**THE STATE OF SOUTH CAROLINA**
**In The Court of Appeals**

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**APPEAL FROM**
**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION**
**W.C.C. FILE NO: 1206236**

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SC Court of Appeals

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**Appellate Case No. 2019-001936**

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**Jennie Cox,..........................................................................Appellant,**

**v.**

**Palmetto State Transportation, Employer, and**
**Cherokee Insurance Company, Carrier,..........................................Respondents,**

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RECORD ON APPEAL

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**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION**

**W.C.C. FILE NO: 1206236**

| | |
|---|---|
| **JENNIE COX,**<br>**Employee**<br>**Claimant,**<br><br>**vs.**<br><br>**PALMETTO STATE TRANSPORTATION,**<br>**Employer,**<br><br>**CHEROKEE INSURANCE COMPANY,**<br><br>**Insurance Company,**<br><br>**Defendants.** | **ORDER** |

HEARING: Held in Anderson, South Carolina on February 2, 2017

APPEARANCES: Claimant represented by Juliette B. Mims, Esquire, of Greer, South Carolina and Adrianne Turner, of Columbia, South Carolina

Defendants represented by Robert E. Horner, Esquire, of Columbia, South Carolina

PURPOSE OF HEARING: To determine issues set forth in Forms 50 and 51, including, Claimant's degree of disability. Whether or not Claimant was rendered totally disabled and whether or not Claimant is entitled to lifetime medicals.

AWARD: The Honorable Aisha Taylor, Commissioner

FILED:

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## APA SUBMISSIONS

Submissions on behalf of Claimant:

1. Grady Hospital
2. American Medical Response of Georgia
3. Greenville Memorial
4. James Fowler, M.D. of GHS Plastic Surgery & Aesthetics
5. GHS Center for Health & Occupational Services
6. Innervision MRI & Imaging
7. Proaxis Therapy
8. Jennifer T. Ellis, M.D. of Hillcrest Family Practice
9. Donald L. Ridgell, DMD of Upstate Prosthodontics, LLC
10. Larry W. Cobb, DMD
11. Wiliam A. Cofer, DMD
12. Walter Grady, D.O
13. Robert E. Brabham, Ph.D.

26. Life Center Health
27. CORA Rehabilitation Center

Submissions by Defendant:

14. Occupational Health
15. Piedmont Oral Surgery
16. Piedmont Oral Surgery questionnaire
17. Center for Health & Occupational Services
18. Impairment rating
19. Hillcrest Family Practice
20. Claimant's 2015 tax returns
21. Letter to Claimant's attorney regarding work
22. Liberty Bell Agency check log & ltr from CA
23. Duvall Group Investigation report
24. Photos
25. Deposition transcript of Claimant
26. Wage Records (submitted at hearing)

## STIPULATIONS

This case came before the undersigned Commissioner in Anderson, South Carolina on February 2, 2017. At the hearing the Claimant was represented by Juliette B. Mims and Adrianne Turner; Palmetto State Transportation and its carrier, Cherokee Insurance Company, was represented by Robert E. Horner with Speed, Seta, Martin, Trivett & Stubley.

The parties stipulated as follows:

1. All parties are subject to, and bound by, the terms and conditions of the South Carolina Workers' Compensation Act ("Act").

2. Notice of the hearing was timely and properly served upon all necessary and proper parties, and the file and its contents, along with the Commissioner's notes, are made part of the record without objection.

3. There were no objections to the submission of APAs and/or exhibits.

4. The Claimant's average weekly wage is $1,327.69, yielding a compensation rate of $725.47.

5. That the Workers' Compensation Commission has jurisdiction over this matter and venue in Anderson County is proper as stipulated by all parties;

6. Claimant seeks benefits under the South Carolina Workers' Compensation Act based upon accidental injuries occurring on May 31, 2012, which occurred while in the course and scope of the Claimant's employment with the Defendant employer. The injury and date of injury are stipulated to and not disputed.

## STATEMENT OF CASE

It is undisputed that on May 31, 2012 Claimant sustained compensable injuries by accident arising out of and in the course of her employment with Palmetto State Transportation as a CDL truck driver. The accident occurred while she was on a delivery in Georgia, when she was removing freight; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. At the time of the accident, she injured her head, teeth, mandible, left shoulder, neck and facial nerves. As a result of the injuries Claimant has sustained, she has been treating for depression due to chronic pain and severe weight loss.

It is the Claimant's position that she has been rendered totally and permanently disabled as a result of the injuries in question and that she is entitled to lifetime medical care.

Palmetto State Transportation and its carrier admit that Claimant did in fact sustain injuries as a result of the above referenced accident, and that she has reached maximum medical improvement, but assert that she is entitled only to permanent partial benefits and continued medical care for her physical injuries as prescribed be Dr. Ridgell and Dr. Cobb.

The following issues are for determination by this Commissioner:

1. Has the Claimant sustained total and permanent disability due to her injuries?
2. To what extent is the Claimant entitled to additional medical care?
3. Is the Claimant entitled to further compensation?

## EVIDENCE OF CASE

The Claimant testified that she is 64 years old, divorced and has two adult daughters. [1] She graduated from Woodmont High School in 1970 and attended TEC, but did not graduate. She obtained her Truck Driver's Class "A" license in 1985, and has worked in that capacity thereafter. At the time of the accident, Claimant had worked for Employer for eleven (11) years, and worked for US Food Service for six (6) years prior to that. Claimant testified that she had no prior physical injuries and was in good health at the time of her injuries. She testified that she did suffer from pre-existing depression related to the death of her grandson who was killed at age 16 in a car accident.

