

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM THE S.C. WORKERS'
COMPENSATION COMMISSION

Opinion No. 2017-UP-443 (S.C. Ct. App. filed Nov. 29, 2017)

RECEIVED
MAR 02 2018

Lettie Spencer,

Respondent, S.C. SUPREME COURT

v.

NHC Parklane,

Employer/Petitioner,

and

Premier Group Insurance Co., Inc. Carrier/Petitioner.

APPENDIX - PART III

Clarke W. McCants, III
Nance, McCants & Massey
PO Box 2881
Aiken, SC 29802
(803) 649-6200 Ext. 21
Attorney for Petitioners

Other Counsel of Record:

Andrew Wade Creech
Garrett Brendan Johnson
Elrod Pope Law Firm
Post Office Box 11091
Rock Hill, South Carolina 29731

RECEIVED
FEB 23 2018

S.C. SUPREME COURT

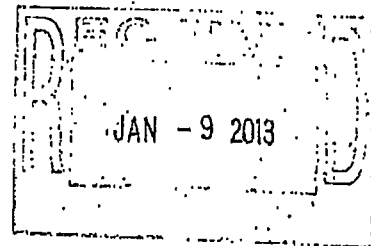
NANCE, McCANTS & MASSEY
ATTORNEYS & COUNSELORS AT LAW
218 NEWBERRY STREET, S.W.
AIKEN, SOUTH CAROLINA 29801

JAMES D. NANCE, L.L.C.
CLARKE W. McCANTS, III, P.C.
A. SEANE MASSEY, L.L.C.
AMY PATTERSON SHUMPERT

POST OFFICE BOX 2881
AIKEN, SC 29803-2881
TELEPHONE: (803) 649-6200
FAX: (803) 649-5566
E-MAIL: MCCANTSSRD@aol.com

January 7, 2013

The Honorable Avery B. Wilkerson
Commissioner
S.C. Workers' Compensation Commission
P. O. Box 1715
Columbia, SC 29202-1715



IN RE: Lettie L. Spencer v. NHC Parklane
SCWCC No.: 1120778
NHC File No.: WC18202011021728
Date of Accident: 6/22/11
Our File No.: MWC12-1203

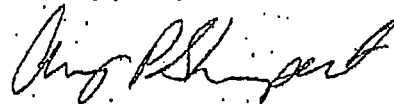
Dear Commissioner Wilkerson:

Please file in the above-referenced matter the enclosed Form 58, Notice of Submission of Evidence and Certificate of Filing and Service thereof upon opposing Counsel. By a copy of this letter, I am serving opposing Counsel with the Form 58 and Notice.

Thank you for your assistance in these regards.

With best regards, I remain

Very truly yours,


for Clarke W. McCants, III

CWMIII/aps
Enclosures

cc: Andrew W. Creech, Esquire (w.encls)

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 1120778
Carrier File # WC1820201102178
Carrier Code # 1100
Employer FEIN _____

Lettie L. Spencer
Claimant's Name

SSN _____

NHC Parklane
Employer's Name

2

Address _____ City _____ State _____

7601 Parklane Road Columbia, SC 29223
Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Premier Group Insurance Company, Inc.
Insurance Carrier

Clarke W. McCants, III P. O. Box 2881, Aiken, SC 29802
Preparer's Name Address

((803) 649-6200
Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident June 22, 2011 2. AWW: \$ 985.05 Comp. Rate: \$ 656.73

3. Type of Injury and body part(s) Low back; alleged psychological overlay

4. Facts in controversy: Whether or not Claimant has reached MMI.

5. Legal issues involved: Liability of Defendants for additional medical treatment.

6. Unusual problems: None

7. Witnesses (designate if expert)* Please see Notice of Submission of Evidence.

8. Exhibits: Please see Notice of Submission of Evidence.

9. Medical evidence: (Indicate report pursuant to R.67-812; deposition or appearance)
Please see Notice of Submission of Evidence.

10. Name, address, and specialty, if any, of the treating physician: William Louis Lehman, Jr., MD
Carolina Orthopaedic Surgery Associates, Rook Hill, SC

11. Impairment ratings body part(s); physician and date of opinion: None to date.

SIGNATURE Clarke W. McCants, III

DATE OF HEARING: 1/17/2013

On behalf of ☐ Claimant ☒ Employer

TIME OF HEARING: 10:00 a.m.

File this form and proof of service on the opposing party according to R.67-811 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Lettie Spencer,
Claimant,

vs.

NHC Parklane,
Employer,

and

Premier Group Insurance Co., Inc.,
Carrier
Defendants.

) WCC File No: 1120778
) Carrier File No: WC1820201102178
) Carrier Code No: 1100
) Employer FEIN:

NOTICE OF SUBMISSION
OF EVIDENCE BY DEFENDANTS

PLEASE TAKE NOTICE that the Employer/Carrier, pursuant to the provisions of the South Carolina Workers' Compensation Law and S. C. Code Ann. Section 1-23-10 (1976), et. seq., submits the following documentary evidence to be included in the record for the above-captioned matter. Copies of the documents listed below are herewith served upon Counsel for the Claimant and will be offered at the hearing for this matter for inclusion in the record.

DOCUMENTARY EVIDENCE

1. Carolina Occupational Healthcare, LLC, 6/27/11 - 9/16/11, Pages 1 - 11;
2. Chester Regional Medical Center, 7/22/11, Pages 12 - 13;
3. Randall G. Drye, M.D., Columbia Neuorsurgical Associates, 8/31/11, Pages 14 - 15;
4. Tony Owens, M.D. S.C. Pain Associates, 11/10/11 - 4/18/12, Pages 16 - 35;
5. Select Physical Therapy, 3/12/12 - 4/24/12, Pages 36 - 46;
6. William L. Lehman, M.D., Carolina Orthopaedic Surgery Associates, P.A., 4/4/12 - 11/26/12, Pages 47 - 62;

7. Springs Memorial Hospital, 9/11/12, Pages 63 - 79.

PLEASE ALSO TAKE NOTICE THAT the Employer may call the following witnesses to testify at the hearing for this matter:

Melissa Argo

Patti Coates

Pam Jackson

Tasha Owens

Porter Nelms

NHC Parklane

" "

" "

" "

Premier Group Insurance Co., Inc.

NANCE, McCANTS & MASSEY

By: 
for Clarke W. McCants, III, Esquire
218 Newberry St., SW
P. O. Box 2881
Aiken, SC 29802-2881
(803) 649-6200 Ext. 21
Counsel for Employer/Carrier

Dated: January 7, 2013

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ORIGINAL RECORD ON
APPEAL

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

NAME

Spencer, Leticia

DATE

6/27/11

TIME

3:00 PM

TECH

2310

HEIGHT

5' 10" inches

WEIGHT

138 lbs.

PULSE

74

BP

139/72

CC

Pushing Mtn Cart onto Felt Sharp Pains in Lower Back

HPI

5 days ago pushing med cart
felt pop in (L5) low back
pushing cart (L5) L5 to calf
hadn't had before (has worsened)
E movement 200 B/B

ROS: ☐ Reviewed ☐ Non-Contributory

PH: ☐ Reviewed ☐ Non-Contributory

FISH: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAMINATION

Post-Op SLR but interference in

(L) low back pain/gaited E (L) SLR

(R) SLR interference

plus pulses + 2/4

Aorta is 5' to 6' and palp

X-ray is 15' and 15' from top of spine
no evidence of fracture
no evidence of fracture
no evidence of fracture

L5 Low Back Strain, but likely radiculopathy (will try
steroids for benefit)

CYCLOZAPRINE
10 mg
30 TABLETS
NDC 8883-3079-32
LOT 0000000000
EXP 02/13

TRAMADOL
50 mg
30 TABLETS
NDC 8883-3079-32
LOT 0000000000
EXP 02/13

ASSESSMENT & PLAN: SEE RETURN TO WORK STATUS FORM ☐

NEXT VISIT IN 7 DAYS OR PRN

PHYSICIAN'S SIGNATURE

DATE 6/27/11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ H.W. BLED SOE, MD

☐ CHARLES BOYTER, MD

☒ THOMAS MOTYCKA, MD

☐

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC
1715 BLANDING ST.
COLUMBIA, SC 29201
PHONE (803) 799-3926 FAX (803) 256-7898

☐ SC VOC	NHC	(Company name)
☒ DWOC		
☐ PRIVATE		
☐ Employment		(Company Name)
☐ Asbestos - NIOSH FORM NEEDED - RADIOLOGIST READS		

X-Ray No. 19060 Patient Name Spencer, Lettie M ☒ ^{Pregnancy statement}
Date 6-27-11 SS DL Age

Requesting Physician: ☐ WRIGHT ☐ HEGQUIST ☒ MOTYCKA ☐ BLEDSOE ☐

History: WC injury

X-Ray Technician's Signature/Name: Robertwell R.T. (R)

☐ Abdomen, IV, 74000	☐ Finger, 3V, 73140	☐ Knee & Tun, 3+1, 73564	☐ Shoulder, 2V, 73030
☐ Abdomen, 3V, 74022	☐ Foot, 2V, 73620	☒ L5-Spine, 3V, 72100	☐ Sinuses, 2V, 70210
☐ Ankle, 3V, 73610	☐ Foot, 3V, 73630	☐ Mandible, 3V, 70100	☐ Sinuses, 3V, 70220
☐ C-Spine, 3V, 72040	☐ Foot-FB, 2V, 73620	☐ Nasal, 3V, 70180	☐ Skull, 2V, 70250
☐ C-Spine, 5V, 72050	☐ Forearm, 2V, 73090	☐ Neck-ST, 2V, 70360	☐ Skull, 4V, 70260
☐ Chest, 1V, 71010	☐ Hand, 3V, 73130	☐ Os calcis, 2V, 73650	☐ T-Spine, 2V, 72070
☐ Chest, 2V, 71020	☐ Hand, 2V, 73120	☐ Pelvis, 1V, 72170	☐ Thumb, 3V, 73140
☐ Clav, 2V, 73000	☐ Hip, 2V, 73510	☐ Ribs, 4V, 71101	☐ Tib & Fib, 2V, 73590
☐ Coccyx & Sacrum 2V 72220	☐ Humerus, 2V, 73080	☐ Ribs-Bilat, 4-5V, 71111	☐ Toes, 3V, 73660
☐ Elbow, 2V, 73070	☐ Knee, 2V, 73560	☐ SI Joint, 3V, 72202	☐ Wrist, 2V, 73100
☐ Elbow, 4V, 73080	☐ Knee, 3V, 73562	☐ Scapula, 2V, 73010	☐ Wrist w/Nav, 3-5V, 73110
☐ Femur, 2V, 73550	☐ Knee & Sun, 3+1, 73564	☐ Shoulder, AC, 2V, 73050	☐ Add View, 4V, 70001
☐ Sternum, 71120			

INITIAL IMPRESSION: L5/S1 facet arthropathy

SIGNATURE ON FILE: ☐ JAMES A. WRIGHT, MD ☐ MITCHELL H. HEGQUIST, MD ☒ THOMAS MOTYCKA, MD
☐ H.W. BLEDSOE, MD ☐ CHARLES BOYTER, MD ☐ , MD

☐ 76140 REQUEST RADIOLOGIST CONSULT

- ☐ Normal Examination
☐ I agree with the initial impression stated above
☐ I disagree with the initial impression; see comments:
☐ Radiologist please review the following area of concern

Radiologist

Date

ROA 469

2

SCANNED

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

1715 BLANDING ST, COLUMBIA, SC 29201

PHONE (803) 799-3926 • FAX (803) 256-7896

RETURN TO WORK STATUS

PATIENT INFORMATION:

NAME Spencer, Leticia S

COMPANY INFORMATION:

COMPANY NAME NHC

CONTACT PERSONS NAME Patty Coates

OCCUPATION / JOB DESCRIPTIONS Nurse

INJURY INFORMATION:

DATE OF INJURY 6, 22, 11 TIME OF INJURY 730 AM / PM

DIAGNOSIS: Low Back Strain (also Radiculopathy) (left)

TREATMENT PLAN
(1) Warm compresses
(2) Cyclobenzaprine at bedtime
(3) Massage for pain
(4) Steroid Taper

INSTRUCTION SHEET GIVEN

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
☐ RETURN TO WORK WITH NO LIMITATIONS AS A
☐ UNABLE TO RETURN TO WORK UNTIL _____
☐ RELEASED FROM CARE
☐ REFERRED FOR SPECIALTY EVALUATION TO _____
☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS:

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
☐ NO PROLONGED BENDING, STOOPING, SQUATTING
☒ NO LIFTING MORE THAN 10 POUNDS
☐ NO USE OF _____
☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ RECOMMENDATIONS
☒ ALTERNATE SITTING, STANDING & WALKING
☐ OTHER RESTRICTIONS

AVOID PILL CRUSHER IF IT CAUSES BACK PAIN

PHYSICIAN'S SIGNATURE

DATE 6, 27, 11

PHYSICIAN'S NAME:

- ☐ MITCHELL H. HEZQUIST, MD
☐ H.W. BLEDSOE, MD
☐ CHARLES BOYTER, MD

- ☐ JAMES WRIGHT, MD
☒ THOMAS MOTYCKA, MD

NEXT APPOINTMENT 07, 05, 11 @ 200

CHECK OUT TIME: 515 INITIALS OK * IF LESS THAN 7 DAYS, NEED AUTHORIZATION

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 799-3928 FAX (803) 258-7896

SCANNED

Patient: SPENCER, LETTIE L

DATE: 7-5-11

TIME: 1:00 PM

TECH: MSC

DOI: 6/22/2011

HEIGHT 5'11" Inches WEIGHT: 138 lbs PULSE: 80 BP 168 / 70 BP

CO: L/L Lumbar Sprain

HPI: Not any better, might even be worse
is on Day 7 of 12 Day Steroid
taper. Using cyclobenzaprine daily, it
makes me drowsy.
Discharge instructions
will assist with back pain

ROS: ☐ Reviewed ☐ Non-Contributory

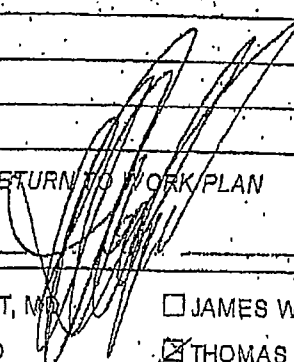
PH: ☐ Reviewed ☐ Non-Contributory

F/SH: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAM: Very uncomfortable appearing - sitting as much as possible
on exam
flexion & extension - bent over positive
back pain
but did not intensify
back pain
no palp repro pain

ASSESSMENT & PLAN: SEE RETURN TO WORK PLAN

NEXT VISIT IN afternoon DAYS OR PRN

PHYSICIAN SIGNATURE: 

DATE: 7-5-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ THOMAS J MOTYCKA, MD

SCANNED

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 799-3928 FAX (803) 258-7896

RETURN TO WORK STATUS

Patient: SPENCER, LETTIE L

Employer: NHC HEALTHCARE - PARKLANE

EMPLOYER CONTACT:

OCCUPATION / JOB DESCRIPTION: NURSE

INJURY INFORMATION:

DATE OF INJURY: 6/22/2011

Diagnosis: 847.2 SPRAIN LUMBAR REGION

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

① Tylenol for Daytime Pain
② Cyclobenzaprine AT BEDTIME
③ Heating Pad after Day's Activities
④ MRI LOW BACK

INSTRUCTION SHEET GIVEN:

⑤ Continue Steroid Taper

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
☐ RETURN TO WORK WITH NO LIMITATIONS AS A _____
☐ UNABLE TO RETURN TO WORK UNTIL ____/____/____
☐ RELEASED FROM CARE
☐ REFERRED FOR SPECIALTY EVALUATION TO _____
☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
☐ NO PROLONGED BENDING, STOOPING, SQUATTING
☒ NO LIFTING MORE THAN 10 POUNDS
☐ NO USE OF _____
☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ RECOMMENDATIONS _____
☐ ALTERNATE SITTING, STANDING & WALKING _____
☒ OTHER RESTRICTIONS: _____

PHYSICIAN SIGNATURE:

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ THOMAS J. MOTYCKA, MD

Check out TIME: _____ Initials: _____

NEXT APPOINTMENT DATE/TIME: _____

*If less than 7 days, Need AUTHORIZATION

ROA 472

Carolina Occupational Healthcare, LLC

1715 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 789-3928 FAX (803) 288-7888

Patient: **SPENCER, LETTIE L**

DATE

TIME

3:50

TECH:

AS

DOI: 8/22/2011

HEIGHT: 62 inches WEIGHT: 138 lbs PULSE: BP / BP

CC: Flu on MRI - of LS-spine

HPI: Still bad (P) low back pain L2-R arm (P)
 Anterior/posterior thigh radiation
 Out of range of motion
 MRI reveals 5/6mm herniation from disc bridge
 at L4/5

THERAPY

ON HS

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ROS: ☐ Reviewed ☐ Non-ContributoryPHI: ☐ Reviewed ☐ Non-ContributoryFISH: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAM: Very uncomfortable - appear along to lower right

PEUR (P) PTTT just to (P) of middle
 at LS Osprey

Can't walking, slightly, due to (P) low back/hip

As low back pain (P) MRI L4/L5 - narrow

P.A. to Ortho

ASSESSMENT & PLAN: SEE RETURN WEEK PLAN

NEXT VISIT IN: 08/29/11 DAYS OR PRI

PHYSICIAN SIGNATURE:

DATE

8-29-2011

☐ MITCHELL H. HEGQUIST, MD☐ JAMES WRIGHT, MD☐ CHARLES BOYTER, MD☒ THOMAS J MOTYCKA, MD☐

Carolina Occupational Healthcare, LLC

1713 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 798-3928 FAX (803) 258-7888

RETURN TO WORK STATUS

Patient: **SPENCER, LETTIE L**Employer: **NHO HEALTHCARE - PARKLANE**

EMPLOYER CONTACT

OCCUPATION / JOB DESCRIPTION: **NURSE**

INJURY INFORMATION:

DATE OF INJURY: **8/22/2011**Diagnosis **847.2 SPRAIN LUMBAR REGION**

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

Discontinue Compressees may offer relief
(2) Ortho Referral
(3) Refill Tylenol/ibuprofen? Tramadol

INSTRUCTION SHEET GIVEN

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
☐ RETURN TO WORK WITH NO LIMITATIONS AS A
☐ UNABLE TO RETURN TO WORK UNTIL _____
☐ RELEASED FROM CARE
☐ REFERRED FOR SPECIALTY EVALUATION TO _____
☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
☐ NO PROLONGED BENDING, STOOPING, SQUATTING
☐ NO LIFTING MORE THAN _____ POUNDS
☐ NO USE OF _____
☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ RECOMMENDATIONS
☐ ALTERNATE SITTING, STANDING & WALKING
☒ OTHER RESTRICTIONS: *AVOID PILL-CRUSHING*
IF IT HURTS BACK

PHYSICIAN SIGNATURE:

DATE

☐ MITCHELL H. HEGQUIST, MD☐ JAMES WRIGHT, MD☐ CHARLES BOYTER, MD☐ THOMAS J. MOTYCKA, MDCheck out TIME *4:30* Initials: *SR*NEXT APPOINTMENT DATE/TIME: *09/12/11*

*If less than 7 days, Need AUTHORIZATION

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

BLANDING STREET
BIA, MO 64201
(800) 788-3828
CO) 228.7888

MITCHELL H. HEDQUIST, MD BH2271714
CHARLES W. ROYER, JR., MD BH1518377
JAMES W. WRIGHT, MD BH2225378
THOMAS J. MOTYCKA, MD BH2042888

and: SPENTNER, Leffe

Diablo Referral

Date: 7-29-2011

ⓈMMA
w/le Dis. Bk
Ⓢcrot

signed, label with drug name

times (No to fill unless indicated)

WRITTEN

M.D.

ⓈUBSTITUTION PERMITTED M.D.

Carolina Occupational Healthcare, LLC

1716 BLANDING STREET, COLUMBIA, SC 29201

PHONE (803) 789-3926 FAX (803) 256-7898

RETURN TO WORK STATUS

Patient: SPENCER, LETTIE L

Employer: NHG HEALTHCARE - PARKLANE

EMPLOYER CONTACT

OCCUPATION / JOB DESCRIPTION: NURSE

INJURY INFORMATION:

DATE OF INJURY: 8/22/2011

Diagnosis 847.2 SPRAIN LUMBAR REGION

ADDITIONAL DIAGNOSIS INFORMATION:

TREATMENT PLAN:

(1) P.O.T. continued
(2) Tramadol & Cyclobenzaprine
(3) TENS UNIT

INSTRUCTION SHEET GIVEN:

RETURN TO WORK STATUS:

- ☐ RETURN TO WORK WITH NO LIMITATIONS
☐ RETURN TO WORK WITH NO LIMITATIONS AS A _____
☐ UNABLE TO RETURN TO WORK UNTIL _____
☐ RELEASED FROM CARE
☐ REFERRED FOR SPECIALTY EVALUATION TO _____
☒ RETURN TO WORK WITH THE FOLLOWING LIMITATIONS (see below)

LIMITATIONS:

- ☐ NO OPERATING OF HEAVY EQUIPMENT, MACHINERY, DRIVING
☐ NO PROLONGED BENDING, STOOPING, SQUATTING
☐ NO LIFTING MORE THAN _____ POUNDS
☐ NO USE OF _____
☐ SIT FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ STAND FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ WALK FOR NO LONGER THAN _____ HOURS PER 8 HOUR WORKDAY
☐ RECOMMENDATIONS _____
☐ ALTERNATE SITTING, STANDING & WALKING
☒ OTHER RESTRICTIONS: Avoid PILL-CRASHING

PHYSICIAN SIGNATURE: _____

DATE: 9-16-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ THOMAS J. MOTYCKA, MD

Check out TIME 3:50 PM Initials: BR

NEXT APPOINTMENT DATE/TIME: 10-14-2011 3:00 PM

*If less than 7 days, Need AUTHORIZATION

Carolina Occupational Healthcare, LLC

1716 BLANDING STREET, COLUMBIA, SC 29201
PHONE (803) 799-3920 FAX (803) 268-7886

Patient: SPENCER, LETTIE L DATE: 9-16-11 TIME: 3:05 TECH: MWC

HEIGHT: 62 inches WEIGHT: 138 lbs PULSE: 80 BP 156 / 62 BP 1

OC: f/u 1BP

HPI: Retires to NEUROLOGY report that nothing surgical
and present to Adj. Spinal & both state that
P.T. said Benet moved from TENN
still full crushing subcutaneous my low back
of 3 weeks

ROS: ☐ Reviewed ☐ Non-Contributory

PH: ☐ Reviewed ☐ Non-Contributory

F/S: ☐ Reviewed ☐ Non-Contributory

PHYSICAL EXAM

BB CP 2nd Cart m
Tender at the L5 S1 area - nothing
more lateral & nothing more superior
The S1 is not tender

McDonald Low back Pain (Overuse Syndrome)
for see du

ASSESSMENT & PLAN: SEE RETURN TO WORK PLAN

NEXT VISIT IN 4 weeks DAYS OR PRN

PHYSICIAN SIGNATURE: [Signature]

DATE 9-16-11

☐ MITCHELL H. HEGQUIST, MD

☐ JAMES WRIGHT, MD

☐ CHARLES BOYTER, MD

☒ Matyden MD

CAROLINA OCCUPATIONAL HEALTHCARE, LLC

1715 BLANDING STREET
COLUMBIA, SC 29201
PHONE: (803) 788-3328
FAX: (803) 268-7888

MITCHELL H. HEGQUIST, MD BH2871714
CHARLES W. BOYTER, JR., MD BB1518377
JAMES WRIGHT, MD AW28392578
THOMAS J. RISTYCKA, MD BM3042888

Patient Name:

Pattie Spencer

Address:

Date:

9-16-2011

R TENS UNIT

AS DIRECTED

☐ unless checked, label with drug name

Refill *0* times (No refill unless indicated)

DISPENSE AS WRITTEN

M.D.

M.D.

SUBSTITUTION PERMITTED

THIS PAGE IS BLANK IN THE
ORIGINAL RECORD ON
APPEAL

FHXH

(VME) JUL 29 2011 9:45/DT. 8144/Hd. 0012074004 P 1

CHESTER REGIONAL MEDICAL CENTER

1 MEDICAL PARK DRIVE

CHESTER SC 29706

RADIOLOGICAL INTERPRETATION

PATIENT NAME: SPENCER, LETTIE
ACCOUNT #: 3102236
EXAM DATE: 7/22/2011
ORDERING: STAFF NON, MD

RM: RAD MR#: 107577
X-RAY#: 17750
D.O.B.:

ATTENDING:

CONSULTING:

MRI
LOW BACK PAIN

7489861 72148 MRI L-SPINE NO CONT

MRI OF THE LUMBAR SPINE, 07/22/11:

HISTORY: 63-year-old with history of lower back pain.
TECHNIQUE: Sagittal and axial T1 and T2 and sagittal STIR weighted MR images of the lumbar spine were performed without the use of radiologic contrast material.

FINDINGS: The vertebral body heights of the lumbar spine are preserved and anatomic alignment maintained. No abnormal marrow signal is identified. The spinal cord conus ends appropriately at T12-L1 disc space level with no evidence of intrathecal mass. Visualized portions of the retroperitoneum are unremarkable.

At the T11-L2, T12-L1 and L1-2 levels no disc herniation or significant neural foraminal narrowing is identified.

At the L2-3 level, no disc herniation or neural foraminal narrowing is identified.

At the L3-4 level, hypertrophic facet changes are identified, however, disc herniation or neural foraminal narrowing is identified.

At the L4-5 level, hypertrophic facet change and ligamentum flavum thickening are identified and combined with a broad-based disc bulge to cause a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing, left greater than right. No central canal stenosis

CONTINUED ON PAGE 2

STAFF NON, MD

Cassara
Occ. Health

787-3028

JUL 29 2011 803-268-7896

256

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9/6/2011 5:30 PM FROM: Fan TO: 18664406782 PAGE: 001 OF 002

COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

www.columbianeurosurgical.com

Spine & Neurological Surgery

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W. Columbia, SC 29108
(803) 784-8700 • (F) 784-0522

OFFICE CONSULTATION

Patient: Lettie F. Spencer
Chart: 130062 WC
Date: 8/31/11

CHIEF COMPLAINT: Onset of severe back pain with some left leg symptoms on 6/22/11.

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old female who works as a nurse at a local nursing home facility. She reports no prior history of low back or leg problems and was doing well when, on 6/22/11 she was at work. She was apparently pushing a medication cart when she was transitioning from carpet to a tile threshold. The cart became stuck and required a great deal of force and as it freed she was thrown forward. She had an immediate onset of sharp pain in her back. The patient states that this failed to improve and over time has worsened in terms of stiffness and pain. In addition, she has some left leg symptoms that travel across the buttock, lateral thigh into the portion of the lateral calf. She has no symptoms in the foot or toes. The patient has been back at work with some restrictions but her pain persists. She describes it as being in the lower lumbar area with the above leg symptoms. She has no similar symptoms in the right leg and no symptoms in the foot or toes. She denies any bowel or bladder incontinence or retention. Her treatment has included various medications and she did undergo an MRI. She arrives today at the request of workman's comp seeking neurosurgical input.

HISTORIES: Allergies: PENICILLIN, DEMEROL, CODEINE. Medications: Potassium, Norvasc, Aldactone, vitamin D, calcium, magnesium, trazodone, Crestor, methimazole, Tricor, Klonopin, and Ultram p.r.n. Illnesses: Hypertension, history of a cervical radiculopathy. Surgeries: Left foot, hysterectomy. Family history and review of systems are well documented in the intake sheet of 8/31/11 and have been reviewed and signed. The information contained is noncontributory except for that in the HPI. Social history: She smokes 1/2 pack/day, does not drink alcohol, is married with two adult children, and is employed and working light duty.

PHYSICAL EXAMINATION: VITALS: HT 5'2", WT 137

GENERAL: The patient is a well-developed individual who is awake, alert and oriented x3. Speech pattern is normal in form and content with attention and memory appropriate for age. **HEENT:** Normocephalic, atraumatic. Neck: Supple without masses. Eyes: Conjugate without scleral injection or icterus. Vision: Grossly intact bilaterally. Hearing: Present in both ears with normal-appearing ears, nose and throat. **LUNGS:** Clear to auscultation and percussion. **HEART:** RR. **ABDOMEN:** Soft, nondistended, nontender with bowel sounds present. **EXTREMITIES:** No cyanosis, clubbing or edema. Distal pulses are present. **SKIN:** No rashes or gross abnormalities noted. **MUSCULOSKELETAL:** Normal ROM of the cervical spine without tenderness, rigidity or step-off deformity. Lhermitte's sign is absent. Spurling's maneuver is negative. Shoulder ROM is normal without pain, tenderness or crepitus. She has very restricted flexion at the waist. SLR reproduces back pain only bilaterally. Patrick's maneuver increases the pain in her back but it does not produce hip discomfort. Hip ROM is full and nonpainful. She is extremely tender to palpation over the lumbar paraspinal muscles and does have some tension if not spasm. No active spasm, kyphosis or scoliosis present. **NEUROLOGICAL:** Cranial nerve exam: II - Vision is normal to finger recognition and tracks the examiner without difficulty. III, IV, VI - EOMV. V - Sensation on the face is intact to light touch. VII - Muscles of facial expression are normal and symmetric. VIII - Hearing is present in both ears. IX, X - Oropharynx elevates symmetrically in the midline. XI - Strength in the sternocleidomastoid and trapezius is intact. XII - Tongue protrudes normally in the midline. Face is symmetric. Strength is 5/5 bilaterally throughout. DTRs are normal and symmetric.

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COLUMBIA NEUROSURGICAL ASSOCIATES, P.A.

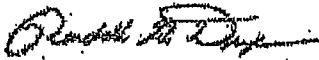
Page 2

Re: Lettie F. Spencer

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

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

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



Randall G. Drye, MD

THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED

RGD / MEH

CNAWT: 4021

Faxed To: Patty Chambers, RN

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APPEAL

Spencer, Leticia L

Office/Outpatient Visit

1 of 2

Visit Date: Thu, Nov 10, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 11/16/2011 11:48:16 AM

Printed on 11/26/2011 at 3:03 pm.

SUBJECTIVE:CC: Pt complains of Low back pain.

HPI: Ms. Spencer is a 45-year-old female with a history of low back pain which began in June of this year. She describes this pain as 8 out of 10 on the NRS with a dull, stabbing, constant and nauseating sensation. Pain is along the lumbosacral spine with radiation in the posterior aspect of the left lower extremity to the left lateral malleolus. Crushing pills at work and utilizing a vacuum cleaner tends to exacerbate her pain while utilizing a TENS unit has alleviated this pain to some extent. She reports her pain is associated with some weakness in the left leg.

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

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Positive for nausea. Negative for vomiting, heartburn, bleeding or constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Current Medications:

Tramadol 60mg Tablet 1-2 q6h prn

OBJECTIVE:**Vitals:**

Current: 11/10/2011 6:19:12 PM

Ht: 6 ft, 2 in; Wt: 130 lbs; BMI: 23.8

BP: 120/70 mm Hg; P: 72 bpm; R: 16 bpm

O2 Sat: 98 %

Pain Index: 8

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERL; non-lotatic sclera.

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

RESPIRATORY: Clear to auscultation bilaterally.

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

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

Spencer, Lettie L.

2 of 2

Office/Outpatient Visit

Visit Date: Thu, Nov 10, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 11/18/2011 11:49:19 AM

Printed on 11/28/2011 at 3:03 pm.

