-5
(R) Hip flex Gr 4-5 ; (R) Hamstrings Gr 4-5 ; (R) Quads Gr 4-5

10. SENSATION/REFLEXES: Intact

11. PALPATION: ITP (R) ankle joint line, knee joint line

12. GAIT: ASSISTIVE DEVICE REQUIRED: Ø walking aids except Dorsal knee brace.

DEVIATIONS: mildly limping
ANTALGIA: MILD: Ø MODERATE: ✓ SEVERE: Ø NONE: Ø

13. TRANSFERS: ASSISTIVE DEVICE REQUIRED: Ø
ANTALGIA: MILD: Ø MODERATE: ✓ SEVERE: Ø NONE: Ø

14. BALANCE: SITTING STATIC: Good STANDING STATIC: Good
DYNAMIC: Good DYNAMIC: Good

WILLIAMSBURG REGIONAL HOSPITAL OUTPATIENT REHAB
PHYSICAL THERAPY EVALUATION

WV0313855

04/29/13

DONALD, RONALD E

DOB: 08/24/67

Sex: M Race: B 45

ALAN, RODNEY

DOB: _____

PATIENT: Ronald E McDonald

15. SKIN CONDITION/EDEMA/GIRTH: NAD

16. SPECIAL TESTS: Ø

17. COMMENTS: Ø

18. CLIENT INFORMED OF PROGRAM MANAGER?
19. CLIENT IN AGREEMENT W/ TREATMENT PLAN?
20. CLIENT INFORMED ABOUT D/C PLAN? CLIENT AGREED W/ PLAN?
21. FAMILY SUPPORT?
22. CLIENT ABLE TO RECEIVE, FOLLOW, CARRY OUT INSTRUCTIONS?

YES ☒	NO _____
YES ☒	NO _____
YES ☒	NO _____
YES ☒	NO _____
YES ☒	NO _____

23. ASSESSMENT: 45 yr old male presenting with (L) knee/ankle weakness, pain & loss of function

24. TREATMENT GIVEN TODAY: Evaluation (15') then ex (4.5')

25. CLIENT'S GOALS: ↑ strength in (L) LE

26. OTHER PARTY/PAYOR GOALS: Ø

27. SHORT TERM GOALS: (4 weeks) (1) (E) in early HEP
(2) ↑ pain (L) knee & ankle to 2/10
(3) ↑ muscle strength (L) LE to CR4/5

28. LONG TERM GOALS: (6 weeks) (1) Resume full strength (L) knee = (E)
(2) Resume CR4/5 strength (L) knee/ankle hip/core muscles
(3) Resume normal gait pattern
(4) Resume good static dynamic balance

29. REHABILITATION POTENTIAL: Good for goals

30. TREATMENT PLAN: ther. exercises, gait train, neuromuscular re-educ; EROM, manual therapy

FREQUENCY: 3x/week

DURATION: 6 weeks

THERAPIST: Rougher

DATE: 4/30/13

REFERRING PHYSICIAN ONLY

RECOMMENDATIONS REGARDING TREATMENT PLAN: _____

PHYSICIAN: _____

DATE: _____

PLEASE SIGN AND DATE ABOVE. THIS PLAN OF CARE IS NOT VALID UNLESS APPROVED BY PHYSICIAN.

Outpatient Rehabilitation Services

Patient Name: Ronald E. McDonald Date: 4/30/13
 Program Manager: Ganghri Treatment Number: 1/18

Initial Progress Note Summary

Physician Orders: ft to eval + Rx
 Frequency of Treatment: 3x wk Total Authorized 18

☒ Initial Therapy Evaluation Complete
☒ Treatment Goals Discussed with Patient and 0 Family Members

Area(s) to be Treated: ① knee / ankle pain, weakness

Initial Treatment Consisted of the Following:

A. Modalities (Include # minutes, positions, and specific areas involved)

1. eval 1 (15')
2. ther ex 3 (45')
3. _____
4. _____
5. _____

B. Therapeutic Exercise

1. 2nd ankle w/ ①: heel slides; SAs hip flex over bolster
2. SLR x 4 ways, prone knee flex x 20 each way.
3. patella slides
4. _____
5. _____

C. Subjective Complaints: Pain level after treatment 0 1 ② 3 4 5 6 7 8 9 10 (circle one)
knee

Skin assessment performed before treatment intact Sensory deficit _____

Comments: _____

Skin assessment performed after treatment intact Color _____

Comments: _____

D. _____ Home exercise/instruction to patient - demonstrations and copy given

- _____ Home program instructions to family
- _____ Patient understood all exercises
- _____ Patient tolerated treatment well
- ☒ Patient's goal for therapy discussed with patient
- ☒ Patient's rehabilitation potential discussed with patient
- ☒ Family participation discussed with patient/family
- _____ Comments _____

Ganghri 2.25 - 4.35
 Therapist Signature

PATIENT/FAMILY EDUCATION FC V00313855 04/29/13
MCDONALD, RONALD E
DOB: 08/24/67
Sex: M Race: B 45
EARNING: ABILITIES: ALAN, RODNEY

_____ No problems noted _____ Cognitive limitations _____ Hearing/vision/speaking impairment
_____ Language barriers _____ Lack of motivation _____ Young child

 Audio Visual By doing Combination

_____ Patient/family able to verbalize or demonstrate understanding _____ Patient needs reinforcement
_____ Patient unable to learn _____ Family involvement

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

2013-04-26 08:25

LING

7777023

8433552488 P 1/2
1 of 1

REFERRAL

RODNEY K. ALAN, MD
Orthopedic Surgery
McLeod Orthopaedics
800 E CHEVES ST STE 480, FLORENCE, SC-295062650
Tel: 843-777-7900 Fax: 843-777-7925

RONNIE E McDONALD
08/24/1967

Date: 04/25/2013

Patient Information:

Patient Name: RONNIE E McDONALD
Patient DOB: 08/24/1967
Patient Insurance: BCBS STATE GROUP
Patient Subscriber No: ZCS37333941
Patient Address: [REDACTED], KINGSTREE, SC, US 29556
Patient Phone: 843-200-1008
Sub Sec# [REDACTED]

Insurance Information:

Subscriber Name: McDONALD, RONNIE E
Subscriber DOB: 08/24/1967
Subscriber Group No: [REDACTED]
Subscriber Address: [REDACTED], KINGSTREE, SC, US 29556
Subscriber Phone: 843-200-1008

Referral From Information:

Provider Name: RODNEY K. ALAN, MD
Provider ID Number: 202935692
Provider UPIN: 892176
Provider NPI: 1568499572
Provider Facility: McLeod Orthopaedics
Provider Specialty: Orthopedic Surgery
Address1: 800 E CHEVES ST STE 480
Address2:
City, State, Zip: FLORENCE, SC, 295062650
Phone: 843-777-7900
Fax: 843-777-7925

Referral To Information:

Provider Name:
Provider ID Number:
Provider UPIN:
Provider NPI:
Provider Facility:
Provider Specialty: Physical Therapist
Address1:
Address2:
City, State, Zip: , ,
Phone:
Appt. Date/Time: 01/01/1901 00:00:00 A
Fax:

Facility Tax ID
Number:

2013-04-26 08:26

ING

7777023

8433552488 P 2/2

REFERRAL

RODNEY K. ALAN, MD
Orthopedic Surgery
McLeod Orthopaedics
800 E CHEVES ST STE 480, FLORENCE, SC-295062650
Tel: 843-777-7900 Fax: 843-777-7925

RONNIE E McDONALD
08/24/1967

Reason For Referral:

Authorization No:	Authorization Type:
Reason:	Eval and treat left knee pain, left ankle pain, ACL tear
Diagnosis:	844.2 - ACL tear
Procedures:	
Visits Allowed:	0
Unit Type:	V (VISIT)
Start Date:	04/25/2013
End Date:	04/25/2014

Notes:

Clinical Notes:

Rodney K. Alan

Discharge Summary

MCLEOD REGIONAL MEDICAL CENTER
655 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Ulmer, John O. PA-C
PATIENT NO.: 000123417842
ADMIT DATE: 02/01/2013
DISCHARGE DATE: 02/07/2013

NAME: McDonald, Ronnie E
MED. REC. NO.: 00-15-76-58
DR. DICTATING: John O. Ulmer, PA-C
DOB: 08/24/1967
PATIENT NO.: 000123417842
ADMIT DATE: 02/01/2013
DISCHARGE DATE: 02/07/2013

ADMITTING DIAGNOSES:

1. Bilateral acetabulum fractures.
2. Left proximal fibula fracture.
3. Remote history of a crushing injury from a logging accident.
4. Remote history of rhabdomyolysis and acute renal failure.

DISCHARGE DIAGNOSIS: 1. Bilateral acetabulum fractures.
2. Left proximal fibula fracture.
3. Remote history of a crushing injury from a logging accident.
4. Remote history of rhabdomyolysis and acute renal failure.
5. Unstable right posterior wall acetabulum fracture requiring open reduction internal fixation.
6. Stable left transverse acetabulum fracture.
7. Elevated glucose without diabetes.
8. Elevated liver function tests resolved.
9. History of gastroesophageal reflux disease, peptic ulcer disease.
10. Minor anemia not requiring blood transfusion.

ADMITTING SERVICE INITIALLY: McLeod orthopedics, Dr. Rodney Alan. Care turned over to Dr. Kyle Watford. McLeod Orthopedic Trauma Service.

CONSULTING SERVICES WERE:

1. McLeod Hospitalist. Ashley Moody, PA. for Dr. Dozier for preoperative evaluation and medical management.
2. Physical Therapy for inpatient rehab therapy during hospital stay.
3. Discharge Planning for home evaluation and home needs.