On May 31, 2012, Claimant was on a delivery in Georgia, when she was removing freight from her truck; a machine fell on her, causing her to fall to the ground face first knocking her unconscious. She was rushed to Grady Memorial in Georgia and then brought by EMS to Greenville Memorial Hospital with injuries to her head, face, mouth and neck, left shoulder, chest, low back and problems breathing. On June 1, 2012, James Fowler, M.D. performed extensive surgical intervention to address Claimant's injuries. Records indicated he performed a bilateral subcondylar mandible fracture, left body comminuted mandible fracture, avulsed maxillary and mandibular teeth, maxillomandibular fixation with screws, open reduction and internal fixation left body mandible fracture and dental tooth extraction.

Claimant was subsequently seen by Stacey Newsom, M.D. at the Center for Health and Occupational Services for chest wall pain and left shoulder pain. Dr. Newsome indicated chest wall contusions and left shoulder contusion with weakness and possible rotator cuff injury. Dr. Newsome instructed Claimant to continue with Lortab for pain, deep breathing exercises and imposed work restrictions limiting Claimant to sedentary work with a five (5) pound lifting restriction and prohibited her from operating commercial motor vehicle.

Claimant had a follow-up with Dr. Fowler on June 11, 2012, after which Dr. Fowler opined that Claimant was to remain in a "levered and wired occlusion for one more week." On July 5, 2012, Claimant underwent surgery to remove the IMG screws.

On July 6, 2012, Claimant underwent an MRI of the left shoulder at Innervision MRI &

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[1] Facts included herein are derived from Claimant's live testimony at the hearing, Claimant's deposition testimony, which was submitted without objection, and medical histories derived from submitted APAs.

Imaging with an impression of "degenerative changes and mild tendinopathy in the suprae and infraspinatus tendons." On July 17, 2012, Claimant returned to Innervision for an x-ray of the chest with an impression of COPD without acute findings. Claimant then returned to Dr. Newsome on July 17, 2012 to review the findings of the MRI and x-ray. Dr. Newsome's diagnosis was chest wall contusions resolving and left shoulder contusion improving. Claimant was to continue the same restrictions with the additional restrictions ordered by Dr. Fowler.

On July 24, 2012, Claimant began treating with Larry W. Cobb, D.M.D at Piedmont Oral Surgery to discuss surgical oral restoration. Dr. Cobb noted Claimant had multiple jaw and teeth fractures and determined he would allow them to heal for an additional three months before attempting restorative procedures. Dr. Cobb also ordered a CT for September and sought preauthorization for implants and restoration.

Claimant again saw Dr. Newsome on August 7, 2012, at which point Dr. Newsome noted left shoulder weakness and tendinosis and chest wall contusion. She recommended physical therapy for strengthening prior to return to full duty. Dr. Newsome stated Claimant could return to work with restrictions of no lifting, pushing or pulling more than 15 pounds occasionally and no operating commercial motor vehicle. Claimant started physical therapy with Proaxis Therapy on August 22, 2012 for her left shoulder pain.

On August 28, 2012, Claimant went to her family doctor, Jennifer T. Ellis, M.D., for a follow-up. Dr. Ellis noted that her depression and insomnia had been getting worse since her last visit and Claimant was also experiencing loss of appetite and loss of interest in pleasurable activities since her work related injury.

On September 4, 2012 Dr. Cobb examined Claimant and stated she was healing well and scheduled a CT. The CT scan on October 3, 2012 also showed she was healing well. Dr. Cobb referred her to Donald L. Ridgell, DM.D. for his evaluation. Claimant saw Dr. Ridgell on October 4, 2012, wherein Dr. Ridgell examined Claimant and agreed with Dr. Cobb that a full mouth extraction of Claimant's natural teeth with implant replacement was the best solution. Dr. Ridgell further noted that he would continue to work along-side Dr. Cobb for the maintenance and upkeep of the implants.

On October 30, 2012 Dr. Cobb opined that Claimant had "a full work up including a physical examination CBCT evaluation to determine the best treatment necessary to restore her teeth for maximum function. She has a very complicated case secondary to her normal petite size and small jaw. This has been further compromised by the very significant jaw injuries

multiple bone fractures and loss of teeth. Her remaining teeth are terminal due to the lack of bone support. These will all have to be removed. She has very minimal maxiallary bone and will lose more when her teeth are removed. She will require extensive bone grafting before any definitive treatment can be achieved. Either one or both bone plates will need to be removed from the mandible before any treatment can be implemented there as well." Dr. Cobb set out the treatment in 5 stages with an estimated cost of $34, 215.00, not including the prosthetic work to be done by Dr. Ridgell.

On November 5, 2012, Claimant saw Dr. Fowler for a follow up examination. Dr. Fowler noted that Claimant had been seen by a prosthodontist and was scheduled for dental restoration. He specifically noted that Claimant's nutrition has been affected in that she had to work to get enough nutrition in and was eating pureed food. Dr. Fowler recommended a softer food diet and that Claimant maintain her nutrition as needed with calorie supplements including Ensure or Carnation Instant Breakfast.

Claimant was discharged from Proaxis on November 6, 2012, after completing 20 visits, to an independent home exercise program. Following her discharge from physical therapy, she returned to Dr. Newsome on November 9, 2012. Dr. Newsome opined that her left shoulder injury was at MMI with an impairment rating of the left shoulder of 2% and stated Claimant could return to work on November 9, 2012 without restrictions with regard to her left shoulder.