NEUROLOGICAL:

Cranial Nerves: II - XII intact.

Reflex Exam: Right biceps 3+, Right triceps 3+, Right patella 3+, Right achilles 3+, Left biceps 3+, Left triceps 3+, Left patella 3+, and Left achilles 3+.

Hoffmann's Sign: Negative bilaterally.

Clonus: None present.

Sensory Exam: No gross deficits noted.

Patrick's Test: Positive on the left side.

Forn's Point: Positive on the left side.

Straight Leg Test: Negative bilaterally.

Tenderness to palpation: L-spine.

MUSCULOSKELETAL:

Gait: Non-antalgic.

Muscle Atrophy: None noted.

Right Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.

Left Motor Exam: 5/5 strength in shoulder, arm, hand grip, hip, leg, dorsiflexion and plantarflexion muscles.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-pressured speech. Normal affect.**Lab/Test Results:** MRI of L-spine 07/22/11

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

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

ASSESSMENT:

724.8 Sacroiliac pain
300.4 Chronic pain syndrome
724.2 Low back pain

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

Patient: Sponser, Lettie L

Date of Exam: 11/21/2011

Dr. Tony Owens
SC Pain Associates
Phone: (803) 437-7246
Fax: (803) 434-6544Left Sacroiliac Joint Injection with Sedation

Procedure:

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

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

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

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11/28/2011 15:34

Received by CorVel Corporation 11/28/2011, 12:37:08 PM Pacific Time, 5782, Page 3 of 6
(FAX)

P.003/005



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

November 21, 2011

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

Please be advised that Ms. Spencer is currently under my medical care. Please excuse her from work until 12/9/11; she has a follow-up appointment scheduled with me at that time.

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

Sincerely,

Tony Owens, M.D.

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ROA 489

Dec. 14, 2011 8:25AM Billing

No: 7377 P. 2

Spencer, Lettie L.

1 of 2

Office/Outpatient Visit

Visit Date: Fri, Dec 9, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:33 AM
Printed on 12/14/2011 at 8:28 am.**SUBJECTIVE:**CC: Follow up Low back pain.HPI: Ms. Spencer is a pleasant 22-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit

1. November 2011, left sacroiliac joint injection, which decreased her pain approximate 80% for about an 18 hour period.

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

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

Norco 5mg/325mg Tablet one po tid prn

Tramadol 50mg Tablet 1-2 q8h prn

OBJECTIVE:Vitals:Current: 12/8/2011 4:50:18 PM

Ht: 5 ft, 2 in

BP: 122/70 mm Hg; P: 71 bpm; R: 16 bpm

O2 Sat 98 %

Pain Index: 9

Exams:CONSTITUTIONAL: Well-nourished and in no apparent distress.EYES: Negative for PERRL; non-icteric sclera.RESPIRATORY: Clear to auscultation bilaterally.CARDIOVASCULAR: Normal rate and rhythm. No murmurs, gallops, or rubs.NEUROLOGICAL:

Cranial Nerves: II - XII intact.

Dec. 14, 2011 8:25AM Billing

No. 7377 P: 3

2 of 2

Spencer, Lettie L.

Office/Outpatient Visit

Visit Date: Fri, Dec 9, 2011 01:00 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 12/13/2011 10:44:38 AM

Printed on 12/14/2011 at 8:23 am.

Fortin's Point: Positive on the left side.

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

Lab/Test Results:

MRI of L-spine 07/22/11

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

ASSESSMENT:

724.8 Sacroiliac pain
338.4 Chronic pain syndrome
724.2 Low back pain

PLAN: Plan

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



SOUTH CAROLINA INTERNAL MEDICINE ASSOCIATES & REHABILITATION, L.L.C.
1 WELLNESS BOULEVARD, SUITE 200
IRMO, SOUTH CAROLINA 29063
PHONE: (803) 749-1111 • FAX: (803) 749-0080

Friday, December 09, 2011

RE: Return to Work Notice for Lettie Spencer

To Whom It May Concern,

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

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

Sincerely,

Choose provider

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

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Spencer, Lettie L.

1 of 3

Office/Outpatient Visit

Visit Date: Fri, Jan 13, 2012 08:45 am

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM
Printed on 02/27/2012 at 10:08 am.**SUBJECTIVE:****CC:** Follow up low back pain.

NP: Ms. Spencer is a pleasant, 3-year-old female with a history of lumbar back pain. She is currently on a medication regimen of Norco, trazodone and Klonopin. Previous medication trials include tramadol and Flexeril.

She has undergone the following interventions with the indicated benefit:

1. November 2011: left sacroiliac joint injection, which decreased her pain approximately 80% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period.

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

ROS:

CONSTITUTIONAL: Positive for weight loss. Negative for fatigue, fever, sweats, weight gain or general weakness.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Positive for nausea and vomiting. Negative for heartburn, bleeding or constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Negative for cramps, pain, weakness, joint pain and muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Past Medical History / Family History / Social History:

... Last Reviewed on 1/13/2012 11:32:28 AM by Shealy, Lisa

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family HX of Pain.**Tobacco/Alcohol/Supplements:**

... Last Reviewed on 1/13/2012 11:33:06 AM by Shealy, Lisa

Tobacco: Currently smokes 1-8 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

Current Problems:

Last Reviewed on 1/13/2012 11:30:18 AM by Shealy, Lisa

Acquired hypothyroidism, other specified cause

HTN

Low back pain

Other hyperlipidemia

Allergies:

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

Spencer, Lettie L.

2 of 3

Office/Outpatient Visit

Visit Date: Fri, Jan 13, 2012 08:48 am

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: BC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM

Printed on 02/27/2012 at 10:08 am.

Demoral HCl

Codeine Sulfate

Percocet

Current Medications:

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

OBJECTIVE:Vitals:

Current: 1/13/2012 11:54:10 AM

Ht: 5 ft, 2 in

BP: 122/72 mm Hg; P: 80 bpm; R: 16 bpm

O2 Sat: 97 %

Pain Index: 8

Exam:**CONSTITUTIONAL:** Well-nourished and in no apparent distress.**EYES:** Negative for PERRL; non-icteric sclera.**RESPIRATORY:** Clear to auscultation bilaterally.**CARDIOVASCULAR:** Normal rate and rhythm. No murmurs, gallops, or rubs.**NEUROLOGICAL:**

Cranial Nerves: II - XII intact.

PSYCHIATRIC: Alert and oriented to person, place and time. Cognition intact. Non-preserved speech. Normal affect.Lab/Test Results:

MRI of L-spine 07/22/11

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

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

ASSESSMENT:

724.8 Sacroiliac pain
338.4 Chronic pain syndrome
724.2 Low back pain

PLAN: 1. Unfortunately Lettie did not respond as expected to the lateral branch radiofrequency ablation. I explained to her that there's no further interventional treatment to offer her at this time. I did offer to send her for a second opinion or

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Spencer, Leticia L.

Office/Outpatient Visit

3 of 3

Visit Date: Fri, Jan 13, 2012 08:45 am

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant Lisa Shealy, MA)

Location: BC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 01/20/2012 02:17:04 PM

Printed on 02/27/2012 at 10:03 am.

surgical evaluation. She declined this treatment option at this time.

2. I will discontinue hydrocodone today due to lack of benefit and I initiated her on a trial of OxyContin due to the constant nature of her pain.

3. I plan to enroll her into hydrotherapy as soon as her pain is better controlled.

4. I also initiate her on a trial of Neurontin to address what I believe is likely neuropathic pain.

5. She will follow up in clinic with me in 4 weeks for further evaluation.

Spencer, Lettie L.

Office/Outpatient Visit

Visit Date: Thu, Feb 9, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SQ Pain Associates, Dr. Tony Owens

1 of 3

Electronically signed by Tony Owens, MD on 02/22/2012 08:42:49 PM
Printed on 02/27/2012 at 10:03 am.**SUBJECTIVE:****OB:** Follow up Low back pain.**HPI:** Ms. Spencer is a pleasant, middle-aged female with a history of lumbar back pain. She is currently on a medication regimen of pregabalin, Klonopin, Oxycodone and Neurontin. Previous medication trials include tramadol, Norco and Flexril.

She has undergone the following interventions with the indicated benefit:

1. November 2011: left sacrospinous ligament injection, which decreased her pain approximately 80% for about an 18 hour period.
2. December 2011: left L5-S2 lateral branch radiofrequency ablation, which decreased her pain for a 2 day time period.

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

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

... Last Reviewed on 1/13/2012 11:32:28 AM by Shealy, Lisa

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family Hx of Pain.**Tobacco/Alcohol/Supplements:**

... Last Reviewed on 1/13/2012 11:33:08 AM by Shealy, Lisa

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

Allergies:

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

Demerol HCl

Spencer, Lettie L.

2 of 3

Office/Outpatient Visit

Visit Date: Thu, Feb 9, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: BC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:48 PM
Printed on 02/27/2012 at 10:03 am.Codeine Sulfate;
Percodilina;Current Medications:

Nucynta ER 50mg Tablets, Extended Release One tablet by mouth BID. May increase to two tabs BID after three days if necessary

Phenergan 25mg Suppository Insert one rectally q8hr prn nausea

Neurontin 300mg Capsules One qhs x 5, then two qhs x 5, then one am and two qhs x 5, then two bid x 5, then two am, one noon and two qhs x 5, then two bid thereafter

Oxycontin 10mg Tablets, Controlled Release One po BID

OBJECTIVE:Vitals:

Current: 2/10/2012 12:43:31 PM

HT: 5 ft, 2 in

BP: 118/72 mm Hg; P: 76 bpm; R: 20 bpm

O2 Sat: 98 %

Pain Index: 8

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

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

NEUROLOGICAL:

Cranial Nerves: II - XII Intact.

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

Lab/Test Results:

MRI of L-spine 07/22/11

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

ASSESSMENT:

724.6 Sacroiliac pain

338.4 Chronic pain syndrome

724.2 Low back pain

PLAN: 1. I believe Lettie initially was having a reaction to the OxyContin, but is likely now suffering from withdrawal symptoms. I will discontinue her OxyContin and Neurontin and I initiated her on extended release Nucynta which I believe will help with her pain and will be less likely to cause GI distress.

Spencer, Lettie L.

Office/Outpatient Visit

Visit Date: Thu, Feb 9, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: Lisa Shealy, MA)

Location: SC Pain Associates, Dr. Tony Owens

3 of 3

Electronically signed by Tony Owens, MD on 02/22/2012 05:42:49 PM

Printed on 02/27/2012 at 10:03 am.

2. She will also utilize Phenylephrine suppositories for nausea as needed.
3. She will follow up in clinic with me in four weeks for further evaluation.

Spencer, Leticia

1 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:38 pm.

SUBJECTIVE:

CC:

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

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:

1. November 2011: Left SI Injection, decreased pain approximately 80% for < 1 day
2. December 2011: Left L5-S2 LB RFA, decreased pain for approximately 2 days.

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

She describes this pain as 5/10 on the NRS with a(n) aching, dull, and frequent sensation. This pain is located in the lumbosacral spine with no radiation.

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Negative for nausea, vomiting, heartburn, bleeding and constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Negative for anxiety, depression, insomnia and homicidal/suicidal thoughts.

Past Medical History / Family History / Social History.

... Last Reviewed on 3/7/2012 1:51:54 PM by Owens, Tony L.

Past Medical History.

Hyperlipidemia

Hypertension

Hypothyroidism

Family History. No Family HX of Pain.

Tobacco/Alcohol/Supplements:

... Last Reviewed on 3/7/2012 1:51:55 PM by Owens, Tony L.

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None.

Current Problems:

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

Acquired hypothyroidism, other specified cause

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Spencer, Lettie L

2 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:38 pm.

Chronic pain syndrome

HTN

Low back pain

Other hyperlipidemia

Sacroiliac pain

Allergies:

Last Reviewed on 3/7/2012 1:51:49 PM by Owens, Tony L.

Dexametrol HCl:

Codaine Sulfate:

Penicillins:

Current Medications:

Last Reviewed on 3/7/2012 1:51:50 PM by Owens, Tony L.

Nucynta 50mg Tablet take one or two tablets every four to six hours as needed for pain pain

Phenergan 25mg Suppository Insert one rectally q6hr prn nausea

OBJECTIVE:

Vitals:

Current 3/8/2012 9:10:09 AM

Ht: 5 ft, 2 in; Wt: 126 lbs; BMI: 22.9

BP: 128/72 mm Hg; P: 88 bpm; R: 16 bpm

O2 Sat: 97 %

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

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

NEUROLOGICAL:

Cranial Nerves: II - XII intact.

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

Lab/Test Results:

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

The following radiology test(s) have been performed with the indicated benefit:

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

ASSESSMENT:

338.4 Chronic pain syndrome

724.8 Sacroiliac pain

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Spencer, Lettie L.

3 of 3

Office/Outpatient Visit

Visit Date: Wed, Mar 7, 2012 01:15 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: SC Pain Associates, Dr. Tony Owens

Electronically signed by Tony Owens, MD on 03/08/2012 01:11:21 PM

Printed on 03/08/2012 at 1:38 pm.

724.2 Low back pain

PLAN:

Chronic pain syndrome

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

Orders:

Office/outpatient visit, established patient, level 3

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Spencer, Lettie I

Office/Outpatient Visit

1 of 3

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 05:27:18 PM

Printed on 04/18/2012 at 5:27 pm.

SUBJECTIVE:

CC:

Mrs. Spencer, a pleasant 55-year old White female, returns to the office today for a follow-up visit regarding pain management.

HPI:

Mrs. Spencer presents today with back pain.

The following interventions have been performed with the indicated benefit:

1. November 2011: Left SI Injection, 80% pain relief for < 1 day
2. December 2011: Left L5-S2 LB PFA, provided pain relief for 2 days

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

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

ROS:

CONSTITUTIONAL: Negative for chills, fatigue, fever and weight change.

EYES: Negative for double vision, blurred vision, redness, eye pain and discharge.

ENT/MOUTH: Negative for bleeding, throat swelling, ulcers, lip lesions and mouth dryness.

RESPIRATORY: Negative for shortness of breath, wheezing, chest tightness and coughing up blood/pus.

CARDIOVASCULAR: Negative for chest pain, palpitations, passing out and extremity swelling.

GASTROINTESTINAL: Negative for nausea, vomiting, heartburn, bleeding and constipation.

GENITOURINARY: Negative for incontinence, impotence, genital burn, difficult urination and discharge.

MUSCULOSKELETAL: Positive for pain. Negative for cramps, weakness, joint pain or muscle loss.

NEUROLOGICAL: Negative for headache, seizures, vertigo, memory loss and concentration difficulty.

PSYCHIATRIC: Positive for depression. Negative for anxiety, insomnia or homicidal or suicidal thoughts.

Past Medical History/Family History/Social History:

... Last Reviewed on 4/18/2012 12:05:27 PM by James, Whitney A

Past Medical History:

Hyperlipidemia

Hypertension

Hypothyroidism

Family History: No Family HX of Pain.

Tobacco/Alcohol/Supplements:

... Last Reviewed on 4/18/2012 12:05:32 PM by James, Whitney A

Tobacco: Currently smokes 1-5 cigarettes per day. Non-drinker

Substance Abuse History:

... Last Reviewed on 1/13/2012 11:33:16 AM by Shealy, Lisa

None

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Spencer, Lettie L.

2 of 3

Office/Outpatient Visit

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on: 04/18/2012 05:27:16 PM

Printed on 04/18/2012 at 5:27 pm.

Current Problems:

Last Reviewed on 4/18/2012 12:05:24 PM by James, Whitney A

Acquired hypothyroidism, other specified cause

HTN

Low back pain

Other hyperlipidemia

Allergies:

Last Reviewed on 4/18/2012 12:05:25 PM by James, Whitney A

Damazol HCl

Codeine Sulfate

Penicillins

Current Medications:

Last Reviewed on 4/18/2012 12:05:26 PM by James, Whitney A

None

OBJECTIVE:

Vitals:

Current: 4/18/2012 1:49:36 PM

Ht: 5 ft 2 in; Wt: 129 lbs; BMI: 23.6

BP: 142/72 mm Hg; P: 92 bpm; R: 20 bpm

O2 Sat: 98 %

Exams:

CONSTITUTIONAL: Well-nourished and in no apparent distress.

EYES: Negative for PERRL; non-icteric sclera.

RESPIRATORY: Clear to auscultation bilaterally.

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

NEUROLOGICAL:

Cranial Nerves: II - XII intact.

Sensory Exam: No gross deficits noted.

Forlin's Point: Positive on the left side.

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

Lab/Test Results:

The following radiology test(s) have been performed with the indicated benefit

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

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

ASSESSMENT:

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Spencer, Lettie L.

3 of 3

Office/Outpatient Visit

Visit Date: Wed, Apr 18, 2012 12:05 pm

Provider: Tony Owens, MD (Supervisor: Tony Owens, MD; Assistant: April Smith, RN)

Location: South Carolina Internal Medicine

Electronically signed by Tony Owens, MD on 04/18/2012 05:27:16 PM

Printed on 04/18/2012 at 5:27 pm.

338.4 Chronic pain syndrome
724.6 Sacroiliac pain
724.2 Low back pain

PLAN:

Chronic pain syndrome

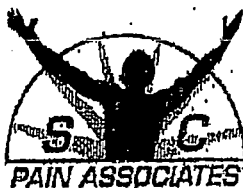
-I continued her current medication regimen without change due to positive benefit.

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

Low back pain

Patient Education Handouts:
Acute Low Back Pain

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SOUTH CAROLINA PAIN ASSOCIATES

TONY OWENS, M.D.

1 WELLNESS BOULEVARD, SUITE 200

IRMO, SOUTH CAROLINA 29063

PHONE: (803) 457-7246

FAX: (803) 454-6544

Wednesday, April 18, 2012

RE: Lettie Spencer

DOB: _____

To Whom It May Concern,

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

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

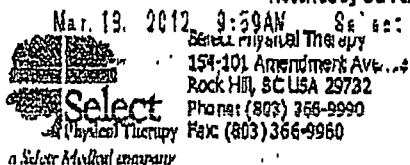
Sincerely,

Tony Owens, M.D.

South Carolina Pain Associates

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THIS PAGE IS BLANK IN THE
ORIGINAL RECORD ON
APPEAL



Physical Therapy
Patient: Judith E. Kiser, MPT
Acct #: 013-610302198
DOB: [REDACTED]
Chiropractor: Judith E. Kiser, MPT
Prim Phys: Tony Owens
Phy Phone: (803) 749-1111
Phy Fax: (803) 749-0030
Sec Phys: Not Specified
Inj. Date: 7/22/2011
Surg. Date: Not Specified

No. 5468 P. 4
Visit Date: Mar 12, 2012
FSC: Workers Compensation
Payor: WC OF SC
Pol/Claims#: Not Specified
Insured: Not Specified
Employer: NHC Parklane
Case Mgt: Not Specified
Visits: 1
Cd/Vs: 0

Initial Evaluation

Diagnosis: Spine: 7242 LUMBAGO

Subjective Examination

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

ADL / Functional Status:

• Premorbid status:

- Basic care: Independent without difficulty. Work status: Full time / Full duty.

• Current status:

- Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence: Requires prolonged time. can not get clothes out of washing machine, vacuum, change sheets

- Occupation: LPN at skilled nursing facility

Chief Complaint:

- Pain: Aggravating Factors: Activities:

- Standing: 20 min Walking: 60 min Sitting: < 30 min

- Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

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

Medical Management:

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

Questionnaire: Disability Index:

- Test Name

Oswestry Disability Index

- Date

03/13/2012

- Assessment

Initial

- Percentage

50.00%

Rehabilitation Expectations/Goals:

- to get better and get stronger

Objective Examination

Muscle Testing: Lower Extremity MMT:

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

Range of Motion: Spine: Active Lumbosacral

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

Treatments

PT/Pain By Education:

- Patient Education 1

Time Elapsed: 5 Minutes, Description: benefits of aquatic therapy then progress to clinic Charge \$5 Self Care / Home Mgt-Training

Therapy Session Time

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

Documented Procedural Code Summary:

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

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Mar. 13. 2012 9:59AM

Session: Physical Therapy

No. 5468 P. 5


 Patient: Laura Spencer
 Acct #: 013-010302198

Visit Date: Mar 12, 2012

• Self Care/Home Management Training 07535 1 5

Assessment

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

Recommendations: Skilled Intervention: Required To:

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

Problems & Goals
Problem #1 Chief Complaint: Pain; Aggravating Factors: Activities: Standing; 20 min

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

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

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

- | | |
|-----------------------|-----|
| • Extension. | 80% |
| • Flexion. | 80% |
| • Side Bending Left. | 80% |
| • Side Bending Right. | 80% |

Problem #4 Muscle Testing: Lower Extremity MMT.

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower Extremity Strength to:

- | | Left | Right |
|------------------|------|-------|
| • Hip Flexion | -5/5 | -5/5 |
| • Knee Extension | -5/5 | -5/5 |
| • Knee Flexion | -5/5 | -5/5 |

Plan**Amount, Frequency and Duration:**

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

Therapeutic Contents:

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

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

Mar. 13. 2012 10:00AM

Session: Physical Therapy

No. 5469 P. 6



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

Referred by: Secure Spencer
Acct #: 033-810302190
DOB:
Clinician: Judith E. Kiser, MPT
Prim Phy: Tony Owens
Phy Phone: (803) 749-1111
Phy Fax: (803) 749-0050
Sec Phy: Not Specified
Inj. Date: 7/22/2011
Surg. Date: Not Specified

Ref Date:
FSC: Workers Compensation
Payor: WC of SC
Pol/Claim#: Not Specified
Insured: Not Specified
Employer: BHC Parklane
Case Mgr: Not Specified
Visits: 1
Cd/No: 0

Plan of Care

Diagnosis: Spine 7242 LUMBAGO

Subjective Examination

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

ADL / Functional Status:

- Premorbid status: Work status: Full time / Full duty.

Rehabilitation Expectations/Goals:

- to get better and get stronger

ADL / Functional Status:

- Current status: Work status: Unable to work secondary to dysfunction, Occupation: LPN at skilled nursing facility

Chief Complaints:

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

Mechanism of Injury:

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

Questionnaires: Disability Index:

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

Assessment

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

Recommendations: Skilled Intervention: Required To:

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

Problems & Goals

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion Spine: Active Lumbosacral.

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

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

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

Problem #4 Muscle Testing: Lower Extremity MMT.

Left Right



Mar. 13, 2012 9:00AM

Service: Physical Therapy

No. 5468 P. 7

Account #: 013-810302198

Visit Date: Mar 12, 2012

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

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower
Extremity Strength to:

	Left	Right
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan**Amount, Frequency and Duration**

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

Therapeutic Contents:

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

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

Please Sign and Return

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

Comments/RevisionsPhysician Signature Terry Owens, MD

Date _____

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Apr. 24, 2012, 2:22 PM
 Select Physical Therapy
 134-101 Amendment Avenue
 Rock Hill, SC USA 29732
 Phone: (803) 966-9990
 Fax: (803) 966-9990
 Select Medical company

Account # 013-610307198
 DOR: 04/15/12
 Clinician: Judith E. Kiser, MPT
 Print Phys: Tony Owens
 Phy Phone: (803) 457-7246
 Phy Fax: (803) 454-6544
 Sec Phys: Not Specified
 Inf. Date: 7/22/2011
 Surg. Date: Not Specified

Note Date: Apr 24, 2012
 FSG: Workers Compensation
 Payor: WC of SC
 Pol/Claim#: Not Specified
 Insured: Not Specified
 Employer: NHC Parttime
 Case Mgr: Not Specified
 Visits: 11
 Cd/Nst: 0

Discharge Summary

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

ADL / Functional Status

Current status:

- Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence; Requires prolonged time; can not get clothes out of washing machine, vacuum, change sheets

- Occupation: LPN at skilled nursing facility

Chief Complaint:

- Pain Aggravating Factors: Activities:

- Standing: no more than 30 min Walking: 60 min Sitting: about an hour with pain meds

- Pain Location: Lumbosacral Area: center of low back

Daily Comments:

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

Mechanism of Injury:

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

Medical Management:

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

Questionnaires: Disability Index:

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

Objective Examination

OBJECTIVE NOTED - 04/17/12

Muscle Testing: Lower Extremity NMT:

	Mar 12, 2012		Apr 17, 2012	
	Left	Right	Left	Right
• Hip Flexion	4/5	4/5	4/5	4/5
• Knee Extension	4/5	4/5	4/5	4/5
• Knee Flexion	4/5	4/5	4/5	4/5
• Ankle Dorsiflexion	5/5	5/5	5/5	5/5

Range of Motion: Spinal Active Lumbosacral:

	Mar 12, 2012	Apr 17, 2012
• Extension(Bilateral - Pain Provoked)	100%	100%
• Flexion	20%	40%
• Side Bending Left(Bilateral - Pain Provoked)	20%	50%
• Side Bending Right(Bilateral - Pain Provoked)	20%	50%

Assessment

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

Based on this patient's clinical presentation, it is my professional opinion that the patient's prognosis at time of discharge is fair. The patient was educated regarding their discharge prognosis and related pathology. The patient demonstrates fair understanding of their home program instructions.

Problems & Goals

Document ID: 18A0132E014
 Judith E. Kiser, MPT, MPT(SC Lic: 4150)

Status: Signed off (secure electronic signature)

Page 1 of 2

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Apr. 24, 2012 2:22 PM

Session: Physical Therapy

Provider: Leticia Spencer

Acct #: 013-610302198

No. 7534 P. 4

Note Date: Apr 24, 2012

Problem #1 Chief Complaint: Pain; Aggravating Factors: Activities; Standing; no more than 30 min

Goal Abandoned Apr 24, 2012, 25 % of Goal Met

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

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

Goal Abandoned Apr 24, 2012, 90 % of Goal Met

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

Problem #3 Range of Motion: Spinal Active Lumbosacral

Goal Abandoned Apr 24, 2012, due to increased pain

Range of Motion Improvements for Active Lumbosacral

Extension: 80%

Flexion: 80%

Side Bending Left: 80%

Side Bending Right: 80%

Problem #4 Muscle Testing: Lower Extremity MMT

Goal Abandoned Apr 24, 2012, 50 % of Goal Met

Musculoskeletal Improvements In: Lower

Extremity Strength to:

Hip Flexion: 4/5

Knee Extension: 5/5

Knee Flexion: 5/5

Left

Right

Plan

Discharge due to:

- per phone call from patient, MD said OK

Judith E. Kiser MPT

Judith E. Kiser, MPT, MPT(SC Lic: 4150)
Signed on Apr 24, 2012 13:49:33

44

Mar. 13. 2012 9:59AM
 Select Physical Therapy
 154-101 Anandmark Ave...
 Rock Hill, SC USA 29732
 Phone: (803) 966-9990
 Fax: (803) 366-9960
 a Select Medical company

Physical Therapy
 Patient: Laura Spender
 Acct #: 013-610802159
 DOB: 11/11/1971
 Clinician: Judith E. Kiser, MPT
 Prim Phys: Tony Owens
 Phy Phone: (803) 749-1111
 Phy Fax: (803) 749-0050
 Sec Phys: Not Specified
 Inj. Date: 7/22/2011
 Surg. Date: Not Specified

No. 5468 P. 4

Visit Date: Mar 12, 2012
 FSC: Workers Compensation
 Payor: WC of SC
 Pol/Claim#: Not Specified
 Insured: Not Specified
 Employer: NHC Parklane
 Case Mgr: Not Specified
 Visits: 1
 Cx/Ns: 0

Initial Evaluation

Diagnosis Spine 7242 LUMBAGO

Subjective Examination

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

ADL / Functional Status:**• Premorbid status:**

• Basic care: Independent without difficulty. Work status: Full time / Full duty.

• Current status:

• Work status: Unable to work secondary to dysfunction. Basic care: Modified Independence: Requires prolonged time. can not get clothes out of washing machine, vacuum, change sheets

• Occupation: LPN at skilled nursing facility

Chief Complaint

• Pain: Aggravating Factors: Activities:

• Standing: 20 min Walking: 60 min Sitting: < 30 min

• Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

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

Medical Management

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

Questionnaire: Disability Index:

• Test Name

• Date

• Assessment

• Percentage

Oswestry Disability Index

03/13/2012

Initial

50.00%

Rehabilitation Expectations/Goals:

• to get better and get stronger

Objective Examination**Muscle Testing: Lower Extremity MMT:**

• Hip Flexion

Left

+4/5

Right

+4/5

• Knee Extension

+4/5

+4/5

• Knee Flexion

+4/5

+4/5

• Ankle Dorsiflexion

-5/5

-5/5

Range of Motion: Spine: Active Lumbosacral:

• Extension(Bilateral - Pain Provoked)

10%

• Flexion(Bilateral - Pain Provoked)

20%

• Side Bending Left(Bilateral - Pain Provoked)

20%

• Side Bending Right(Bilateral - Pain Provoked)

20%

Treatments**PT/Family Education:**

• Patient Education 1

Time Elapsed: 5 Minutes, Description: benefits of aquatic therapy then progress to clinic, Charge As: Self Care / Home Mgt-Training

Therapy Session Time

• Therapy Session Start Time

12:03 PM

• Therapy Session Stop Time

12:35 PM

Documented Procedural Code Summary:

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

Mar. 13, 2012 9:59AM

Session: Physical Therapy

No. 5468 P. 5


 Patient: LARRY SPENCER
 Acct #: 013-810302198

Visit Date: Mar 12, 2012

 • Self Care/Home Management
 Training

07535

1

5

Assessment

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

Recommendations: Skilled Intervention: Required To:

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

Problems & Goals

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate standing for 1 hr

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

- Pt able to tolerate sitting up to 1 hr

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

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

- | | |
|----------------------|-----|
| • Extension | 80% |
| • Flexion | 80% |
| • Side Bending Left | 80% |
| • Side Bending Right | 80% |

Problem #4 Muscle Testing: Lower Extremity MMT.

LTG Achieve by May 11, 2012.

Musculoskeletal Improvements In: Lower

Extremity Strength to:

- | | Left | Right |
|------------------|------|-------|
| • Hip Flexion | -5/5 | -5/5 |
| • Knee Extension | -5/5 | -5/5 |
| • Knee Flexion | -5/5 | -5/5 |

Plan

Amount, Frequency and Duration:

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

Therapeutic Contacts:

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

Judith E. Kiser MPT

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

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Mar. 13, 2012 9:00AM Select Physical Therapy
 Select Physical Therapy
 154-101 Amendment Ave.
 Rock Hill, SC USA 29732
 Phone: (803) 356-9990
 Fax: (803) 356-9960

Account # 012-510302198
 DOB: [REDACTED]
 Clinician: Judith E. Kleer, MPT
 Prim Phy: Tony Owens
 Phy Phone: (803) 749-1111
 Phy Fax: (803) 749-0050
 Sec Phy: Not Specified
 Inq. Date: 7/22/2011
 Surg. Date: Not Specified

No. 5468 P. 6

Visit Date: Mar. 12, 2012
 FSC: Workers Compensation
 Payer: WC OF SC
 Pol/Claim#: Not Specified
 Insured: Not Specified
 Employer: NHC Parklane
 Case Mgr: Not Specified
 Visits: 1
 Cx/Ref: 0

Plan of Care

Diagnosis spine 7242 LUMBAGO

Subjective Examination

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

ADL / Functional Status:

• Premorbid status: Work status: Full time / Full duty.