PROCEDURE PERFORMED ON PATIENT: Dr. Kyle Watford, 02/05/2013, open reduction internal fixation of right posterior wall acetabulum fracture

BRIEF HISTORY OF HOSPITAL STAY: Mr. Ronnie McDonald is a 45-year-old African American male
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Discharge Summary

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Ulmer, John O. PA-C
PATIENT NO.: 000123417842
ADMIT DATE: 02/01/2013
DISCHARGE DATE: 02/07/2013

who is involved in a serious logging accident on January 7, 2013. The patient states he was crushed by several logs that fell onto his pelvis and thigh region. The patient was seen and evaluated and admitted at Williamsburg Regional Hospital with bilateral acetabulum fractures secondary to a crush injury. As a result of his injury the patient developed rhabdomyolysis as well as some acute renal failure. Mr. McDonald was eventually transferred to Carolinas Rehab on 01/29/2013. He continued to complain of pain to his left lower extremity as well as to his pelvis. The patient was sent as a referral to see Dr. Rodney Alan on 02/01/2013 for urgent evaluation regarding his leg and pelvic pain. The patient was seen by an orthopedist at Williamsburg Regional Hospital. His recommendations were non-operative treatment of his acetabulum fracture as well as his left fibula fracture. The patient was toe touch weight bearing right lower extremity and weight bearing as tolerated right lower extremity in a CAM Boot.

At Rehab the patient complained of instability with his right hip and felt as if his right hip was popping out of place posteriorly. Evaluation by Dr. Rodney Alan on 02/01/2013 in the clinic. He felt that Mr. McDonald had a more complex acetabulum fracture and needed further evaluation and treatment with concern of unstable right posterior wall fracture on the right side. The patient was admitted to McLeod Regional Medical Center from the office as a direct admit with orders for further evaluation, CT of the pelvis to determine the exact kind of acetabular fracture as well as CT of his left lower extremity and ankle. CT of his pelvis revealed a right posterior wall acetabulum fracture with displacement posteriorly as well as a transverse left acetabulum fracture that was non-displaced.

CT of the left lower extremity ankle showed no fracture distally but the patient had known proximal fibula fracture.

LABS ON ADMISSION: White count 5.72, Hemoglobin 11.8, Hematocrit 36.4, Platelets were 270.

CHEMISTRY PROFILE: Stable.

SODIUM 139, Potassium 3.7, Chloride 103, CO2 23, BUN 16, Creatinine 0.90, Glucose was 115. LFT's slightly elevated with Alk Phos of 272, AST of 62.

The patient was placed on bedrest, non-weightbearing, bilateral lower extremities. SCDs were ordered. Further imaging includes an AP pelvis as well as Judet views of bilateral hips were ordered. Posterior hip precautions were applied to the right lower extremity. Pain is controlled with Morphine and Hydrocodone. Lovenox was started for deep venous thrombosis prophylaxis during his hospital stay prior to surgery. Labs were followed. H and H remained stable at 11.6, 36.1. The Hospitalist was consulted for preoperative evaluation, medical management as well as evaluation for some EKG changes the patient was having without any acute chest pain, negative Troponin work-up. The patient was found stable. The patient was given medical clearance for surgery.

Mr. McDonald was taken to the Operating Room on 02/05/2013 by Dr. Watford and open reduction internal fixation of the right posterior wall acetabulum fracture. He had no complications for surgery. He was transferred to the post-anesthetic care unit, back to the 11th floor in stable condition. The patient

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Discharge Summary

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Ulmer, John O. PA-C
PATIENT NO.: 000123417842
ADMIT DATE: 02/01/2013
DISCHARGE DATE: 02/07/2013

received Ancef perioperatively. Lovenox was tolerated on postoperative Day 1. H and H postoperative Day 1 was 10.5, 32.6, Vital signs were stable. He was afebrile. The patient was neurovascularly intact to the right lower extremity. He could dorsiflex, plantarflex, positive EHL. Three views of the pelvis, AP as well as Judet views as well as CT scan of the pelvis postoperatively were ordered and were reviewed showing good reduction of the right posterior wall acetabulum fracture. Physical Therapy was consulted to see and evaluate. The patient was non-weightbearing of the right lower extremity. And weight bear as tolerated to the left lower extremity.

Mr. McDonald has been followed by the Hospitalist Service, is stable from their standpoint, started on Zantac for his reflux and peptic ulcer disease. LFTs are resolving with a negative Hepatitis A, B, and C. Elevated Glucose was minimal, not requiring any insulin. Minor anemia was stable.

Recommendations were to follow outpatient with his primary doctor. More ambulant, the patient has done very well. He is done with physical therapy, maintaining non-weightbearing right lower extremity. Postoperative dressing was changed on postoperative day two. Incision was clean, dry and intact without any drainage Hemovac drain was pulled. The patient will be on Lovenox for deep vein thrombosis prophylaxis, SCDs. The patient is stable for discharge home.

DISCHARGE MEDICATIONS INCLUDE:

Zantac 150 twice a day.
Colace 100 mg. twice a day.
Lovenox 40 mg. subcu daily.
Indomethacin 50 mg. capsule 1 capsule oral twice a day for 30 days.
Multivitamin daily.
Percocet 5/325 1 - 2 p.o. q. 4-6 hours PRN pain. #90 are given.
Oxycontin 20 mg. 1 p.o. twice a day.

DISCHARGE PLAN: The patient may be discharged home today. He will follow-up with Dr. Kyle Watford in two weeks. The patient is non-weightbearing right lower extremity. Weight bear as tolerated left lower extremity CAM boot. Posterior hip precautions need to be applied for right hip. The patient has been instructed on daily dressing changes with air strip to right hip. He will continue incentive spirometer. The patient will be on Lovenox for 3 weeks. Percocet and Oxycontin have been given for pain. The patient will continue Indomethacin for one month to help prevent heterotopic ossification.

Mr. McDonald will need to follow with primary doctor for review of his elevated liver function tests. Have these rechecked, as these were found elevated during his hospital stay.

The patient is stable on discharge.

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LOQX MCDONALD, RONNIE E Enc #123417842 2/1/2013 - 2/7/2013 Discharge Summary two sigs
(Interfaced) 2/1/2013 Ulmer, John O. PA-C 1 DS0002

Discharge Summary

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Ulmer, John O. PA-C
PATIENT NO.: 000123417842
ADMIT DATE: 02/01/2013
DISCHARGE DATE: 02/07/2013

Kyle E. Watford, M.D. John O. Ulmer, PA-C

bkw
DD: 02/07/2013 03:31 P
DT: 02/08/2013 10:46 A Job #: 1126095

cc: Rodney K Alan, M.D.
John O. Ulmer, PA-C
Kyle E. Watford, M.D.

Signed by ULMER PA-C, JOHN O. on 09-Feb-2013 09:05:37 -05:00
Signed by WATFORD MD, KYLE E. on 14-Feb-2013 08:31:10 -05:00

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Operative Report

MCLEOD REGIONAL MEDICAL CENTER
555 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Watford, Kyle E. M.D.
PATIENT NO.: 000123417842
DATE OF SURGERY/PROCED: 02/05/2013

NAME: McDonald, Ronnie E 11ST114201
MED. REC. NO.: 00-15-76-58
DR. DICTATING: Kyle E. Watford, M.D.
DOB: 08/24/1967
PATIENT NO.: 000123417842
DATE OF SURGERY: 02/05/2013

PREOPERATIVE DIAGNOSIS: Right posterior wall acetabulum fracture.

POSTOPERATIVE DIAGNOSIS: Right posterior wall acetabulum fracture.

PROCEDURE: Open reduction internal fixation right posterior wall acetabulum fracture.

SURGEONS: Dr. Watford, and Hicks, PA-C

IMPLANTS USED: Stryker Orthopedics ____ system.

INDICATIONS FOR SURGERY: Mr. McDonald is a 45 year old gentleman who suffered an injury just over four weeks prior with some sort of logging accident and at that time it is unclear exactly what his diagnosis was or exactly the impression he was given, but somehow he had essentially a delayed diagnosis until he saw Dr. Alan at McLeod Orthopedics just a few days ago. At that time Dr. Alan recognized the fact that he had a very significant acetabulum fracture with a right posterior wall acetabular fracture and he actually had a very low transverse acetabulum fracture on the left side. After reviewing his films and consulting with me we did talk with the patient regarding the fact that even at four weeks out we felt with the degree of comminution he had in his posterior wall as well as some large marginal impaction fragments of his right hip that he would benefit from open reduction internal fixation. We went through exactly what this would involve and tried to make sure he understood that it would be still some risk with the fact that it was four weeks out whether or not we would be able to obtain an anatomic reduction of the pieces of his posterior wall however since he has such a physical job and he is only 45 years old a very healthy thin individual we did feel this was advantageous to pursue this route instead of continuing to treat him nonoperatively. After discussing this with him and going through the risks and benefits associated with it he seemed to understand all this and wished to proceed.

OPERATIVE TECHNIQUE: The patient was taken to the main surgical suite. After successful induction of general anesthetic his right hip area was prepped and draped in usual sterile fashion. I made a standard posterior approach to his right acetabulum and identified the posterior wall fragment. We were able to use a Cobb elevator to remove some of the callous along the posterior column of his acetabulum. As we did this we were essentially able to outline the original fracture lines of his posterior wall which I felt was very advantageous. After doing this we were then able to elevate this area exposing the articular fragments of his posterior wall as we reflected the portion of the posterior wall still attached to this capsule. We then encountered essentially three marginally impacted fragments. All of these were

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Operative Report

MCLEOD REGIONAL MEDICAL CENTER
655 East Cheves Street
Florence, SC 29501-0551

NAME: MCDONALD, RONNIE E
11ST114201
MED. REC. NO.: 00157658
DR. DICTATING: Watford, Kyle E. M.D.
PATIENT NO.: 000123417842
DATE OF SURGERY/PROCED: 02/05/2013

elevated using a curved osteotome and then we used the femoral head essentially as a model to reduce all three of these. As we reduced these we used some allograft to place just behind the area where we had elevated filling the void of impacted bone just subchondrally and then we were able to reduce the posterior wall fragment on top of these and we held this provisionally with 2.0 K-wire while we then placed two spring plates along the posterior column of his acetabulum, one more superior and one more inferior. After spring plates were in place these seemed to nicely hold the posterior wall in appropriate position. We also contoured and placed a six hole curved 3.5 reconstruction plate along the posterior column of the acetabulum attaching this with two 3.5 screws in the Ischium and two in the Ilium. This seemed to afford us very nice fixation. We then used the C-arm image intensifier to make sure that we had all of our hardware well away from the hip joint itself. Once we were assured of this we irrigated with copious amounts of normal saline and closed with #2 Quill for the deep fascia and then 2-0 Quill for the subcutaneous tissue. Staples were used for the skin. Dressings were applied. He was then awakened and taken to the Recovery Room in stable condition. There were no apparent complications.