On January 31, 2013, Claimant began her restoration with Dr. Cobb as follows:

a) 01/13/13 bilateral sinus graft, removal of superior bone plate and surgical removal of teeth numbers 4, 6, 11, 21, 22, 26, 27, 28, 29;
b) 04/29/13 surgical implant placement of teeth numbers 20, 23, 25, 27, 30; and
c) 07/17/13 surgical implant placement of teeth number 3, 5, 6, 11, 12, 14.

During the process of her oral reconstructive surgery, Dr. Cobb referred Claimant to a nutritionist. He stated that she is "very malnourished. The success of our treatment depends on her ability to heal. I believe that all of our treatment may be in jeopardy if her overall nutrition does not improve."

On July 15, 2013, Claimant returned to Dr. Ellis for a follow-up. Dr. Ellis stated Claimant is doing "about the same." "She is currently experiencing fatigue, weight loss of 25 pounds over the past year and loss of appetite. Claimant states she gets hungry and tries to eat but it hurts." Dr. Ellis refilled her anxiety and insomnia medications of Alprazolam Oral 0.5 mg and Restoril Oral Capsule 30 mg.

Upon her healing from the restoration surgeries, Claimant returned to work on August 12, 2013. Claimant testified that although she did her absolute best to perform her work duties in the same manner as before the accident, she continued to have difficulties and was never able to perform her duties as well as before she was injured. Significantly, despite her commendable attempt to return to work, Claimant continued to experience pain, inability to maintain proper nutrition except through the use of nutritional supplements, and suffered from weaknesses, fatigue and inability to concentrate.

On October 6, 2014, Claimant returned to the Center for Health & Occupational Services for reevaluation of her left shoulder. Claimant was seen by Brian Svazas, M.D. and advised him that she was having some difficulties in the left shoulder with it being sore after long truck runs. Claimant also discussed difficulties with the left ear with intermittent hearing diminution. Dr. Svazas advised that he believed the complaints she had in the left scapular border were likely related to her work injury to the shoulder. He advised that physical therapy could help clear up some of the soft tissue areas. Dr. Svazas found her at MMI with a 6% left shoulder rating and opined that "she may need some ongoing therapy to this shoulder going forward."

Dr. Ridgell opined on April 9, 2015 that Claimant will need future medical care by way of "maintenance procedures annually- more expensive than natural teeth, replace or refurbish appliances every 6-8 years and oral surgeon visit in 5 years for radiograph/CT scan." Dr. Ridgell continues to see Claimant every 6 months.

Claimant last saw Dr. Cobb on April 27, 2015 where he released her to MMI with the following impairment ratings: 15%- diet limited to soft or semi solid foods, 85% of normal function, 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion0 5-6mm, 2% facial disorder- scar, 1% nerve disorder- permanent numbness of lower lip and chin on left side, for a 25% whole person. He also stated that she will need prosthetic maintenance and replacement.

Claimant continued to have pain in her jaw and returned to Dr. Fowler on June 8, 2015 and again on June 15, 2015 with draining sinus to the left jaw in the region of a previous ORIF and plate and screw placement for a compound fracture of an atrophic mandible. Claimant went out of work again on June 20, 2015 due to these issues and on July 5, 2015 Dr. Fowler performed surgery for removal of the indwelling device of the mandibular bone along with removal of plate and screws, bone biopsy and bone grafting.

Dr. Fowler released her to return to work, which Claimant did in August 2015. Claimant

had a follow-up appointment with Dr. Fowler on October 12, 2015, wherein Dr. Fowler stated "she has residual numbness from the left mental nerve that may be permanent."

In October 2015, Claimant went from running team driving to single driving.

Throughout these surgeries for her mouth, Claimant continued to see Dr. Ellis for routine follow ups and prescription refills for her depression that continued to get worse. At her appointment on March 3, 2016, Dr. Ellis noted that since Claimant has gone to single driving, it was physically and mentally wearing her out. Dr. Ellis further noted it was still uncomfortable for her to eat as her- "teeth not lined up" and that Claimant had lost a significant amount of weight as a result. Dr. Ellis took her out of work until she could gain some weight. Claimant went to her dentist, William A Cofer, D.M.D. on April 14, 2016 to get his opinion as to the pain she continues to have chewing and earing her food. Dr. Cofer opined "I believe the reason she is having difficulties chewing and eating is due to the numbness on the left side of her lower jaw. She has had a loss of sensation since her accident.....Unfortunately; it is unlikely that she will regain any meaningful sensation due her accident." Over the next several months, Claimant was able to show good weight improvement and return to work on June 1, 2016. However, Claimant testified she did not experience a corresponding return at her pre-accident strength. In fact, Claimant indicated her lack of strength, consistent fatigue and inability to maintain concentration rendered truck driving an unsafe occupation for her to continue. She testified credibly and without challenge from the Employer that she had conveyed her concerns to her supervisor and he indicated that the company would not be comfortable accepting the liability implications stemming from her symptoms. Claimant did not receive temporary total benefits for this period of time she was out.

Claimant ran nonstop runs for a few weeks with constant pain over her entire body. On June 14, 2016 she notified the Employer that she was in too much pain, could not work and needed additional treatment.