Rehabilitation Expectations/Goals:

• to get better and get stronger

ADL / Functional Status:

• Current status: Work status: Unable to work secondary to dysfunction. Occupation: LPN at skilled nursing facility

Chief Complaints:

• Pain: Aggravating Factors: Activities:

• Standing: 20 min Walking: 60 min Sitting: < 30 min

• Pain: Location: Lumbosacral Area: center of low back

Mechanism of Injury:

• 6-22-11 Pushing a med chart; had to give it a shove to get over rim at door felt immediate sharp pain in back

Questionnaires: Disability Index:

• Test Name:

Cowestry Disability Index

• Date:

03/13/2012

• Assessment:

Initial

• Percentage:

50.00%

Assessment

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

Recommendations: Skilled Intervention: Required To:

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

Problems & Goals

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

• Able to tolerate standing for 1 hr

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

LTG Achieve by May 11, 2012.

Functional Improvements In:

• Able to tolerate sitting up to 1 hr

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

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

LTG Achieve by May 11, 2012.

Range of Motion Improvements to: Active Lumbosacral:

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

Problem #4 Muscle Testing: Lower Extremity MMT.

Left

Right



Mar. 13, 2012 9:00AM

Session: Physical Therapy

No. 5468 P. 7

Acct #: 013-610302198

Visit Date: Mar 12, 2012

• Ankle Dorsiflexion	-5/5	-5/5
• Hip Flexion	-4/5	-4/5
• Knee Extension	-4/5	-4/5
• Knee Flexion	+4/5	+4/5
LTC Achieve by May 11, 2012.		
• Musculoskeletal Improvements In: Lower Extremity Strength to:	Left	Right
• Hip Flexion	-5/5	-5/5
• Knee Extension	-5/5	-5/5
• Knee Flexion	-5/5	-5/5

Plan

Amount, Frequency and Duration:

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

Therapeutic Contents:

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

Judith E. Kiser, MPT

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

Please Sign and Return

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

Comments/Revisions

Physician Signature Tommy Owens, MD

Date

45

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

Appointment List for Spencer, Lettie

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

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

Additional Instructions:

4-3-12 11:00
 4-5-12 11:00
 4-10-12 11:00
 4-12-12 11:00
 Thank you,
 Select Physical Therapy
 4-18-12 11:00

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THIS PAGE IS BLANK IN THE
ORIGINAL RECORD ON
APPEAL

05/09/2012 16:34

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18333247545 ELROD-POPE LAW FIRM

PAGE 04/11

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

PATIENT INFO:		SEX: Female	
Name: LETTIE SPENCER			
Address:		PHONE Work:	
EMPLOYER: NHC Park Ave Columbia, SC			
RESPONSIBLE PARTY:		DOB:	
Name: Self		PHONE Home:	
Address:		PHONE Cell:	
EMPLOYER:		PHONE Work:	

The following questions **MUST BE ANSWERED** prior to seeing the physician.What are we seeing you for today? Back pain1) WHEN DID THIS PROBLEM BEGIN? (date) 6-22-11

2) If accident: Check the appropriate type

Accident? ☒ YES ☐ NO		Place where accident occurred: <u>S.C.</u>	
Auto Accident ☐ Other ☐		Did someone else cause this injury? ☐ YES ☒ NO	
☒ Work Related Injury			

3) Who referred you to our office?

Referred by: Friends

Notes: If referred notes are sent

4) INSURANCE INFORMATION:

Insurance to be filed 1st: BGBS

Person Insured: <u>Self: Spencer</u>	Employer: <u>Wait for BC</u>
DOB: <u></u>	Relation: <u>Wait for BC</u>

Insurance to be filed 2nd:

Person Insured: <u></u>	Employer: <u></u>
DOB: <u></u>	Relation: <u></u>

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

HOME ☐ CELL ☒ WORK ☐VIA EMAIL ☐ email address:

LETTIE SPENCER

Patient ID: 123171-15

DOB: 11/28/1947 (64 years)

04/17/2012 10:09 am

LETTIE B SPENCER DOB 11/28/1947

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Printed with PrintDirect Mail version. All other information is from the patient's record.

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ELROD POPE LAW FIRM

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

Thank you for choosing COSA as your healthcare provider.

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

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

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

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

CONTACT FROM PRACTICE/AGENTS: When you provide us with a wireless telephone or land line number you are giving us and our representatives/agents your prior express consent to call that number.**LIABILITY CLAIMS:** The undersigned acknowledges that COSA does not accept third party liability as the sole means of payment for services. Payment is expected in full at the time of service unless other arrangements have been made. In the event of other medical insurance, all claim forms and subrogation forms must be completed prior to services being rendered. The undersigned authorizes COSA to establish a valid lien against any settlement, claim, judgment or verdict as a result of said claim, for the full amount of services rendered and not previously paid by the patient.

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

MEDICAL RECORDS: The undersigned authorizes COSA to release medical records, according to HIPAA guidelines, which relate to treatment rendered to insurance carriers, including workers compensation employees and nurse case managers for the purpose of payment of claims. This may include but is not limited to medical records, medical opinions and test results.**MRICARE, MEDICARE, and GOVERNMENT AUTHORIZATIONS:** The undersigned certifies the information given in applying for payment of services provided under TITLES XVIII and XXIX of the Social Security Act is correct and request payment to be made in their behalf. The undersigned states they do not have:

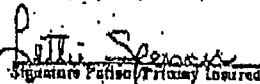
-Other group/private insurance that should be filed primary and has provided COSA with all insurance information

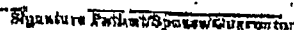
-Has not been involved in a third party liability claim for which another party is liable and if so, has provided COSA with detailed billing information as required

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

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

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


 Signature Patient/Primary Insured


 Signature Patient/Spouse/Guardian


 Date

LETTIE SPENCER

04/17/2012 10:09 AM

LETTIE B SPENCER DOB 11/28/1947

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PAGE 06/11

COSA
CAROLINA ORTHOPAEDIC
SURGERY ASSOCIATES

134 Professional Park Drive
Rock Hill, SC 29732
Phone: (803) 329-3130
Fax: (803) 329-2811

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

History of Present Illness

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

CHIEF COMPLAINT: low back pain

REFERRING PHYSICIAN: Dr Robert Bradley

PRIMARY CARE PHYSICIAN: same

ACCOMPANIED BY: spouse

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

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

Subjective Transcription

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

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

SPENCER, LETTIE

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Allergies**PENICILLIN**; rash swelling
DEMEROL; rash swelling**Past Medical History**

No reported breathing problems

Hypertension

Thyroid Problem

None - Liver/Kidney

None - Neurologic

None - Blood

Hysterectomy

Crowns

Dentures

Vision Problems; glasses

General Anesthesia

Family History

Myocardial Infarction: Father

Hypertension: Mother

Social History

No Drug Use

Non Drinker/No Alcohol Use

Tobacco Use: 1/2 pack per day

Living Situation: spouse

Current Work/Study Status: Full-time

Medication History

Potassium 20 mg (1 daily) Active.

Magnesium Oxide (400MG Tablet 1 Oral daily) Active.

Aldactone (25MG Tablet 1 Oral daily) Active.

Norvasc (10MG Tablet 1 Oral daily) Active.

Calcium Carbonate (600MG Tablet 1 Oral daily) Active.

Trazodone HCl (100MG Tablet 1 Oral daily) Active.

Klonopin (0.5MG Tablet 1 Oral daily) Active.

Crestor (20MG Tablet 1 Oral daily) Active.

Tapazole (10MG Tablet 1 Oral daily) Active.

Tricor (145MG Tablet 1 Oral daily) Active.

Fish Oil Concentrate (300MG Capsule 1 Oral daily) Active.

Nucynta ER (50MG Tablet ER 12HR 1 Oral every four-six hours with food, as needed for pain) Active.

Past Surgical

Hysterectomy

Cervical Disectomy

Review of Systems

General: Not Present- Fever, Weight Gain, and Weight Loss.

Skin: Not Present- New Lesions and Ulcer.

HEENT: Not Present- Visual Loss, Hearing Loss, Sleep Apnea, Hoarseness, Sore Throat and Voice Changes.

Respiratory: Not Present- Cough, Difficulty Breathing, Hemoptysis and Wheezing.

Cardiovascular: Present- Hypertension. Not Present- Chest Pain, Edema, Elevated Blood Pressure and Palpitations.

Gastrointestinal: Not Present- Abdominal Pain, Change in Bowel Habits, Difficulty Swallowing and Heartburn.

Neurological: Not Present- Difficulty Speaking and Visual Changes.

Psychiatric: Not Present- Change in Sleep Pattern and Mood changes.

Endocrine: Not Present- Appetite Changes, Cold Intolerance, Excessive Thirst, Excessive Urination and Hair Changes.

Hematology: Not Present- Abnormal Bleeding and Easy Bruising.

SPENCER, LBTTE

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04/04/2012 02:12 PM

Weight: 128 lb Height: 62 in

Body Surface Area: 1.59 m² Body Mass Index: 23.41 kg/m²

Pulse: 64 (Regular) P.Ox: 95% (Room air)

Objective Transcription

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

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

Assessment & Plan**Unspecified Diagnosis****Current Plans:**

- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 04/04/2012, No Refill. Active.

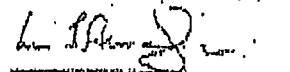
Assessments Transcription

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

Plan Transcription

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

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



Electronically signed by William L. Lehman

SPENCER, LETTIE

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PAGE 10/11



134 Professional Park Drive
Rock Hill, SC 29752
Phone: 803-329-3130
Fax: 803-329-2811

Patient Name: LETTIE B SPENCER
Date of Birth:
Account: 179171-LS
Date: 04/12/2012

To Whom it May Concern:

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

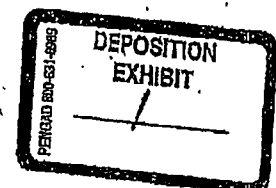
Work Restrictions / Additional Instructions

Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

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

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

William L. Lehman



SPENCER, LETTIE

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05/09/2012 15:34

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

LETTIE B SPENCER
04/12/2012 03:20 PM
Patient #: 179171-LS

History of Present Illness

Assessment & Plan
Unspecified Diagnosis
Current Plans:

- Sit Down Work Only WITH ABILITY TO CHANGE POSITIONS

Electronically signed by William L. Lehman

SPENCER, LETTIE

Page 1 / 1

SCANNED

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

LETTIE B SPENCER
09/17/2012
Patient #: 179171-LS

History of Present Illness

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

Subjective Transcription

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

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

Objective Transcription

Ms. Spencer is alert and conversant, oriented X3. Vital signs: Temperature - 98.2; Pulse - 75. Respiration - 15. There is satisfactory range of motion of the lumbar spine, though somewhat limited in flexion. There are radicular symptoms but no definite neurologic deficit.

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

Assessment & Plan

Unspecified Diagnosis

Current Plans:

- Sit Down Work Only

Low Back Pain (724.2)

Current Plans:

THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED (724.4)

Current Plans:

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

Assessments Transcription

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

Plan Transcription

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

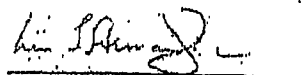
Ms. Pat Chambers, RN, CCM, Corvel Corporation, was available after examination for clarification and facilitation of care on behalf of Ms. Spencer.

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

William L. Lehman, Jr., M.D. / as 801_1101

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

Pat Chambers, NCM, Corvel - fax: 866-440-6787



Electronically signed by William Lehman MD



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

Procedure Order

Ordering Site

INDIAN LAND OFFICE
6237 Suite 313 Carolina Commons Drive
Indian Land, SC 29707
(803) 329-3130 X 216 Delores
Fax: (803) 329-2611
985-4580

Report Date: 10/29/2012

Patient Information

LETTIE B SPENCER

Gender: Female Date of Birth: SSN (la:

Patient Insurance Information

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

Procedures Ordered

REFERRAL / CONSULT (ADD COMMENTS)

Note: refer to Dr. Nandurkar for esp 7 SNRB LEFT L-5 and pain management
Diagnosis: Radiculitis (729.2)
Ordered by: William Lehman, MD

End of Procedures Ordered

Electronically signed by William Lehman MD

LETTIE B SPENCER

Patient #: 179171-LS

DOB:

Monday, October 29, 2012

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Received by CorVel Corporation 10/30/2012, 12:25:40 PM Pacific Time, 6762, Page 1 of 4

2012-10-30 15:14

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ROA 529

LETTIE B SPENCER
10/25/2012
Patient #: 179171-LS
DOB: [REDACTED]

History of Present Illness

The patient is a [REDACTED] year old female who presents for a recheck of Back pain.

Subjective Transcription

64 year old woman presents for further follow up regarding her work related injury which occurred on 6/12/11 when functioning as an LPN at National Health Care for approximately 3-1/2 years. I had been provided with extensive records from Columbia Neurosurgical Associates, Randall Drye, M.D. who saw her once upon referral from the company physician who saw her initially after the injury. She was referred for pain management to Tony Owens, M.D. at South Carolina Pain Associates in Columbia, SC. undergoing left sacroiliac joint injection on one occasion, radiofrequency ablation on the left at L3, S1 and S2, performed November and December 2011 with no relief. She has also undergone physical therapy which offered no relief.

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

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

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

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

SPENCER, LETTIE

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Received by CorVel Corporation 10/30/2012, 12:25:40 PM Pacific Time, 8782, Page 2 of 4

2012-10-30 15:14

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ROA 530

Objective Transcription

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

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

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

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

Assessment & Plan

Radiculitis (729.2)

Current Plans:

- REFERRAL / CONSULT (ADD COMMENTS); Routine (refer to Dr. Nandurkar for eval 7 ENRB LEFT L-5 and pain management)
- Neurontin 600MG, 1 Tablet three times daily, #90, 10/23/2012, No Refill. Active.
- Nucynta 75MG, 1-2 Tablet every six hours, as needed for pain, #40, 10/23/2012, No Refill. Active.
- Sit Down Work Only
- Follow up in 1 month or as needed

Assessments Transcription

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

Plan Transcription

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

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

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

William L. Lehman, Jr., M.D. / as 801 1950

SPENCER, LETTIE

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1 >> Nvel Corporation P 3/4

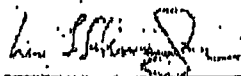
Received by CorVel Corporation 10/30/2012, 12:25:40 PM Pacific Time, 6782, Page 3 of 4

2012-10-30 15:15

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ROA 531

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



Electronically signed by William Lehman MD

SPENCER, LETTIE

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Received by CorVel Corporation 10/30/2012, 12:28:40 PM Pacific Time, B702, Page 4 of 4

2012-10-30 15:15

60

ROA 532



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

LETTIE B SPENCER

11/26/2012

Patient #: 179171-JS

DOI

History of Present Illness

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

Subjective Transcription

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

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

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

Objective Transcription

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

Assessment & Plan

Low back pain (724.2)

Current Plans:

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

Chronic back pain (724.5)

Current Plans:

Stenosis of lumbosacral spine (724.02)

Current Plans:

Assessments Transcription

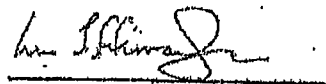
WORK INJURY 6/12/11 WITH ONGOING BACK AND LEFT LEG RADICULAR SYMPTOMS, MILD STENOSIS L4-5 CONSISTENT WITH SYMPTOMS, SEVERE DEPRESSIVE SYMPTOMATOLOGY.

Plan Transcription

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

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

Patty Chambers, RN, CCM, nurse case manager, Corvel Corporation - fax: 866-440-6782
Premier Group Insurance; Claim #WC18202011021728, P.O. Box 1122, Murfreesboro, TN 37133



Electronically signed by William Lehman MD

SPENCER, LETTIE

Page 2 / 2

SCANNED⁶²

ROA 534

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ORIGINAL RECORD ON
APPEAL

SPENCER, LETTIE F

Lehman, William L. MD

Lehman, William L. MD

F

D006334539

REG SDC OPS

M000594470

09/11/2012

EXAM#	TYPE/EXAM	RESULT
000748585	RAD/MYELOGRAM-LUMBAR	

CLINICAL HISTORY: Back pain

EXAMINATION: Myelogram of the lumbar spine.

REPORT:

After informed signed consent and with procedure and risk explained to the patient and questions answered, lumbar myelogram performed using fluoroscopic guidance. Using sterile technique and 1% Xylocaine anesthesia, a 22-gauge spinal needle was used to gain access to the CSF space at the L4-L5 level and 12 mL of Isovue-M 200 contrast administered.

There were no immediate post procedure complications.

The exam documents mild spinal stenosis at the L4-L5 level. The exam does not demonstrate myelographic findings to suggest a focal disc herniation. Bony structures are intact.

IMPRESSION:

Findings of mild central canal stenosis at L4-L5, lumbar myelogram otherwise unremarkable.

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

CC: William L. Lehman MD

Technologist: JO C. TUCKER, RT
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/27/2012 (0854)

PAGE 1

Signed Report Printed From PCI

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ROA 536

SPENCER, LETTIE, F

F

D006334539

Lehman, William L. MD

REG SDC OPS

M000594470

Lehman, William L. MD

09/11/2012

EXAM#	TYPE/EXAM	RESULT
000748584	CT/LUMBAR SPINE WITHOUT CONTRAS	

CLINICAL HISTORY: Back pain.

EXAMINATION: CT of the lumbar spine, post myelogram.

REPORT:

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

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

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

The T11-T12 level is unremarkable.

The T12-L1 level is unremarkable.

The L1-L2 level is unremarkable.

The L2-L3 level is unremarkable.

The L3-L4 level is unremarkable.

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

The L5-S1 level is unremarkable

IMPRESSION:

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

PAGE 1

Signed Report Printed From PCI (CONTINUED)

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ROA 537

SPENCER, LETTIE F

D006334539

Lehman, William L. MD

REG SDC OPS

M000594470

Lehman, William L. MD

09/11/2012

EXAM#	TYPE/EXAM	RESULT
000748584	CT/LUMBAR SPINE WITHOUT CONTRAS	
	<Continued>	

Remaining lumbar disc space levels without significant findings.

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

CC: William L. Lehman MD

Technologist: JULIE H. COX, RT(R)
Transcribed Date/Time: 09/11/2012 (1257)
Transcriptionist: RAD.HAYVI
Printed Date/Time: 09/27/2012 (0854)

PAGE 2

Signed Report Printed From PCI

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ROA 538



To: Wesley, Sandy Date Completed: _____
From: Garner Requestor's Extension: 1488
Date Requested: _____ Hospital Service Code/Department: 138
Patient Name: Lettie Spencer Admit/Discharge Dates: 9/11/12
Account Number: 06334539 Medical Record Number: M594470 500
Account Balance: 8644.13 DOB ✓

Medical Record Copy Request	Check Appropriate Request
Emergency Department Record: _____	☒ 1st Request
Medical Records:	☐ 2nd Request
Abstract Only: <u>K</u>	☐ 3rd Request
Entire Chart: _____	
Other: _____	

RECEIVED
OCT 01 2012
PGI

Please send to:
Company: PREMIER GROUP
Address: PO Box 1122 Murfreesboro, TN 37133
Premier Group
P.O. Box 1122 Murfreesboro TN 37133
Attention: _____

Notes: _____
Explain Inquiry in Detail: M.B.
Date Shipped: _____ Tracking Number or Label: _____

Patient Label

412
9-27-12
70636962 ⑤ 66
ROA 539

SPRINGS MEMORIAL HOSPITAL

800 West Meeting Street
Lancaster, SC 29720
REGISTRATION FORM

PATIENT DEMOGRAPHICS

ACCOUNT NO. D006334539 ADMISSION DATE 09/11/12 MEDICAL RECORD NO. M000594470
ROOM/BED ADMISSION TIME 0803 FINANCIAL CLASS WORKERS COMPENSATI
TYPE DISCH DATE DISCH TIME SS# LOC/SVC OPS
PRIM LANGUAGE ENGLISH INTERP. PHONE

PATIENT NAME SPENCER, LETTIE F DOB AGE SEX F RACE W
HOME PHONE
COUNTY
RELIGION MARITAL STATUS LEGALLY SEPARATED

PATIENT EMPLOYER PERSON TO NOTIFY
NAME DISABLED NAME NEELEY, GEORGIA
STREET STREET
CITY/STATE/ZIP CITY/STA
PHONE PHONE

GUARANTOR/RESPONSIBILITY PARTY NEXT OF KIN
NAME SPENCER, LETTIE NAME
STREET STREET
CITY/STATE/ZIP CITY/STATE/ZIP
PHONE PHONE RELATIONSHIP

GUARANTOR EMPLOYER ACCIDENT/ARRIVAL/PHYSICIAN DATA
NAME DISABLED ACCIDENT DATE 06/22/11 TIME
STREET ARRIVAL MODE
CITY/STATE/ZIP ATTEND DR. Lehman, William L. MD
PHONE ADM/PAM DR. Lehman, William L. MD

INSURANCE POLICY GROUP SUBSCRIBER
ADDRESS CITY STATE ZIP CODE PHONE

WORKMENS COMPENSATION WC18202011021728 SPENCER, LETTIE

REASON FOR VISIT SCIATICA, 724.2 ADMIT CLERK BUS.MOSTE
ACCIDENT TYPE EMPLOYMENT RELATED COMMENT PSNDT/TM

PATIENT DIAGNOSIS PATIENT PROCEDURES

CONSULTATIONS

PHYSICIAN'S SIGNATURE

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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

APPELLATE CASE NO. 2015-002112

Lettie Spencer, ...Appellant,

v.

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

RECORD ON APPEAL

VOL 4 OF 4

Clark W. McCants, III
Amy P. Shumpert
Nance, McCants & Massey
PO Box 2881
Aiken, SC 29802
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Attorneys for Respondents

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Garrett B. Johnson
Elrod Pope Law Firm
212 East Black Street
PO Drawer 11091
Rock Hill, SC 29731
(803) 324-7574

Attorneys for Appellant

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SPRINGS MEMORIAL CODING FORM

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NAME: SPENCER, RUTH L.		ACCOUNT: 800594470	
ADM DATE: 09/11/12	ATTEND PHYS: Lehman, William L. MD	UNIT #: M000594470	SEX: F
DIS DATE: 09/11/12	DISCH DISP: HOME/SELF CARE	AGE:	DOB:
LOS: 1	PT CLASS: SDC	FIN CLASS: WC	ABS STATUS: FINAL
DIAGNOSIS: ADMIT: PRINC: 724.02 SPINAL STENOSIS, LUMBAR REG, W/OUT NEUROGENIC CLAUDICAT SECOND:			
OPERATIONS: DATE: 09/11/12 PROC: 87.21 CONTRAST MYELOGRAM SURG: WENT.			
CPT CODES: CPT: 62284 INJECTION FOR MYELOGRAM			
ABSTRACTOR: GORDON, NANCY		ABSTRACTING STATUS DATE: 09/13/12	

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SPENCER, LETTIE F Discharge 09/11/2012 1 Lehman, William L. MD D008334539 M000594470
Gender : Female
Age : 84

Claim Type (Medicare APC - HOPD)

99 Other

APC Overall Claim Disposition

4 Claim denied, rejected, suspended or returned to provider, or single day claim w all line items denied or rejected, w only pre-payment edits.

APC Claim Edit

0027 OCE- Only incidental services reported. (CR)

APC Bill Type

13X Hospital Outpatient

APC Condition Code

9999 No/Unknown Condition Code

APC Detailed CPT Procedures

62284 Injection procedure myelography/CT spinal
APC: 18900 - Incidental services packaged into APC rate
Rptd Units: 1
REV: 9999 - No Rev Code entered; partial OCE edits only
Status: N - Items and Services packaged into APC rates.
09/11/2012 WEAT

Dx Reason for Visit

7242 Lumbago (low back pain)

Primary Diagnosis

72402 Spinal stenosis of lumbar region, without neurogenic claudication

ICD-9-CM Procedures

8721 Contrast myelogram
09/11/2012 WEAT

CPT-4 five-digit codes and/or nomenclature are copyright 2011 American Medical Association.

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SPRINGS MEMORIAL HOSPITAL
Lancaster, South Carolina

Page 1

HOME MEDICATIONS REPORTED BY PATIENT ON ADMISSION

SPENCER, LETTIE F

H000594470

Lehman, William L. MD

Allergies: CODEINE, HEPRIDINE (From Demerol Hcl), PENICILLINS
WEIGHT: lbs oz Kg HEIGHT: ft in cm

Medication	Dose/Route/Frequency	When Taken	Refill/Status
Tapentadol Hydrochloride (Nucynta)	50 MG PO Q4HR	09/11/12 0500	mcburgess
Spirolactone (Aldactone)	25 MG PO DAILY	09/10/12	mcburgess
Trazodone (Desyrel)	100 MG PO QHS	09/10/12	mcburgess
Methimazole (Tapazole)	10 MG PO DAILY	09/10/12	mcburgess

Permanent Chart Copy: Place in Home Medication Section. Do NOT Discard

SPENCER, LETTIE F
SPRINGS MEMORIAL

MO00694470
0006334539

FX4

DO NOT USE	CORRECT USAGE - Write	DO NOT USE	CORRECT USAGE - Write	DO NOT USE	CORRECT USAGE - Write
U or u	unit	X mg	0.1 mg	"g" or gg or UG	Mg or microgram
IU	International unit	X.0 mg	X mg	Mg80.	Magnesium sulfate
QD or Q.D. or qd	daily	MS	Morphine or magnesium sulfate	TW	8 times weekly or three times weekly
QOD or Q.O.D. or qod	Every other day	MSO ₄	Morphine	PZI	Protamine zinc insulin
ZnSO ₄	Zinc sulfate	Qn or QN	Every night	U-SR	Un satisfactory result

****SEND COPY OF ALL NEW ORDERS TO PHARMACY**

SPRINGS MEMORIAL HOSPITAL

INFORMED CONSENT

AUTHORIZATION AND CONSENT TO SURGERY, ANESTHETIC AND OTHER MEDICAL SERVICES

1. The undersigned patient or authorized representative of the patient authorizes and consents to the performance of the following surgery or procedure in Springs Memorial Hospital, Inc. (herein referred to as Hospital)

lumbar ct myelogram with flexion and extension views

Upon himself or herself or _____, to be performed under the direction of the undersigned physician/surgeon and such associates, partners, assistants or designees as may be selected by such physician/surgeon to perform such surgery or procedure.

2. It is recognized that, during the course of the surgery or procedure, unforeseen conditions may necessitate additional or different procedures or services than those set forth above; and the above named physician/surgeon and such associates, partners, assistants or designees selected by such physician/surgeon are authorized and requested to perform such procedures as are, in such physician's/surgeon's professional judgement, necessary and desirable.

Consent is hereby granted to the administration of such anesthetics as may be considered necessary or advisable by the person responsible for such service with the exception of: _____

It is understood that, during any surgery or procedure, certain risks and complications may occur. The below-listed risks and complications have been fully explained; and it is understood the listed risks are among other risks and complications inherent in any surgery or procedure when anesthesia, medications, blood, surgical instruments and human judgement are required.

- (a) Cardiac arrest, irregular heart beat or heart attack, with possible loss of life.
- (b) Blood loss requiring blood transfusion (s).
- (c) Emboli (blood clot) traveling to the lungs, to the brain or the extremities.
- (d) Subsequent infection which could require additional treatment such as abscess, wound infection, pneumonia.
- (e) Injury to adjacent organs (parts of body close to those directly being operated upon).
- (f) Allergic reaction.
- (g) Other complications and risks to my operation are: _____

Date: _____

Time: _____

- (h) Complications of anesthesia including moderate sedation could include drug reactions, loss of ability to maintain airway or other factors including a possibility of brain damage or even death. Different options for sedation were discussed.

5. Consent is hereby granted for the disposal by Hospital authorities of any tissues, organs, non-viable fetus or other parts of the body which may be removed during the course of the operation or procedure.
6. Should the above surgery or procedure be for sterilization or result in sterilization, it is understood the result will be that the undersigned patient may not be able to cause conception, conceive or bear children. The undersigned patient or authorized representative of the patient and the spouse of the patient, release from any and all liability which may arise as a result of the above surgery or procedure, the Hospital, its nurses and employees; together with all physicians/surgeons in any way connected with said surgery or procedure and agree to repay any damages including attorney fees sustained by the Hospital nurses, employees or physicians/surgeons as a result of any damages claimed or obtained by any person as a result of this surgery or procedure.

I understand that the practice of medicine and surgery is not an exact science, and no guarantees have been made to me with regard to this operation.

7. The undersigned patient or authorized representative of the patient and the spouse of the patient, when required, represent that the signing of this informed consent acknowledges the Informed Consent has been read by them or it has been read to them and that such Consent is understood and that the possible risks, complications and benefits that can result from the surgery or procedure are understood.

YMC Burger Ph
WITNESS

Leticia Spencer
PATIENT OR AUTHORIZED PERSON

WITNESS

9/11/12
DATE

0855
TIME

A.M. or P.M.