Kyle E. Watford, M.D.

ja
DD : 02/05/2013 12:38 P
DT : 02/06/2013 10:22 A
ET: Edited by GAN 02/06/2013 13:53
Job #: 1125204
cc: Rodney K Alan, M.D.
Kyle E. Watford, M.D.

Signed by WATFORD MD, KYLE E. on 14-Feb-2013 08:31:14 -05:00

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Report for MCDONALD, RONALD E (MRN: 312589)

4 Page 1 of 1

TEST: Discharge SummaryCollected Date & Time: 02/12/13 07:47

Result Name	Results	Units	Reference Range
Discharge Summary	Carolinas Carolinas Rehabilitation Hospital 121 E. Cedar Street Florence, SC 29506 843 661 3900		

DISCHARGE SUMMARY

NAME: RONALD E MCDONALD

MRN:	312589	ROOM:	CR217	DOB:	08/24/1967
ACCOUNT#:	3451755	BED:	1	AGE:	45
SERVICE CODE:	REH			SEX:	M
ADM DATE:	01/29/2013	DIS DATE:	02/01/2013	DOS:	

DICTATED BY: ADORA MATTHEWS, MD
ATTENDING PHYSICIAN: ADORA MATTHEWS
PRIMARY CARE PHYSICIAN: PRIMARY UNKNOWN

DISCHARGE DIAGNOSES: Multiple trauma secondary to logging injury
with previously undiagnosed fracture found while in rehabilitation.

BRIEF HISTORY: The patient is a 45-year-old black male who was
injured in a logging accident in which he was noted to have sustained
bilateral acetabular fractures which were treated conservatively and
an ankle sprain. He was stabilized and transferred to Carolinas
Rehabilitation.

HOSPITAL COURSE: The patient had significant knee pain noted during
his hospitalization on the left, and workup was consistent with a
previously undiagnosed fracture of the fibula. This patient was
referred to Dr. Rodney Alan of McLeod Orthopedics and was transferred
out to Dr. Alan's care on February 1, 2013, for definitive orthopedic
management of this previously undiagnosed fracture.

Adora Matthews, MD

This job has been electronically signed by: Adora Matthews MD
on 02/12/2013 at 8:41:00 AM (EST) Verification:
6284963720130212084100 D

Print CC:

Fax CC:

D Date/Time: 02/11/2013 02:05 PM ET

T Date/Time: 02/12/2013 03:24 AM ET
R Date/Time:
S Job #: CARHS62849637
D Job #: 312496
MT: 1128331 /89617

Page 1 of 1

Other Clinicians who have viewed this Result in Portal or Rounding

A. [REDACTED]

Report for MCDONALD, RONALD E (MRN: 312589)

☒ Results List

Select All Tests Check 5 on All Selected

Check 5 on Selected Components for CHEST PA/LATERAL

☒ TEST: CHEST PA/LATERAL

Collected Date & Time: 07/24/00 00:00

Result Name	Results	Units	Reference Range
☒ CHEST PA/LATERAL	Patient Name: MCDONALD, RONALD (..)		
Patient Name: MCDONALD, RONALD E.			
Unit Number: H312589			

EXAMS	REASON FOR EXAM	CPT CODE
000354237 CHEST PA/LATERAL		

PA AND LATERAL CHEST 7/24/00

HX: Blunt trauma.

The heart, mediastinum and pulmonary vessels are normal. Clear lungs. Old lateral left rib fractures with mild residual pleural thickening. There is improved aeration bilaterally compared with previous study of 7/2/00. There is a fracture 3 cm from the distal aspect of the left clavicle. No angulation with minimal offset. Intact thoracic vertebrae.

IMPRESSION: NO ACTIVE DISEASE. OLD LEFT CLAVICLE AND LEFT RIB FRACTURE.

** Manually signed by STEVEN CREEDMAN MD **
Reported and signed by: STEVEN CREEDMAN MD

CC: DONALD A BALDER MD; FRANK TREFNEY M.D.
Dictated Date/Time: 07/25/2000-0857

Other Clinicians who have viewed this Result in Portal or Rounding

☒ Results List

Select All Tests

Check 5 on All Selected

Williamsburg Regional Hospital
Kingsree, South Carolina

DISCHARGE SUMMARY

NAME: MCDONALD, RONALD E
DOCTOR: VEMULA, NAGASUMANTH
ADMIT DATE: 01/26/13

MED REC #: M089187
PT ACCT #: V00307019

DISCHARGE DATE:

DOB: 08/24/67

DATE OF ADMISSION: 1-26-13
DATE OF DISCHARGE: 1-29-13

DISCHARGE DIAGNOSIS:

1. MINIMALLY DISPLACED BILATERAL ACETABULAR FRACTURES INVOLVING THE LEFT HIP ANTERIORLY AND THE RIGHT HIP POSTERIORLY.
2. RHABDOMYOLYSIS - RESOLVED.
3. ACUTE RENAL FAILURE - RESOLVED.

REHAB COURSE: 45-YEAR-OLD MALE WITH NO PAST MEDICAL HISTORY. HE WAS WORKING ON THE LOG WOODS AND WAS HIT BY A LOG ON THE RIGHT SIDE. HE MAINLY COMPLAINED OF LEFT HIP PAIN. IN THE ER, HE WAS LATER FOUND TO HAVE BILATERAL SMALL NON-DISPLACED ACETABULAR FRACTURE ANTERIORLY ON THE LEFT SIDE AND POSTERIORLY ON THE LEFT HIP. HE WAS ALSO NOTED TO HAVE ANKLE SPRAIN. ON INITIAL WORK UP, HE HAD CREATININE OF 1.4. HE HAD A GRADE III LEFT ANKLE SPRAIN. HE WAS PLACED ON STIRRUP SPLINT. HE WAS GIVEN IV FLUIDS BECAUSE OF ELEVATED CPK OF 3482. ON IV FLUID HYDRATION, CPK LEVELS HAVE GRADUALLY TRENDED DOWN TO 250. LAST SMA-7 SHOWED SODIUM 136, POTASSIUM 4.5, CHLORIDE 102, BICARB 28, UREA 18, CREATININE 1, GLUCOSE 96. HE WAS LATER PUT ON SWING BED CARE FOR SHORT TERM REHAB. ON INITIAL PHYSICAL THERAPY EVALUATION, HE WAS MODIFIED INDEPENDENT FOR BED MOBILITY IN ROLLING IN BED FROM RIGHT TO LEFT. HE WAS INDEPENDENT FOR SCOOTING TO SITTING. HE WAS MODIFIED INDEPENDENT FOR SCOOTING TO SUPINE. FOR SUPINE TO SITTING AND FROM SITTING TO SUPINE, HE WAS MODIFIED INDEPENDENT WITH TRAPEZOID BAR. HIS SITTING BALANCE WAS GOOD. STANDING BALANCE WAS GOOD. ON STATIC, DYNAMIC STANDING BALANCE WAS POOR. HE WAS ABLE TO WALK 150 FEET WITH ROLLING WALKER AND CONTACT GUARD ASSIST. PATIENT HAD UNEQUAL STRIDE. HE HAD DECREASED ENDURANCE. PAIN WAS A LIMITING FACTOR. PATIENT DOES NOT WANT TO BE AT THIS FACILITY. HE REQUESTED TO BE TRANSFERRED TO CAROLINAS ACUTE IN-PATIENT REHAB. PATIENT HAS BEEN ACCEPTED BY CAROLINAS IN-PATIENT REHAB FOR TOMORROW. PATIENT AT PRESENT IS MEDICALLY STABLE TO BE TRANSFERRED FROM THIS FACILITY TO CAROLINAS REHAB ON 1-29-13.

DISCHARGE MEDICATIONS:

1. PERCOCET 10/325 Q4 PRN FOR PAIN.
2. MAALOX 30 ML Q6 PRN FOR INDIGESTION.
3. PROTONIX 40 MG Q DAY.
4. FOLIC ACID 1 MG Q DAY.
5. LOVENOX 40 MG Q HS.
6. FERROUS SULFATE 325 MG TID.
7. SENNA 2 TABS PO BID.

NAGASUMANTH VEMULA, M.D.

1/30
DATE

4pm
TIME

Williamsburg Regional Hospital
Kingstree, South Carolina

DISCHARGE SUMMARY

NAME: MCDONALD, RONALD E

MED REC #: M089187

DOCTOR: VEMULA, NAGASUMANTH

PT ACCT #: V00307019

ADMIT DATE: 01/26/13

DISCHARGE DATE:

DOB: 08/24/67

NV/MC

DD: 01/28/13, (1537)

DT: 01/29/13, (1016)

Williamsburg Regional Hospital
Kingstree, South Carolina

HISTORY & PHYSICAL

NAME: MCDONALD, RONALD E
DOCTOR: GAMBLE, TROY BELSER JR
ROOM #: K231
ADMIT DATE: 01/07/13

DATE OF BIRTH: 08/24/67
MED REC #: M089187
PT ACCT #: V00305717
SER DATE: 01/07/13

=====

DATE OF ADMISSION: 1-7-13

CHIEF COMPLAINT: ACETABULAR FRACTURE.