While awaiting authorization for additional treatment from the Employer, Claimant's attorney sent her for an Independent Medical Evaluation with Walter Grady, DO on July 21, 2016. Upon physical examination of the Claimant and review of her prior extensive medical treatment history, Dr. Grady gave Claimant an impairment rating of 17% to the left upper extremity, 28% to left shoulder impairment and 10% whole person.

Claimant's attorney also scheduled a physiological and vocational evaluation with Robert E. Brabham, Ph.D. on August 8, 2016. Dr. Brabham has opined that "she would be unable to

effectively perform the essential duties in any gainful work activity."

Claimant sought treatment at the Wellness Center on her own on August 17, 2016, as she was in pain and Employer had not approve physical therapy as requested. She was making progress at the Wellness Center and her primary care doctor, Dr. Ellis, opined that she should continue there. Employer eventually authorized work hardening at CORA Rehabilitation. Claimant completed treatment three (3) times a week for several hours for a total of 20 visits between October 24, 2016 and December 19, 2016 at CORA Rehabilitation. Notably, CORA's December 19, 2016 Functional Capacity Test results indicated Claimant is not able to perform several of the minimal material handling requirements for a truck driver.

Claimant testified that she loved her job and wanted to continue working, however, due to the pain, weakness, fatigue and anxiety she experiences is not able to perform the job. As well, Claimant also remains unable to conduct her day-to-day living activities in the same manner as before her injuries.

## FINDING OF FACT

1. I find that the parties of this proceeding are subject to and bound by the terms of the Title 42 of the South Carolina Code of Laws, Annotated, dealing with South Carolina Workers' Compensation Law with Palmetto State Transportation and Cherokee Insurance Company, employer and carrier.
2. After observing the demeanor of Claimant while she testified at the hearing, the medical records, and the other exhibits in evidence, I find that the testimony of Claimant to be fully credible regarding her work injury and its effect on her current quality of life, including her inability to work.
3. I find that the Claimant sustained admitted compensable injuries by accident arising out of in the course of her employment on Mary 31, 2012, injuries to her teeth, mandible, left shoulder, neck, facial nerve and scarring to her chin.
4. I find that based upon the medical opinions of Dr. Ellison and Dr. Brabham and testimony submitted, that Claimant had preexisting depression and her injuries caused an aggravation and/or exacerbation of the preexisting condition and is therefore compensable under the Act.
5. I find that at the time of the accident, Claimant was an employee of the Palmetto State Transportation as a truck driver.

6. I find that the applicable average weekly wage of the Claimant is One Thousand Three Hundred Twenty Seven and 69/100 ($1,327.69) Dollars, corresponding to a compensation rate of is Seven Hundred Twenty-Five and 47/100 ($725.47) Dollars, which was stipulated by Claimant's counsel and defense counsel at the hearing.

7. I find that the Claimant has been unable to work since June 2016 and is permanently and totally disabled pursuant to S.C. Code Ann. Section 42-9-10 as a result of her combined injuries. This finding is based on the preponderance of the evidence as a whole including the medical evidence, the credible testimony of the Claimant, and the vocational assessment of Robert Brabham, Ph.D., Claimant's age, education and work history also weighed into this decision.

8. I find that the Claimant is entitled to a lump-sum payment of the commuted value of Five Hundred (500) weeks of benefits less any amounts previously paid by Defendants in the form of temporary compensation.

9. I find that Claimant is entitled to lifetime medical treatment for her work injuries pursuant to S.C. Code Ann. Section 42-15-60 including lifetime repair, replacement and/or removal of any retained hardware. Defendants are responsible for lifetime causally related medical expenses. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.

10. The Claimant is entitled to a lump-sum payment and that the settlement proceeds of Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 ($300,938.67) Dollars shall be allocated as follows:

    (a) One Hundred Thousand Three Hundred Two and 85/100 ($100,302.85) Dollars for attorney's fee and Three Thousand Eight Hundred Fifty Eight and 45/100 ($3,858.45) Dollars for related litigation expenses and costs to Juliette B. Mims;

    (b) One Hundred Ninety Six Thousand Seven Hundred Seventy Seven and 37/100 ($196,777.37) Dollars to the Claimant in compromise settlement of disputed future lost earnings for a period of 20.90 years or 1,086.8 weeks, the life expectancy of the Claimant (DOB; 08/14/1952) at the rate of One Hundred Eighty One and 06/00 ($181.06) Dollars per week, pursuant to §19-1-150 of the South Carolina Code of Law, as amended.

See *Utica-Mohawk vs. Orr*, 227 S.C. 226, 87 S.E.2d 589 (1955); *Sciarotta vs. Bowen*, 837 F.2d 135 (3rd Cir. 1988); *James v. Anne's Inc.*, 688 S.E.2d 562 (S.C. 2010); See also on remand: *Sciarotta vs. Secretary of H.H.S.*, 735 F. Supp. 148 (D.N.J. 1989).

## CONCLUSIONS OF LAW

It is the conclusion of the Hearing Commissioner that the following and other sections of the South Carolina Code of Laws, 1976, as amended, apply in this case:

1. Section 42-1-130 defines "employee"; Section 42-1-120 defines disability; Section 42-1-360 defines "exempt businesses"; Section 42-9-10 defines "amount of compensation for total disability"; Section 42-1-100 defines "compensation"; Section 42-1-160 defines "injury" and "personal injury"; Section 42-15-60 governs medical care; and Commission Rules 67-601 through 67-615 set forth the contested case procedures.