RELATIONSHIP IF SIGNED BY AUTHORIZED PERSON

SPOUSE

Gamm Weaver
PHYSICIAN/SURGEON OBTAINING CONSENT

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Procedure Name <u>Lumbar CT myelogram with flexion and</u>		Date <u>9/11/12</u>	
1. To Be Completed By Patient Care Area After Patient Admitted: <u>extension views</u>			
Patient Identity Confirmed Using 2 Identifiers		☒ Yes ☐ N/A	Initials/Time <u>MB</u>
Informed Consent Confirmed		☒ Yes ☐ N/A	Initials/Time <u>MB</u>
Completed History and Physical and Update		☒ Yes ☐ N/A	Initials/Time <u>MB</u>
Site is Marked By Procedure Physician		☒ Yes ☐ N/A	Initials/Time <u>MB</u>
Alternative to Site Marking: Site Identified by: <u>Special Armband</u>		☐ Obvious Defect ☐ Dressing ☐ Other	
2. Prior to Entering Procedure Room or Administration of Anesthesia RN or Imaging Technologist Confirms:			
Patient Identity Confirmed Using Two Identifiers		☐ Yes ☐ N/A	
Procedure Confirmed with Patient or Patient Representative		☐ Yes ☐ N/A	
Procedure Site Marked and Confirmed With Consent		☐ Yes ☐ N/A	
Consent: All Information Matches to Patient		☐ Yes ☐ N/A	
Orders Completed (date and time checked):		☐ Yes ☐ N/A	
History and Physical and Update Completed (date and time checked)		☐ Yes ☐ N/A	
Pre-anesthesia Assessment Completed (date and time checked)		☐ Yes ☐ N/A	
Radiological Images; Lab; Diagnosis Testing (available and matched to patient ID)		☐ Yes ☐ N/A	
Blood/Blood Products: Confirmed Necessity or Availability		☐ Yes ☐ N/A	
Resource Availability Matched to Patient and Planned Procedure: medications; equipment; supplies; implants;		☐ Yes ☐ N/A	
Sterility of Supplies and Instrumentation Confirmed		☐ Yes ☐ N/A	Initials/Time
3. Fire Risk Assessment: Assign a 1 for Yes, 0 for No; total score of all three criteria indicates risk level below			
Procedure site or incision above the xiphoid or airway procedure		Yes=1 No=0	
Oxygen source (face mask/nasal cannula; LMA; ET tube)		Yes=1 No=0	
Ignition source (Uni-polar cautery, laser, fiber-optic light)		Yes=1 No=0	
Total Score:			Initials/Time
Score of 1 or 2 - Low Risk with Potential to Convert:		Initiate Routine Protocol:	
* Use ESU pencil holder, utilize laser standby mode;		* Standby mode for fiber-optic light source when not in use	
* Alcohol based prep solution to dry 3 minutes		* Remove volatile solution from sterile field as soon as possible	
* Prevent pooling of prep solution		* CO ₂ Fire Extinguisher readily available	
Score of 3 - Initiate High Risk Fire Protocol:		Initiate All Protocol Above, In Addition To:	
* Use Wet Sponges		* Saline/Water available for fire suppression	
* Electro-cautery settings minimized, use Bi-polar if possible		* Syringe of saline available for procedures in oral cavity	
* Room air mixed with O ₂ at lowest concentration when face masked; nasal cannula in use			
4. Procedure Time-Out: Stop all activities. Time-out must be performed immediately prior to start of procedure			
Patient Identity Confirmed Using 2 Identifiers		☐ Yes ☐ No	2nd Procedure ☐ Yes ☐ No
Consent: All Information Matches to Patient		☐ Yes ☐ N/A	☐ Yes ☐ N/A
Site Marked, Stated and Viewed by Procedure Team (circle):		Right Left N/A	Right Left N/A
Pre-Procedure Antibiotics Administered		☐ Yes ☐ N/A	☐ Yes ☐ N/A
Fire Safety Efforts Communicated Within Team		☐ Yes	Initials/Time ☐ Yes Initials/Time
Team Completed Time Out and Verbalized Agreement/Concerns		☐ Yes ☐ N/A	Initials/Time ☐ Yes Initials/Time
Team Members Participating: Initials		Initials	Initials
Team Members Participating: Initials		Initials	Initials
5. Procedure Sign Out-RN Confirms with Physician Prior to Leaving Procedure Room:			
Name of Operative Procedure Confirmed by Surgeon as compared to consent		☐ Yes ☐ No	
Specimens Identified and labeled:		☐ Yes ☐ N/A	
Communication of Sponge, Sharp and Instruments Counts		☐ Yes ☐ N/A	
Hemodynamic Safety Concerns Communicated:		☐ Yes ☐ N/A	
Team member reviews any key concerns for recovery and management of patient:			Initials/Time
Signature, Titles, and Initials of Personnel Documenting on this Form			
Signature <u>MB</u>	Title <u>RN</u>	Initials <u>MB</u>	Date <u>9/11/12</u> Time <u>0855</u>
Signature	Title	Initials	Date Time
Signature	Title	Initials	Date Time
Signature	Title	Initials	Date Time



PRE-PROCEDURE IDENTIFICATION AND VERIFICATION		☐ Check here if more than one form is used
Procedure: <u>Lumbar Myelogram</u>	Date: <u>9-11-12</u>	
IDENTIFY: Two identifiers used to identify patient.	☒ Yes ☐ N/A	
CONSENT: Patient/parent/guardian states procedure, side, site, and physician performing procedure agrees with signed consent.	☒ Yes ☐ N/A	
DOCUMENTATION: Confirm H&P, Consent, Orders (all signed, dated and timed) all agree as to patient, procedure, side, site, surgeon, and plan of care.	☒ Yes ☐ N/A	
ANESTHESIA: Anesthesia pre-procedure evaluation is present and signed, dated, timed.	☒ Yes ☐ N/A	
LAB & DX TESTING: Correctly labeled diagnostic reports are available and accurately matched to patient.	☒ Yes ☐ N/A	<u>Oct 9, 2012</u>
PRE-PROCEDURE SITE MARKING		
IDENTIFY: Two identifiers used to identify patient.	☒ Yes ☐ N/A	
DOCUMENTATION: Before marking, confirm all agree (signed, dated & timed) H&P, Consent, Order, Images, or Radiology Reports if applicable.	☒ Yes ☐ N/A	
PATIENT INVOLVEMENT: Patient/parent/guardian was involved in identifying site.	☒ Yes ☐ N/A	
PROCEDURE PHYSICIAN: Name of the provider privileged to perform the procedure who marked the site: <u>Tommy Weaver MD</u>	☒ Yes ☐ N/A	<u>Oct 9, 2012</u>
ALTERNATE PROCESS: For marking site as required for patient. Site is identified by: _____	☐ Yes ☒ N/A	<u>Initials/Time</u>
☐ Special arm band ☐ Obvious defect or dressing ☐ Other: _____	☐ Yes ☒ N/A	<u>Initials/Time</u>
PRE-PROCEDURE ROOM IDENTIFICATION		
Prior to moving patient to the procedure room the patient was identified and the resources confirmed.	☒ Yes ☐ N/A	
SITE MARK: The marked site will be visible after the patient is prepped and draped.	☒ Yes ☐ N/A	
MEDICATIONS: Irrigations, fluids, and antibiotics for the procedure are available.	☒ Yes ☐ N/A	
BLOOD OR BLOOD PRODUCTS: Blood products are available for procedure.	☒ Yes ☐ N/A	
RADIOLOGIC IMAGES: Imaging studies and results are available in room.	☒ Yes ☐ N/A	
RESOURCES: Special equipment, implants, and supplies are available for procedure.	☒ Yes ☐ N/A	<u>9:25 AM</u>
IDENTIFY: Two identifiers used to identify patient.	☒ Yes ☐ N/A	<u>Initials/Time</u>
PROCEDURE TIME OUT		
The team that is actively participating in the procedure is involved in the Time Out, and the following elements are stated aloud by the person leading the Time Out immediately prior to starting the procedure:		
1. Identify patient, procedure, side, laterality, spine level, or surface agrees with consent.	☒ Yes ☐ N/A	
2. Site marking is visible after prep and drape.	☒ Yes ☐ N/A	
3. Intraoperative imaging identifies the specific spine level, in addition to skin marker.	☒ Yes ☐ N/A	
4. Imaging studies and results are present, properly labeled, and displayed.	☒ Yes ☐ N/A	
5. Position is appropriate for the procedure.	☒ Yes ☐ N/A	
6. Pre-procedure antibiotics have been administered.	☒ Yes ☐ N/A	
7. Procedure team declares any safety precautions based on history or medication use.	☒ Yes ☐ N/A	
Team Time Out agreement.	☒ Yes ☐ No	<u>Initials/Time</u>
If No, explain actions to reconcile discrepancy: _____		
Names/roles or procedure team members involved in Time Out: <u>Tommy Weaver, Jo Tucker, Amy Hatcher</u>		
Prior to the end of the procedure, verbally verify with the physician that the <u>Lumbar Myelogram</u>		
procedure performed matches the consent. If no, explain _____		
<u>Tommy Weaver</u> <u>Jo Tucker RTR</u> <u>Oct 9, 2012</u>		
Signature(s), Title and Initials of Person(s) Documenting on this Form		

Universal Protocol Checklist
OR-1601 (Rev. 08/09)

Front

Patient Label

SPENCER, LETTIE F
SPRINGS MEMORIAL SDC 0006334539
TXN M000594470
09/11/12 Lehman, William L. M



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ROA 547

D006334539

M000594470

SPENCER, LETTIE F

FXW CLI

09/11/12 Lehman, William L. MD

SPRINGS MEMORIAL HOSPITAL
TB SCREENScreen (Signs & Symptoms of TB) Placed X by all those that apply)

☐ Persistent productive Cough > 2 weeks Duration	☐ Coughing up Blood
☐ Night sweats	☐ Weight Loss
☐ Anorexia	☐ Fever

Plan of Action☒ Does not meet above criteria

If Patient has Four or more symptoms:

☐ Place patient in private room utilizing airborne isolation precautions until chest x-ray report is available. (Need to get orders for Chest X-ray)Does the patient have a Persistent Productive Cough from above screen? NO
Is the Chest x-ray positive or negative?

** A positive Chest x-ray is defined as one with fibrotic lesions/inflammatory process, cavitary lesions/nodules.

If the patient has no persistent productive cough and chest x-ray is clear, the patient may be placed in a regular room, unless pt is immunocompromised (HIV positive, receiving chemotherapy, or children ≤ 5 .)☐ If patient has a persistent productive cough and a positive chest x-ray airborne isolation including a negative pressure room is indicated, until a physician clinically rules out TB (PPD test if no previous documentation of a positive chest x-ray, and sputums for AFB smear/culture times 3 if symptomatic-need orders.☐ Mask patient while in transit (White N-95 mask)☐ Flag record and door with Airborne isolation sticker.☐ If patient cannot tolerate mask, place in a private room and instruct patient to cover cough and sneezes (provide tissues). Employee must wear a HMPA-filtered respirator. Place patient in separate waiting area apart from other patients if possible.☐ If TB suspected by physician, write an order for infection control consult.☐ If patient has active TB and has not completed therapy, place in airborne isolation until documented not to be infectious. (negative AFB smears x 3 or greater than 3 weeks anti-TB medications)☐ Refer to Health Department of Residence if PPD positive.Risk Factors (These patients are considered high-risk)

Homeless
HIV positive/AIDS (request PPD if HIV positive)
Foreign born persons
Low income, including high risk minorities
Alcoholics
Previous TB

IV drug users
Resident of long-term care facility (incl. prison)
Immunosuppressed
Exposure to TB
History of positive PPD

SIGNATURE

09/11/12
DATE

8. GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES (continued from page 1):

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I agree and understand that all physicians (including fellows, residents, and interns), dentists, oral surgeons, and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

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Patient
Initials

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

9. ADVANCE DIRECTIVE ACKNOWLEDGEMENT:

Federal law requires that patients be provided information about their rights to make advance health care decisions, including a Living Will, Durable Medical Power of Attorney or designation of a surrogate decision maker for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Facility. *Please check one:*

- ☐ I have executed an advance directive and have supplied a copy to the Facility.
- ☒ I have executed an advance directive and have been requested to supply a copy to the Facility.
- ☐ I have reviewed the directive(s) on file with this Facility and it is / they are my current directive(s).
- ☐ I have not executed an advance directive. I have received information about advance directives from this Facility.
- ☐ I have not executed an advance directive. I have requested advance directive information from this Facility.
- ☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Facility.

10. RESEARCH STUDIES: *Please check one:*

☒ No ☐ Yes Are you currently a participant in any research study or project? If yes, please briefly describe what is being studied (drug, medical device or other) _____
Who can the Facility contact with questions about the study? _____

11. SMOKING CESSATION INFORMATION:

☒ Upon admission, I received the Smoking Cessation Information Packet, which includes information on: health risks associated with smoking, community resources for smoking cessation programs and health risks associated with second hand smoke. If I have further interest in smoking cessation programs and education, I will request additional information from the facility staff or my physician.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative <i>Lettie Spencer</i>		Date 4/1/12	Time 804
Relationship to Patient <i>Self</i>		Interpreter, if Utilized	Date Time
Witness Signature <i>M. Kelley</i>	Date 4/1/12	Time 804	If Telephone Consent, Second Witness Signature Date Time

Inpatient / Outpatient Conditions of Admission and Consent to Medical Treatment
ADM-1701G (Rev. 01/10, 05/12) Page 2 of 2

Patient Label

SPENCER, LETTIE F
SPRINGS MEMORIAL SDC U005334539
w/ M000694470
09/11/12 Lehman, William L. M

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If at any time you request that a nurse call your attending physician regarding your personal medical care, the nurse shall place a call to the attending physician or his or her designee to inform him or her of your concern. If you are able to communicate with and desire to call your attending physician or designee, upon your request, the nurse must provide you with the telephone number

and assist you in placing the call. A nurse or other clinical staff to whom such a request is made or who receives multiple requests may notify his or her immediate supervisor for assistance.

If you have personal medical care concerns, you may access prompt assistance via the patient assistance system by picking up the phone and dialing 0 for the hospital operator and telling them that you have an urgent patient care concern. A call will be placed immediately to the administrator on call who shall promptly assess, or cause to be assessed, the urgent patient care concern and cause the patient care concern to be addressed.

PART II: As a patient, you and your family have the responsibility to:

1. Give accurate and complete health information concerning your present complaints, past illnesses, hospitalizations, medications, allergies and other matters relating to your health.
2. Report any changes in your condition to the responsible practitioner.
3. Follow the rules and regulations, as explained to you, concerning patient care and your conduct as a patient.
4. Request further information concerning anything you do not understand.
5. Follow the treatment plan developed with the practitioner and express concerns related to your ability to follow the proposed course of treatment.
6. Accept the outcomes of your refusal to follow the treatment plan or instructions provided by your practitioner.
7. Be considerate of other patients and hospital personnel by avoiding unnecessary noise, smoking or causing distractions, and, by respecting others' property including that of the hospital.

The PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES has been explained to me and a copy has been provided to me.

SPENCER, LETTIE F
 SPRINGS MEMORIAL SOC D006334639
 FXW M000594470
 09/11/12 Lehman, William L. #

Lettie Spencer
 Patient or legally authorized representative

9/11/12
 Date

J. Mosley
 Witness

9/11/12
 Date

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**SPRINGS MEMORIAL HOSPITAL
PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES**

1 of 3 pages

Springs Memorial Hospital recognizes the rights and responsibilities of patients and provide impartial access to treatment or accommodations that are available or medically indicated, without regard to race, creed, sex, national origin, color, handicap, age, religion or source of payment for care. It is recognized that any specific procedure or service is always subject to modification, depending on the circumstances of particular case.

PART 1: As a patient you have the right to:

1. Have the hospital promptly notify a family member/representative and your physician of your admission to the hospital.
2. Considerate, respectful care at all times and under all circumstances with recognition of personal dignity.
3. Personal and Informational privacy as indicated below:
 - To wear appropriate personal, religious or other symbolic items which do not interfere with diagnostic procedures or treatment.
 - To be interviewed/examined in surroundings which assure reasonable visual and auditory privacy, including:
 - a. the attendance of a person of your own sex during certain parts of a physical exam, treatment or procedure performed a health professional of the opposite sex;
 - b. not to remain disrobed longer than is required for completing the medical purpose that required the disrobing.
 - To expect discrete discussion or consultation of your case, and that persons not directly involved in your care will not be present without your permission.
 - To have your medical record read only by those directly involved in your treatment or in the monitoring of its quality and by others only with your written permission or that of your legally authorized representative.
 - To expect that all communication and other records pertaining to your care, including source of payment for treatment, be treated as confidential.
 - To expect request a transfer to another room if another patient or visitor is unreasonable disturbing you.
4. Expect reasonable safety with regard to hospital practices and environment. To be free from mental, physical, sexual and verbal abuse, neglect, and exploitation.
5. Be free from physical restraints and drugs that are used for restraint or for coercion, discipline, convenience, or retaliation by staff. Restraint is to be used only when less restrictive interventions have been ineffective.
6. Know the identity and professional status of those providing services to you and to know the physician or other practitioner primarily responsible for your care, including; a) any professional relationships among those treating you, b) the relationship to any other health care or educational institution involved in your care. Your participation in clinical training programs or data gathering for research purposes is voluntary.
7. Obtain, from the practitioner responsible for your care, complete and current information concerning your diagnosis (to the degree known), treatment, alternatives, risks and prognosis in terms and language you can reasonably be expected to understand. Should it be medically inadvisable to you the information, it will be made available to your legally authorized representative.
8. Access people outside the hospital by means of visitors, and verbal and written communication.
9. Access to an interpreter, as necessary if you do not speak or understand English or if you are hearing or speech impaired.
10. Reasonable informed participation in decisions involving your health care, including; a) advance directive to which the hospital must adhere, b) clear, concise explanations of your condition, all proposed technical procedures, possible risk to mortality, serious side effects, problems related to recovery, success probabilities and probable person(s) responsible for authorizing and performing procedures and treatments, the hospital's intent to participate in human experimentation or research/educational projects that affect your care or treatment c) name of person(s) responsible for authorizing and performing procedure to participate in human experimentation or research or treatment. You have the right to refuse to participate

SPENCER, LETTIE F
SPRINGS MEMORIAL SDC 0006334539
FXW M000594470

09/11/12 Lehman, William L. M

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ur care

Springs Memorial Hospital

SPRINGS MEMORIAL Lehman, William L. M

CL1 09/11/12

0006334539

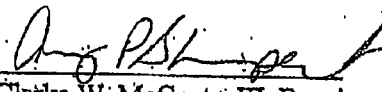
[illegible][illegible]

CERTIFICATE OF FILING AND SERVICE

I HEREBY CERTIFY THAT I HAVE this date filed the attached document(s) with the South Carolina Workers' Compensation Commission, Post Office Box 1715, Columbia, South Carolina 29202, and served a copy of said document(s) upon the following, by first class mail with sufficient postage affixed thereto to insure proper delivery:

Andrew W. Creech, Esquire
Elrod-Pope Law Firm
P.O. Box 11091
Rock Hill, SC 29731

NANCE, MCCANTS & MASSEY

By: 
for Clarke W. McCants, III, Esquire
P. O. Box 2881
Aiken, SC 29802
(803) 649-6200 Ext.21

Dated: January 7, 2013

Nance, McCants & Massey
Attorneys & Counselors at Law
218 Newberry Street S.W.
Aiken, South Carolina 29802
Telephone (803) 649-6200

AUG 25 2014

James D. Nance, LLC
Clarke W. McCants, III, P.C.
A. Shane Massey, LLC
Amy Patterson Shumpert
Blair Ballard Massey

COPY

Post Office Box 2881
Aiken, SC 29802-2881
Fax: (803) 649-5566
mccants3rd@aol.com

August 22, 2014

The Honorable Aisha Taylor
Commissioner
S.C. Workers' Compensation Commission
P. O. Box 1715
Columbia, SC 29202-1715

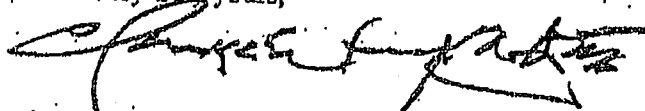
IN RE: Lettie L. Spencer v. NHC Parklane
SCWCC No.: 1120778
NHC File No.: WC18202011021728
Our File No.: MWC12-1203

Dear Commissioner Taylor:

Please file in the above-referenced matter the enclosed Form 58, Notice of Submission of Evidence and Certificate of Filing and Service thereof upon opposing Counsel. By a copy of this letter, I am serving opposing Counsel with the Form 58 and Notice.

Thank you for your assistance in these regards. With best regards, I remain

Very truly yours,



Clarke W. McCants, III

CWMIII/epe
Enclosures

cc: Andrew W. Creech, Esquire (w/ enc)



PRE-HEARING BRIEF
WCC File No: 1120778

Claimant's Name: Little Spencer Employer's Name: The Palmettos of Parklane
Address: _____ Address: 7811 Parklane Road
City: _____ State: _____ Zip: _____ City: Columbia State: SC Zip: 29223
Home Phone: _____ Work Phone: () _____ Carrier: Premier Group Insurance Co.
Preparer's Name: Clarke W. McCants, III Preparer's Phone #: 803-640-6200

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$ 656.73 2. AWW: \$ 985.05 Date of Injury: 6/22/11
3. Type of Injury and body part(s): Lower back and psyche
4. Facts in controversy: Whether or not Claimant has reached maximum medical improvement and, if so, the extent, if any, of permanent disability
5. Legal issues involved: Whether or not Claimant is in need of additional medical treatment; extent of permanent disability
6. Unusual aspects: None known at this time
7. Witnesses (designate if expert):* See Notice of Submission of Evidence
8. Exhibits: _____
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See Notice of Submission of Evidence
10. Name, address, and specialty, if any, of the treating physician:
See Notice of Submission of Evidence
11. Impairment rating(s); body part(s); physician and date of opinion: 9% lumbar spine, Dr. William Lehman, 4/2/13
12. I am amending my Form 50/51 in the following manner: Defendants reserve the right to amend

☒ Mediation

- ☐ a. Mediation is requested to be ordered pursuant to Reg. 67-1801 B.
☐ b. Mediation is requested 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: See attached.

Signature: _____ Email: McCants3rd@aol.com
Date of hearing: 9/3/14 Time needed for hearing: 1 hour

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

8. Sanjay Nandurkar, M.D., Piedmont Interventional Spine & Pain Center, 1/28/13 - 6/20/13, Pages 106 - 118;
9. W. Brian O'Malley, Ph.D., The Rehab Center, 3/7/13 - 6/13/13, Page 119 - 122;
10. Video Surveillance Reports of Claimant, 8/22/12 - 6/24/13, Pages 123 - 153; (1 thru 10 previously submitted)
11. Boston Diagnostic Imaging, 3/18/04, Page 154;
12. Dr. Amy Dorn, 4/21/04 - 2/21/06, Pages 155 - 160;
13. Spine & Brain Neurosurgery, 6/15/04 - 11/23/05, Pages 161 - 166;
14. AAA Report of Claim, 9/13/05, Pages 167 - 168;
15. Neuroskeletal Imaging, 8/16/05, Page 169;
16. Chester Regional Medical Center, 1/26/09 - 3/6/14; Pages 170 - 222;
17. Deposition of Dr. William Lehman, 1/9/13, Pages 223 - 274; and,
18. Surveillance Videos of Claimant, 8/23/12 - 8/1/14.

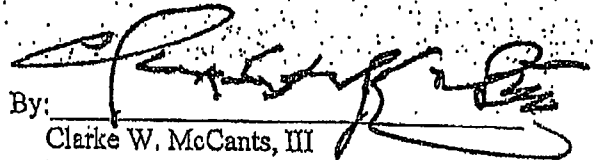
PLEASE ALSO TAKE NOTICE THAT the Employer may call the following witnesses to testify at the hearing for this matter:

Melissa Argo	NHC Parklane
Patti Coates	" "
Pam Jackson	" "
Tasha Owens	" "
Scott Thomas	Meridian Investigative Group
Dennis Croghan	" "
Andrew LaLonde	" "

Porter Nelms

Premier Group Insurance Co., Inc.

NANCE, McCANTS & MASSEY

By: 

Clarke W. McCants, III

P. O. Box 2881

Aiken, SC 29802-2881

(803) 649-6200

Dated: August 22, 2014

CERTIFICATE OF FILING AND SERVICE

I HEREBY CERTIFY THAT I HAVE this date filed the attached document(s)
with the South Carolina Workers' Compensation Commission, Post Office Box 1715, Columbia,
South Carolina 29202, and served a copy of said document(s) upon the following, by first class
mail with sufficient postage affixed thereto to insure proper delivery:

Andrew W. Creech, Esquire
Elrod-Pope Law Firm
P.O. Box 11091
Rock Hill, SC 29731

NANCE, MCCANTS & MASSEY

By: Erin P. Elam

Erin P. Elam, Paralegal
P.O. Box 2881
Aiken, SC 29802
(803) 649-6200 Ext.21

Dated: August 22, 2014

BOSTON DIAGNOSTIC IMAGING - ALTAMONTE

398 E. Altamonte Drive Altamonte Springs, Florida 32701 Phone: 407-331-9355 Fax: 407-331-9481

PATIENT'S NAME: FREEMAN, LETTIE

CHART ID: 72600

SSN:

DOB/SEX:

PATIENT PH:

DOS:

DR. JOHN P. BELLOMO
6442 EDGHWATER DRIVE
ORLANDO, FL 32810

EXAMINATION: MRI CERVICAL SPINE WITHOUT CONTRAST

CLINICAL INDICATION: Pain and tingling and numbness in the left arm in a patient with neck pain.

TECHNIQUE: Multiplanar, multisequential images were obtained without contrast.

FINDINGS: Anterior spurs are seen at C5-C6. There is mild straightening of normal cervical lordosis. Disc-space narrowings are mild at C5-C6 and at C6-C7. This matches the findings aforementioned in plain x-rays. No congenital abnormality is present. Cervical spinal cord is normal in size, in contour, in intensity, and in location. No abnormality is seen at craniovertebral junction or at C1-C2. No disc abnormality is seen at C2-C3, C3-C4, or C4-C5. At C5-C6, there is mild broad-based bulge of the intervertebral disc, and each lateral neural foramen is at lower limits of normal.

At C6-C7, there is eccentric protrusion of disc material and to the left lateral neural foramen, causing occlusion of that foramen for a tight left lateral neural foraminal stenosis. There is some evidence of spur formation here as well as disc herniation. No abnormality is seen at C7-T1, T1-T2, or T2-T3.

IMPRESSION

1. There is a left lateral disc herniation in the left lateral neural foramen at C6-C7 causing nerve root compression. There may be an element of degenerative osteophytic formation present here as well.
2. Mild broad-based bulge of disc is seen at C5-C6.

RICHARD BAGBY, M.D./kek

D: 3/18/2004 T: 3/19/2004 8:07 AM

Job: 2160

Electronically Signed by: Richard Bagby, MD on Friday, March 19, 2004

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

John L. Ley, P.A.-C.

10000 W. Colonial Drive, Ste 487 Ocoee, FL 34761

(407) 296-1923

OFFICE VISIT

DATE: 04-21-04

PATIENT: Freeman, Leticia

DOB:

SUBJECTIVE COMPLAINT: The patient is here for E&M of neck pain. She has a cervical disc and was referred to Dr. Razack and is scheduled for surgery next week. She has no cardiovascular complaints. No neurologic complaints other than that in her left arm. She is having no double vision or blurry vision. No chest pain, pressure or tightness. No coughing, wheezing or shortness of breath. She is somewhat anxious. She has stopped smoking in preparation for her surgery.

CURRENT MEDICATIONS: Vioxx 25 mg PO q.d., Lisinopril 20 mg, Lipitor 20 mg, Prevacid 30 mg, Elavil 50 mg.

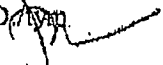
OBJECTIVE FINDINGS: Neck: supple, carotids 2+, no bruits. Chest: clear to auscultation, percussion and palpation. Cardiac: regular rhythm, normal S1 and S2, no murmur, no gallop. Abdomen: soft, non-tender, no masses, no organomegaly. Extremities: without cyanosis, clubbing or edema.

IMPRESSION:

1. Cervical disc
2. Hypertension
3. Hypercholesterolemia
4. Anxiety
5. Smoker

PLAN:

Ativan 0.5 mg PO t.i.d. p.r.n. anxiety. Continue Vioxx. She will get preoperative blood work and electrocardiogram at the hospital.

Amy K. Dorn, M.D. 

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

John L. Ley, P.A.-C.

10000 W. Colonial Drive

Ste. 487

Ocoee, FL 34761

(407) 296-1923

Office Note

Office Note

Office Note

Date: 11/17/04

Name: Lettice Freeman

Date of Birth:

Subjective Complaint: The patient is here for E/M of hypertension, restless leg syndrome, hyperlipidemia. Since I have seen her last, she has had 2 surgeries on her neck, she is doing much better. She is out of pain, she is no longer needing pain medications. She has been out of her blood pressure medicines and her blood pressure has been labile.

Meds: Lisinopril 20 mg, Lipitor 20 mg, Prevacid 30 mg, Elavil 50 mg.

Review of Systems: Otherwise unremarkable. She is not smoking, not drinking.

Physical Examination: Neck: supple, carotids 2+, no bruits. Chest is clear to auscultation, percussion, palpation. Cardiac exam: 1/6 systolic murmur, left sternal border, regular rhythm. Abdomen: soft, non-tender, no masses, no organomegaly. Extremities: without cyanosis, clubbing or edema.

Impression:

1. New heart murmur.
2. Hyperlipidemia.
3. Restless leg syndrome.
4. Hypertension.
5. Smoker.
6. Anxiety.

Plan: Cardiac echo, CBC, CMP, TSH. Klonopin 0.5 mg, start Lisinopril 20/12.5 mg, recheck in a month.

Amy K. Dorn, M.D. *AKD*

*unc 11.7
270/45/37
TSH
Cup/unc*

*rechecked
unc
TSH*

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

John L. Ley, P.A.-C.

10000 W. Colonial Drive Ste. 487 Ocoee, FL 34761 (407) 296-1923

Office Note

Office Note

Office Note

Date: 12/15/04

Name: Lettie Freeman

Date of Birth:

Subjective Complaint: The patient is here for E/M of hypertension. We recently placed her on Lisinopril 20/12.5 mg. She says her pressures have been fine. She did not increase her Lipitor to 40 mg because she was out of it when her blood tests were done last month. She is back on Lipitor 20 mg. She is tolerating Klonopin well and it works well for her restless legs.

Meds: Lisinopril 20/12.5 mg, Lipitor 20 mg, Prevacid 30 mg, Elavil 50 mg, Klonopin 0.5 mg.

Physical Examination: Neck: supple, carotids 2+, no bruits. Chest is clear. Cardiac exam: regular rhythm, normal S1, S2, 2/6 systolic murmur, left sternal border.

Impression:

1. Hypertension.
2. Hyperlipidemia.
3. Restless leg.
4. Smoker.
5. Anxiety.

Plan: Refer for colonoscopy, mammogram. Cardiac echo was done which shows some mild mitral insufficiency, no significant valvular disease.

Amy K. Dorn, M.D./sk

ND
4622

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

10000 W. Colonial Drive, Ste 487

John L. Ley, P.A.-C.
Ocoee, FL 34761

(407) 296-1923

OFFICE VISIT

DATE: 06-02-05

PATIENT: Freeman, Lette

DOB:

SUBJECTIVE COMPLAINT: The patient is here for E&M of hyperlipidemia, hypertension and restless leg syndrome. Since I've seen her last, she saw Dr. Brint for colonoscopy. He was not able to complete the study. She did have a barium enema. They were not able to complete that because of rectal soreness. She says her blood pressures have been under good control. Restless leg is relatively under control with Klonopin 1 PO q.p.m. She still has tingling in her arms from her cervical spine disease.

CURRENT MEDICATIONS: Lisinopril 20/12.5 mg, Lipitor 20 mg, Prevacid 30 mg, Elavil 50 mg, Klonopin 0.5 mg.

SOCIAL HISTORY: She is still smoking.

REVIEW OF SYSTEMS: No double vision, blurry vision or blindness. No chest pain, pressure or tightness. No coughing, wheezing or shortness of breath. No N&V, diarrhea or constipation. No polyuria or dysuria. No numbness, weakness or slurred speech.

OBJECTIVE FINDINGS: PERRLA, BOM'S intact. Sclerae, TM's and throat not injected. Neck: supple, carotids 2+, no bruits, adenopathy, thyromegaly or JVD. Chest: clear to auscultation, percussion and palpation. Cardiac: regular rhythm, normal S1 and S2, no murmur, no gallop. Abdomen: soft, non-tender, no masses, no organomegaly. Extremities: without cyanosis, clubbing or edema. Pulses are 2+.

IMPRESSION:

1. Hypertension
2. Hyperlipidemia
3. Restless leg syndrome
4. History of smoking
5. Anxiety
6. Chronic cervical spine symptoms from surgery

PLAN:

Refer for stress test in view of risk factors. We'll check a coronary risk and CMP. Recheck in 4 months. Again, advised to stop smoking. We'll check a chest x-ray.

Amy K. Dorn, M.D./*AD*

CR *Tun* *al* *Ad*

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

John L. Ley, P.A.-C.

10000 W. Colonial Drive
Office Note

Sta. 487
Office Note

Ocoee, FL 34761

(407) 296-1923
Office Note

Date: 11/01/05

Name: Lettie Freeman

Date of Birth:

Subjective Complaint: The patient is here for E/M of hypertension and hypercholesterolemia. She comes in letting me know that she was in another auto accident. The same person who hit last year hit her this year. She did see Dr. Razack who evaluated her upper back and her lower back. She has bulging disks and she has been in physical therapy. No surgery is planned.

Meds: Lisinopril 20/12.5 mg, Lipitor 20 mg, Elavil 50 mg, Klonopin 0.5 mg hs, Prevacid 30 mg, Lortab prn.

Review of Systems: Negative other than her back and neck pain. She is rarely smoking, not drinking.

Physical Examination: Neck: supple, carotids 2+, no bruits, adenopathy, thyromegaly, JVD. Chest is clear to auscultation, percussion, palpation. Cardiac exam: regular rhythm, normal S1, S2, no murmur, no gallop. Abdomen: soft, non-tender, no masses, no organomegaly. Extremities: without cyanosis, clubbing, or edema.