HISTORY OF PRESENT ILLNESS: RONALD MCDONALD IS A 45-YEAR-OLD AFRICAN AMERICAN MALE WHO WAS WORKING IN THE LOG WOODS TODAY AND WAS HIT BY A LOG ON THE RIGHT SIDE BUT COMPLAINED OF LEFT HIP PAIN. HE PRESENTED TO THE EMERGENCY ROOM WHERE A CT OF THE HEAD WAS DONE WHICH WAS NEGATIVE WITH NO INTRACRANIAL BLEED. CT OF HIS ABDOMEN AND PELVIS WAS NEGATIVE; HOWEVER, THERE WAS A SMALL NON-DISPLACED FRACTURE OF THE ACETABULUM OF THE LEFT HIP WITH A CHIP NOTED. DR. SKINNER WAS CALLED AND HE IS ADMITTING THE PATIENT AND HE HAS ASKED THAT WE FOLLOW THE PATIENT FOR MEDICAL CONSULTATION.

PAST MEDICAL HISTORY: NEGATIVE FOR SERIOUS ILLNESS OR INJURY.

FAMILY HISTORY: HIS FATHER DIED OF AN MI. HIS MOTHER IS ALIVE AND WELL.

SOCIAL HISTORY: HE DOES SMOKE. HE IS AN OCCASIONAL ETHANOL CONSUMER ON THE WEEKENDS.

MEDICATIONS: NONE.

ALLERGIES: NONE KNOWN.

REVIEW OF SYSTEMS: OTHERWISE NEGATIVE ON A 10 SYSTEM REVIEW.

PHYSICAL EXAMINATION:

GENERALLY: HE IS A WELL DEVELOPED, WELL NOURISHED BLACK MALE IN NO ACUTE DISTRESS.

VITAL SIGNS: BLOOD PRESSURE 178/100, PULSE 78, TEMPERATURE 98.0.

HEENT EXAM: PERRL. BOMI. DISCS ARE SHARP. TMS ARE NORMAL. NO HEMOTYMPANUM.

THROAT IS CLEAR. NECK IS SUPPLE WITHOUT THYROMEGALY OR BRUITS.

CARDIAC EXAM: REVEALS A REGULAR RATE AND RHYTHM WITHOUT MURMURS, GALLOPS OR CLICKS.

LUNGS: CLEAR TO AUSCULTATION AND PERCUSSION.

EXAMINATION OF THE ABDOMEN: REVEALED BOWEL SOUNDS TO BE ACTIVE. NO LOCALIZING TENDERNESS. NO HEPATOSPLENOMEGALY.

EXTREMITIES: REVEAL MULTIPLE CONTUSIONS AND ABRASIONS ON THE LEFT LOWER LEG. THERE IS PAIN ON THE LEFT HIP.

NEUROLOGICAL EXAM: CRANIAL NERVES II-XII ARE INTACT. NO MOTOR DEFICIT. NO SENSORY DEFICIT. NO CEREBELLAR SIGNS. REFLEXES ARE NOT TESTED.

EKG REVEALS SINUS RHYTHM, RIGHT AXIS NON-SPECIFIC ST AND T WAVE CHANGES, QUESTIONABLE LEAD REVERSAL ON THE EKG GIVEN THIS YOUNG MALE.

LABORATORY DATA: WHITE COUNT 9.8, HEMOGLOBIN 16.0, HEMATOCRIT 48.0. MCV ELEVATED SLIGHTLY AT 95. PLATELET COUNT 195,000. PT AND PTT WERE NORMAL. SODIUM LOW AT 130.

Williamsburg Regional Hospital
Kingstree, South Carolina

HISTORY & PHYSICAL

NAME: MCDONALD, RONALD E
DOCTOR: GAMBLE, TROY BELSER JR
ROOM #: K231
ADMIT DATE: 01/07/13

DATE OF BIRTH: 08/24/67

MED REC #: M089187

PT ACCT #: V00305717

SER DATE: 01/07/13

POTASSIUM 3.3 BUT APPARENTLY LAB IS HAVING PROBLEMS TODAY. CREATININE 1.4, GLUCOSE 117.

IMPRESSION:

1. LEFT ACETABULAR FRACTURE.
2. MULTIPLE ABRASIONS OF LEG.
3. ISOLATED ELEVATED BLOOD PRESSURE READING.
4. ABNORMAL EKG - WONDER ABOUT LEAD REVERSAL.
5. MILDLY ELEVATED MCV.
6. ELEVATED CREATININE - MAY BE DUE TO DEHYDRATION AND PRE-RENAL AZOTEMIA.

PLAN: WILL ADMIT HIM NOW. WILL BEGIN IV FLUID HYDRATION. WILL FOLLOW HIS SERIAL H&HS CLOSELY GIVEN THE BLUNT TRAUMA TO HIS ABDOMEN AND CHEST. DR. SKINNER HAS KINDLY ADMITTED HIM BUT I WILL FOLLOW HIM WITH HIM FOR MEDICAL ISSUES. WE WILL FOLLOW SERIAL H&HS AND HIS CREATININE. HE WILL NEED FOLATE, B12 TO LOOK AT HIS ELEVATED MCV. WILL KEEP A VERY CLOSE EYE ON HIS BLOOD PRESSURE. HIS TETANUS SHOT IS UP TO DATE.

TROY B. GAMBLE, JR., M.D.

TG/MC

DD: 01/07/13, (1637)

DT: 01/07/13, (1724)

1/11/13
DATE

5:15
TIME

Williamsburg Regional Hospital
Kingstree, South Carolina

CONSULTATION REPORT

NAME: MCDONALD, RONALD E
PT ACCT #: V00305717
ATTENDING DR: GAMBLE, TROY BELSER JR
MED REC #: M089187
ROOM #: K231
DATE OF BIRTH: 08/24/67

DATE OF ADMISSION: 1-7-13

DATE OF CONSULTATION: 1-8-13

CHIEF COMPLAINT: ACETABULAR FRACTURE.

SUBJECTIVE: PATIENT IS A 45-YEAR-OLD BLACK MALE WHO WAS INVOLVED IN A LOGGING ACCIDENT YESTERDAY INVOLVING THE SPLITTING MACHINE. HE HAS HAD INJURY TO HIS LEFT SIDE, WAS ADMITTED BY DR. GAMBLE TO WORK HIM UP FOR POTENTIAL CRUSH INJURIES. AT THAT POINT, IT WAS NOTED THAT HE HAD AN ACETABULAR FRACTURE WITH COMPLAINTS OF PAIN INVOLVING HIS LEFT HIP AND ALSO LEFT ANKLE.

OBJECTIVE:

GENERAL: PATIENT IS A WELL DEVELOPED BLACK MALE IN NO ACUTE DISTRESS. EXAMINATION OF LEFT HIP: AT THIS TIME SHOWS SIGNIFICANT PAIN ON GENERAL MANIPULATION OF THE HIP WITH THE LOWER EXTREMITY TO BE STABLE IN POSITION. NO SHORTENING OR EXTERNAL ROTATION NOTED. HE HAS SOME POINT TENDERNESS NOTED ON THE POSTERIOR ASPECT OF HIS LEFT HIP WITH SIGNIFICANT SWELLING NOTED OF HIS ANKLE AND TENDERNESS OF BOTH MALLEOLI. HE HAS A NORMAL NEUROVASCULAR EXAM.

CT SCAN OF THE PELVIS SHOWS POSTERIOR WALL FRACTURE WITH SOME COMMINUTION INVOLVING ABOUT 3 MM OF THE POSTERIOR WALL. THIS IS ALL OUT LATERAL TO THE PELVIS ITSELF. X-RAYS OF THE ANKLE ARE ESSENTIALLY WITHIN NORMAL LIMITS WITH WHAT LOOKS TO BE AN OLD AVULSION FRACTURE OF THE BEAK OF THE TALUS.

ASSESSMENT:

1. STATUS-POST POSTERIOR DISLOCATION OF LEFT HIP WITH POSTERIOR ACETABULAR FRACTURE.
2. GRADE III LEFT ANKLE SPRAIN.

PLAN:

1. AS FAR AS THE LEFT ANKLE GOES, WE ARE GOING TO GO AHEAD AND PLACE HIM INTO A STIRRUP SPLINT.
2. WILL REPEAT PELVIC FILMS.
3. WILL CONTINUE WITH BEDREST FOR STABILIZATION AND ALSO FOR CONTINUED FOLLOW UP BY DR. GAMBLE CONCERNING HIS TRAUMA.

THANK YOU FOR ALLOWING ME TO SEE MR. MCDONALD.

WRIGHT S. SKINNER, III., M.D.
WS/MC
DD: 01/08/13, (1519)
DT: 01/09/13, (1207)

DATE

TIME

Williamsburg Regional Hospital
Kingstree, South Carolina

CONSULTATION REPORT

NAME: MCDONALD, RONALD E
PT ACCT #: V00305717
ATTENDING DR: GAMBLE, TROY BELSER JR
MED REC #: M089187
ROOM #: K231
DATE OF BIRTH: 08/24/67

DATE OF ADMISSION: 1-7-13

CHIEF COMPLAINT: ACETABULAR FRACTURE.