Accordingly, as provided in the South Carolina Code of Laws, 1976, as amended, it is the determination of this Commissioner:

1. That under Section 42-1-60, the Carrier is authorized under Section 42-5-20 to insure.

2. That under Section 42-1-130, the Claimant was a covered employee at the time in question.

3. That under Section 42-1-140, the Defendant was a covered employer under the Act.

4. That under Section 42-9-30, the Claimant sustained injuries by accident arising out of and in the course of her employment resulting in an accidental injury.

5. That under Section 42-9-10, the Claimant is deemed permanently disabled.

6. That under Section 42-15-60, the Claimant is entitled to lifetime medical treatment for her work injuries.

## ORDER

IT IS THEREFORE ORDERED ADJUDGED AND DECREED that Claimant is permanently and totally disabled and is entitled to Total Disability Compensation in the amount of 500 weeks. The insurance carrier previously paid 48 weeks of temporary total benefits through

August 21, 2015; leaving 452 weeks to commute. The claimant is hereby awarded and shall be paid the commuted value of the remaining 452 weeks which equals Three Hundred Thousand Nine Hundred Thirty Eight and 67/100 ($300,938.67) Dollars.

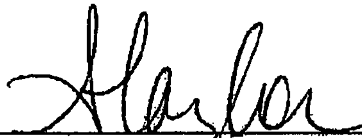
IT IS FURTHER ORDERED that the Employer is responsible for lifetime causally related medical expenses as outlined in the Findings hereinabove. This includes but is not necessarily limited to: her teeth, mandible, left shoulder, neck, facial nerve and depression. The depression was aggravated by her accident.

IT IS FURTHER ORDERED that Cherokee Insurance Company is and shall be the responsible carrier and shall provide coverage for the Employer with reference to

this claim.

AND IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Aisha Taylor

**CERTIFICATE OF SERVICE**

**This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid, in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).**
**May 23, 2017**

**By: Renee Smith, Administrative Assistant to Commissioner Taylor**

DECISION AND ORDER OF THE
SOUTH CAROLINA WORKERS' COMPENSATION
COMMISSION APPELLATE PANEL

| | | |
|---|---|---|
| Jennie Cox,<br><br>Employee,<br>vs.<br><br>Palmetto State Transportation,<br><br>Employer,<br><br>and<br><br>Cherokee Insurance Company,<br><br>Carrier,<br>Defendants. | ) | WCC FILE NO: 1206236<br><br>**FULL COMMISSION DECISION AND ORDER** |

HEARING DATE: February 2, 2017, in Columbia, South Carolina.

APPEARANCES: Claimant represented by Juliette B. Mims, Esquire of the Mims Law Firm and Adrianne Turner, Esquire of Columbia, South Carolina.

Defendants represented by Robert E. Horner, Esquire of Columbia, South Carolina.

PANEL: Commissioner Susan S. Barden, Chair
Commissioner Avery B. Wilkerson
Commissioner R. Michael Campbell

FILED: May 21, 2018

This matter came before the South Carolina Workers' Compensation Full Commission on appeal by the Defendants from the Decision and Order of the Hearing Commissioner Aisha Taylor. In the Order dated May 23, 2017, the Hearing Commissioner found Claimant to be

permanently and totally disabled from a compensable injury that occurred on May 31 , 2012. For the reasons set forth below, we reverse and remand.

## STATEMENT OF THE CASE

This claim arose out of an admitted injury to the Claimant, employed as tractor trailer driver for Defendant, Palmetto Transportation Company. On May 30, 2012, the claimant suffered compensable injuries after a machine fell on her causing injuries to her face and shoulder. Her injuries to her face included the removal of her remaining teeth and dental implant replacements, surgery to her upper and lower mandibles, and physical therapy for her shoulder.

The case went to a hearing on the Claimant's Form 50 on the issue of permanency. Per her Form 58, Claimant alleged, "head, neck, cognitive brain and traumatic brain dysfunction, jaw, teeth, soft tissue, nerves, left shoulder, chest, mid back and low back problems, breathing problems, depression and severe weight loss." Claimant alleged she was permanently and totally disabled due to fatigue which she contended was caused by malnutrition caused by injuries to her jaw and teeth. Defendants admitted that Claimant had suffered the loss of teeth, suffered an impairment to her jaw per the authorized treating physician's Form 14B, and suffered a 6% impairment to her shoulder.

In determining that Claimant was permanently and totally disabled, the Hearing Commissioner relied on the medical opinions of Dr. Ellis, the claimant's family physician, and Dr. Brabham, a psychiatrist who performed a one-time physiological and vocational evaluation of Claimant. The Hearing Commissioner determined that Claimant was entitled to lump-sum payment of the commuted value of five hundred weeks of benefits less any amount previously paid by Defendants in the form of temporary compensation. The Hearing Commissioner also found that pursuant to S.C. Code Ann. § 42-15-60, Claimant was entitled to lifetime benefits for

causally related medical expenses including, but not limited to lifetime repair, replacement and/or removal of any retained hardware and causally related medical treatment for her teeth, mandible, left shoulder, neck, facial nerve, and depression.

Defendants timely filed the Form 30, Request for Appeal, respectfully submitting the following errors of law:

1. That the Hearing Commissioner committed an error of law when she found the Claimant was permanently and totally disabled without requiring the Claimant to establish, by medical evidence stated to a reasonable degree of medical certainty, that Claimant's alleged fatigue, or any other alleged debilitating condition, in March 2016 was related to her work-related accident that occurred in May 2012.