Impression:

1. Hypertension.
2. Hyperlipidemia.
3. Chronic back pain.
4. Status-post neck surgery.
5. History of smoking.
6. Restless leg syndrome.
7. Anxiety.

Plan: Same medicines. Recheck in 3 to 4 months.

Amy K. Dorn, M.D. *byf*

Amy K. Dorn, M.D.

Richard P. Nathanson, M.D.

Scott D. Marsel, M.D.

John L. Ley, P.A.-C.

10000 W. Colonial Drive
Office Note

Ste. 487

Office Note

Ocoee, FL 34761

(407) 296-1923
Office Note

Date: 02/21/06

Name: Lettie Freeman

Date of Birth:

Subjective Complaint: The patient is here for E/M of hypertension, hyperlipidemia, restless leg. She says that she has been feeling well other than for her numbness in her hands and neck pain. She has been seeing Dr. Razzak, neurosurgeon for this. She does have carpal tunnel, uses splints. Blood pressures have been under good control.

Meds: Lisinopril 20/12.5 mg, Lipitor 20 mg, Elavil 50 mg, Klonopin 0.5 mg hs, Prevacid 30 mg, Lortab prn.

Review of Systems: No double vision, blurry vision. No chest pain, pressure, tightness, no coughing, wheezing, shortness of breath. No nausea, vomiting, diarrhea or constipation. No polyuria, dysuria. She continues to smoke, does not drink.

Physical Examination: Neck: supple, carotids 2+, no bruits. Chest: clear. Cardiac exam: regular rhythm, normal S1, S2, no murmur, no gallop. Abdomen: soft, non-tender, no masses, or organomegaly. Extremities: without cyanosis, clubbing or edema.

Impression:

1. Hyperlipidemia.
2. Hypertension.
3. Chronic back pain.
4. Chronic neck pain, status-post surgery.
5. Carpal tunnel syndrome.
6. Restless leg syndrome.
7. Smoker.
8. Anxiety.

Plan: Fasting CBC, CMP, TSH, coronary risk. Recheck in 6 months.

Amy K. Dorn, M.D./sk



SPINE & BRAIN NEUROSURGERY CENTER

77 Underwood Street

Suite 400

Orlando, FL 32806

(407) 423-7172

June 15, 2004

Health Central of Windemere
4875 Casson Cove Drive
Orlando, Florida

RE: LETTIE FREEMAN

To Whom It May Concern:

Please be advised that the patient noted above is cleared to return to work on a light duty basis, pending further evaluation on July 14, 2004. Patient may work a maximum of four hours per day with the following restrictions. No lifting, pushing, pulling anything over 10 lbs. No climbing ladders or working with arms above shoulder level.

If you should be in need of any further information please contact this office.

Sincerely,

Nizam Razaack, M.D.

SPINE & BRAIN NEUROSURGERY CENTER

77 Underwood Street

Suite 400

Orlando, FL 32806

(407) 423-7172

July 14, 2004

Health Central of Windermere

Attn: Human Resources

RE: LETTIE FREEMAN

To Whom It May Concern:

Please be advised that the patient noted above is cleared to return to work as of July 19, 2004. The patient is restricted to a 6 hour work day. No lifting, pushing, and/or pulling anything over 10 lbs.

Patient will be evaluated within thirty days to assess restrictions. If you should be in need any further information, please contact this office.

Sincerely,

Nizam Razack, M.D.

SPINE & BRAIN NEUROSURGERY CENTER

77 Underwood Street

Suite 400

Orlando, FL 32806

(407) 423-7172

October 18, 2004

RE: LETTIE FREEMAN

To Whom It May Concern:

Please be advised that the patient noted above is cleared to return to work as of Monday, October 25, 2004. Patient is cleared to commence work on a 4 hour per day schedule with gradual increase as tolerated by patient. Full time clearance pending further evaluation on or about November 03, 2004.

If you should be in need of any further evaluation, please contact this office.

Sincerely,

Nizam Razack, M.D.

SPINE & BRAIN NEUROSURGERY CENTER

77 Underwood Street

Suite 400

Orlando, FL 32806

(407) 423-7172

August 8, 2005

RE: LETTIE FREEMAN

To Whom It May Concern:

Mrs. Freeman will need to be out of work until her next visit which is 8/23/05, at this time we will know of her restrictions.

If you have any questions regarding this patient please don't hesitate to call the number above.

Sincerely,

Nizam Razack, M.D.
Rosemarie Farina, NP

Spine & Brain Neurosurgery Center
77 West Underwood St., Suite 400
Orlando, Florida 32806
407-423-7172
FAX 407-423-9509

FREEMAN, LETTIE

OFFICE NOTES

October 18, 2005

Ms. Freeman is doing well with the use of the TENS unit for her low back pain. She does occasionally get numbness in her right upper extremity in the mornings only. Her neurological examination is stable. She has been doing much better from physical therapy. I will see her back in follow-up on a p.r.n. basis.

Nizam Razack, M.D.

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Spine & Brain Neurosurgery Center
77 West Underwood St., Suite 400
Orlando, Florida 32806
407-423-7172
FAX 407-423-9509

FREEMAN, LETTIE

OFFICE NOTE
November 23, 2005

The patient was last seen on October 18th, at which time she was in for low back pain, which she reported was much better with a TENS unit. She is here today complaining of increased neck pain. The patient states that she had neck pain at the time of her original accident, but it had subsided about a month or so ago. The pain began again and it was going down into her arms bilaterally, worse on the right. She had tried using her TENS unit on her neck, as it helps her back, but she found it to be of very little help. She had been to therapy in the past and found that it helped. She has continued to do her exercises, but they are not longer helping. She states that her arm pain was there prior to her therapy, but it is much worse now. It is going down to her hands. There is numbness and tingling present in the hands and arms. It goes into all fingers. She finds that her hands are getting weak, as well as arm weakness. She is finding it difficult to lift up small items. She has her films from August of 2005, but she has not had any new films taken. Motor strength was tested and was found to be 4+/5 in the deltoids bilaterally, biceps were 5-/5 on the right and 5/5 on the left. Triceps were 4+/5 on the right and 5-/5 on the left. Wrist extensors, hand grips and interosseous muscles were 4+/5 on the right and 5-/5 on the left. Sensory was intact to light touch and pinprick in the upper extremities, however, it was diminished bilaterally. Deep tendon reflexes were 2+ in the right biceps, 1+ in the left biceps, 2+ in the brachioradialis bilaterally, 2+ on the right triceps, 1+ on the left triceps. Range of motion of the cervical spine was decreased. There was no pain with palpation to the neck, however, there were moderate spasms present bilaterally. Negative Lhermitte's sign. Negative Spurling's sign. Negative Hoffmann's sign.

Data Review: MRI scan dated 08/15/05 revealed C5-6 bulging disc with evidence of a prior fusion at C6-7 to C7-T1.

Impression: Disc displacement.

Treatment Recommendations: The patient was advised that she may want to undergo a new cervical MRI, as her pain and her symptoms have increased significantly. She was given a script for a cervical MRI, as well as Lortab 5mg, 1-2 tablets p.o. q4-6h p.r.n. pain, #40 with no refill and Flexeril 10mg 1 tablet p.o. q.h.s. p.r.n. spasms, #15 with no refill. She was advised to have her cervical MRI performed at the center that did the MRI the last time. She should bring both films when she comes to her follow-up appointment as soon as she has her MRI.

Rosemarie Parina, NP-C
Nizam Razaek, M.D.
RF/d&d/cp

1
DICTATED BUT NOT READ
TO EXPEDITE DELIVERY

ATTENDING PHYSICIAN'S REPORT

PLEASE TYPE OR PRINT

1. Patient Name: <u>Little Freeman</u>		2. Age: _____
3. Does the condition described by the patient agree with the information contained in your records? ☒ YES ☐ NO, explain _____		
4. Please describe the injury: <u>servicel pain; low back pain - sprain/strain cerv & lower spine</u>		
5. Did you ever treat the patient prior to this accident? ☐ YES ☒ NO		6. If "YES", give the period: _____
7. Was there a pre-existing condition that caused or contributed to this injury? ☐ YES ☒ NO		
8. If "YES", describe: _____		
9. Was the patient confined in a hospital as a result of this injury? ☐ YES ☒ NO		
10. If "YES", please provide hospital name, address, telephone number, and date of admission: _____		
11. In your opinion, at the time of this accident, patient was in the following condition: ☐ Healthy ☐ Sick ☐ Intoxicated ☐ Under the influence of non-prescribed narcotics		
12. If "YES" (Sick, Intoxicated, or Under the influence of non-prescribed narcotics), did you lose the opportunity contributed to or caused the accident to occur? ☐ YES ☒ NO		
13. If "YES", give the patient's last result of a pain your best: _____		
14. If your medical treatment of this patient was not solely for accidental injury, give either the date on which treatment was for injuries alone or the percentage of your bill applicable to such treatment: _____		

(THIS SECTION SHOULD ALSO BE COMPLETED IF DISMEMBERMENT OR SIGHT LOSS OCCURRED)

DISMEMBERMENT	LOSS OF SIGHT
1. Which limb was injured? ☐ Left Leg ☐ Right Leg ☐ Left Arm ☐ Right Arm	1. Which eye was injured?
2. Explain extent of injury: _____	2. Did this injury require surgery? ☐ YES ☒ NO
3. Give date of surgery: _____	2a. If "YES", name the physician: _____
4. Describe point(s) of limb where severed or amputated: _____	3. Give degree of vision in each eye, and if irreparable the approximate date of loss: LEFT EYE: _____ RIGHT EYE: _____ Please Specify: _____ How Severe: _____ Approximate date of vision loss: _____ Approximate date of blindness: _____

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date: <u>9/15/05</u>	Physician's name (Please Print): <u>KIRK W. RAZACK, MD</u>	Physician's signature: <u>Rosemarie Farina, APRN</u>
Physician's address: _____	Physician's telephone number: _____	Physician's fax number: _____
Physician's signature: <u>Rosemarie Farina, APRN</u>		

NOTE: THE COMPLETION OF THIS REPORT IS REQUIRED IN ORDER TO PROCESS YOUR PATIENT'S CLAIM.

ALDI 10000-337X

ROA 574

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NEUROSKELLETAL IMAGING

1315 South Orange Avenue • Orlando, FL 32806
(407) 999-9977 • Fax (407) 999-9988 • WWW.NEUROSKELLETAL.COM

Little Freeman

DOB

Dr. Nizam Razaok

Exam Date: 08/15/2005

702115

08/16/2005

MRI OF THE LUMBOSACRAL SPINE

INDICATION FOR SCAN

Lumbago.

TECHNIQUE

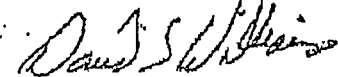
An ultra-high resolution MRI scan of the lumbar spine was performed on the new GE short bore whole body 3-Tesla Excite MRI system with T1-weighted spin echo pulse sequences and T2-weighted fast spin echo pulse sequences in the sagittal and axial planes.

FINDINGS

At L4-5, there is a minimal bulging annulus posteriorly. However, the central spinal canal and neural foramina are within normal limits. There is some minimal effacement of subarachnoid space ventrally. At remaining levels, intervertebral discs, central spinal canal and neural foramina appear normal. There is normal marrow signal throughout. The conus medullaris appears normal.

IMPRESSION

At L4-5, there is a mild posterior bulging annulus with minimal effacement of subarachnoid space ventrally. However, overall central spinal canal and neural foramina are within normal limits at this level. The remainder of the examination is negative.



David S. Williams, M.D.

ABR Certified Diagnostic Radiology

DSW/aa

Chester Regional Medical Center
One Medical Park Drive
Chester, SC, 29706
803-591-3161

INITIAL ASSESSMENT FORM

PRIORITY: 4

Patient: SPENCER, LETTIE

Semi-Urgent

DOB:

SEX: F

Chester Regional Medical Center

PI #: 1068135

MR #: 0000107577

Date: 1/28/2009

EDP: CROW, DANIEL R

Worker's Comp:

PCP: BRADLEY, ROBERT L

Emp. Referred:

Presentation Time: 15:38

Triage Time: 15:41

Arrival Mode: AMB - POV

Height:

Weight: 140 lbs.

84 kgs.

LMP: POST HYSTERE

Last Tetanus: Acc By: Spouse

Chief Complaint: ARM PAIN (COMPLETE ARM/NO KNOWN INJURY)

Brief Assessment: RIGHT ARM PAIN FOR 3 DAYS, NO MEDS FOR PAIN, UNKNOWN PAIN RADIATES FROM SHOULDER TO HAND.

NIGHT SWEATS

NO

PNEUMONIA VACC

NO

WEIGHT LOSS

NO

NUMBNESS

NO

ANOREXIA

NO

DECREASED

NO

HEMOPTYSIS

NO

SENSATION

NO

FEVER

NO

ROM INTACT

YES

DOMESTIC ABUSE

NO

PULSE DISTAL TO

NO

SUSPECTED

INJURY ABSENT

CAP REFILL > 2

NO

SECONDS 2

SECONDS

Vital Signs

T: 99.7 PO

P: 64 Regular

R: 19 Unlabored

BP: 148/078

O2: 99 99

Pain Intensity Scale:

10

Pain Location:

Sudden Onset:

Pre-Hospital Treatment:

NO OTC MEDS TODAY

Pediatric Assessment:

N/A

Past Medical History:

Chronic Pain, Depression, HTN, Hysterectomy 1970's, MVA 2003, Neck Surgery 2003 & 2, Neuropathy,
Chronic Pain, Depression, HTN, Hysterectomy 1970's, MVA 2003, Neck Surgery 2003 & 2, Neuropathy
Cleocin, Codeine, Demerol, Cleocin, Codeine, Demerol

Allergies:

Medicines:

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THIS DOCUMENT IS NOT INCLUDED IN THE MEDICAL RECORD

ROA 576

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Chester Regional Medical Center
One Medical Park Drive
Chester, SC 29706
803-681-3131

PATIENT DISPOSITION PAGE

Patient: SPENCER, LETTIE
DOB:
EDP: CROW, DANIEL R
PCP: BRADLEY, ROBERT L
Date: 1/28/2009

Chester Regional Medical Center
PI #: 1068135
MR #: 0000107577
Worker's Comp:
Emp. Referred:
Acuity: 4

Patient Disposition: DC - HOME

Presenting Complaint: ARM PAIN (COMPLETE ARM/NO KNOWN INJURY)

PI Topic:

Discharge Diagnosis: Extremity pain, etiology uncertain, Hypokalemia,

Primary Nurse: JLK

Follow-up / Admitting Phys: BRADLEY, ROBERT L
Physician Consulted: No

Physician Name:
Time Called: 00:00

On Call:
Call Returned: 00:00

Services Rendered: EXAM Labs X-Ray; Meds

Phone Consultation:
Time In: 00:00
Reason for Consultation:
Services Provided:

Time Out: 00:00

Presentation Time: 15:38

Initial Vital Signs

Triage Time: 15:41

Assess: 16:10

Exam: 16:44

T: 99.7 PO
P: 64 Regular
R: 18 Unlabored
BP: 148/079
O2: 99 99
Pain Intensity Scale:
Pain Location:

Discharge Vital Signs

T: 99 T
P: 64 Regular
R: 16 Unlabored
BP: 128/058
O2: 98 98
Pain Intensity Scale: 4
Pain Location: multiple areas

Admit Ready for Room:

Disposition Date/Time: 1/28/2009
7:10:00 PM

Payor Type: Blue Cross

ER Patient: Yes

Transfer Information

Referring Physician:

Receiving Physician:

Receiving Facility Representative:

Receiving Facility:

Reason for Transfer:

Transport Mode:

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THIS DOCUMENT IS NOT INCLUDED IN THE MEDICAL RECORD

ROA 577

171

Patient: SPENCER, LETTIE DOR: 11/28/1947 Patient #: 1094018 MRN: 0000107577 Date In: 7/5/2010

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: RB6 07/05/2010 13:04

SPENCER, LETTIE is a 62 year old F that presented to the Emergency Department at 11:57 by POV - AMB. The patient was triaged at 11:58 with the following vital signs: T: 98 PO, P: 97 Regular, R: 17 Unlabored, BP: 145/074, SPO2: 98 Amt: RA, Pain: 5 ear. The patient's primary care physician is BRADLEY, ROBERT L.

Chief Complaint -- EAR ACHE

Exam Time: 12:34

History obtained from: patient.

History limited by: N/A.

Onset of symptoms was 2 week(s) ago.

Symptoms are present now.

pt c/o sinus infection, L max sinus pain, ear pain bilat; saw PMD, given Septra then Avelox (1/2 thru) and flonase, shot of decadron last Tue and Cipro ear drops. No fever. Concerned because she isn't getting better.

REVIEW OF SYSTEMS: RB6 07/05/2010 13:05

Constitutional: negative fever.

ENT: negative difficulty swallowing.

Cardiovascular: negative chest pain.

Respiratory: negative shortness of breath.

Gastrointestinal: negative abdominal Pain.

PAST MEDICAL AND SURGICAL HISTORY: RB6 07/05/2010 13:05

Past Medical History: positive Depression, positive HTN, positive Chronic Pain, positive Hysterectomy 1970's, positive MVA 2003, positive Neck Surgery 2003 & 2, positive Neuropathy.

PMH: HTN, hypothy, chol, RLS

PSH: Neck surg, hysterectomy

FAMILY AND SOCIAL HISTORIES, ALLERGIES AND MEDS: RB6 07/05/2010 13:06

Allergies: Cleocin, Codeine, Demerol, PENICILLIN

Medications: Klonopin 0.5MG PO nightly, POTASSIUM 20MG ORAL EVERY 12HRS, NORVASC 10MG ORAL DAILY, TRAZODONE 100MG ORAL NITELY, CRESTOR 20MG ORAL NITELY, METHEMAZOLE 10MG ORAL NITELY, TRICOR 145MG ORAL NITELY; A*VERIFIED TODAY

Family History has been reviewed and is not pertinent. SH: Works at NH, MD, +cig, +etoh

Patient: SPENCER, LETTIE DOB:

Patient #: 1094019 MRN: 0000107677 Date In: 7/5/2010

PHYSICAL EXAMINATION: RB6 07/05/2010 13:06

General: WD, well nourished and in NAD. Vital signs noted. Nursing documentation reviewed.

HEENT: Head/Face: Normocephalic / atraumatic. Eyes: Pupils equal, round and reactive to light.

Extraocular motion intact. Ears: Left otic canal normal. Left TM is normal. Right otic canal normal.

Right TM is normal. Nose: Normal external appearance. Septum midline and intact. Pharynx: Posterior pharynx is unremarkable.

Neck: Supple with no palpable adenopathy.

Respiratory: No respiratory distress. Lungs clear with equal breath sounds bilaterally.

Cardiovascular: PMI normal. RRR. S1, S2 normal with no murmurs, clicks, gallops or rubs. All distal pulses 2+ and symmetric.

Abdomen: Bowel sounds are normoactive. Abdomen is soft, flat, non-tender, without organomegaly or palpable mass.

Neurologic: Mental Status: awake and alert. Oriented X 3.

CLINICAL IMPRESSION: RB6 07/05/2010 13:06

1. Sinusitis

DISPOSITION: RB6 07/05/2010 13:11

Disposition: Patient discharged to home.

Condition: Stable.

Certified Med Emerg: Patient's condition represents a certified medical emergency. Disposition date/time: 07/05/2010 13:11.

Discussed care with patient. Explained findings, diagnosis, and need for follow-up care.

INSTRUCTIONS: RB6 07/05/2010 13:11

Discharge plans discussed with patient who verbalizes understanding and willingness to comply.

Prescription(s) written for: Prednisone 20 mg; Take 3 pills daily for 2 days then 2 pills daily for 2 days

then 1 pill daily for 2 days then 1/2 pi; Quantity: 15 (fifteen); Refills: 0 (zero) || Darvocet N 100: 1

(one) by mouth every 4 (four) hours as needed for pain; Quantity: 20 (twenty); Refills: 0 (zero). Patient has received printed discharge instructions.

Patient agrees to follow up with BRADLEY, ROBERT L. Instructed to obtain follow up care in two days.

Patient agrees to return to Emergency Department immediately if symptoms worsen or fail to improve.

Take pain medicine and prednisone as directed. Use AFRIN NASAL SPRAY twice daily for 3-7 days only. Continue Avalex.

PHYSICIAN ORDERS

(1) PO Darvocet N-100 give 2 [RB6] ordered at 7/5/2010 13:07

(1) PO Prednisone 60 mg [RB6] ordered at 7/5/2010 13:11

Chester Regional Medical Center
One Medical Park Drive, Chester, SC, 29706
803-581-3151

Patient: SPENCER, LETTIE DOB: 11/28/1947 Patient #: 1094019 MRN: 0000107577 Date In: 7/6/2010

ROBERT B BORUCKI MD All text in this document clearly marked by RB6 has been authored and
legally signed by use of electronic device. 07/05/2010 13:12

Requester: WEBUSER
Requested By: WEBUSER

Radiology Results
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

DATE: 01/07/2013
Page: 13

RADIOLOGY TEST INFORMATION

Type/source: RAD MRI L-SPINE WO CONT Order #: 813117489861 Account: 3102226
Medical Record Number: 0000107577 DOB: Gender: FEMALE
Status: F 15:34 Order Date: 07/22/2011 Patient Name: SPENCER, LETTIE
Result Date/Time: 07/25/2011 Order Time: 10:20 Admit Date: 07/22/2011

PHYSICIANS Dictating: REUTER, ROBERT

Signature: REUTER, ROBERT

RESULT TEXT

MRI

LOW BACK PAIN

Procedure Acknowledge Date: 07/22/2011 11:30:00

MRI OF THE LUMBAR SPINE, 07/22/11:

HISTORY: I with history of lower back pain.

TECHNIQUE: Sagittal and axial T1 and T2 and sagittal STIR weighted MR images of the lumbar spine were performed without the use of radiologic contrast material.

FINDINGS: The vertebral body heights of the lumbar spine are preserved and anatomic alignment maintained. No abnormal marrow signal is identified. The spinal cord conus ends appropriately at T12-L1 disc space level with no evidence of intrathecal mass. Visualized portions of the retroperitoneum are unremarkable.

At the T11-L2, T12-L1 and L1-2 levels no disc herniation or significant neural foraminal narrowing is identified.

At the L2-3 level, no disc herniation or neural foraminal narrowing is identified.

At the L3-4 level, hypertrophic facet changes are identified, however, disc herniation or neural foraminal narrowing is identified.

At the L4-5 level, hypertrophic facet changes and ligamentum flavum thickening are identified and combined with a broad based disc bulge to cause a component of inferior neural foraminal narrowing bilaterally as well as a component of lateral recess narrowing, left greater than right. No central canal stenosis is identified.

At the L5-S1 level, no disc herniation or neural foraminal narrowing is identified.

175

PRINTED BY
07/25/2011 10:05:10
Requested By: WEBUSER

Radiology Results
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

DATE: 8/13
01/02/2013
Page: 2

RADIOLOGY TEST INFORMATION

Type/Source: RAD MRI L-SPINE WO CONT Order #: 813117489881 Account: 3102226
Medical Record Number: 0000107577 DOB: Gender: FEMALE
Status: F 15:34 Order Date: 07/22/2011 Patient Name: SPENCER, LET
Result Date/Time: 07/25/2011 Order Time: 10:20 Admit Date: 07/22/2011

PHYSICIANS Dictating: REUTER, ROBERT Signature: REUTER, ROBERT

RESULT TEXT

IMPRESSION: MILD DEGENERATIVE DISC DISEASE OF THE LUMBAR SPINE...
MOST PROMINENT AT L4-S AS DESCRIBED ABOVE.

DD: 07/22/2011 00:00 Dictated By: REUTER, MD, ROBERT
DT: 07/22/2011 19:07 MPS Signed By: REUTER, MD, ROBERT

REUTER, MD ROBERT
Dictated By
REUTER, MD ROBERT
Reviewed & Signed

Lettie Spencer

告知

6-15-13

ABDOMEN: obese scaphoid flat
benign tender (n - red - sv) diffuse epigastric
suprapubic periumbilical (ankle) A L
soft, NT RUQ RLQ LUQ LLQ
rebound RUQ RLQ LUQ LLQ
guarding voluntary involuntary
HES R/Ss increased decreased absent
HSM liver "tender" palpable
mass RUQs

GENITALIA: detained
 FEMALE vulva atrophied lesion
external WNL fast excoriation hyperemia atrophy
vagina WNL discharge white green (n - mod - g)
atrophied (n - mod - sv)
Cx WNL concurrent (n - mod - sv)
perineal atrophied
perineal lesion (absent)
urethra enlarged tender maloriented
unable to adequately palpate; urethra indurated
R: obesity pale coarctation
atrophied Tx indurated tender R L (n - mod - sv)
atrophied mass atrophied mass R L

HEENT	Tired R L (in - mod - sv)
Throat clear	Throat clear R L
	Throat clear and swollen R L
Pharynx Whit	Pharynx whitish (in - mod - sv)
	Swallowing R L (in - mod - sv)
Nose Whit	Nose: clear, moist, bloody
	Mucous: pale, boggy, hyperemic
	Turbinate: enlarged, congested
Sinus pain	Tender over sinuses (in - mod - sv)
	R L, maxillary frontal
Find benign	nasopharynx, uvula, uvula
	Hemorrhage, epistaxis, R L
	epistaxis, R L
Neck SWN	cardiac enlargement, R L, tender
	anterior chest, posterior
Neck PAIN	from R L: muscle, neck, chest
Throat	enlarged, throat, nodules
Swallow	swallow, R L

QUEST: _____ What was it L (in mod - sig)
 How big? _____ miles H L
 How far? _____ months H L

PROTAL	tolerant
✓ rash	excoriation infection rash
✓ hemorrhoids	nodular hemangiomas
	internal hemorrhoids
✓ hemorrhagic WNL	epithelial tissue right testis
OB (+)	OB (+) gross blood positive

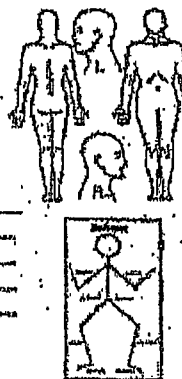
HEART: Ischyrtancho BPM neg frag
Brachyrtancho BPM neg frag
 10.14.15 sinuiter M holostole distole
 one LLSB LLSB AUSB ALSB

EXTENTS: adams peak to 2nd D+ N L
0 O.C.E
joint NT
epinal NT
epinal/parspinal tendons

BREASTS: detached Size: min med lg pend
areolar mass cm H L at color
tender non-tender firm soft fixed mobile
discharge N L bloody
nipples WNL ipple hyper retro N L
axilla symph nodes cm N L axilla supra ax
fixed mobile tender non-tender hard soft

SKIN: (mark on diagram)
 2 teeth

NEURO/ normal gait normal height
 CNR-18 WNL
 Motor WNL
 Sensory WNL
 Reflexes WNL
 Cerebellar WNL



SPENCER, LETTIE F (id #80469, dob:

Encounter Summary

Patient

Name	SPENCER, LETTIE (65, F) ID# 80469	Appt. Date/Time	07/17/2013 09:30AM
DOB	11/28/1947	Service Dept.	CHE_Chester Internal Medicine and Surgical Associa

Provider

ROBERT BRADLEY MD

Insurance

Med Primary: MEDICARE B-SC: PALMETTO GBA
 Insurance #: 259746627T
 PCP: BRADLEY, ROBERT LEE
 Referring Provider Name: BRADLEY, ROBERT LEE
 Med Secondary: AARP HEALTHCARE OPTIONS (MEDICARE SUPPLEMENT)
 Insurance #: 32098925111
 PCP: BRADLEY, ROBERT LEE
 Referring Provider Name: BRADLEY, ROBERT LEE
 Prescription: CMX - Member is ineligible. Patient found on payor's files, but not covered on date of inquiry.
 Prescription: ORX - Member is eligible.

Chief Complaint

low back pain

FOLLOWUP VISIT - VIIBRYD IS HELPING WITH DEPRESSION, DR.DELPHIA /DR. ADLAKHA

Problems

Reviewed Problems

- Unspecified hypothyroidism (244.9)
- Mixed hyperlipidemia (272.2)
- Depressive disorder, not elsewhere classified (311)
- Essential hypertension; benign (401.1)
- Lumbago (724.2)
- Adult failure to thrive (783.7)

Allergies

Reviewed Allergies

CELONTIN
 CODEINE
 DEMEROL
 PENICILLINS

Medications

Reviewed Medications

Name	Date
AMLODIPINE 5 MG TABLET	08/20/13 filled
CLONAZEPAM 1 MG TABLET	07/15/13 filled
KLOR-CON M20 MEQ TABLET, EXTENDED RELEASE	06/19/13 filled
METHIMAZOLE 10 MG TABLET	05/05/13 filled
NUCYNTA 75 MG TABLET	07/17/13 entered
Take 1 tablet(s) every 4 hours by oral route.	
SPIRONOLACTONE 25 MG TABLET	05/17/13 filled
TRAZODONE 60 MG TABLET	07/15/13 filled
VIIBRYD 40 MG TABLET	07/17/13 entered
Take 1 tablet(s) every day by oral route.	

Social History

Reviewed Social History

General IM
 Smoking Status: Current every day smoker.
 Smoker (1/2 PPD).
 Alcohol Intake: None.

Past Medical History

Reviewed Past Medical History
 Hyperlipidemia: Y

SPENCER, LETTIE F (Id #80469, dob:

Hypertension: Y
Hypothyroidism: Y

Vitals

Ht: 5 ft 2 in Wt: 94 lbs BMI: 17.2
BP: 121/64 sitting L arm Pulse: 78 bpm regular O2Sat: 94% Room Air
T: 96.7 F° ear

ROS

Constitutional: Constitutional: no significant weight gain or loss and no fever, fatigue, pallor, night sweats, exercise intolerance, or generalized weakness.

Eyes: Eyes: no scotoma, photophobia, redness, discharge, itching, floaters, dry eyes, vision change, blurred vision, double vision, visual loss, or foreign body sensation.

ENMT: Ears: no tinnitus, fullness, difficulty hearing, or ear pain. Nose: no drainage, congestion, obstruction, sneezing, frequent nosebleeds, or olfactory disturbance. Mouth/Throat: no mouth ulcers or breathing and no snoring, hoarseness, sore throat, bleeding gums, dry mouth, oral abnormalities, teeth abnormalities, change in taste, voice change, or post-nasal drainage.

Cardiovascular: Cardiovascular: no chest pain/discomfort or pain on exertion; no shortness of breath when walking or breath when lying down; and no palpitations, lightheadedness, edema, cyanosis, arrhythmia, arm pain on exertion, known heart murmur, or paroxysmal nocturnal dyspnea.

Respiratory: Respiratory: no cough, wheezing, stridor, snoring, shortness of breath, coughing up blood, sputum production, painful respiration, known TB exposure, chest tightness, or sleep apnea.

Gastrointestinal: Gastrointestinal: no nausea, vomiting, diarrhea, heartburn, dysphagia, constipation, bloating, odynophagia, hemorrhoids, jaundice, abdominal pain, bloody stool, black or tarry stools, rectal bleed, recent change in bowel habits, painful defecation, fecal incontinence, or weight loss and not vomiting blood and normal appetite.

Genitourinary: Genitourinary: no abnormal bleeding or urethral discharge; no incontinence, hematuria, impotence, nocturia, dysuria, difficulty urinating, increased frequency, feelings of urgency, foul urine odor, flank pain, passage of stone/gravel, or suprapubic pain; normal lubrication of vaginal mucosa and urinary output; and complete emptying of bladder.