HISTORY OF PRESENT ILLNESS: RONALD MCDONALD IS A 45-YEAR-OLD AFRICAN AMERICAN MALE WHO WAS WORKING IN THE LOG WOODS TODAY AND WAS HIT BY A LOG ON THE RIGHT SIDE BUT COMPLAINED OF LEFT HIP PAIN. HE PRESENTED TO THE EMERGENCY ROOM WHERE A CT OF THE HEAD WAS DONE WHICH WAS NEGATIVE WITH NO INTRACRANIAL BLEED. CT OF HIS ABDOMEN AND PELVIS WAS NEGATIVE; HOWEVER, THERE WAS A SMALL NON-DISPLACED FRACTURE OF THE ACETABULUM OF THE LEFT HIP WITH A CHIP NOTED. DR. SKINNER WAS CALLED AND HE IS ADMITTING THE PATIENT AND HE HAS ASKED THAT WE FOLLOW THE PATIENT FOR MEDICAL CONSULTATION.

PAST MEDICAL HISTORY: NEGATIVE FOR SERIOUS ILLNESS OR INJURY.

FAMILY HISTORY: HIS FATHER DIED OF AN MI. HIS MOTHER IS ALIVE AND WELL.

SOCIAL HISTORY: HE DOES SMOKE. HE IS AN OCCASIONAL ETHANOL CONSUMER ON THE WEEKENDS.

MEDICATIONS: NONE.

ALLERGIES: NONE KNOWN.

REVIEW OF SYSTEMS: OTHERWISE NEGATIVE ON A 10 SYSTEM REVIEW.

PHYSICAL EXAMINATION:

GENERALLY: HE IS A WELL DEVELOPED, WELL NOURISHED BLACK MALE IN NO ACUTE DISTRESS.
VITAL SIGNS: BLOOD PRESSURE 178/100, PULSE 78, TEMPERATURE 98.0.

HEENT EXAM: PERRL. EOMI. DISCS ARE SHARP. TMs ARE NORMAL. NO HEMOTYMPANUM.
THROAT IS CLEAR. NECK IS SUPPLE WITHOUT THYROMEGALY OR BRUITS.

CARDIAC EXAM: REVEALS A REGULAR RATE AND RHYTHM WITHOUT MURMURS, GALLOPS OR CLICKS.
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QUESTIONABLE LEAD REVERSAL ON THE EKG GIVEN THIS YOUNG MALE.

LABORATORY DATA: WHITE COUNT 9.8, HEMOGLOBIN 16.0, HEMATOCRIT 48.0. MCV ELEVATED
SLIGHTLY AT 95. PLATELET COUNT 195,000. PT AND PTT WERE NORMAL. SODIUM LOW AT 130,
POTASSIUM 3.3 BUT APPARENTLY LAB IS HAVING PROBLEMS TODAY. CREATININE 1.4, GLUCOSE
117.

Williamsburg Regional Hospital
Kingstree, South Carolina

CONSULTATION REPORT

NAME: MCDONALD, RONALD E
PT ACCT #: V00305717
ATTENDING DR: GAMBLE, TROY BELSER JR
MED REC #: M089187
ROOM #: K231
DATE OF BIRTH: 08/24/67

IMPRESSION:

1. LEFT ACETABULAR FRACTURE.
2. MULTIPLE ABRASIONS OF LEG.
3. ISOLATED ELEVATED BLOOD PRESSURE READING.
4. ABNORMAL EKG - WONDER ABOUT LEAD REVERSAL.
5. MILDLY ELEVATED MCV.
6. ELEVATED CREATININE - MAY BE DUE TO DEHYDRATION AND PRE-RENAL AZOTEMIA.

PLAN: WILL ADMIT HIM NOW. WILL BEGIN IV FLUID HYDRATION. WILL FOLLOW HIS SERIAL H&HS CLOSELY GIVEN THE BLUNT TRAUMA TO HIS ABDOMEN AND CHEST. DR. SKINNER HAS KINDLY ADMITTED HIM BUT I WILL FOLLOW HIM WITH HIM FOR MEDICAL ISSUES. WE WILL FOLLOW SERIAL H&HS AND HIS CREATININE. HE WILL NEED FOLATE, B12 TO LOOK AT HIS ELEVATED MCV. WILL KEEP A VERY CLOSE EYE ON HIS BLOOD PRESSURE. HIS TETANUS SHOT IS UP TO DATE.

TROY B. GAMBLE, JR., M.D.

TG/MC

DD: 01/07/13, (1637)

DT: 01/07/13, (1724)

11/8/13
DATE

2:20
TIME

PROGRESS NOTES

SUESS, STEVEN H.

PROGRESS NOTES

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
	(cont.)
	P: 1) (2) on 9/20 → 10/11/13
	2) 10/11/13
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PROGRESS NOTES

012637
Rev. 2/97

DAI HETCO CONTINUED

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB:08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1-8-73 1020	Spoke to pt. + wife regarding d/c plans. Pt. has sustained injury on his job. Will follow up re d/c needs.

012637
Rev. 2/97

PROGRESS NOTES

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Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/8/13	Hospital
2/1/13	S: 90 lb male pain & swelling today
	Ch. Aclab. BP - 107/71
	Cor - RPE
	Lung - clear
	Abd - soft, nondist
	Extrem - 10 lb ankle swelling - RLE
	Lab - H-M - 11.7/34.9
	Temp - 36.5
	CPR - 4927 → 5437 Score - 70
	U/A - 24 RBC / large hyaline casts
	Cat. on adw. 1-4
	A. (12) Acetabulum fracture
	1. CPK - 20 to muscle pain
	2. ALE ?
	3. Ankle Pp. Movement
	4. T.MOU
	5. Abdom. ESTE - 2 local pericard
	6. (12) Ankle pain
	7. 10 Ankle S.C.
	8. X-ray 12 Ankle
	9. Dr. Stewart to see today
	10. 12/13 of follow up
	11. 12/13 of follow up - all day
	12. 12/13 of follow up

PROGRESS NOTES

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/7/13	~~Exacerbated~~ S. Very low for aden. feel better O. Afebrile / BP-126/73 C - M Lungs - clear Hx S.H. Exposure - aden. w. Am. Hops Lungs: 155 / 96 6-108 1.2 (1/10/14) 4/1 31 3-7 Cpk-667 WBC-10.4 Hct-44/33.5 Hgb-16.7, 000 ECG - S wave. Hardly any ST waves. Low ECG / low wave A. ① Acetaminophen 650mg ② ↑ Cpk 20 to muscle trauma ③ A/E - myositis ④ Multiple lvs adenoma ⑤ 1 MCV - mild ⑥ low Amel. Specimen ⑦ ECG lvs were low placed P. ① Orthopedic consult re Dr. Skinner ② Get urine albumin / Allen / creat ③ w/ Aldy. for TEN for 1 Mac

PROGRESS NOTES

012637
Rev. 2/97

PA-11710-10/10/12

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
9/20/13	S: still complaining of O: agt - EUS started 7 Rep → ? Gas (P) Op → Union system indication of (P) epio location = post wall (X) Op A: (X) no reaction (X) Op P: placed into ex → with post wall rotation @ 90° - freed ex gas bubbles → moving back up to HPG
11/10/13	0725 SpO ₂ 94% on 2L O ₂ = 97% = M/P
11/10/13 @ 933 AM	P.T. note: orders rec'd. NSG reports 11 PAW + OEMA OF (2) HIP + PENDING RESULTS X-MY OF PELVIS. PT WILL HOLD EVAL PENDING CLARIFICATION OF MILK INTAKE AND SNAKEBITE RESISTANCE DORSAL

012637
Rev. 2/97

PROGRESS NOTES

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Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR
V00305717 01/07/13

DATE	PROGRESS NOTES
1/11/13	(Hospitalist)
6:10 PM	S: Low pain today. Lat. belly
	O: A/white P/white
	Cor - low
	lung - clear
	Abd - soft, nontender
	Ext - low pedal edema
	U/L Leg - NO DVT - Large Hemorrh
	12/10/12 = 5 = 12.6 cor - 1.2
	2/1 37.4 = 10
	C/W - 4.97
	WBC - 9.4/12.1
	Neut - 65.00
	A: (1) (2) Acetaminophen 650
	(3) (4) - high bandage - NO DVT
	(5) Folate deficiency
	(6) AKI - stable
	(7) Metoprolol per team - daily
	Pain med - low dose - allow
	creat & GFR
	(8) Ketorolac - at PCT nephrology da
	(9) Glab - regular
	(10) O/Pu - per Dr. [illegible]

PROGRESS NOTES

012637
Rev. 2/97

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

ACDONALD, RONALD E
DOB: 08/24/67
K231-1
Sex: M Race: B 45
GAMELE, TROY BELSER JR

DATE PROGRESS NOTES

12/10/13 [Hospital] High SNA done
S: Filly AP - 106/70
O: Affected Car - Bar
Lungs - clear
Hts - 5 ft
Eyes - Low Lendama / Esophagus (L)
Arterial pressure high
Civ - 133
Civ - 16
Labr 182/87
 77
 9.2

wbc - 9.4 Hct - 9.6/28.0 platelets - 187,000

A - (R) Acetabulum Fr
(2) High Hemoglobin - no DVT
(3) R/L to Pulley - bag removed
(4) Pharyngeal abscess - resolved
(5) ACE - resolving
P. (1) PICC - Nervez from R/L
(2) DVT prophylaxis
(3) Hip Fr - No pain or swelling
(4) R/L to upper arm
(5) W/C in arm

PROGRESS NOTES.