2. That the Hearing Commissioner erred as a matter of law when she found that the testimony of Dr. Brabham supported the Claimant's position that she was permanently and totally disabled, as Dr. Brabham is not a medical doctor who was qualified to establish, to a reasonable degree of medical certainty, that Claimant's alleged fatigue in 2016 was causally related to her work-related injury suffered in May 2012.

3. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled because the Claimant failed to establish to a reasonable degree of medical certainty that any alleged symptoms she was having in March 2016 for which she took herself out of work were related to malnutrition which was related to her work-related injury.

4. That the Hearing Commissioner erred as a matter of law when she found that the report of Dr. Brabham supported the Claimant's position that she was permanently and totally disabled, as Dr. Brabham's report failed to meet the required standard for medically complex cases.

5. That the Hearing Commissioner erred as a matter of law in relying upon Dr. Brabham's report to support the conclusion that the Claimant was permanently and totally disabled, as Dr. Brabham's report contained erroneous information regarding the Claimant's ability to work—namely, Dr. Brabham reported that after her work related accident, the Claimant attempted to work for one week but was unable to continue when, in fact, the Claimant worked from November 2012 until March 2016 when she took herself out of work.

6. That the Hearing Commissioner erred as a matter of law in relying upon the records of Dr. Ellis to support the Claimant's position that she was permanently and totally disabled, as Dr. Ellis never establish in any form that the Claimant was permanently and totally disabled, as in fact, Dr. Ellis returned the Claimant to work after writing her a work excuse for several weeks, stating that there was no basis for the Claimant not to return to work.

7. That the Hearing Commissioner erred as a matter of law in relying upon Dr. Ellis in finding that the Claimant was permanently and totally disabled, as Dr. Ellis never causally related, to a reasonable degree of medical certainty, any of Claimant's medical conditions to her work-related accident, and to the contrary, stated that the Claimant's absence from work was not related to her work-related injury.

8. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled because the Claimant failed to establish to a reasonable degree of medical certainty that any alleged symptoms she was having in March 2016 for which she took herself out of work were related to malnutrition which was related to her work-related injury.

9. That the Hearing Commissioner erred as a matter of law when she found that Dr. Ellis' records supported the position that the Claimant was permanently and totally disabled,

as Dr. Ellis found no reason for Claimant to be out of work and wrote the Claimant back to work.

10. That the Hearing Commissioner erred as a matter of law in finding that the Claimant's weight loss/current weight alone would be sufficient to establish that the Claimant suffered malnourishment or fatigue resulting from the accident, when Claimant weighed less in 2013, 2014, and 2015, when she worked for three years as a CDL driver following her accident, and moreover, the Hearing Commissioner went beyond her qualifications and arrived at a medical conclusion that she was not qualified to make regarding the issue of the Claimant's weight when no other medical doctor testified that the Claimant suffered from malnourishment or fatigue that resulted in a permanent and total disability.

11. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when Dr. Stacy Newsom opined that the Claimant could return to work on November 9, 2012, without restrictions, and Claimant did return to work without restrictions.

12. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when the Claimant's dietary restrictions in 2016 were identical to the restrictions she had in 2012 and 2013 when she was released by her treating physicians to return to work and Claimant never had an alteration in those restrictions.

13. That the Hearing Commissioner erred as a matter of law in finding the Claimant permanently and totally disabled when Dr. Brian Svazas opined that the Claimant had suffered a 6% impairment to her shoulder and could attend physical therapy if desired,

though Claimant declined further physical therapy, but was otherwise able to return to work without restrictions.

14. That the Hearing Commissioner erred in finding that the Claimant was permanently and totally disabled because factually, there is no support for such a conclusion, and to the extent there are any facts, such facts fail to rise to the level of established beyond the preponderance of the evidence that the Claimant is permanently and totally disabled.

15. That the Hearing Commissioner erred in finding that there were sufficient facts to find the Claimant permanently and totally disabled, as such facts are not supported by the greater weight of the evidence;

16. That the Hearing Commissioner erred in finding that Dr. Brabham was credible in his opinions, as Dr. Brabham's report was factually erroneous in multiple regards and were not established by the evidence, including but not limited to the fact that Dr. Brabham stated that "to her credit, Ms. Cox tried to return to work, and actually drove a one week run. However, she was exhausted while doing so, and since that time, she has been unable to return to any gainful employment whatsoever, because of her on-the-job injuries on May 31, 2012." Dr. Brabham erroneously believe that Claimant had not worked in almost four years. Dr. Brabham's opinions were also erroneous in the following particulars: (1) that Claimant had lost 20 pounds since the accident; (2) in relying upon the Claimant's opinion for medical causation, nothing that in Claimant's opinion her weight loss was due to ongoing dental issues; (3) that Claimant had major problems falling asleep when, in fact, Claimant had been on insomnia medication for years, and before the accident; (4) he stated that due to her injury, she was unable to handle any type of work that would require her to maintain the same position for more than 30 minutes which was wholly erroneous in light of the fact the

Claimant drove tractor trailer trucks for 11 hours (or in 11 hour shifts) in 2013, 2014, 2015, and two months into 2016 without ever once calling in sick or declining to take a run.

17. That the Hearing Commissioner erred in relying upon Dr. Brabham's report to the extent he opined that she took Xanax because of the accident and that her injury was the cause of her current problems because Dr. Brabham only stated that "it was reasonable to conclude" the accident was the cause, which does not meet the most probably, to a reasonable degree of medical certainty standard which is required in this case and all medically complex cases.

18. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled, with such a conclusion unsupported by the facts, against the greater weight of the evidence, not supported by a preponderance of the evidence and such a conclusion constituted an abuse of discretion.

19. That the Hearing Commissioner erred in finding the Claimant permanently and totally disabled and failed to consider such facts which established otherwise the following facts, and the Hearing Commissioner erred in finding the Claimant credible, based upon the following facts which establish Claimant was not credible:

a. That the Claimant returned to work driving long distance, over-the-road trucking jobs from November 2012 until March 2016, when she voluntarily took herself out of work;

b. That at the time she took herself out of work, Claimant reported that she "hurt all over" and stopped showing up for work.

c. That prior to taking herself out of work in March 2016, Claimant never once turned down an assignment to drive, never took vacation or sick leave, and accepted

every driving offer given to her (her employment was not forced dispatch and Claimant was free to accept or turn down any job she wanted).

d. That in 2013, the Claimant earned $57,602.75 in her employment as an OTR driver with Palmetto State Transport.

e. That in 2014, the Claimant earned $75,464.77 in her employment as an OTR driver with Palmetto State Transport.

f. That in 2015, the Claimant earned $63,693.25 in her employment as an OTR driver with Palmetto State Transport.

g. That the Claimant's dietary restrictions never changed from 2012 until 2016;

f. That Claimant did not receive or seek any additional physical therapy to her shoulder and still had the 6% rating to her shoulder from Dr. Svazas;

h. That although the Claimant lost the approximate 9-11 natural teeth she had at the time of the accident, the Claimant's lost teeth were replaced with dental implants, which allowed her to eat 85% solid good and 15% semi-solid food;

i. that the Claimant took herself out of work in March 2016 and was not taken out of work by Dr. Ellis, though Dr. Ellis later approved several weeks out of work after the fact, though Dr. Ellis later stated that she could not medically continue to write the Claimant out of work beyond May 2016;

j. that the Claimant did not lose 25 pounds as alleged, and in fact, at various times, weighed near the same after the accident as she did before the accident, and by December 2016, weighed more than she did at any time before her accident;

k. that the Claimant had a longstanding history of depression that was recorded long before this accident, and in fact, she admitted that her depression was related to the death of her grandson and not this accident, and at no time in the nearly give years between her accident and the Hearing did the Claimant ever request, seek, or receive any therapy related to her depression;

l. that to the extent Claimant had some depression, she was placed on an anti-depression by Dr. Ellis and within a matter of two months felt much better;

m. That the Claimant was already on anxiety and insomnia medications before this accident and that there is no evidence or medical testimony that the accident was the cause of her continuing to receive these prescriptions over the four years she continued to work;

n. That in October 2015, the Claimant went being a team driver on a dedicated route to being a single driver running various routes, but despite this change, the Claimant still did not turn down an assignment or try to work any reduced hours prior to her voluntarily ceasing her employment in March 2016;

o. That although Dr. Cofer opined that the Claimant had numbness in her jaw because of the accident, this numbness had been present since the accident and formed the basis of Dr. Cobb giving her a 2% impairment to the facial nerve, and thus was not a new finding or recent development that impacted her ability to work and there was no medical testimony causally related any of Claimant's alleged malnourishment or fatigue or "body aches" to her facial nerve;

p. That the Claimant returned to work on June 1, 2016, but walked off the job two weeks later, without a doctor's excuse and was not written out of work for this absence and to this day, has never been written out of work by a medical doctor;

q. That Dr. Ellis never opined that the Claimant was permanently and totally disabled;

r. That in completing her disability paperwork, Dr. Ellis specifically stated that the Claimant's ongoing medical problems were not related to her work-related injury;

s. That the Claimant's testimony that her employer was "not comfortable accepting the liability implications stemming from her symptoms" is not credible due to the fact that her Employer continued to offer her employment through her absence, did not terminate her from her employment, and in October 2016, specifically offered Claimant a job driving as a team driver after Claimant represented that driving as a single driver was part of her concerns, but despite this, Claimant did not return to work;

t. That although Claimant stated she worked two weeks in June 2016 "with constant pain over her entire body," not doctor found that these alleged pains were causally related to her accident in May 2012, and the records of Dr. Ellis do not reflect any such pains ever being documented;

u. And other facts as shown by the record and will be briefed at the appropriate time.

20. That the Hearing Commissioner erred in finding that the Employer "authorized work hardening" when the Employer, as a benevolent employer, arranged for work hardening based upon Claimant's assurances that she could return to work if allowed to participate in or complete a "full body" program.

21. That the Hearing Commissioner erred in finding the Claimant was unable to return to work due to pain, weakness, fatigue, and anxiety, when there was no medical evidence causally related an inability to return to work to such alleged medical conditions.

22. That the Hearing Commissioner erred in Finding of Fact #4, as neither Dr. Ellis nor Dr. Brabham testified that the Claimant suffered an aggravation or exacerbation of a pre-existing condition that was, to a reasonable degree of medical certainty, causally related to her accident in May 2012.

23. That the Hearing Commissioner erred in Finding of Fact #7, as there was no medical evidence to establish that the Claimant was permanently and totally disabled because of her accident in May 2012, no medical evidence Claimant was permanently disabled, and no medical evidence stated to a reasonable degree of medical certainty, thus constituting an error of law.

24. That the Hearing Commissioner erred in Finding of Fact #7 in finding that Dr. Brabham and/or the Claimant was credible, for the reasons set forth herein.