Musculoskeletal: Musculoskeletal: no muscle aches or weakness; no joint contractures, swelling, or warmth; and no arthralgias/joint pain, back pain, or swelling in the extremities.

Neurologic: Neurologic: no weakness, numbness, tingling, seizures, dizziness, headaches, loss of consciousness, or nocturnal leg discomfort.

Endocrine: Endocrine: no fatigue, polyphagia, polyuria, gynecomastia, hyperpigmentation, increased thirst, hair loss, cold intolerance, heat intolerance, or weight change and normal hair growth.

Hematologic/Lymphatic: Hematologic/Lymphatic no petechiae, swollen glands, easy bruising, or excessive bleeding.

Physical Exam

Patient is a

Constitutional: General Appearance: healthy-appearing, well-nourished, well-developed, and appears younger than stated age. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood, affect, and attentiveness and active and alert. Thought Process: ordered. Orientation: to time, place, and person. Memory: no personality changes or problems reported driving and recent memory normal and remote memory normal. Speech normal speech and comprehension.

Head: Head: normocephalic and atraumatic.

Eyes: Pupils: PERRLA. EOM: EOMI. Sclerae: non-icteric.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no sinus tenderness or nasal discharge and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal and good air movement.

Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR.

180

SPENCER, LETTIE F (Id #80469, dob:

Neck vessels: no carotid bruits.

Abdomen: Inspection and Palpation: no scars, tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Bruits: no bruit. Bowel Sounds: normal. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal, normal tone, and no signs of parkinsonism. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

Neurologic: Gait and Station: normal gait, station, pivot, base, arm swing; get up and go test, and functional reach test. Reflexes: DTRs 2+ bilaterally throughout.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, or jaundice.

Assessment / Plan

Hypertension is stable, continue current therapy. dyslipidemia-continue current tx

1. UNSPECIFIED HYPOTHYROIDISM (244.9)
 - HYPOTHYROIDISM: AFTER YOUR VISIT

2. MIXED HYPERLIPIDEMIA (272.2)
 - HYPERLIPIDEMIA: AFTER YOUR VISIT

3. DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED (311)
 - LEARNING ABOUT MOOD DISORDERS
 - VIIBRYD 40 MG TABLET - Take 1 tablet(s) every day by oral route. Qty: 30 tablet(s) Refills: 2 Pharmacy: BJ-LO PHARMACY #268

4. ESSENTIAL HYPERTENSION; BENIGN (401.1) - con
 - HIGH BLOOD PRESSURE: AFTER YOUR VISIT

5. LUMBAGO (724.2) - chronic, followed via workmen comp
 - BACK PAIN: AFTER YOUR VISIT

6. ADULT FAILURE TO THRIVE (783.7)

Return to Office
None recorded.

Encounter Sign-Off

Encounter signed-off by Robert Bradley, MD, 07/17/2013.

Encounter performed and documented by Robert Bradley, MD

Encounter reviewed & signed by Robert Bradley, MD on 07/17/2013 at 1:11pm

SPENCER, LETTIE F (Id #80469, dob:

Encounter Summary

Last amended by Robert Bradley, MD on 09/19/2013 at 6:08pm

Patient

Name	SPENCER, LETTIE (	Appt. Date/Time	09/19/2013 02:30PM
DOB	11/28/1947	Service Dept.	CHE_Chester Internal Medicine and Surgical Associa
Provider	ROBERT BRADLEY MD		
Insurance	Med Primary: MEDICARE-B-SC: PALMETTO GBA Insurance #: 259748827T PCP: BRADLEY, ROBERT LEE Referring Provider Name: BRADLEY, ROBERT LEE Med Secondary: AARP HEALTHCARE OPTIONS (MEDICARE SUPPLEMENT) Insurance #: 32098925111 PCP: BRADLEY, ROBERT LEE Referring Provider Name: BRADLEY, ROBERT LEE Prescription: ORX - Member is eligible.		

Chief Complaint

APPOINT. WITH CAROLINA PULMONARY/ DISCUSS THYROID SCAN / WORKSMAN COMP. -PHYSICALTHERAPY X5DAY S WKLY. HANDI-CAP STICKER.

Problems

- Reviewed Problems
- Unspecified acquired hypothyroidism (244.9)
 - Mixed hyperlipidemia (272.2)
 - Depressive disorder, not elsewhere classified (311)
 - Restless legs syndrome (rls) (333.94)
 - Benign essential hypertension (401.1)
 - Lumbago (724.2)
 - Insomnia, unspecified (780.62)
 - Adult failure to thrive (783.7)

Allergies

Reviewed Allergies
 CELONTIN
 CODEINE
 DEMEROL
 PENICILLINS

Medications

Reviewed Medications	
Name	Date
AMLODIPINE 5 MG TABLET Take 1 tablet(s) every day by oral route for 30 days.	09/19/13 prescribed
CLONAZEPAM 1 MG TABLET Take 1 tablet(s) every day by oral route for 30 days.	09/19/13 prescribed
KLOR-CON M20 MEQ TABLET, EXTENDED RELEASE Take 2 tablet(s) every day by oral route for 90 days.	09/19/13 prescribed
METHIMAZOLE 10 MG TABLET Take 1 tablet(s) every day by oral route for 90 days.	09/19/13 prescribed
NUCYNTA-75 MG TABLET Take 1 tablet(s) every 4 hours by oral route.	07/17/13 entered
SPIRONOLACTONE 25 MG TABLET Take 1 tablet(s) every day by oral route as directed for 90 days.	09/19/13 prescribed
TRAZODONE 60 MG TABLET Take 2 tablet(s) every day by oral route for 30 days.	09/19/13 prescribed

Social History

Reviewed Social History
 General IM
 Smoking Status: Current every day smoker.
 Smoker (1/2 PPD).
 Alcohol Intake: None.

SPENCER, LETTIE F (Id #80469, dob:

Past Medical History

Reviewed Past Medical History
Hyperlipidemia: Y
Hypertension: Y
Hypothyroidism: Y

Document Review

Discussed the following orders:
• TRAZODONE 50 MG TABLET - 09/19/13
• SPIRONOLACTONE 25 MG TABLET - 09/19/13
• METHIMAZOLE 10 MG TABLET - 09/19/13

Vitals

Wt: 108 lbs 09/19/2013 02:49 pm	BP: 125/95 sitting L arm 09/19/2013 02:49 pm 140/74 sitting L arm 09/19/2013 03:24 pm	BP Cuff Size: small adult 09/19/2013 02:49 pm
Pulse: 89 bpm regular 09/19/2013 02:49 pm	RR: 18 09/19/2013 02:49 pm	O2Sat: 94% Room Air 09/19/2013 02:49 pm
T: 95.2 F° ear 09/19/2013 02:49 pm	Ht: 5 ft 2 in 09/19/2013 02:49 pm	BMI: 19.4 09/19/2013 02:49 pm

ROS

Constitutional: Constitutional: no significant weight gain or loss and no fever, fatigue, pallor, night sweats, exercise intolerance, or generalized weakness.

Eyes: Eyes: no scotoma, photophobia, redness, discharge, itching, floaters, dry eyes, vision change, blurred vision, double vision, visual loss, or foreign body sensation.

ENMT: Ears: no tinnitus, fullness, difficulty hearing, or ear pain. Nose: no drainage, congestion, obstruction, sneezing, frequent nosebleeds, or olfactory disturbance. Mouth/Throat: no mouth ulcers or breathing and no snoring, hoarseness, sore throat, bleeding gums, dry mouth, oral abnormalities, teeth abnormalities, change in taste, voice change, or post-nasal drainage.

Cardiovascular: Cardiovascular: no chest pain/discomfort or pain on exertion; no shortness of breath when walking or breath when lying down; and no palpitations, lightheadedness, edema, cyanosis, arrhythmia, arm pain on exertion, known heart murmur, or paroxysmal nocturnal dyspnea.

Respiratory: Respiratory: no cough, wheezing, stridor, snoring, shortness of breath, coughing up blood, sputum production, painful respiration, known TB exposure, chest tightness, or sleep apnea.

Gastrointestinal: Gastrointestinal: no nausea, vomiting, diarrhea, heartburn, dysphagia, constipation, bloating, odynophagia, hemorrhoids, jaundice, abdominal pain, bloody stool, black or tarry stools, rectal bleed, recent change in bowel habits, painful defecation, fecal incontinence, or weight loss and not vomiting blood and normal appetite.

Genitourinary: Genitourinary: no abnormal bleeding or urethral discharge; no incontinence, hematuria, impotence, nocturia, dysuria, difficulty urinating, increased frequency, feelings of urgency, foul urine odor, flank pain, passage of stone/gravel, or suprapubic pain; and complete emptying of bladder and normal urinary output.

Musculoskeletal: Musculoskeletal: no muscle aches or weakness; no joint contractures, swelling, or warmth; and no arthralgias/joint pain, back pain, or swelling in the extremities.

Neurologic: Neurologic: no weakness, numbness, tingling, seizures, dizziness, headaches, loss of consciousness, or nocturnal leg discomfort.

Endocrine: Endocrine: no fatigue, polyphagia, polyuria, gynecomastia, hyperpigmentation, increased thirst, hair loss, cold intolerance, heat intolerance, or weight change and normal hair growth.

Hematologic/Lymphatic: Hematologic/Lymphatic no petechiae, swollen glands, easy bruising, or excessive bleeding.

Physical Exam

Patient is a 65-year-old female.

Constitutional: General Appearance: healthy-appearing, well-developed, appears younger than stated age, and too thin. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood, affect, and attentiveness and active and alert. Thought

SPENCER, LETTIE F (Id #80469, dob:

Process: ordered. **Orientation:** to time, place, and person. **Memory:** no personality changes or problems reported driving and recent memory normal and remote memory normal. **Speech:** normal speech and comprehension.

Head: Head: normocephalic and atraumatic.

Eyes: Pupils: PERRLA. EOM: EOMI. Sclerae: non-icteric.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no sinus tenderness or nasal discharge and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal and good air movement.

Cardiovascular: Apical impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits.

Abdomen: Inspection and Palpation: no scars, tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Bruits: no bruit. Bowel Sounds: normal. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal, normal tone, and no signs of parkinsonism. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

Neurologic: Gait and Station: normal gait, station, pivot, base, arm swing, get up and go test, and functional reach test. Reflexes: DTRs 2+ bilaterally throughout.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, or jaundice.

Assessment / Plan

1. UNSPECIFIED ACQUIRED HYPOTHYROIDISM (244.9)

- METHIMAZOLE 10 MG TABLET - Take 1 tablet(s) every day by oral route for 90 days. Qty: 90 tablet(s) Refills: 3
Pharmacy: BI-LO PHARMACY #5716
- ENDOCRINOLOGY REFERRAL

2. MIXED HYPERLIPIDEMIA (272.2)

3. DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED (311)

4. BENIGN ESSENTIAL HYPERTENSION (401.1) - con

- KLOCON M20 MEQ TABLET, EXTENDED RELEASE - Take 2 tablet(s) every day by oral route for 90 days. Qty: 180 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716
- SPIRONOLACTONE 25 MG TABLET - Take 1 tablet(s) every day by oral route as directed for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716
- AMLODIPINE 5 MG TABLET - Take 1 tablet(s) every day by oral route for 30 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716

5. LUMBAGO (724.2) - chronic, followed via workmen comp,

PT GOING TO DAILY
DAILY PHYSICAL THERAPY IN CHARLETTE
NUCYNTA 75 MG AS DIRECTED

6. INSOMNIA, UNSPECIFIED (780.52)

- TRAZODONE 60 MG TABLET - Take 2 tablet(s) every day by oral route for 30 days. Qty: 60 tablet(s) Refills: 3
Pharmacy: BI-LO PHARMACY #5716
- INSOMNIA: AFTER YOUR VISIT

7. RESTLESS LEGS SYNDROME (RLS) (333.94)

- CLONAZEPAM 1 MG TABLET - Take 1 tablet(s) every day by oral route for 30 days. Qty: 30 tablet(s) Refills: 3
Pharmacy: BI-LO PHARMACY #5716

Return to Office

- Robert Bradley, MD for Established Patient 15 at CHE_Chester Internal Medicine and Surgical Association 01/09/2014

Amendment Sign-Off

Encounter signed-off by Robert Bradley, MD, 09/18/2013.

CHESTER MEDICAL GROUP LLC • One Medical Park Drive, Chester SC 29706-9701

SPENCER, LETTIE F (Id #80469, dob:)

Encounter performed and documented by Robert Bradley, MD

Encounter reviewed & signed by Robert Bradley, MD on 09/19/2013 at 6:04pm

Amendment closed by Robert Bradley, MD on 09/19/2013 at 6:06pm

SPENCER, LETTIE F (Id #80469, dob
Encounter Summary

Patient

Name	SPENCER, LETTIE (98, F) ID# 80469	Appt. Date/Time	01/09/2014 10:16AM
DOB		Service Dept.	CHE_Chester Internal Medicine and Surgical Associa

Provider ROBERT BRADLEY MD

Insurance Med Primary: MEDICARE B-SC: PALMETTO GBA
 Insurance #: 259746627A
 Policy/Group #: 9321
 PCP: BRADLEY, ROBERT LEE
 Referring Provider Name: BRADLEY, ROBERT LEE
 Med Secondary: AARP HEALTHCARE OPTIONS (MEDICARE SUPPLEMENT)
 Insurance #: 32098925111
 PCP: BRADLEY, ROBERT LEE
 Referring Provider Name: BRADLEY, ROBERT LEE
 Prescription: ORX - Member is eligible.

Chief Complaint

endocrinologist-appoint. in FEB.

ROUTINE CHECKUP / c/o pressure @ bladder area and tenderness @ pelvic site.

Problems

- Reviewed Problems**
- Hyperthyroidism
 - Increased pressure
 - Mixed hyperlipidemia
 - Adult failure to thrive syndrome
 - Benign essential hypertension
 - Low back pain
 - Restless legs
 - Hypothyroidism
 - Insomnia
 - Depressive disorder

Allergies

Reviewed Allergies
 CELONTIN
 CODEINE
 DEMEROL
 PENICILLINS

Medications

Reviewed Medications	
Name	Date
amlodipine 5 mg tablet TAKE ONE TABLET BY MOUTH ONCE DAILY.	01/09/14 prescribed
clonazepam 1 mg tablet Take 1 tablet(s) every day by oral route for 30 days.	01/09/14 prescribed
Klor-Con M20 mEq tablet, extended release Take 1 tablet(s) twice a day by oral route for 90 days.	01/09/14 prescribed
methimazole 10 mg tablet Take 1 tablet(s) every day by oral route for 90 days.	01/09/14 prescribed
Nucynta 75 mg tablet Take 1 tablet(s) every 4 hours by oral route.	07/17/13 entered
spironolactone 25 mg tablet Take 1 tablet(s) every day by oral route as directed for 90 days.	01/09/14 prescribed
trazodone 50 mg tablet Take 2 tablet(s) every day by oral route for 30 days.	12/13/13 filled

Social History

Reviewed Social History
 General IM

SPENCER, LETTIE F (id #80469, dob:

Advance directive: Y.
Smoking Status: Current every day smoker.
Smoker (1/2 PPD).
Alcohol Intake: None.

Past Medical History

Reviewed Past Medical History
Hyperlipidemia: Y
Hypertension: Y
Hypothyroidism: Y

Family History

Reviewed Family History

GYN History

Reviewed GYN History

Vitals

01/09/2014 10:48 am
Wt: 109 lbs BP: 131/68 sitting L arm BP Cuff Size: small adult
Pulse: 56 bpm regular RR: 18 O2Sat: 98% Room Air
T: 96.9 F° ear Ht: 5 ft 2 in BMI: 19.9

ROS

Constitutional: Constitutional: no significant weight gain or loss and no fever, fatigue, pallor, night sweats; exercise intolerance, or generalized weakness.

Eyes: Eyes: no scotoma, photophobia, redness, discharge, itching, floaters, dry eyes, vision change, blurred vision, double vision, visual loss, or foreign body sensation.

ENMT: Ears: no tinnitus, fullness, difficulty hearing, or ear pain. Nose: no drainage, congestion, obstruction, sneezing, frequent nosebleeds, or olfactory disturbance. Mouth/Throat: no mouth ulcers or breathing and no snoring, hoarseness, sore throat, bleeding gums, dry mouth, oral abnormalities, teeth abnormalities, change in taste, voice change, or post-nasal drainage.

Cardiovascular: Cardiovascular: no chest pain/discomfort or pain on exertion; no shortness of breath when walking or breath when lying down; and no palpitations, lightheadedness, edema, cyanosis, arrhythmia, arm pain on exertion, known heart murmur, or paroxysmal nocturnal dyspnea.

Respiratory: Respiratory: no cough, wheezing, stridor, snoring, shortness of breath, coughing up blood, sputum production, painful respiration, known TB exposure, chest tightness, or sleep apnea.

Gastrointestinal: Gastrointestinal: no nausea, vomiting, diarrhea, heartburn, dysphagia, constipation, bloating, odynophagia, hemorrhoids, jaundice, abdominal pain, bloody stool, black or tarry stools, rectal bleed, recent change in bowel habits, painful defecation, fecal incontinence, or weight loss and not vomiting blood and normal appetite.

Genitourinary: Genitourinary: no abnormal bleeding or urethral discharge; no incontinence, hematuria, impotence, nocturia, dysuria, difficulty urinating, increased frequency, feelings of urgency, foul urine odor, flank pain, passage of stone/gravel, or suprapubic pain; and complete emptying of bladder and normal urinary output.

Musculoskeletal: Musculoskeletal: no muscle aches or weakness; no joint contractures, swelling, or warmth; and no arthralgias/joint pain, back pain, or swelling in the extremities.

Neurologic: Neurologic: no weakness, numbness, tingling, seizures, dizziness, headaches, loss of consciousness, or nocturnal leg discomfort.

Endocrine: Endocrine: no fatigue, polyphagia, polyuria, gynecomastia, hyperpigmentation, increased thirst, hair loss, cold intolerance, heat intolerance, or weight change and normal hair growth.

Hematologic/Lymphatic: Hematologic/Lymphatic no petechiae, swollen glands, easy bruising, or excessive bleeding.

Physical Exam

Patient is a

Constitutional: General Appearance: healthy-appearing, well-nourished, well-developed, and appears younger than stated age.
Level of Distress: NAD. Ambulation: ambulating normally.

SPENCER, LETTIE F (Id #80469, dob:

Psychiatric: Insight: good judgement. Mental Status: normal mood, affect, and attentiveness and active and alert. Thought Process: ordered. Orientation: to time, place, and person. Memory: no personality changes or problems reported driving and recent memory normal and remote memory normal. Speech normal speech and comprehension.

Head: Head: normocephalic and atraumatic.

Eyes: Pupils: PERRLA. EOM: EOMI. Sclerae: non-icteric.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no sinus tenderness or nasal discharge and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal and good air movement.

Cardiovascular: Apical impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits.

Abdomen: Inspection and Palpation: no scars, tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Bruits: no bruit. Bowel Sounds: normal. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hemla: none palpable.

Musculoskeletal: Motor Strength and Tone: normal, normal tone, and no signs of parkinsonism. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

Neurologic: Gait and Station: normal gait, station, pivot, base, arm swing, get up and go test, and functional reach test. Reflexes: DTRs 2+ bilaterally throughout.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, or jaundice.

Assessment / Plan:

1. Benign essential hypertension - con

401.1: Essential hypertension; benign essential hypertension

- amlodipine 5 mg tablet - TAKE ONE TABLET BY MOUTH ONCE DAILY. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716
- spironolactone 25 mg tablet - Take 1 tablet(s) every day by oral route as directed for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716
- Klor-Con M20 mEq tablet, extended release - Take 1 tablet(s) twice a day by oral route for 90 days. Qty: 180 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716

2. Restless legs

333.94: Other and unspecified extrapyramidal diseases and abnormal movement disorders; restless legs syndrome (rls)

- clonazepam 1 mg tablet - Take 1 tablet(s) every day by oral route for 30 days. Qty: 30 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716

3. Adult failure to thrive syndrome - encourage better intake, stop smoking

783.7: Symptoms concerning nutrition, metabolism, and development; adult failure to thrive

4. Hyperthyroidism

242.90: Thyrotoxicosis without mention of goiter or other cause; thyrotoxicosis without mention of goiter or other cause, and without mention of thyrotoxic crisis or storm

- methimazole 10 mg tablet - Take 1 tablet(s) every day by oral route for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI-LO PHARMACY #5716
- HYPERTHYROIDISM: AFTER YOUR VISIT

5. Increased pressure - c/o increase urinary pressure for the last 2 month, denied frequency; feels like something in bladder, pt concern about bladder cancer. apparently sister had bladder cancer. will refer pt to urology for evla.

796.4: Other abnormal clinical findings

6. Depressive disorder - vlibyrd worked, but pt could not afford.

will start Cymbalta 30mg one week x 2 weeks then Cymbalta 60mg one daily. pt to call for script.

- 311: Depressive disorder, not elsewhere classified

Return to Office

- Robert Bradley, MD for Established Patient 15 at CHE_Chester Internal Medicine and Surgical Associa on 05/08/2014 at

CHESTER MEDICAL GROUP LLC • One Medical Park Drive, Chester SC 29706-9701

SPENCER, LETTIE F (Id #80469, dob:

09:00 AM

Encounter Sign-Off

Encounter signed-off by Robert Bradley, MD, 01/09/2014.

Encounter performed and documented by Robert Bradley, MD

Encounter reviewed & signed by Robert Bradley, MD on 01/09/2014 at 11:40am

SPENCER, LETTIE F (id #80469, dob:

Encounter Summary

Patient

Name	SPENCER, LETTIE (66, F) ID# 80469	Appt. Date/Time	05/20/2014 02:45PM
DOB		Service Dept.	CHE_Chester Internal Medicine and Surgical Associa
Provider	ROBERT BRADLEY MD		
Insurance	Med Primary: MEDICARE-B-SC: PALMETTO GBA Insurance #: 259746627A Policy/Group #: 9321 PCP: BRADLEY, ROBERT LEE Referring Provider Name: BRADLEY, ROBERT LEE Med Secondary: AARP HEALTHCARE OPTIONS (MEDICARE SUPPLEMENT) Insurance #: 32088925111 PCP: BRADLEY, ROBERT LEE Referring Provider Name: BRADLEY, ROBERT LEE Prescription: ORX - Member is eligible. details		

Chief Complaint

Followup: Mixed hyperlipidemia
 Followup: Benign essential hypertension
 Followup: Chronic interstitial cystitis
 Followup: Hyperthyroidism
 Followup: Hypothyroidism
 Followup: Urethral stenosis
 Followup: Adult failure to thrive syndrome
 Followup: Insomnia
 Followup: Increased pressure
 Followup: Depressive disorder
 Followup: Restless legs
 Followup: Low back pain
 DR. COWAN = CYSTOSCOPY- MARCH 4TH

BACK & BLADDER DISCOMFORT / WILL RESCH. FOR MEDICARE PHYS.

Problems

Reviewed Problems

- Hyperthyroidism
- Hypothyroidism
- Mixed hyperlipidemia
- Depressive disorder
- Restless legs
- Benign essential hypertension
- Chronic interstitial cystitis
- Urethral stenosis
- Low back pain
- Insomnia
- Adult failure to thrive syndrome
- Increased pressure

Allergies

Reviewed Allergies

CELONTIN
 CODEINE
 DEMEROL
 PENICILLINS

Medications

Reviewed Medications

Name	Date
amlodipine 5 mg tablet TAKE ONE TABLET BY MOUTH ONCE DAILY.	05/25/14 prescribed
clonazepam 1 mg tablet Take 1 tablet(s) every day by oral route for 30 days.	05/20/14 prescribed
Elmiron 100 mg capsule	05/06/14 filled

SPENCER, LETTIE F (Id #80469, dob:

Klor-Con M20 mEq tablet, extended release Take 1 tablet(s) twice a day by oral route for 90 days.	05/20/14 prescribed
methimazole 10 mg tablet Take 1 tablet(s) every day by oral route for 90 days.	05/20/14 prescribed
Nucynta 75 mg tablet TAKE 1 TABLET BY MOUTH EVERY 8 HOURS	02/11/14 filled
Pyridium 200 mg tablet Take 1 tablet(s) 3 times a day by oral route.	05/20/14 entered
spironolactone 25 mg tablet Take 1 tablet(s) every day by oral route as directed for 90 days.	05/20/14 prescribed
tamsulosin ER 0.4 mg capsule, extended release 24 hr	05/06/14 filled
trazodone 50 mg tablet Take 2 tablet(s) every day by oral route for 30 days.	05/20/14 prescribed
Vibryd 40 mg tablet Take 1 tablet(s) every day by oral route.	05/26/14 prescribed

Vaccines

Reviewed Vaccines

Vaccine Type	Date	Amt	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Influenza										
Influenza, high dose seasonal	01/09/14	0.5 mL	IM	LA	UH922A sanofi pasteur	06/30/14	01/09/14	01/09/14	NB	

Social History

Reviewed Social History

General IM

Advance directive: Y

Smoking Status: Current every day smoker.

Smoker (1/2 PPD).

Alcohol Intake: None.

Past Medical History

Reviewed Past Medical History

Hyperlipidemia: Y

Hypertension: Y

Hypothyroidism: Y

Family History

Reviewed Family History

GYN History

Reviewed GYN History

Document Review

Discussed the following orders:

- methimazole 10 mg tablet - 05/20/14
- clonazepam 1 mg tablet - 05/20/14
- trazodone 50 mg tablet - 05/20/14
- spironolactone 25 mg tablet - 05/20/14
- Klor-Con M20 mEq tablet, extended release - 05/20/14
- amlodipine 5 mg tablet - 05/20/14
- Vibryd 40 mg tablet - 05/20/14

Vitals

05/20/2014 04:14 pm

Wt: 110 lbs

BP: 144/71 sitting L arm

BP Cuff Size: small adult

Pulse: 67 bpm regular

RR: 18

O2Sat: 96% Room Air at Rest

T: 97.6 F° oral

Ht: 5 ft 2 in

BMI: 20.1

ROS

SPENCER, LETTIE F (Id #80469, dob:

Constitutional: Constitutional: no significant weight gain or loss and no fever, fatigue, pallor, night sweats, exercise intolerance, or generalized weakness.

Eyes: Eyes: no scotoma, photophobia, redness, discharge, itching, floaters, dry eyes, vision change, blurred vision, double vision, visual loss, or foreign body sensation.

ENMT: Ears: no tinnitus, fullness, difficulty hearing, or ear pain. Nose: no drainage, congestion, obstruction, sneezing, frequent nosebleeds, or olfactory disturbances. Mouth/Throat: no mouth ulcers or breathing and no snoring, hoarseness, sore throat, bleeding gums, dry mouth, oral abnormalities, teeth abnormalities, change in taste, voice change, or post-nasal drainage.

Cardiovascular: Cardiovascular: no chest pain/discomfort or pain on exertion; no shortness of breath when walking or breath when lying down; and no palpitations, lightheadedness, edema; cyanosis, arrhythmia, arm pain on exertion, known heart murmur, or paroxysmal nocturnal dyspnea.

Respiratory: Respiratory: no cough, wheezing, stridor, snoring, shortness of breath, coughing up blood, sputum production, painful respiration, known TB exposure, chest tightness, or sleep apnea.

Gastrointestinal: Gastrointestinal: no nausea, vomiting, diarrhea, heartburn, dysphagia, constipation, bloating, odynophagia, hemorrhoids, jaundice, abdominal pain, bloody stool, black or tarry stools, rectal bleed, recent change in bowel habits, painful defecation, fecal incontinence, or weight loss and not vomiting blood and normal appetite.

Genitourinary: Genitourinary: no abnormal bleeding or urethral discharge; no incontinence, hematuria, impotence, nocturia, dysuria, difficulty urinating, increased frequency, feelings of urgency, foul urine odor, flank pain, passage of stone/gravel, or suprapubic pain; and complete emptying of bladder and normal urinary output.

Musculoskeletal: Musculoskeletal: no muscle aches or weakness; no joint contractures, swelling, or warmth; and no arthralgias/joint pain, back pain, or swelling in the extremities.

Neurologic: Neurologic: no weakness, numbness, tingling, seizures, dizziness, headaches, loss of consciousness, or nocturnal leg discomfort.

Endocrine: Endocrine: no fatigue, polyphagia, polyuria, gynecomastia, hyperpigmentation, increased thirst, hair loss, cold intolerance, heat intolerance, or weight change and normal hair growth.

Hematologic/Lymphatic: Hematologic/Lymphatic: no petechiae, swollen glands, easy bruising, or excessive bleeding.

Physical Exam

Patient is a

Constitutional: General Appearance: healthy-appearing, well-nourished, well-developed, and appears younger than stated age. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood, affect, and attentiveness and active and alert. Thought Process: ordered. Orientation: to time, place, and person. Memory: no personality changes or problems reported driving and recent memory normal and remote memory normal. Speech normal speech and comprehension.

Head: Head: normocephalic and atraumatic.

Eyes: Pupils: PERRLA. EOM: EOML. Sclerae: non-icteric.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no sinus tenderness or nasal discharge and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal and good air movement.

Cardiovascular: Apical impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits.

Abdomen: Inspection and Palpation: no scars, tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Bruits: no bruit. Bowel Sounds: normal. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal, normal tone, and no signs of parkinsonism. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis, edema, varicosities, or palpable cord.

SPENCER, LETTIE F (Id #80469, dob:

Neurologic: Gait and Station: normal gait, station, pivot, base, arm swing, get up and go test, and functional reach test. Reflexes: DTRs 2+ bilaterally throughout.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, or jaundice.

Assessment / Plan

1. Benign essential hypertension - con
401.1: Benign essential hypertension.
 - amlodipine 5 mg tablet - TAKE ONE TABLET BY MOUTH ONCE DAILY. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
 - Klor-Con M20 mEq tablet, extended release - Take 1 tablet(s) twice a day by oral route for 90 days. Qty: 180 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
 - spironolactone 25 mg tablet - Take 1 tablet(s) every day by oral route as directed for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
2. Insomnia
780.52: Insomnia, unspecified
 - trazodone 50 mg tablet - Take 2 tablet(s) every day by oral route for 30 days. Qty: 60 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
3. Restless legs
333.94: Restless legs syndrome (rls)
 - clonazepam 1 mg tablet - Take 1 tablet(s) every day by oral route for 30 days. Qty: 30 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
4. Hyperthyroidism
242.90: Thyrotoxicosis without mention of goiter or other cause, and without mention of thyrotoxic crisis or storm
 - methimazole 10 mg tablet - Take 1 tablet(s) every day by oral route for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
5. Mixed hyperlipidemia
272.2: Mixed hyperlipidemia
6. Chronic interstitial cystitis - referral to urology
595.1: Chronic interstitial cystitis
7. Urethral stenosis - REFERRAL TO UROLOGY
598.9: Urethral stricture, unspecified
8. Low back pain - PAIN MANAGEMENT
724.2: Lumbago
9. Depressive disorder
311: Depressive disorder, not elsewhere classified
 - Vilbryd 40 mg tablet - Take 1 tablet(s) every day by oral route. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Robert Bradley, MD, 05/25/2014.

Encounter performed and documented by Robert Bradley, MD

Encounter reviewed & signed by Robert Bradley, MD on 06/26/2014 at 1:59pm.