012637 .
Rev. 2/97

[illegible]

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

MCDONALD, RONALD E

K231-1

DOB: 08/24/67

K231-1
Sex: M Race: B 45

GAMBLE, TROY BELSER JR

Y00305717

92/07/13

[illegible]

PROGRESS NOTES

012637 .
Rev. 2/97

ALL METALS MONITORING

PROGRESS NOTES

01/07/13
V00305717
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

PROGRESS NOTES

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/12/13	<u>Hospital</u>
10/10/12	S: Still low but better - up on wheelchair
	On Avelar BP 128/68
	Co - R
	Weg - clear
	ABG - sat 100%
	Ex - 10 Drip still full portocath
	Lab - 133 92 8-124 Co - 1-1
	310 35 1.4
	CPR - 2297
	Weg - 2.7 Hct - 31/24.5
	A: Avelar for
	1) Drip Lander
	2) Avelar 20 to infuse low & high
	3) Lander in high
	4) Metoprolol - ready
	5) Avelar ready Lander
	6) Folate deficiency
	R: 1) Cont Drip 10/100 C/P / C/W
	2) 1000 Ortho sugar for the morning
	3) C/W Drip 10/100 C/P / C/W
	4) Folate deficiency
	5) Surg bed down

PROGRESS NOTES

012637
Rev. 2/97

PHOTO COPYED FROM ORIGINAL

PROGRESS NOTES

V00305717
MCDONALD, RONALD E 01/07/13
K231-1
Sex: M Race: B DOB: 08/24/57
45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
140 Jan	Dinner at Boston (2) → Beginn 00B CPT and Western AVH
	(2)

PROGRESS NOTES

P135

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/14/13	(Hospital)
2:00 PM	S: Constipated - no response d/l L: mild hct C: A/G: B/-119/71 Cm - A/G Lung - clear & dx A/G - S/G E: Hct - 14.5 Labs - 133/95 G-118 Cw-1.04 3.8/32 B-14 C/L: 1914 (1.5m 500+) W: 7.0 A/G: 8.7/20.5 p/w-22, 000 A-1 @ A/G: 1.5 1) Phosphatase - 1.5 2) Aspartate - w & L & High blood level 3) Alkaline phosphatase 4) ALT - 1.5 5) Platelet count 6) Cw - 1.04 7) A/G - 1.5 8) W - 7.0 9) Hct - 14.5

PROGRESS NOTES

012637
Rev. 2/97

PAI MFTO PRINTING 374-2742

PROGRESS NOTES

V00305717 ,
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1-14-13 1630	Discussed d/c. & rehab options w/ pt. & spouse. Discussed living w/ Bed Rehab but pt. & spouse will not commit to coverage of SNF Rehab, but will cover Acute Inpatient Rehab. Pt. & spouse requested referral to HealthSouth Rehab Hospital. Placed call to Kathy Barnes for referral, she will be here tomorrow to evaluate pt. for HealthSouth. Pt. & spouse pleased to care here.

Jean M. Bazzel

PROGRESS NOTES

P137

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GIMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/15/13	(Hospitalized) S: High risk
2 nd yr	C: Yellow B1-103/73 C - H W - clear A - clear, white G - clear, Tpt. No fever - 100
	Lab - CBC - 8.0 Hct - 21/24.7 plate - 309,000 135/92 G - 106 W - 102 4.1/32 R - 19
	A - ① Acetabulum Lp ② Rheumatoid arthritis - mild ③ Anemia - stable ④ AFE - present ⑤ Sclero defec
	P - ① Ischemic with sub-epicardial infarct rel. to atherosclerosis ② Card PVO prophylaxis & fibrin fibrinogen

PROGRESS NOTES

012637
Rev. 2/97

VALMETTO PRINTING 374-2600

PROGRESS NOTES

V00305717

01/07/13

VO0305717
MCDONALD, RONALD E
DO

K231-1

DOB: 08/24/67

K231-1 45
Sex: M Race: B
JOHN F. FELSNER JR

SEX: M RACE: W
GAMBLE, TROY ELSER JR

DATE _____

PROGRESS
NOTES

DATE	PROGRESS NOTES
01/15/13 @ 1430	Phone call to Kathy Barnes at Health South message left regarding potential referral family notified for Dr. M/G

1/15/13 (a)

15/10 - SpO₂ on Room air = 100% - Pt in NAD - O₂ Dc.H - Aortic
cat

1-15-13
17 (X)

Health South Rehab Hosp -
Eval in progress will initiate pre-cert.
in Ark. Thank you for referral. Kathy Barnes, RN
cell 758-2090

$$\frac{116}{12} \text{Pb}$$

P.T. NOTE. Pt reports T's @ knee / calf / ankle pain. Hx of
2nd degree burn to @ knee + 1st degree burn to
1st degree burn to thigh / leg. Pt. cannot walk +
medication MD + non-steroidal NSAIDs. 2003 PT

1-16-13
1500

Awaiting call from Kathy Barnes c Health South
for present info. Jean McRae

PROGRESS NOTES

PALMETTO PRINTING 574-2000

Willameburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/14/13	S. More pain & swelling in (L) leg today
1/14/13	① BP-100/68, 1-68; A/Pelvic Exam - Mu Weg - clear Abd - soft Ext - Coll. Ask w/CD some swelling / tenderness C/L - 946
	A-2-2 Worsen (L) Ankle & calf pain - No DVT
	① Acetaminophen 4x ② Phlebotomy - weekly ③ Anemia - 20 to 30% low in Hb ④ APT - resolved ⑤ Ankle swelling
	Pk ① Repeat MRI of (L) leg today to rule out DVT
	② PK. Dr. Skinner to discuss Ankle

PROGRESS NOTES

012637
Rev. 2/97

PALMETTO PRINTING 312-2863

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/17/13	S. S. My in Junction in Charleston
3/1/13	① A. A. b. b. 81-108/63 Car - Rm Wing - clean in Rm P Food - 50% of normal Ext - 1/2 of normal Lab - WBC - 7.0 Hct - 24.9 plate - 364,000 Urea - no DLT ① Prostatectomy / prostate ② Prostatectomy / prostate ③ Prostatectomy / prostate ④ Prostatectomy / prostate ⑤ Prostatectomy / prostate ⑥ Prostatectomy / prostate ⑦ Prostatectomy / prostate ⑧ Prostatectomy / prostate ⑨ Prostatectomy / prostate ⑩ Prostatectomy / prostate ⑪ Prostatectomy / prostate ⑫ Prostatectomy / prostate ⑬ Prostatectomy / prostate ⑭ Prostatectomy / prostate ⑮ Prostatectomy / prostate ⑯ Prostatectomy / prostate ⑰ Prostatectomy / prostate ⑱ Prostatectomy / prostate ⑲ Prostatectomy / prostate ⑳ Prostatectomy / prostate ㉑ Prostatectomy / prostate ㉒ Prostatectomy / prostate ㉓ Prostatectomy / prostate ㉔ Prostatectomy / prostate ㉕ Prostatectomy / prostate ㉖ Prostatectomy / prostate ㉗ Prostatectomy / prostate ㉘ Prostatectomy / prostate ㉙ Prostatectomy / prostate ㉚ Prostatectomy / prostate ㉛ Prostatectomy / prostate ㉜ Prostatectomy / prostate ㉝ Prostatectomy / prostate ㉞ Prostatectomy / prostate ㉟ Prostatectomy / prostate ㊱ Prostatectomy / prostate ㊲ Prostatectomy / prostate ㊳ Prostatectomy / prostate ㊴ Prostatectomy / prostate ㊵ Prostatectomy / prostate ㊶ Prostatectomy / prostate ㊷ Prostatectomy / prostate ㊸ Prostatectomy / prostate ㊹ Prostatectomy / prostate ㊺ Prostatectomy / prostate ㊻ Prostatectomy / prostate ㊼ Prostatectomy / prostate ㊽ Prostatectomy / prostate ㊾ Prostatectomy / prostate ㊿ Prostatectomy / prostate

PROGRESS NOTES

012637
RAV 2/97

Williamsburg Regional Hospital
Kingstree, SC

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
	<i>antoi</i> <i>cardiac catheter</i> <i>2013 - 2013</i> <i>at pain</i> <i>not starting</i> <i>pt. cont. c PT</i>
1-18-13	Spoke to Kathy Barnes re health. Worth regarding pre-cert for ptes admission. Due to circumstances of work-related injury, it is taking more time for pre-cert. May be first of next week. Pt. still meeting acute care criteria, will continue to follow. Pt. aware of above. <i>Jan McKenzie</i>

PROGRESS NOTES

012637
Rev 2/97

PROGRESS NOTES

V00305717
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

012637
Rev. 2/97

PALMETTO PRINTING 374-2436

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/20/83	<u>Hospital</u>
9 ¹⁵ 6 AM	S: no new signs
	O: Afebrile BP - 102/67 Cm - AM Lungs - clear Abd - soft Ext - Active touch to a little
	Wabs - 136 / 104 G - 124 wt - 1.05 4.2 / 20 B - 12
	CPR 250 UBC - 520 Hct - 8.4 / 25.3 plate - 394,000
	A: (1) Acetaminophen 5p (2) Phenytoin - 1000 (3) Anesthetics (4) ABT - 1000 (5) Folate 1000 - 1000
	P.O. DIC IVFs (1) Arter aneurysm from rebleed