SPENCER, LETTIE F (Id #80469, dob:
Encounter Summary

Patient

Name	SPENCER, LETTIE (86, F) ID# 80469	Appt. Date/Time	05/20/2014 02:45PM
DOB		Service Dept.	CHE_Chester Internal Medicine and Surgical Associa

Provider

ROBERT BRADLEY MD

Insurance

Med Primary: MEDICARE-B-SC: PALMETTO GBA
Insurance #: 259746827A
Policy/Group #: 9321
PCP: BRADLEY, ROBERT LEE
Referring Provider Name: BRADLEY, ROBERT LEE
Med Secondary: AARP HEALTHCARE OPTIONS (MEDICARE SUPPLEMENT)
Insurance #: 32098925111
PCP: BRADLEY, ROBERT LEE
Referring Provider Name: BRADLEY, ROBERT LEE
Prescription: ORX - Member is eligible. details

Chief Complaint

Followup: Mixed hyperlipidemia
Followup: Benign essential hypertension
Followup: Chronic interstitial cystitis
Followup: Hyperthyroidism
Followup: Hypothyroidism
Followup: Urethral stenosis
Followup: Adult failure to thrive syndrome
Followup: Insomnia
Followup: Increased pressure
Followup: Depressive disorder
Followup: Restless legs
Followup: Low back pain
DR. COWAN = CYSTOSCOPY- MARCH 4TH

BACK & BLADDER DISCOMFORT / WILL RESCH. FOR MEDICARE PHYS.

Problems

Reviewed Problems

- Hyperthyroidism
- Hypothyroidism
- Mixed hyperlipidemia
- Depressive disorder
- Restless legs
- Benign essential hypertension
- Chronic interstitial cystitis
- Urethral stenosis
- Low back pain
- Insomnia
- Adult failure to thrive syndrome
- Increased pressure

Allergies

Reviewed Allergies

CELONTIN
CODEINE
DEMEROL
PENICILLINS

Medications

Reviewed Medications

Name	Date
amlodipine 5 mg tablet TAKE ONE TABLET BY MOUTH ONCE DAILY.	06/25/14 prescribed
clonazepam 1 mg tablet Take 1 tablet(s) every day by oral route for 30 days.	06/20/14 prescribed
Elmiron 100 mg capsule	05/06/14 filled

SPENCER, LETTIE F (Id #80469, dob:

Klor-Con M20 mEq tablet, extended release Take 1 tablet(s) twice a day by oral route for 90 days.	05/20/14 prescribed
methimazole 10 mg tablet Take 1 tablet(s) every day by oral route for 90 days.	05/20/14 prescribed
Nuoynta 75 mg tablet TAKE 1 TABLET BY MOUTH EVERY 8 HOURS	02/11/14 filled
Pyridium 200 mg tablet Take 1 tablet(s) 3 times a day by oral route.	05/20/14 entered
spironolactone 25 mg tablet Take 1 tablet(s) every day by oral route as directed for 90 days.	05/20/14 prescribed
tamsulosin ER 0.4 mg capsule, extended release 24 hr	05/08/14 filled
trazodone 50 mg tablet Take 2 tablet(s) every day by oral route for 30 days.	05/20/14 prescribed
Vilbryd 40 mg tablet Take 1 tablet(s) every day by oral route.	05/26/14 prescribed

Vaccines

Reviewed Vaccines

Vaccine Type	Date	Amt.	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Influenza										
Influenza, high dose seasonal	01/09/14	0.5 mL	IM	LA	UH922A	sanofi pasteur	08/30/14	01/09/14	01/09/14	NB

Social History

Reviewed Social History

General IM

Advance directive: Y.

Smoking Status: Current every day smoker.

Smoker (1/2 PPD).

Alcohol intake: None.

Past Medical History

Reviewed Past Medical History

Hyperlipidemia: Y

Hypertension: Y

Hypothyroidism: Y

Family History

Reviewed Family History

GYN History

Reviewed GYN History

Document Review

Discussed the following orders:

- methimazole 10 mg tablet - 05/20/14
- clonazepam 1 mg tablet - 05/20/14
- trazodone 50 mg tablet - 05/20/14
- spironolactone 25 mg tablet - 05/20/14
- Klor-Con M20 mEq tablet, extended release - 05/20/14
- amlodipine 5 mg tablet - 05/20/14
- Vilbryd 40 mg tablet - 05/20/14

Vitals

05/20/2014 04:14 pm

Wt: 110 lbs

BP: 144/71 sitting L arm

BP Cuff Size: small adult

Pulse: 67 bpm regular

RR: 18

O2Sat: 96% Room Air at Rest

T: 97.6 F° oral

Ht: 5 ft 2 in

BMI: 20.1

RQS

SPENCER, LETTIE F (id #80469, dob:

Constitutional: Constitutional: no significant weight gain or loss and no fever, fatigue, pallor, night sweats, exercise intolerance, or generalized weakness.

Eyes: Eyes: no scotoma, photophobia, redness, discharge, itching, floaters, dry eyes, vision change, blurred vision, double vision, visual loss, or foreign body sensation.

ENMT: Ears: no tinnitus, fullness, difficulty hearing, or ear pain. Nose: no drainage, congestion, obstruction, sneezing, frequent nosebleeds, or olfactory disturbances. Mouth/Throat: no mouth ulcers or breathing and no snoring, hoarseness, sore throat, bleeding gums, dry mouth, oral abnormalities, teeth abnormalities, change in taste, voice change, or post-nasal drainage.

Cardiovascular: Cardiovascular: no chest pain/discomfort or pain on exertion; no shortness of breath when walking or breath when lying down; and no palpitations, lightheadedness, edema, cyanosis, arrhythmia, arm pain on exertion, known heart murmur, or paroxysmal nocturnal dyspnea.

Respiratory: Respiratory: no cough, wheezing, stridor, snoring, shortness of breath, coughing up blood, sputum production, painful respiration, known TB exposure, chest tightness, or sleep apnea.

Gastrointestinal: Gastrointestinal: no nausea, vomiting, diarrhea, heartburn, dysphagia, constipation, bloating, odynophagia, hemorrhoids, jaundice, abdominal pain, bloody stool, black or tarry stools, rectal bleed, recent change in bowel habits, painful defecation, fecal incontinence, or weight loss and not vomiting blood and normal appetite.

Genitourinary: Genitourinary: no abnormal bleeding or urethral discharge; no incontinence, hematuria, impotence, nocturia, dysuria, difficulty urinating, increased frequency, feelings of urgency, foul urine odor, flank pain, passage of stone/gravel, or suprapubic pain; and complete emptying of bladder and normal urinary output.

Musculoskeletal: Musculoskeletal: no muscle aches or weakness; no joint contractures, swelling, or warmth; and no arthralgias/joint pain, back pain, or swelling in the extremities.

Neurologic: Neurologic: no weakness, numbness, tingling, seizures, dizziness, headaches, loss of consciousness, or nocturnal leg discomfort.

Endocrine: Endocrine: no fatigue, polyphagia, polyuria, gynecomastia, hyperpigmentation, increased thirst, hair loss, cold intolerance, heat intolerance, or weight change and normal hair growth.

Hematologic/Lymphatic: Hematologic/Lymphatic no petechiae, swollen glands, easy bruising, or excessive bleeding.

Physical Exam

Patient is a

Constitutional: General Appearance: healthy-appearing, well-nourished, well-developed, and appears younger than stated age. Level of Distress: NAD. Ambulation: ambulating normally.

Psychiatric: Insight: good judgement. Mental Status: normal mood, affect, and attentiveness and active and alert. Thought Process: ordered. Orientation: to time, place, and person. Memory: no personality changes or problems reported driving and recent memory normal and remote memory normal. Speech normal speech and comprehension.

Head: Head: normocephalic and atraumatic.

Eyes: Pupils: PERRLA. EOM: EOMI. Sclerae: non-icteric.

ENMT: Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no sinus tenderness or nasal discharge and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

Neck: Neck: supple, FROM, trachea midline, and no masses. Thyroid: no enlargement or nodules and non-tender.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal and good air movement.

Cardiovascular: Apical impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits.

Abdomen: Inspection and Palpation: no scars, tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Bruits: no bruit. Bowel Sounds: normal. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable.

Musculoskeletal: Motor Strength and Tone: normal, normal tone, and no signs of parkinsonism. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis; edema, varicosities, or palpable cord.

SPENCER, LETTIE F (id #80469, dob:

Neurologic: Gait and Station: normal gait, station, pivot, base, arm swing, get up and go test, and functional reach test. Reflexes: DTRs 2+ bilaterally throughout.

Skin: Inspection and palpation: no rash, lesions, ulcer, induration, nodules, or jaundice.

Assessment / Plan

1. Benign essential hypertension - con
401.1: Benign essential hypertension
• amlodipine 5 mg tablet - TAKE ONE TABLET BY MOUTH ONCE DAILY. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
• Klor-Con M20 mEq tablet, extended release - Take 1 tablet(s) twice a day by oral route for 90 days. Qty: 180 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
• spironolactone 25 mg tablet - Take 1 tablet(s) every day by oral route as directed for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
2. Insomnia
780.52: Insomnia, unspecified
• trazodone 50 mg tablet - Take 2 tablet(s) every day by oral route for 30 days. Qty: 60 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
3. Restless legs
333.94: Restless legs syndrome (rls)
• clonazepam 1 mg tablet - Take 1 tablet(s) every day by oral route for 30 days. Qty: 30 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
4. Hyperthyroidism
242.90: Thyrotoxicosis without mention of goiter or other cause, and without mention of thyrotoxic crisis or storm
• methimazole 10 mg tablet - Take 1 tablet(s) every day by oral route for 90 days. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268
5. Mixed hyperlipidemia
272.2: Mixed hyperlipidemia
6. Chronic interstitial cystitis - referral to urology
595.1: Chronic interstitial cystitis
7. Urethral stenosis - REFERRAL TO UROLOGY
598.9: Urethral stricture, unspecified
8. Low back pain - PAIN MANAGEMENT
724.2: Lumbago
9. Depressive disorder
311: Depressive disorder, not elsewhere classified
• Vilbryd 40 mg tablet - Take 1 tablet(s) every day by oral route. Qty: 90 tablet(s) Refills: 3 Pharmacy: BI LO PHARMACY 5268

Return to Office

None recorded.

Encounter Sign-Off

Encounter signed-off by Robert Bradley, MD, 05/25/2014.

Encounter performed and documented by Robert Bradley, MD

Encounter reviewed & signed by Robert Bradley, MD on 05/25/2014 at 1:59pm

Name: Leticia Spencer

Date: _____

ix HTN, Hypothyroid

A B O

10. Fracture VLP
Thyroxine 100mg QOD - 8 daily VLP
episodic weakness SOB/clammy feeling
No hyper/hypertension chest for chest pain

Other: _____

VISUAL ACUITY RIGHT LEFT BOTH
 (with/without glasses) 20/ 20/ 20/

Smoker: ☒ Yes ☐ No Ex 12 pk 2014 No: ETOH
 Hx: (dates) Pap. _____ Mammogram _____
 BOS _____ Colonoscopy _____

Allergies: PCN, Demoral, Codine, Lethal

PH: ☒ No change ☐ Change Date _____

FH: ☐ No change ☐ Change Date _____

SH: ☒ No change ☐ Change Date _____

Subjective: ROS - Reviewed - see HPI

Const	ENT	Eyes	Hem/Lymp	Resp	CV	GI	Skin	GU	Gyn	MS	Endo	Neuro	Psych
fever	pain	pain	anemia	SOS	chest pain	indigestion	pruritis	dysuria	discharge	stiffness	low BG	HA	depression
chills	congested	red	Bu Infect	whooping	palpitations	reflux	rash	polyuria	itching	warin	low BG	weakness	anxiety
malaise	drainage	discharge	bruising	cough	edema	nausea	ulcers	nocturia	dryness	redness	low thyroid	numbness	stressed
weight loss	hoarse	vision	bleeding	sputum	orthopnea	vomiting	rashes	flank pain	dyspnea	swelling	low thyroid	clonus	suicidal
fatigue	PND	glasses		hemoptysis	HTN	abd pain	wounds/abs		vasomotor	back pain	polyuria	sensory chg	ideas
weak	blurred	contacts		asthma	incor lipids	diarrhea	wound	hematuria	breast pain	neck pain	polydipsia	mem chg	insomnia
anorexia	hearing loss	allergies		no sweat	PND	constipation	hair loss		nipple d/c	leg pain	polyphagia	balance	
	sore throat			chest pain	DOE	blood	dry skin		breast lump	joint pain	wt loss	coordination	
					claudication	inergas							

Other: HT 5'2" WT 105 T 96 P 74 R 18 BP 123/44 CO 94
 Glucose Fasting - NO

Obtained by: _____

Reviewed by: _____

Assessment/Plan:

Meds: Bilo

Other: _____

Adaptation to the
 weight loss
 - repeat lab
 - heart

Same chronic low back pain
 - work on core w/ PT

Depression

- die agitated

HTN

V Nowas 54 7.5 dm

Reviewed Meds/SE ☒
 Cont. Current Meds ☐

See LIST
 REFS 90 day supply

TP
 *Unable to take
 Cymbalta
 Burning sensation

#80

Previous/Recent Labs/Rad Review ☐
 LAB: CBC UA C&S Microalb Protime
 A10 Glucose Lipid ALT KOH

RAD: BOS Mammogram

OTHER: PFT EKG

CONSULTS:

EDUCATION: HTN DM OP SBE
 STE DIET/NUTR LIPIDS

F/U: _____ days 8 wks _____ mths _____ PRN
 _____ OOW _____ OOS _____

COUNSELING: >50% OV _____ (time)
 Level Visit 1 2 3 4
 NP Reviewed/POD with: _____
 Obtain records from: _____

hypothyroid

- on levothyroxine 100 mcg daily

meds

levothyroxine 150 mcg daily

Labs next visit:

Rad next visit:

12/20/13

ASu Lab ↑ wbc

repeat consult, refer - HMO/09

198

Female Visit/Progress Note

Patient Name Leticia Freeman

DOB

Date 1-16-13

C/O: Full

Hx MTN, Hypothyroid

Y: F LA B O

Other:

VISUAL ACUITY RIGHT LEFT BOTH
(with/without glasses) 20/ 20/ 20/

Smoker: Yes No 12 pack/day 70 ETOH
HM: (dates) Pap Mammogram
BDS Colonoscopy

PH: ☒ No change ☐ Change Date

FH: ☒ No change ☐ Change Date

SH: ☒ No change ☐ Change Date

Subjective: ROS Reviewed

Const	ENT	Eyes	HemLymph	Resp	CV	GI	Skin	GU	Gyn	MS	Endo	Neuro	Psych
fever chills malaise weight loss fatigue weak anorexia	pain congested drainage hoarse PND bleeding hearing loss sore throat	pain red discharge vision glasses contacts allergies	anemia Bx infect bruising bleeding	SOB wheezing cough sputum hemoptysis asthma no sweat chest pain	chest pain palpitations edema orthopnea HTN Incr lipids PND DOE claudication	indigestion reflux nausea vomiting abd pain diarrhea constipation blood inc gas	pruritis rash ulcers nails mole/lesion wound hair loss dry skin	dysuria polyuria nocturia flank pain hematuria	discharge itching dyspareunia dyspareunia vasomotor breast pain nipple c/o breast lump	stiffness warm redness swelling back pain neck pain leg pain joint pain	inc BG dec BG inc thyroid dec thyroid polyuria polydipsia polyphagia wt loss	HA weakness numbness dizziness sensory chg men dig balance coordination	depression anxiety stressed suicidal ideas insomnia

Other: HT 5'2 WT 107 T8.3 P.78 R/L BP 124/66 CO 95
Glucose Fasting 10

Obtained by:

Reviewed by:

Assessment/Plan:

Meds: Bik

Other:

Acute Stress Syndrome
- res day

Dyspnea

ginkgo 60 mg

weight loss / Anorexia / Failure to thrive

- enter Megace 400mg po bid

Severe low back pain

- follow Dr. [unclear]

Reviewed Meds/SE ☐
Cont Current Meds ☐

See LIST

Previous/Recent Labs/Rad Review ☐
LAB: CBC UA C&S Microalb Prolime
A10 Glucose Lipid ALT KOH

RAD: BDS Mammogram

OTHER: PFT EKG

CONSULTS:

EDUCATION: HTN DM OP SBE
STE DIET/NUTR LIPIDS

FU: ___ days ___ wks ___ mths ___ PRN

___ OOW: ___ OOS

COUNSELING: >50% OV (time)

Level Visit 1 2 3 4

NP Reviewed PQO with:

Obtain records from:

Signature:

[Signature]

Labs next visit:

Rad next visit:

1/16/17

199

FROM

Patient Name

Little Inman

Date 1/15/13

GENERAL:

☒ Well ☒ ill/dysphagia: ☐ malaise
☒ WOWN ☐ distress ☐ unkempt/discharged
☒ NAD ☐ obese (m - mod - morbid - truncal)

PSYCH:

☒ alert/oriented ☐ depressed ☐ anxious ☐ agitated
☒ memory intact ☐ flat ☐ disoriented (person - place - time)
☐ forgetful ☐ MMSE Score

HEENT:

☒ TM's clear ☐ TM red ☐ A ☐ L (m - mod - sv)
☐ TM scar dull fluid ☐ A ☐ L
☒ pharynx WNL ☐ EAC swollen red cerumen ☐ A ☐ L
☐ pharynx erythematous (m - mod - sv)
☒ nose WNL ☐ tonsils swollen ☐ A ☐ L (m - mod - sv)
☐ rhinorrhea: clear purulent bloody
☐ mucosa: pale boggy hyperemic
☐ turbinates: enlarged congested
☒ sinus pain ☐ tender over sinuses: (m - mod - sv)
☐ A ☐ L maxillary frontal

☒ fundi benign

☐ narrow arteries ☐ AV nicking
☐ hemorrhage exudate ☐ A ☐ L
☒ neck SWN ☐ papilledema ☐ A ☐ L
☐ cervical adenopathy ☐ A ☐ L tender

☒ neck FROM

☐ thyroid ☐ ROM limited 2's muscle vocal rigidity
☒ bruits ☐ enlarged ☐ bruit ☐ nodules
☐ carotid bruit ☐ A ☐ L

CHEST:

☒ clear BS's ☐ wheezes ☐ A ☐ L (m - mod - sv)
☒ R, R, R, W ☐ rales ☐ A ☐ L
☐ rhonchi ☐ A ☐ L

HEART:

☒ SRR ☐ tachycardia @ ☐ BPM reg irreg
☒ M, R, A ☐ bradycardia @ ☐ BPM reg irreg
☐ murmur ☐ MI holosystolic diastolic
apex LLSB LUSB RUSB ALSB

BREASTS:

☐ mass ☐ deferred Size: ☐ sm ☐ med ☐ lg pend
☐ DC ☐ mass: ☐ cm ☐ A ☐ L at ☐ o'clock
☐ nipples WNL ☐ tender non-tender firm soft fixed mobile
☐ LN's ☐ discharge ☐ A ☐ L bloody
☐ nipple inverted retracted ☐ A ☐ L
☐ lymph node: ☐ cm ☐ A ☐ L axilla supraclav
fixed mobile tender non-tender hard soft

ABDOMEN:

☒ benign ☐ obese ☐ scaphoid ☐ flat
☒ soft, NT ☐ tender (m - mod - sv) diffuse epigastric
suprapubic periumbilical flank (OYA) A L
RUQ RLQ LUQ LLO
☐ rebound RUQ RLQ LUQ LLO
☐ guarding voluntary involuntary
☒ BS ☐ BS's increased decreased absent
☒ HSM ☐ liver spleen palpable
☒ mass ☐ mass

GENITALIA:

☐ deferred ☐ vulva atrophic lesion
FEMALE ☐ external WNL ☐ rash excoriation hyperemic aruncle
☐ vagina WNL ☐ discharge white green (m - mod - lg)
☐ Cx WNL ☐ stenotic (m - mod - sv)
☐ cervix tender (m - mod - sv)
☐ parous nulliparous
☐ cervical lesion (shown)
☐ uterus WNL ☐ uterus: enlarged tender retroverted
☐ unable to adequately palpate: uterus adnexa
2: obesity pain cooperation
☐ adnexal Tx ☐ adnexa tender ☐ A ☐ L (m - mod - sv)
☐ adnexal mass ☐ adnexal mass ☐ A ☐ L

RECTAL:

☐ deferred ☐ rash ☐ excoriation irritation rash:
☐ hemorrhoids ☐ external hemorrhoids
☐ internal hemorrhoids
☐ sphincter WNL ☐ sphincter loose tight tender
☐ OB (-) ☐ OB (+) gross blood positive

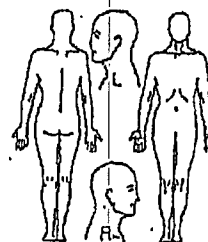
EXTAMS:

☒ C, C, E ☐ edema pedal 1+ 2+ 3+ A L
☐ joint NT ☐ joint tenderness:
☐ spinal NT ☐ spinal/paraspinal tenderness

Pulses	Carotid	Radial	Femoral	DP	PT
R					
L					

SKIN: (mark on diagram)

☒ rash



NEURO:

☒ alert ☐ sedated ☐ lethargic
☒ CN2-12 WNL
☐ Motor WNL
☐ Sensory WNL
☐ Reflexes WNL

Female Visit/Progress Note

Patient Name: Bettie Spencer

Date: 1-22-13

DOB: _____

Hx: HTN, Hypert thyroid

W F LA B O

C/O: aching - cough - clear when blown
nose - fever - had flu shot
flu test - Neg.

Other: _____

VISUAL ACUITY RIGHT LEFT BOTH
 (with/without glasses) 20/ 20/ 20/

Smoker: Yes No Ex 10 PK/day

HM: (date) Pap. _____ Mammogram _____

BOS: _____ Colonoscopy _____ No ETOH

Allergies: Penicillin / Serraval / codeine / cefepim

PH: ☐ No change ☐ Change Date _____

FH: ☐ No change ☐ Change Date _____

SH: ☐ No change ☐ Change Date _____

Subjective: ROS

Const	ENT	Eyes	HemLymph	Resp	CV	GI	Skin	GU	Gyn	MS	Endo	Neuro	Psych
fever	pain	pain	anemia	SOB	chest pain	indigestion	pruritis	dysuria	discharge	stiffness	inc BG	HA	depression
chills	congested	red	bu infect	wheezing	palpitations	reflux	rash	polyuria	itching	warm	dec BG	weakness	anxiety
malaise	drainage	discharge	bruising	cough	edema	nausea	ulcers	nocturia	dryness	redness	inc thyroid	numbness	stressed
weight loss	hoarse	vision	bleeding	sputum	orthopnea	vomiting	nales	flank pain	dyspareunia	swelling	dec thyroid	dizziness	suicidal
fatigue	PND	glasses		hemoptysis	HTN	abd pain	moles/itch		vasomotor	back pain	polyuria	sensory chg	ideas
weak	bleeding	contacts		asthma	incor lipids	diarrhea	wound	hematuria	breast pain	neck pain	polydipsia	men chg	insomnia
anorexia	hearing loss	allergies		noc sweat	PND	constipation	hair loss		nipple d/c	leg pain	polyphagia	balance	
	sore throat			chest pain	DDE	blood	dry skin		breast lump	joint pain	wt loss	coordination	
					claudication	lacryes							

Other: Ht 5'2" Wt 106 T96.5 P 62 R 18 BP 115/40 O2 97

Glucose Fasting

Obtained by: _____

Reviewed by: _____

Assessment/Plan:

Meds:

Other:

Acute
viral syndrome

Acute URI

decadron 8, 1m

Rx Levo 500, 1 day x 7 #7

Rx Phendyl

10cc 5 4-6 mg x 800

Zyrtec 10, 1 day #15

tylenol 650, 1 day #6

Reviewed Meds/SE ☒
 Cont. Current Meds ☐
See LIST

Previous/Recent Labs/Rad Review ☐
 LAB: CBC UA CaS Microalb Protime
 A1C Glucose Lipid ALT KOH

RAD: BDS Mamm

OTHER: PFT EXG

CONSULTS:

EDUCATION: HTN DM OP SBE
 STE DIET/NUTR LIPIDS

F/U: _____ days _____ wks _____ mths _____ PRN
 _____ QOW _____ QOS

COUNSELING: >50% DV _____ (time)
 Level Visit 1 2 3 4
 NP Reviewed POC with: _____
 Obtain records from: _____

Signature: _____

next visit:

Rad next visit:

Bonadur

1/2/13

FROM

Patient Name

Lettie Spencer

Date

3/23/13

GENERAL:

WOWN

NAD

☒ frail ☒ thin/weak/b ☐ malaise
☐ distress ☐ unkempt/dischvepled
☐ obese (m - mod - morbid - truncal)

PSYCH:

alar/oriented

memory intact

☐ depressed ☐ anxious ☐ agitated
☐ flat ☐ disoriented (person - place - time)
☐ forgetful ☐ MMSE Score

HEENT:

TM's clear

pharynx WNL

nose WNL

sinus pain

fund benign

neck SWN

neck FROM

thyroid

bruits

☐ TM red R L (m - mod - sv)
☐ TM scar dull fluid R L
☐ EAC swollen red cerumen R L
☐ pharynx erythematous (m - mod - sv)
☐ tonsils swollen R L (m - mod - sv)
☐ rhinorrhea: clear, purulent, bloody
☐ mucosa: pale boggy hyperemic
☐ turbinates: enlarged congested
☐ tender over sinuses (m - mod - sv)
☐ R. L. maxillary, frontal
☐ narrow arteries ☐ AV nicking
☐ hemorrhage exudate R L
☐ papilledema R L
☐ cervical adenopathy R L tender
☐ anterior, shotty posterior
☐ ROM limited 2+: muscle nuchal rigidity
☐ enlarged ☐ bruit ☐ nodules
☐ carotid bruit R L

CHEST:

clear BS's

R, R, R, W

☐ wheezes R L (m - mod - sv)
☐ rales R L
☐ rhonchi R L

HEART:

BMR

M, R, G

☐ tachycardia @ ☐ BPM reg irreg
☐ bradycardia @ ☐ BPM reg irreg
☐ murmur ☐ M. holosystolic diastolic
☐ apex LLSB LUSB RUSB RLSB

BREASTS:

mass

DC

nipples WNL

LN's

☐ deferred Size: sm med lg pend
☐ mass: ☐ cm R L at ☐ o'clock
☐ tender non-tender firm soft fixed mobile
☐ discharge R L bloody
☐ nipple inverted retracted R L
☐ lymph node: ☐ cm R L axilla supraclav
☐ fixed mobile tender non-tender hard soft

ABDOMEN:

benign

soft NT

BS

HSM

mass

☐ obese ☐ scaphoid ☐ flat
☐ tender (m - mod - sv) diffuse epigastric
☐ suprapubic periumbilical flank (CVA) R L
☐ RUQ RLQ LUQ LLQ
☐ rebound RUQ RLQ LUQ LLQ
☐ guarding voluntary involuntary
☐ BS's increased decreased absent
☐ liver spleen palpable
☐ mass

GENITALIA:

FEMALE

external WNL

vagina WNL

Cx WNL

uterus WNL

adnexal Tx

adnexal mass

☐ deferred
☐ vulva atrophic lesion
☐ rash excoriation hyperemic caruncle
☐ discharge white green (m - mod - lg)
☐ stenotic (m - mod - sv)
☐ cervix tender (m - mod - sv)
☐ parous nulliparous
☐ cervical lesion (shown)
☐ uterus: enlarged tender retroverted
☐ unable to adequately palpate; uterus adnexa
☐ 2: obesity pain coarperation
☐ adnexa tender R L (m - mod - sv)
☐ adnexal mass ☐ adnexal mass R L

RECTAL:

rash

hemorrhoids

sphincter WNL

OB (-)

☐ deferred
☐ excoriation irritation rash:
☐ external hemorrhoids
☐ internal hemorrhoids
☐ sphincter loose tight tender
☐ OB (+) gross blood positive

EXT/MS:

C, C, E

joints NT

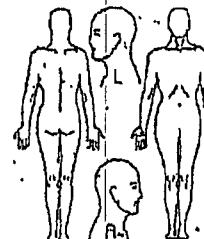
spinal NT

☐ edema pedal 1+ 2+ 3+ R L
☐ joint tenderness:
☐ chronic low back pain
☐ spinal/paraspinal tenderness

Pulses	Carotid	Radial	Femoral	DP	PT
R					
L					

SKIN: (mark on diagram)

rash



NEURO:

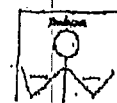
CN2-12 WNL

Motor WNL

Sensory WNL

Reflexes WNL

☒ alert ☐ sedated ☐ lethargic



ROA 608

FROM

Patient Name

Lettie Spencer

Date

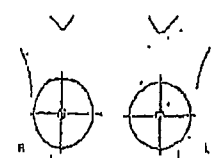
1/2/13

GENERAL: ☐ frail ☐ thin/cachectic ☐ malaise☒ WDOWN ☐ distress ☐ unkempt/dischveled☒ NAD ☐ obese (m - mod - morbid - truncal)PSYCH: ☐ depressed ☐ anxious ☐ agitated☒ alert/oriented ☐ flat ☐ disoriented (person - place - time)☒ memory intact ☐ forgetful ☐ MMSE ScoreHEENT: ☐ TM red R L (m - mod - sv)☒ TM's clear ☐ TM scar dull fluid R L☐ EAC swollen red cerumen R L☒ pharynx WNL ☐ pharynx erythematous (m - mod - sv)☐ tonsils swollen R L (m - mod - sv)☒ ndge WNL ☐ rhinorrhea: clear purulent bloody☐ mucosa: pale boggy hyperemic☐ turbinates: enlarged congested☒ sinus pain ☐ tender over sinuses: (m - mod - sv)☐ R L maxillary frontal☐ fundi benign ☐ narrow arteries ☐ AV nicking☐ hemorrhage exudate R L☐ papilledema R L☒ neck SWN ☐ cervical adenopathy R L tender☐ anterior shotty posterior☒ neck FROM ☐ ROM limited 2: muscle nuchal rigidity☒ thyroid ☐ enlarged ☐ bruit ☐ nodules☒ bruits ☐ carotid bruit R LCHEST: ☐ wheezes R L (m - mod - sv)☒ clear BS's ☐ rales R L☒ R,R,R,W ☐ rhonchi R LHEART: ☐ tachychardia@ ☐ BPM reg irreg☒ RRR ☐ bradychardia@ ☐ BPM reg irreg☒ M,R,G ☐ murmur ☐ MI holosystolic diastolic

apex LLSB LUSB RUSB RLSB

BREASTS: ☐ deferred Size: 3m mod - lg pend☐ mass ☐ mass: ☐ cm R L at ☐ o'clock☐ tender non-tender firm soft fixed mobile☐ DC ☐ discharge R L bloody☐ nipples WNL ☐ nipple inverted retracted R L☐ LN's ☐ lymph node: ☐ cm R L axilla supraclav

fixed mobile tender non-tender hard soft

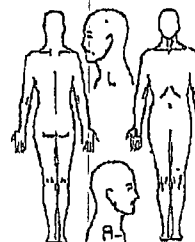
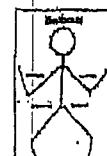


1/2/13

ABDOMEN: ☐ obese ☐ scaphoid ☐ flat☒ benign ☐ tender (m - mod - sv) diffuse epigastric☐ suprapubic periumbilical flank (CVA) R L☒ soft, NT ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ☐ rebound RUQ ☐ RLQ ☐ LUQ ☐ LLQ☐ guarding voluntary involuntary☒ BS ☐ BS's increased decreased absent☒ HSM ☐ liver spleen palpable☐ mass ☐ massGENITALIA: ☐ deferredFEMALE ☐ vulva atrophic lesion☐ external WNL ☐ rash excoriation hyperemic caruncle☐ vagina WNL ☐ discharge white green (m - mod - lg)☐ stenotic (m - mod - sv)☐ Cx WNL ☐ cervix tender (m - mod - sv)☐ parous nulliparous☐ cervical lesion (shown)☐ uterus WNL ☐ uterus: enlarged tender retroverted☐ unable to adequately palpate: uterus adnexa☐ 2: obesity pain cooperation☐ adnexal Tx ☐ adnexa tender: R L (m - mod - sv)☐ adnexal mass ☐ adnexal mass R LRECTAL: ☐ deferred☐ rash ☐ excoriation irritation rash:☐ hemorrhoids ☐ external hemorrhoids☐ internal hemorrhoids☐ sphincter WNL ☐ sphincter: loose tight tender☐ OB (-) ☐ OB (+) gross blood positiveEXT/MS: ☐ edema pedal 1+ 2+ 3+ R L☒ C,C,E ☐ joint tenderness:☐ joints NT☐ spinal NT ☐ spinal/paraspinal tenderness

Pulse	Carotid	Radial	Femoral	DP	PT
R					
L					

SKIN: (mark on diagram)

☒ rashNEURO: ☒ alert ☐ sedated ☐ lethargic☐ CN2-12 WNL☐ Motor WNL☐ Sensory WNL☐ Reflexes WNL☐ Cerebellar WNL

ROA 609

Female Visit/Progress Note

Patient Name Lettie SpencerDate 12/19/12DOB 10/1/25Hx HTN, HypertrophicY. LA B 0C/O: HT loss - & Appetite"Depressed"Dark discomfort
Unable to do things
that she wants to do

Other:

VISUAL ACUITY: RIGHT 20/ LEFT 20/ BOTH 20/
(with/without glasses)Smoker: Yes No Ex No: ETOHHM: (dates) Pap 12/19/12 Mammogram 12/19/12BDS ColonoscopyAllergies: Demerol, Pen, Codeine, CelebrexPH: ☒ No change ☐ Change DateFH: ☒ No change ☐ Change DateSH: ☒ No change ☐ Change DateSubjective: ROS - Reviewed - S u b j e c t

Const	ENT	Eyes	HeinLymph	Resp	CV	GI	Skin	GU	Gyn	MS	Endo	Neuro	Psych
fever	pain	pain	anemia	SOS	chest pain	indigestion	pruritis	dysuria	discharge	stiffness	inc BG	HA	depression
chills	congested	red	Ba infect	wheezing	pallidations	reflux	rash	polyuria	itching	warm	dec BG	weakness	anxiety
malaise	drainage	discharge	bruising	cough	edema	nausea	ulcers	nocturia	dryness	redness	inc thyroid	numbness	stressed
weight loss	hoarse	vision	bleeding	spitum	orthopnea	vomiting	nails	flank pain	dyspareunia	swelling	dec thyroid	dizziness	suicidal
fatigue	PND	glasses		hemoptysis	HTN	abd pain	moles/chg		vasomotor	back pain	polyuria	sensory chg	ideas
weak	bleeding	contacts		asthma	inc lipids	diarrhea	wound	hematuria	breast pain	neck pain	polydipsia	man chg	insomnia
anorexia	hearing loss	allergies		not sweat	PND	constipation	hair loss		nipple d/o	leg pain	polyphagia	balance	
	sore throat			chest pain	DOE	blood	dry skin		breast lump	joint pain	wt loss	coordination	
					claudication	inc rgs							

Other: HT 5'2 WT 110 T97 P92 R/L BP 140/74 CO 97
Glucose Fasting - 10

Obtained by:

Reviewed by:

Assessment/Plan:

Meds: Bilo

Other:

HTN - Nourish 10 + 10Dyslipidemia- ticoz 10 + 10Severe low back pain- Naloxone 50 + 10weight loss / Adult Feature to thornDr. Lehman - Orthopedic
Consider: Nerve BlockDepression- Cymbalta 30, 1 day x 2 wksSignature: Cymbalta 30, 1 day x 2 wksHypertension
fasten 10 + 10Reviewed Meds/SE ☒
Cont. Current Meds ☐See LIST✓Myoclonus
400mg po
bid#1 nurse
8/11/12Previous/Recent Labs/Rad Review ☐LAB: CBO UA O&S Microab Prolime
ATC Glucose Lipid ALT KOH

RAD: BDS Mamm

OTHER: PFT EKG

CONSULTS:

EDUCATION: HTN DM OP SBE
STE DIET/NUTR LIPIDSF/U: 4 days 4 wks 4 mths PRNOOW OOSCOUNSELING: >50% OV 4 (time)

Labs next visit:

Rad next visit:

Bradley12/19/12201

Patient Name

Lette Spence

Date

12/19/12

GENERAL: ☐ frail ☐ thin/ cachectic ☐ malaise
☒ WORN ☐ distress ☐ unkempt/discoveled
☒ NAD ☐ obese (m - mod - morbid - truncal)

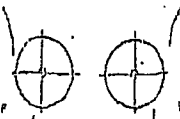
PSYCH: ☐ depressed ☐ anxious ☐ agitated
☒ alert/oriented ☐ flat ☐ disoriented (person - place - time)
☒ memory intact ☐ forgetful ☐ MMSE Score

HEENT: ☐ TM red ☐ R ☐ L (m - mod - sv)
☒ TM's clear ☐ TM scar dull fluid R L
☐ EAC swollen red cerumen R L
☒ pharynx WNL ☐ pharynx erythematous (m - mod - sv)
☐ tonsils swollen R L (m - mod - sv)
☒ nose WNL ☐ rhinorrhea: clear purulent bloody
☐ mucosa: pale boggy hyperemic
☐ turbinates: enlarged congested
☐ sinus pain ☐ tender over sinuses: (m - mod - sv)
☐ R L maxillary frontal
☒ fundi benign ☐ narrow arteries ☐ AV nicking
☐ hemorrhage exudate R L
☐ papilledema R L
☒ neck SWN ☐ cervical adenopathy R L tender
☐ anterior: shotty posterior
☒ neck FROM ☐ ROM limited 2°: muscle nuchal rigidity
☒ thyroid ☐ enlarged ☐ bruit ☐ nodules
☒ bruits ☐ carotid bruit R L

CHEST: ☐ wheezes R L (m - mod - sv)
☒ clear BS's ☐ rales R L
☐ R, R, R, W ☐ rhonchi R L

HEART: ☐ tachycardia @ ☐ BPM reg irreg
☒ RRR ☐ bradycardia @ ☐ BPM reg irreg
☒ Q, M, R, G ☐ murmur ☐ VI holosystolic diastolic
 apex LLSB LUSB RUSB RLSB

BREASTS: ☐ deferred, Size: sm med lg pend
☐ mass ☐ mass: ☐ cm R L at ☐ o'clock
☐ tender, non-tender firm soft fixed mobile
☐ DCQ ☐ discharge R L bloody
☐ nipples WNL ☐ nipple inverted retracted R L
☐ LN's ☐ lymph node: ☐ cm R L axilla supraclav
 fixed mobile tender non-tender hard soft



Initials

Anadgum

12/19/12

ABDOMEN: ☐ obese ☐ scaphoid ☐ flat
☒ benign ☐ tender (m - mod - sv) diffuse epigastric
 suprapubic periumbilical flank/GVA
☒ soft NT RUO RLO LUO LLO
☐ rebound RUO RLO LUO LLO
☐ guarding voluntary involuntary
☒ (+) BS ☐ BS's increased decreased absent
☒ HSM ☐ liver spleen palpable
☒ mass ☐ mass

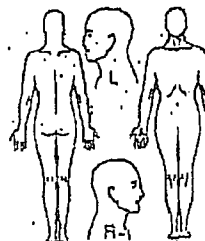
GENITALIA: ☐ deferred
 FEMALE ☐ vulva atrophic lesion
☐ external WNL ☐ rash excoriation hyperemic caruncle
☐ vagina WNL ☐ discharge white green (m - mod - lg)
☐ stenotic (m - mod - sv)
☐ Cx WNL ☐ cervix tender (m - mod - sv)
☐ parous nulliparous
☐ cervical lesion (shown)
☐ uterus WNL ☐ uterus: enlarged tender retroverted
☐ unable to adequately palpate: uterus adnexa
 2°: obesity pain cooperation
☐ adnexal Tx ☐ adnexa tender R L (m - mod - sv)
☐ adnexal mass ☐ adnexal mass R L

RECTAL: ☐ deferred
☐ rash ☐ excoriation irritation rash:
☐ hemorrhoids ☐ external hemorrhoids
☐ internal hemorrhoids
☐ sphincter WNL ☐ sphincter loose tight tender
☐ OB (-) ☐ OB (+) gross blood positive

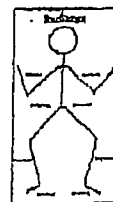
EXT/MS: ☐ edema pedal 1+ 2+ 3+ R L
☒ C, C, E ☐ joint tenderness:
☐ joints NT ☐ spinal NT ☐ spinal/paraspinal tenderness

Pulses	Carotid	Radial	Femoral	DP	PT
R					
L					

SKIN: (mark on diagram)

☒ rashNEURO: ☒ alert ☐ sedated ☐ lethargic

☒ CN2-12 WNL
☐ Motor WNL
☐ Sensory WNL
☐ Reflexes WNL
☐ Cerebellar WNL



Report: PAB120
08/13/2014 09:57:45
Requested By: BAKERPA

Radioogy Results
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 1

RADIOLOGY TEST INFORMATION

Type/source: RAD U/S THYROID/NECK
Medical Record Number: 0000107577

Account: 3139817

Patient Name: SPENCER, LETTIE

Status: Final

DOB:

Gender: FEMALE

Result Date/Time: 08/05/2013 18:26

Order Date: 08/02/2013

Order #: 4245897

Order Time: 10:47

Admit Date: 08/02/2013

PHYSICIANS Dictating: REGAN, SALLY WEBB

Signature: REGAN, SALLY WEBB

RESULT TEXT

US THYROID

THYROID NODULE

Procedure Acknowledge Date: 08/02/2013 11:08 AM

Clinical History

EXAM: Ultrasound of the thyroid 08/02/2013

INDICATION: Enlarged thyroid. The patient has been on thyroid medications for 5 years

TECHNIQUE: Ultrasound evaluation was obtained of the thyroid gland.

COMPARISON: No prior studies.

FINDINGS: The isthmus is 5 millimeters.

The right lobe measures 2.2 x 4.1 x 2.02 centimeters. The thyroid gland is hypervascular. No dominant masses are seen. There is mild nodularity.

The left lobe measures 2.9 x 4.1 x 1.7 centimeters. The gland is hypervascular. There is mild nodularity.

Report: PAB120
08/13/2014 09:57:45
Requested By: BAKERPA

Radiology Results
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 2

RADIOLOGY TEST INFORMATION

Type/source: RAD U/S THYROID/NECK
Medical Record Number: 0000107577
Status: Final

Account: 3139817
DOB:
Order Date: 08/02/2013
Order Time: 10:47

Patient Name: SPENCER, LETTIE
Gender: FEMALE
Order #: 4245697
Admit Date: 08/02/2013

PHYSICIANS Dictating: REGAN, SALLY WEBB

Signature: REGAN, SALLY WEBB

RESULT TEXT

IMPRESSION: Hypervascular thyroid gland. Possibly the patient has Graves disease. I am uncertain of the patient's thyroid condition.

Toxic goiter would be another consideration.

Correlating with her thyroid function studies is needed.

Left thyroid scan may actually be of benefit as well.

DT: 08/05/2013 06:25 PM

Dictated By: REGAN, SALLY WEBB MD

DF: 08/05/2013 06:25 PM

Signed By: REGAN, SALLY WEBB MD

DT: 08/05/2013 06:25 PM

Dictated By: REGAN, SALLY WEBB MD

DF: 08/05/2013 06:25 PM

Signed By: REGAN, SALLY WEBB MD

eAbstract Summary
CHRM-Chester 813

Medical Record # 0000107577 Encounter # 3139817 Name SPENCER, LETTIE

Admission Date	08/02/2013	Encounter Type	Output Ultrasound
Discharge Date	08/02/2013	Race	AFR/AMERICAN
Birthdate		Primary Payer	M-Medicare
Admission Type	Elective	Sex	Female
Admission Source	Physician Referral	LOS	1
Discharge Disposition	Home/Self-Care	Admission Service	Medicine
		Discharge Service	Medicine
Admit MD	1746	BRADLEY, ROBERT LEE	
Discharge MD	1746	BRADLEY, ROBERT LEE	
RVDX	2410	NONTOX UNINODULAR GOITER	
Princ Diag	2410	NONTOX UNINODULAR GOITER	
Charge Code	76536	US EXAM OF HEAD AND NECK	8/2/2013

Coded	08/05/2013	NScott1
Bill Submitted	08/05/2013	NScott1
Abstracted	08/05/2013	NScott1
Abstract Status:	Complete	

NOT FOUND

Report: PAB120
08/13/2014 09:58:14
Requested By: BAKERPA

Microbiology Results
CHESTER REGIONAL MEDICAL CENTER
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 1

MICROBIOLOGY RESULTS

Type/source: MIC CULTURE URINE
Status: Final
Result Date/Time: 03/08/2014 21:40

Account: 1163645
Order Date: 03/05/2014
Order Time: 12:53

Patient Name: SPENCER, LETTIE
Order #: C3050141
Admit Date: 03/05/2014

PHYSICIANS Dictating:

Signature:

RESULT TEXT

Chester Regional Medical Center
1 Medical Park Drive, Chester, SC, 29706
Dr. Craig F. Hart, MD.

Source: URINE
Site: Clean catch

Collected: 03/05/14 13:41
Received : 03/05/14 13:41

Culture Urine

FINAL 03/08/14 21:40

03/08/14 NO GROWTH AT 48 HOURS.

eAbstract Summary
CHRM-Chester 813

Medical Record # .0000107577 Encounter # 1163645 Name SPENCER, LETTIE

Admission Date	03/05/2014	Encounter Type	Emergency Rm
Discharge Date	03/05/2014	Race	N
Birthdate		Primary Payer	Medicare
Admission Type	Emergency	Sex	Female
Admission Source	Physician Referral	LOS	1
Discharge Disposition	Home/Self-Care	Admission Service	
		Discharge Service	Emergency Room
Admit MD	8247	MCFARLAND, III, MARION	
Discharge MD	8247	MCFARLAND, III, MARION	
RVDX	78820	RETENTION OF URINE NOS	
Prinq Diag	78820	RETENTION OF URINE NOS	
Other Diag	311	DEPRESSIVE DISORDER NEC	
Other Diag	7245	BACKACHE NOS	
Other Diag	33829	CHRONIC PAIN NEC	
Other Diag	4019	HYPERTENSION NOS	
Charge Code	81001	URINALYSIS, AUTO W/SCOPE	3/5/2014
Charge Code	87086	URINE CULTURE/COLONY COUNT	3/5/2014

Coded	03/06/2014	kristinad
Bill Submitted	03/06/2014	kristinad
Abstracted	03/06/2014	kristinad
Abstract Status:	Complete	

NOT FOUND

eAbstract Summary
CHRM-Chester 813

Medical Record # 0000107577 Encounter # 1163596 Name SPENCER, LETTIE

Admission Date	03/06/2014	Encounter Type	Emergency Rm
Discharge Date	03/06/2014	Rate	N
Birthdate		Primary Payor	M-Medicare
Admission Type	Emergency	Sex	Female
Admission Source	Physician Referral	LOS	1
Discharge Disposition	Home/Self-Care	Admission Service	
		Discharge Service	Emergency Room
Admit MD	8247	MCFARLAND, III, MARION	
Discharge MD	8247	MCFARLAND, III, MARION	
RVDX	V536	FITTING URINARY DEVICES	
Princ Diag	78820	RETENTION OF URINE NOS	
Other Diag	4019	HYPERTENSION NOS	
Other Diag	2720	PURE HYPERCHOLESTEROLEM	
Other Diag	3051	TOBACCO USE DISORDER	
Other Diag	V148	HX-DRUG ALLERGY NEC	
Other Diag	V140	HX-PENICILLIN ALLERGY	
Charge Code	81001	URINALYSIS, AUTO W/SCOPE	3/6/2014
Charge Code	87086	URINE CULTURE/COLONY COUNT	3/6/2014
Charge Code	99283	EMERGENCY DEPT VISIT	3/6/2014

Coded	03/08/2014	tori.chopak
Bill Submitted	03/08/2014	tori.chopak
Abstracted	03/08/2014	tori.chopak
Abstract Status:	Complete	

NOT FOUND

Report:PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Nurse Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 1

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med Rec: 0000107577

Pat Type: E

Type: MED Dict: 03/06/2014 10:09 EDNN1163696

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

Nurse's Notes

Chester Regional Medical Center

Name: Lettie Spencer

Age: yrs

Sex: Female

DOB:

MRN: 0000107577

Arrival Date: 03/06/2014

Time: 10:09

Account#: 1163696

Bed F1

Private MD:

Diagnosis: Urinary Retention

Presentation:

03/06

10:21 Presenting complaint: Patient states: RETURN FOR FOLEY REMOVAL TODAY. Transition of care: patient was not received from another setting of care.

rs

10:21 Method Of Arrival: Walk-in

10:21 Acuity: ESI 4

rs

rs

Triage Assessment:

10:24 General: Appears in no apparent distress, Behavior is appropriate for age. Pain: Denies pain. Suicide Risk Assessment: Suicidal Thinking Present No (0 points).

rs

Historical:

- Allergies: Meperidine; Clindamycin; Codeine; PCN;
- Home Meds:

1. Norco Oral Unknown as needed
2. Norvasc Oral 5 mg daily
3. Aldactone Oral 25 mg daily
4. Potassium Chloride Oral 10 mEq daily
5. Viibryd Oral 40 mg daily

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Nurse Chart
CHESTER REGIONAL MEDICAL CENTER
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 2

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict: 03/06/2014 10:09 EDNN1163696

Physician: MCFARLAND, MARION F.

Admt: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

- 6. Neurontin Oral 300 mg three times a day
- 7. Flomax Oral 0.4 mg daily
- 8. Trazodone Oral 100 mg at bedtime
- 9. Klonopin Oral 1 mg at bedtime
- 10. Tapazole Oral 10 mg at bedtime
- 11. Nucynta Oral 75 mg every 8 hours
- 12. Zanaflex Oral 4 mg every 8 hours
- 13. Vitamin C Oral daily
- 14. Fish Oil Oral 3 TIMES PER WEEK
- 15. Women's One Daily Oral daily
- PMHx: DEPRESSION; Chronic Back Pain; HYPERTENSION; HIGH CHOLESTEROL;
- PSHx: cystocopy yesterday; neck ; left foot x 2 ; HYSTERECTOMY;
- History obtained from: patient.
- Immunization history: Last tetanus immunization: > 10 years ago.
- Family history: Not pertinent.
- Social history: Smoking status: Patient uses tobacco products, smokes one-half pack cigarettes per day, No barriers to communication noted. Speaks appropriately for age.
- Hospitalizations: : No recent hospitalization is reported.

Screening:

10:25 Abuse screen: Denies threats or abuse. Tuberculosis screening: rs
Never had TB. Pneumonia Screening: Total Score: 0 Pts., no action
required at this time. Fall Risk: None identified (0 points).

Assessment:

10:25 Present on Arrival: Central Line: NO. Foley Catheter: YES, rs
Wound/Pressure Ulcer: NO. Nursing diagnosis: anxiety: actual;.

Vital Signs:

10:24 BP 144 / 067; Pulse 68; Resp 18; Temp 97.7(O); Pulse Ox 96% on R/A; rs
Weight 48.53 kg (R); Height 5 ft. 2 in. (157.48 cm) (R); Pain 0/10;
11:36 BP 137 / 72 RA Sitting (auto/reg); Pulse 64; Resp 16 S; Temp ss1

Report:PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Nurse Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold:813
Page:3

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 000Q107677

Pat. Type: E

Type: MED. Dict.: 03/06/2014 10:09 EDNN1163696

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

97.5(T); Pulse Ox 96% on R/A; Pain 0/10;
10:24 Body Mass Index 19.57 (48.53 kg, 157.48 cm)

rs

ED Course:

10:12 Patient arrived in ED.

tr

10:21 Sanders, Rogerlene, RN is Primary Nurse.

rs

10:21 Triage completed.

rs

10:25 Arm band placed on right wrist. Patient placed in exam room on
stretcher.

rs

10:26 ED Rounding: Call light is within patient's reach, and patient has
been educated on it's use. Family Update: Patient does not have any
family members to update Pending Items and/or Delays. Patient is
not awaiting any further diagnostics and/or procedures at this time
Patient has been instructed that nurse will re-visit within 30
minutes.

rs

10:26 Patient has correct armband on for positive identification. Bed in
low position. Call light in reach. Side rails up X2.

rs

10:39 Urinalysis Auto W/micro Sent.

rs

10:57 McFarland, Marion, MD is Attending Physician.

mfm

11:35 No procedures required assistance by the nurse.

ss1

11:36 ED Rounding: Pain Reassessment: denies any pain at this time.

ss1

11:37 Culture Urine Sent.

ss1

Administered Medications:

No medications were administered

Outcome:

11:31 Discharge ordered by MD.

mfm

11:36 Discharged to home ambulatory.

ss1

11:36 Braden Scale-Adult not applicable, the patient was discharged.

11:36 Discharge Assessment: vital signs assessed, patient awake and
alert no apparent distress

11:36 Discharge instructions given to patient, Instructed on discharge
instructions, follow up and referral plans. Demonstrated

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Nurse Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 4

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE
DOB:
Req By: MCFARLAND, MARION F.
Med. Rec: 0000107577 Pat. Type: E
Type: MED Dict: 03/08/2014 10:09 EDNN1163696
Physician: MCFARLAND, MARION F.

Admit: 03/08/2014 10:09
Gender: FEMALE
Discharge: 03/08/2014 11:37
Location: 0
Transcribed: 03/08/2014 11:37

understanding of instructions, No Prescriptions were written by the
provider for this patient.

11:37 Patient left the ED.

ss1

Signatures:

Sanders, Rogerlene, RN	RN	rs
Robinson, Teresa, Reg	Reg	tr
McFarland, Marion, MD	MD	mfm
Stevens, Stacie, RN	RN	ss1

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Physician Chart
CHESTER REGIONAL MEDICAL CENTER
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 1

Report Status: Final

Patient: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict.: 03/06/2014 10:09 EDPN1163696

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

Physician Documentation

Chester Regional Medical Center

Name: Lettie Spencer

Age: 66 yrs

Sex: Female

DOB: 11/28/1947

MRN: 0000107577

Arrival Date: 03/06/2014

Time: 10:09

Account#: 1163696

Bed: F1

Private MD:

ED Physician: McFarland, Marion

Disposition:

03/06

11:32 Electronically authenticated by: marion mcfarland.

mfm

Disposition Summary:

03/06 Discharged to Home/Self Care. MSE completed.. Impression: Urinary Retention.

11:31

- Condition is Stable.

mfm

- Discharge Instructions: Urinary Retention, Acute, Female.

- Medication Reconciliation Form form.

- Follow up: Private Physician; When: 5 - 6 days; Reason: Continuity of care.

- Problem is new.

- Symptoms are resolved.

HPI:

10:30 This 66 yrs old Caucasian Female presents to ER via Walk-in with

mfm

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Physician Chart
CHESTER REGIONAL MEDICAL CENTER
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 2

Report Status: Final

Pat Nbr: 1163698 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict.: 03/06/2014 10:09 EDPN1163698

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

complaints of Recheck.

10:58 The patient presents with catheter removal. Onset: The symptoms/episode began/occurred acutely, 2 day(s) ago, and improved yesterday. Modifying factors: The symptoms are alleviated by cath. Associated signs and symptoms: The patient has no apparent associated signs or symptoms. Severity of symptoms: At their worst the symptoms were severe, in the emergency department the symptoms have resolved. The patient's method of birth control includes nothing. The patient has been recently seen at the Chester Regional Medical Center Emergency Department, yesterday, for similar complaints the patient was told to return for a recheck.

mfm

Historical:

- Allergies: Meperidine; Clindamycin; Codeine; PCN;

- Home Meds:

1. Norco Oral Unknown as needed
2. Norvasc Oral 5 mg daily
3. Aldactone Oral 25 mg daily
4. Potassium Chloride Oral 10 mEq daily
5. Viibryd Oral 40 mg daily
6. Neurontin Oral 300 mg three times a day
7. Flomax Oral 0.4 mg daily
8. Trazodone Oral 100 mg at bedtime
9. Klonopin Oral 1 mg at bedtime
10. Tapazole Oral 10 mg at bedtime
11. Nucynta Oral 75 mg every 8 hours
12. Zanaflex Oral 4 mg every 8 hours
13. Vitamin C Oral daily
14. Fish Oil Oral 3 TIMES PER WEEK
15. Women's One Daily Oral daily

- PMHx: DEPRESSION; Chronic Back Pain; HYPERTENSION; HIGH CHOLESTEROL;

- PSHx: cystocopy yesterday; neck ; left foot x 2 ; HYSTERECTOMY;

- History obtained from: patient.

- Immunization history: Last tetanus immunization: > 10 years ago.

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Physician Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29708

Cold: 813
Page: 3

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE
DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict.: 03/08/2014 10:09 EDPN1163696

Physician: MCFARLAND, MARION F.

Admit: 03/08/2014 10:09

Gender: FEMALE

Discharge: 03/08/2014 11:37

Location: 0

Transcribed: 03/08/2014 11:37

- Family history: Not pertinent.
- Social history: Smoking status: Patient uses tobacco products, smokes one-half pack cigarettes per day, No barriers to communication noted. Speaks appropriately for age.
- Hospitalizations: : No recent hospitalization is reported.

ROS:

10:59 All other systems are reviewed and negative. Constitutional: Negative for chills, fever. Cardiovascular: Negative for chest pain. Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea. GU Positive for urinary symptoms, catheter removal for urinary retention. Neuro: Negative for altered mental status. mfm

Exam:

11:00 Constitutional: The patient appears in no acute distress, alert, awake, comfortable, non-diaphoretic, non-toxic, well developed, well hydrated, well groomed, well nourished. mfm

11:00 Eyes: Periorbital structures: appear normal.

11:00 Cardiovascular: Rate: normal.

11:00 Respiratory: Exam negative for acute changes.

11:00 Abdomen/GI: Palpation: abdomen is soft and non-tender, in all quadrants.

11:00 GU: a foley is noted.

11:00 Musculoskeletal/extremity: Exam is negative for acute changes.

11:00 Skin: Exam negative for acute changes.

11:00 Neuro: Exam negative for acute changes.

Vital Signs:

10:24 BP 144 / 067; Pulse 68; Resp 18; Temp 97.7 (O); Pulse Ox 96% on R/A; rs
Weight 48.53 kg (R); Height 5 ft. 2 in. (157.48 cm) (R); Pain 0/10;

11:36 BP 137 / 72 RA Sitting (auto/reg); Pulse 64; Resp 16 S; Temp 97.5 (T); Pulse Ox 96% on R/A; Pain 0/10; ssl

10:24 Body Mass Index 19.57 (48.53 kg, 157.48 cm) rs

Report;PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Physician Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold:813
Page:4

Report Status: Final

Pat Nbr: 1163698 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict: 03/06/2014 10:09 EDPN1163698

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

MDM:

11:01 Differential diagnosis: urinary tract infection, catheter removal. mfm
Data reviewed: vital signs, nurses notes, lab test result(s),
urinalysis. Counseling: I had a detailed discussion with the
patient and/or guardian regarding: the historical points, exam
findings, and any diagnostic results supporting the discharge/admit
diagnosis, lab results, the need for outpatient follow up, a
urologist, to return to the emergency department if symptoms worsen
or persist or if there are any questions or concerns that arise at
home. Response to treatment: the patient's symptoms have markedly
improved after treatment.

11:24 Counseling: I had a detailed discussion with the patient and/or
guardian regarding: if cannot urinate return for re cath. mfm

11:31 Patient medically screened. mfm

03/06

10:32 Order name: Urinalysis Auto W/micro; Complete Time: 11:30 rs

03/06

11:30 Interpretation: Normal Except: Nitrites pos; Bilirubin 3; Blood
250; RBCs 20-50. mfm

03/06

11:30 Order name: Culture Urine mfm

Dispensed Medications:

No medications were administered

Signatures:

Dispatcher MedHost

Sanders, Rogerlene, RN

RN

EDMS

rs

McFarland, Marion, MD

MD

mfm

Stevens, Stacie, RN

RN

ssl

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Physician Chart
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29708

Cold: 813
Page: 5

Report Status: Final

Pat Nbr: 1163698 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: MED Dict: 03/06/2014 10:09 EDPN1163698

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

Report:PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Order Summary
CHESTER REGIONAL MEDICAL CENTE
1 MEDICAL PARK DRIVE
CHESTER SC 29708

Cold:813
Page:1

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E.

Type: MED Date: 03/06/2014 10:09 EDOS1163696

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

Order Summary

Name: Lettie Spencer

MRN: 0000107577

66 yrs

/Caucasian

/Female

Arrival: 03/06/2014

10:09

Chief Complaint: Recheck

Departure Date: 03/06/2014

Departure Time: 11:37

Orders:

Lab

Order: Culture Urine; Ordered: 03/06 11:30; By: mfm; For: mfm; In

Process Unspecified: 03/06 12:13; By: EDMS; Order Method:

Electronic

Order: Urinalysis Auto W/micro; Ordered: 03/06 10:32; By: rs; For:

mfm; Reviewed: 03/06 11:30; By: mfm; Order Method: Verbal - Read

back; Sign Off: McFarland, Marion, MD - 03/06 10:58

Order Signatures:

McFarland, Marion, MD, MD, mfm;

Sanders, Rogerlene, RN, RN, rs;

Report: PAB120
08/13/2014 10:03:57
Requested By: BAKERPA

Disposition Summary
CHESTER REGIONAL MEDICAL CENTER
1 MEDICAL PARK DRIVE
CHESTER SC 29706

Cold: 813
Page: 1

Report Status: Final

Pat Nbr: 1163696 SPENCER, LETTIE

DOB:

Req By: MCFARLAND, MARION F.

Med. Rec: 0000107577

Pat. Type: E

Type: ED Dict: 03/06/2014 10:09 EDDS1163696

Physician: MCFARLAND, MARION F.

Admit: 03/06/2014 10:09

Gender: FEMALE

Discharge: 03/06/2014 11:37

Location: 0

Transcribed: 03/06/2014 11:37

Discharge Summary

Chester Regional Medical Center

Name: Lettie Spencer

Emergency Department

Age: 66 yrs

Sex: Female

DOB: 11/28/1947

MRN: 0000107577

Arrival: 03/06/2014

10:09

Account#: 1163696

Departure Date: 03/06/2014

Departure Time: 11:37

Private MD:

Outcome: Discharge

Location: Home/Self Care. MSE completed.

Condition: Stable

Chief Complaint: Recheck

Diagnosis: Urinary Retention

Prescriptions:

Follow up:

Custom Notes:

Attending Physician: McFarland, Marion, MD

Private MD:

Mid Level Provider:

Orders: Urinalysis Auto w/micro, Culture Urine

Discharge Instruction: Discharge Summary Sheet, Urinary Retention,

Acute, Female, Medication Reconciliation Form