PROGRESS NOTES

DATE	PROGRESS NOTES
1/21/13	1/21/13 S: Person does not feel good today - today Dr. A. L. White BP - 124/84 Com - All Leg - clear Arm - All Com - Leg L. Shm. feet Lab 136 / 124 G - 124 CO - 1.31 4.2 / 24 A - 12 WBC - 8.0 Hb - 8.9 / 24.3 R - 392,000 A. L. White: L. 1. Pharyngitis - new 2. Arthritis - new 3. Allergy - new 4. Allergy - new 5. Allergy - new 6. Allergy - new 7. Allergy - new 8. Allergy - new 9. Allergy - new 10. Allergy - new 11. Allergy - new 12. Allergy - new 13. Allergy - new 14. Allergy - new 15. Allergy - new 16. Allergy - new 17. Allergy - new 18. Allergy - new 19. Allergy - new 20. Allergy - new 21. Allergy - new 22. Allergy - new 23. Allergy - new 24. Allergy - new 25. Allergy - new 26. Allergy - new 27. Allergy - new 28. Allergy - new 29. Allergy - new 30. Allergy - new 31. Allergy - new 32. Allergy - new 33. Allergy - new 34. Allergy - new 35. Allergy - new 36. Allergy - new 37. Allergy - new 38. Allergy - new 39. Allergy - new 40. Allergy - new 41. Allergy - new 42. Allergy - new 43. Allergy - new 44. Allergy - new 45. Allergy - new 46. Allergy - new 47. Allergy - new 48. Allergy - new 49. Allergy - new 50. Allergy - new 51. Allergy - new 52. Allergy - new 53. Allergy - new 54. Allergy - new 55. Allergy - new 56. Allergy - new 57. Allergy - new 58. Allergy - new 59. Allergy - new 60. Allergy - new 61. Allergy - new 62. Allergy - new 63. Allergy - new 64. Allergy - new 65. Allergy - new 66. Allergy - new 67. Allergy - new 68. Allergy - new 69. Allergy - new 70. Allergy - new 71. Allergy - new 72. Allergy - new 73. Allergy - new 74. Allergy - new 75. Allergy - new 76. Allergy - new 77. Allergy - new 78. Allergy - new 79. Allergy - new 80. Allergy - new 81. Allergy - new 82. Allergy - new 83. Allergy - new 84. Allergy - new 85. Allergy - new 86. Allergy - new 87. Allergy - new 88. Allergy - new 89. Allergy - new 90. Allergy - new 91. Allergy - new 92. Allergy - new 93. Allergy - new 94. Allergy - new 95. Allergy - new 96. Allergy - new 97. Allergy - new 98. Allergy - new 99. Allergy - new 100. Allergy - new
1-21-13 1700	Unable to pre-cert pt. for HealthSouth Rehab. Pt. aware + OK to skilled rehab here if insurance will pre-cert. Will attempt this. <i>Janet Kenzie</i>

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1-22-13 11:30	Call placed to Linda Danielson c BOBS to discuss pre-cert. & rate negotiation for diving bed here. Also faxed request for diving bed approval. Will cont. to follow. <i>Jean McInnes</i>

PROGRESS NOTES

V00305717

01/07/13

MCDONALD, RONALD E

K232-1

DOB: 08/24/67

Sex: M Race: B 45

GAMBLE, TROY BELSER JR

[illegible]

PROGRESS NOTES

PALIETTO PRINTING 374 7249

PROGRESS NOTES

V00305717

V00305717
MCDONALD, RONALD E
DO

K231-1

K231-1
Sex: M Race: B 45
TROY BELSER J

Sex: M Race: E
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1/24/13	(Hospitality)
6.1.13	S: No contacts O: Absolute - 132.0p Co = 100 Leg = 100 Pro = 100 Quanta = 100
	A = 100 B = 100

PROGRESS NOTES

PALMETTO FRUIT 13 3/4-2 1/2 IN

PROGRESS NOTES

GAMBLE, TROY BELSER JR

012637
Rev. 2/97

FALSE TO PRINTS 374 2813

PROGRESS NOTES

V00305717 01/07/13
MCDONALD, RONALD E
K231-1 DOB: 08/24/67
Sex: M Race: B 45
GAMBLE, TROY BELSER JR

DATE	PROGRESS NOTES
1-25-13 1500	Received authorization for skilled nursing rehab for 7 days. Will plan to dis pt. from acute care & admit to Swing Bed here tomorrow (1-26-13). Pt. aware & agreeable to this. Discussed this w/ Dr. Hamble & Dr. Vernula, will follow pt. in Swing Bed. Dr. Allen also notified & approved. Patient for Swing Bed admit. (Janet McKenzie)

DECISION AND ORDER OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 1301480

Ronnie McDonald	)
Claimant,	)
	)
vs.	)
	)
Gregg Blakely Logging, Inc./	)
J Mac's Express, LLC	)
Employer,	)
	)
Palmetto Timber Fund/	)
Carrier,	)
	)
South Carolina	)
Uninsured Employers' Fund	)
	)
	)

HEARING:

Held in Andrews, South Carolina on June 10, 2013.

APPEARANCES:

Claimant represented by Joe Ann Calvy, Esquire of Kingstree, South Carolina. Defendant, Gregg Blakely Logging, Inc., represented by Walter H. Barefoot, Esquire, of Florence, South Carolina. Defendant, J Mac's Express, LLC unrepresented. Defendant, Uninsured Employers' Fund represented by Lisa C. Glover, Esquire, of Columbia, South Carolina.

PURPOSE OF HEARING:

To determine the issues set forth on Forms 50 and 51.

DECISION AND ORDER:

By Susan S. Barden, Commissioner

FILED:

August 13, 2013.

I. APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence at the time of the hearing:

Claimant's

	NAME OF APA # PROVIDER/OTHER(S)	DATE(S) OF RECORDS	NUMBER
1.	McLeod Regional Medical Center	02/01/13-02/07/13	1-6
2.	McLeod Physician Associates	02/01/13-04/25/13	7-19
3.	Carolinas Rehabilitation Hospital	01/29/13-02/01/13	20-22
4.	Williamsburg Regional Hospital	01/07/13-01/29/13	23-24
5.	Correspondence from WCC	01/25/13-02/13/13	25-26
6.	W-2 from Employer for 2011- 2012		27-28
7.	W-2 from Employer for 2012		29
8.	Check Stubs	01/06/12-10/12/12	30-42
9.	Invoice from Employer	09/24/12-01/11/13	43-63

Defendants: Gregg Blakely Logging, Inc.

	NAME OF APA # PROVIDER/OTHER(S)	DATE(S) OF RECORDS	NUMBER
1.	Records of Jimmy McFadden/J Mac's Express	03/11/11-01/04/13	64-85

Defendants : J Mac's Express, LLC

None

Defendants: Uninsured Employers' Fund

None

II. STIPULATIONS

The parties stipulate to the following matters:

1. The Commission has jurisdiction to hear the matters presented.
2. Venue is proper in Georgetown County.
3. The parties had notice of the hearing scheduled for June 10, 2013.
4. This matter came before the Commission on a Form 50 filed by the Claimant.
5. The Commissioner's notes and the Administrative Procedures Act submissions are a part of the record.
6. The South Carolina Workers' Compensation Commission has jurisdiction over the parties and issues involved;

Without objection, the Commission's file was made a part of the record in this matter with the exception of any self-serving declaration or unstipulated medical reports.

This hearing was initially scheduled for May 31, 2013 at 11:30 a.m. Mr. McFadden, the owner of J Mac's Express, LLC, was subpoenaed to attend but was not there when the case was called at 11:30 a.m. He arrived approximately 40 minutes later. Mr. McFadden was advised of his rights to have an attorney represent him. The hearing was then rescheduled for June 10, 2013 at 10:00 a.m. and he was Ordered to attend the hearing. At that time, the attorneys for the Claimant and for Gregg Blakely Logging, Inc, made Motions to Compel Mr. McFadden to attend. The attorneys for the Claimant and for Gregg Blakely Logging, Inc, also made Motions to Compel Mr. McFadden to respond to Subpoenas they had previously served him that he had not responded to and the response time had expired. All Motions were granted. On June 10, 2013, Mr. McFadden had responded to all subpoenas and was present for the hearing.

The attorney for the Defendant, Gregg Blakely Logging, Inc., also made a Motion to Postpone the initial hearing that was scheduled for May 31, 2013 for 30 days, contending that the carrier, Palmetto Timber SI Fund did have time to engage in

discovery such as deposing Claimant and gathering all the medical records, including those from the newly listed medical providers, and doing other investigation regarding the claim in time to have its defense prepared in time for the hearing. The Postponement was granted for 10 days.

III. STATEMENT OF THE CASE

Claimant filed this action against J Mac's Express, LLC, his employer, Gregg Blakely Logging, Inc., the alleged statutory employer, and the South Carolina Uninsured Employers' Fund (UEF). Claimant filed a Form 50 contending that if his employer is uninsured, then he is either the statutory employee of Gregg Blakely Logging or UIF is subject to the Act. Claimant contends that once the proper defendant/defendants are identified, then he is entitled to payment of all past medical care, payment for ongoing medical care, reimbursement and payment of all mileage and prescriptions. He further contends that he is entitled to temporary total disability compensation from the date of injury and continuing on a running award.

IV. EVIDENCE OF THE CASE

Claimant's Testimony

Claimant testified that he is 45 years old, married, and has children. He completed high school and has a diploma. Claimant testified that on January 7, 2013, he injured both hips, his left leg, pelvis, and left ankle when he was hit and dragged by a log. The driver of the crane was trying to load the log on a truck at the time he was hit. Since that time, his direct employer has refused to pay benefits. Claimant indicated that at the time of the injury, he was Mr. McFadden's employee and that although in October of 2012, Mr. McFadden stopped deducting state and federal taxes from his payroll, it was Claimant's understanding that he was still an employee of J Mac's Express, LLC and had been since 2010. He indicated that from October of 2012 and continuing until the end of the 2012 year, taxes were not deducted from his payroll.

monies. He also indicated that his job duties remained the same. That Mr. McFadden continued to pay Claimant, continued to have control over Claimant's work details and how he performed them, continued to furnish the work truck and any other equipment or supplies needed, continued to make any necessary repairs to the work truck, and continued to receive direct payment from the people they were servicing. Claimant indicated that he was never paid directly by any of the service providers, that the providers continued to call Mr. McFadden for any services they needed, and that he never used the work truck to do any work other than that what Mr. McFadden instructed him to do.

The Claimant testified that prior to his injury Mr. Blakely, owner of Gregg Blakely Logging, Inc., contacted his employer and asked that J Mac's Express provide them with a service. The service required Claimant to use J Mac's Express's truck and Gregg Blakely Logging, Inc.'s log trailer to haul logs to the mill. Claimant testified that Mr. McFadden and Mr. Blakely entered into the agreement to haul logs and Mr. Blakely paid J Mac's Express directly. He even testified that J Mac's Express had to change a tire on the log trailer. He also testified that this was the first time that J Mac's Express had hauled logs, and that he helped Mr. McFadden find the job with Blakely Logging, Inc.

The Claimant testified that he is still receiving medical treatment, that he has had surgery on his hip, and he may need surgery on his knee. He has not worked since the date of the injury.

Jimmy McFadden, Owner of J Mac's Express's Testimony:

Mr. McFadden testified that he is the owner of J Mac's Express. He testified that at the time of the injury he had 4 or more employees working for him and that Claimant was one of those employees. He testified that although he was subject to the act, he did not have workers' compensation insurance at the time of the injury. He testified that he received the monies for services provided, and then he in turn paid Claimant and the other employees. He testified that even after he stopped deducting state and federal taxes from Claimant's payroll in October of 2012, he still considered

Claimant to be an employee and his pay remained the same. He testified that he made all repairs on the trucks and paid for all fuel. He testified that this was the first time he had agreed to haul logs and that he is generally in the business of hauling dry freight, such as fiber, scrap, paper, logs, produce, and polyester.

Gregg Blakely, Owner of Blakely Logging, Inc.'s Testimony:

Gregg Blakely testified that he is the owner of Blakely Logging, Inc. and that on the date of the injury, J Mac's Express, Inc. was providing a service to his business. He testified that he is in the business of harvesting timber, processing the timber, and transporting the processed timber to the mill. At the time of the accident, his business was using the J Mac's Express, Inc. truck and employee/claimant to haul logs to the mill. He testified that at the time of the injury, he employed more than 4 or more employees and that he had workers' compensation insurance at the time of the injury. He also testified that being able to haul logs to the mill is an important, necessary, essential, and integral part of his business, and that the work J Mac's Express, Inc.'s employee was providing to his business at the time of the injury was the identical activity performed by his own employees. His employees also use his trucks to haul logs to the mill.

Medical Evidence

The medical evidence show that Claimant received bilateral hip fractures, left ACL tear of the left knee, left ankle, and pelvic pain as a result of this injury. Medical evidence also shows that he has had right hip surgery.

V. FINDINGS OF FACT

1. Claimant alleges that he injured his hips, pelvis, left knee, and left ankle in a work-related accident on January 7, 2013, while employed with J Mac's Express, a claim I find is supported by the greater weight of the evidence.
2. Claimant is 45 years of age (testimony of Claimant).
3. Claimant is a high school graduate (testimony of Claimant).
4. Jimmy McFadden is the owner of J Mac's Express (testimony of McFadden).
5. Gregg Blakely is the owner of Blakely Logging (testimony of Blakely).
6. On the date of the accident, J Mac's Express was in the business of hauling fiber, scrap, paper, logs, produce, and polyester (testimony of McFadden).
7. On the date of the accident, the business of Blakely Logging was harvesting timber, processing the timber, and transporting the processed timber to the mill. Owner Blakely admits that transporting timber is an important, essential part of his business, such that he does not get paid if he does not haul the logs to the mill. Further, Blakely owns 3 tractor-trailer trucks used for hauling logs (testimony of Blakely).
8. Blakeley Logging contracted with J Mac's Express to haul logs to the mill for Blakeley Logging. On the date Claimant was injured, Claimant was hauling logs for Blakely through Claimant's employment with J Mac's Express (testimony of Blakely; testimony of McFadden).
9. On the date of the accident, J Mac's Express regularly employed 4 or more employees (testimony of Claimant; testimony of McFadden).
10. On the date of the accident, J Mac's Express was uninsured (testimony of

McFadden).

11. On the date of the accident, Claimant was the direct employee of J Mac's Express, and not an independent contractor: (a) in performance of his job duties, Claimant drove a tractor-trailer truck belonging to J Mac's Express; (b) Claimant was required by J Mac's Express to keep the tractor-trailer truck clean; (c) J Mac's Express directly paid for/provided fuel, repairs, tires, and truck washing; Claimant did not have to pay or provide (initially or otherwise) for these items; (d) J Mac's Express paid Claimant weekly, and in cash; (e) although Claimant was not given a specific/precise time to leave in order to deliver/pick up a load, there was in fact a time frame within which Claimant knew he had to operate; (f) if something went wrong while en route, Claimant called McFadden for direction/instructions; (g) J Mac's Express provided Claimant's CB radio; (h) Claimant did not determine what he would be paid for a load; for the logging trips, the determination of the charge for the loads was decided strictly by McFadden and Blakely; (i) for logging trips, Claimant had to use Blakely's route (for all intents and purposes); (j) McFadden admits that he was Claimant's boss, and that Claimant was "pretty much under my control;" (k) through McFadden and Blakely's agreement, Blakely provided the trailer for hauling logs that Claimant used in performance of his job duties (testimony of Claimant; testimony of McFadden).
12. On the date of the accident, Claimant had been employed by J Mac's Express since 2010. Although McFadden stopped withholding Claimant's taxes in 2012, nothing else changed as far as their employment relationship is concerned (testimony of Claimant; testimony of McFadden).

13. I fully considered the fact that (a) Claimant provided his own cell phone; (b) McFadden paid Claimant a percentage of the load; (c) McFadden did not instruct Claimant to work/leave/arrive at an exact, precise time; and (d) Claimant was the initial "finder" (for McFadden's business) of the logging work with Blakely; I find this was nothing more than Claimant's trying to help his boss obtain business, which in turn helped Claimant (testimony of Claimant; testimony of McFadden).
14. Although Claimant had a certain latitude with his job (such as when precisely to leave/arrive), Claimant was required to pick up and deliver McFadden's loads every day. McFadden considered his employees "family," which I find accounts for some of the latitude/hands-off approach of McFadden. Instead of instructions from McFadden as to when a driver needed to arrive, it was actually Blakely who determined when Claimant needed to arrive/leave (testimony of McFadden; testimony of Claimant).
15. Claimant is Blakely Logging's statutory employee; Blakely Logging is Claimant's statutory employer.
16. J Mac's Express is directly liable for benefits. If J Mac's Express is unwilling or unable to provide benefits, Palmetto Timber Fund is liable, but is entitled to indemnity pursuant to Section 42-1-440.
17. Claimant to receive temporary total disability benefits from January 7, 2013, to the present and continuing, until further order of the Commission or agreement of the parties. Credit shall be given for the \$600 Claimant received from J Mac's

Express and Blakely Logging.

18. Claimant shall receive reimbursement for causally-related medicals pursuant to the Commission's fee schedule. This includes, but is not limited to, Claimant's right hip ORIF surgery (*e.g.*, Claimant's APA #1, pages 5-6).
19. Pursuant to the Commission's fee schedule, Claimant is to be evaluated for his residual injuries by McCloud Orthopedics, and shall receive any indicated/appropriate treatment.
20. Claimant has not reached maximum medical improvement. I base this finding on the medical evidence in its entirety.
21. Permanency is premature.
22. Claimant's average weekly wage is \$608.18, yielding a compensation rate of \$405.47. McFadden testified that he was uncertain as to whether the invoices were factored into the W-2 figure. Further, the "math" of the invoices does not completely "add up," and McFadden had no explanation for the discrepancies; he was repeatedly "not sure," and he could "not recall." I decline to speculate beyond the amount set forth on the W-2 (testimony of McFadden; *See* Claimant's APA #6, page 27, and Claimant's APA #8).
23. Defendants' Motion to Postpone was granted, and Defendants were granted 10 additional days for discovery. Further, the undersigned issued Orders to Compel. Defendants objected to the hearing going forward on the re-set date of June 10, 2013, as Defendants had sought more than 10 additional days for discovery. The undersigned would have granted Defendants' request for additional days for discovery beyond the 10-day postponement, except for the fact that Defendants'

request must be countered with Claimant's due process right to a timely hearing---
-particularly with regard to a denied claim where no benefits have been provided
for 5 months.

VI. CONCLUSIONS OF LAW

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant, J Mac's Express, LLC was a covered employer under the act.
2. Under § 42-1-400 and § 42-1-420 to § 42-1-450, Defendant, Gregg Blakely Logging, Inc., was the covered statutory employer of the Claimant and Claimant was its covered statutory employee.
3. Claimant sustained an injury by accident arising out of and in the course of his employment on January 7, 2013 within the meaning of § 42-1-160.
4. Claimant is entitled to additional medical treatment necessary to lessen the period of disability. § 42-15-60.
5. Under §§ 42-9-10 and 42-9-190, Claimant was disabled within the meaning of the Act from January 7, 2013 and is still disabled as of the date of this hearing.

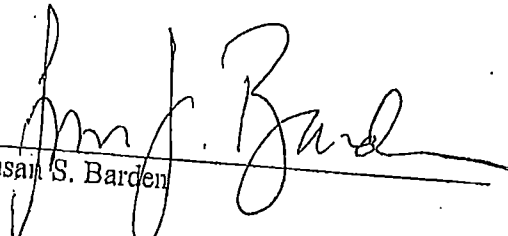
VII. AWARD

IT IS THEREFORE ORDERED that the direct Employer/Statutory Employer shall pay to Claimant temporary total disability compensation at the compensation rate of \$405.47 from January 7, 2013 and continuing on a running award until further Order of the Commission. J Mac's Express is directly liable for benefits. If J Mac's Express is unwilling or unable to provide benefits, Palmetto Timber Fund is liable, but is entitled to indemnity pursuant to Section 42-1-440.

IT IS FURTHER ORDERED that the direct Employer/Statutory Employer

shall provide causally related medical treatment to Claimant until he reaches maximum medical improvement. J Mac's Express is directly liable for the Claimant's medical care. If J Mac's Express is unwilling or unable to provide the medical care, Palmetto Timber Fund is liable, but is entitled to indemnity pursuant to Section 42-1-440.

AND IT IS SO ORDERED.


Susan S. Barden

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.
August 13, 2013

By: Kristi Love, Administrative Assistant to Commissioner Barden