25. That the Hearing Commissioner erred in Finding of Fact #8 in finding that the Claimant was entitled to a lump sum, as the Hearing Commissioner failed to take into account the standard for awarding lump sum benefits as required by Thompson v. Steel Erectors, 369 S.C. 606 (Ct. App. 2006); moreover, the Hearing Commissioner erred in finding the Claimant was entitled to a lump sum, as the award in such a manner deprives the Defendants of their ability to establish that the Claimant underwent a change of condition for the better, depriving them of a statutory right.

26. That the Hearing Commissioner erred in Finding of Fact #9 in finding that the Claimant had suffered an aggravation of depression, as there was no medical evidence from a

qualified medical doctor, stated to a reasonable degree of medical certainty, establishing that the Claimant suffered an aggravation of depression causally related to her work-related accident of May 2012, and in finding the Claimant was entitled to future medical care for depression when Claimant had never asked for, sought, or received depression related to her accident. Moreover, there is no evidence that the Claimant's pre-existing depression was quiescent but rather was an ongoing issue and therefore such condition could not be compensable under South Carolina law and Gordon v. E.I. Du Pont De Nemours Co., 228 S.C. 67, 76 (S.C. 1955), or at a minimum, expert testimony was required to establish causation.

27. That the Hearing Commissioner erred in Conclusion of Law #5, as said finding is not supported by the evidence and erroneous as a matter of law and fact for the grounds set forth herein.

28. That the Hearing Commissioner erred in Conclusion of Law #6, as said finding is not supported by the evidence and erroneous as a matter of law and fact for the grounds set forth herein.

29. That the Hearing Commissioner erred in failing to find that the Claimant suffered complete loss of earning capacity from her May 2012 injury, as is required to establish permanent and total disability; to the extent such a finding can be inferred, it is against the preponderance of the medical and lay evidence presented.

30. That the Hearing Commissioner erred in failing to find that the Claimant had an inability to perform services other than those so limited in quality, dependability, and quantity that a reasonable market for them did not exist, as is required to establish permanent

and total disability; to the extent such a finding can be inferred, it is against the preponderance of the medical and lay evidence presented.

31. That the Hearing Commissioner failed to properly place the burden of proof on the Claimant as is required under the Act, as the Claimant failed to show that she had made reasonable efforts to obtain employment and had failed because of an injury produced handicap.

32. Even assuming Claimant established that she was unable to be an OTR driver, the same of which is denied, the Claimant failed to establish by a preponderance of the evidence that she was unable to work in other suitable employment, as the medical and lay evidence establish she was capable of working.

## EVIDENCE OF THE CASE

On May 31, 2012, the Claimant, while working in the course and scope of her employment as a tractor trailer driver for Palmetto State Transport, suffered injuries after a machine fell on her, knocking her to the ground. Because of the accident, the Claimant suffered injuries to her face and shoulder. Her injuries to her face included the removal of her remaining teeth (over time), surgery to her upper and lower mandibles, and the implantation of dental implants/dentures.

As to her left shoulder, Claimant was seen by Dr. Stacy Newsom. Claimant underwent an MRI of the shoulder which showed no physical injury and was deemed to be nonsurgical. Claimant started physical therapy with Proaxis Therapy on August 22, 2012, for her left shoulder pain.

On July 24, 2012, Claimant began treating with Dr. Larry W. Cobb at Piedmont Oral Surgery. Dr. Cobb determined that she needed an additional three months before attempting

restorative procedures. Dr. Cobb subsequently associated Dr. Ridgell with regard to the dental implants of the Claimant. It was later determined that she would need removal of her remaining natural teeth, bone grafting, and either one or both mandible plates had to be removed.

By November 9, 2012, the Claimant had completed physical therapy on her shoulder and was released to return to work by Dr. Newsom. (APA p. 285) The Claimant and her Employer both agreed that Claimant's position as a driver with Palmetto State did not require her to lift over 35 pounds because Palmetto State is a "no touch" freight hauler, i.e., the drivers do not have to load/unload the freight. With this understanding, Dr. Newsom released the Claimant to return to work at Palmetto State without restrictions. (APA p. 285). Dr. Newsom also found that Claimant had a 2% impairment to her left shoulder. (Id.)

On January 31, 2013, Claimant had her remaining 9 teeth removed. On April 29, 2013, the Claimant had 5 dental implants inserted. On July 7, 2013, Claimant had 6 dental implants. During this period, the Claimant continued to work as an over-the-road truck driver, except for when she was recovering for 4 to 6 weeks following each procedure. Both before and after the accident, the Claimant was driving as a team driver, and running a dedicated route from Greenville, South Carolina to Brownsville, Texas. While driving as a team driver, Claimant would still drive 10 hours straight before having her team driver relieve her, just as she would if she had been a solo driver. (H.T. 35-37).

On October 6, 2014, Claimant was seen by Dr. Brian Svazas for her shoulder. (APA p. 295). She complained that she had trouble reaching behind her and when driving her zero-clearance mower. (Id.) She stated that her range of motion and strength in the left arm were doing quite well. (Id.) She noted some soreness when driving long runs when she uses her left arm to steer and her right arm to flip switches. (Id.) She did not sleep on the left side but

otherwise had no difficulties with her left arm. (Id.) On exam, she could put her arm through full ranges of motion. She had no weakness in the arm. (Id.) She was pain free on supraspinatus and infraspinatus testing with no weakness with either maneuver. (Id.) She reported that the pain was alleviated with Tylenol. (Id.)

Dr. Svazas found that "the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career." (APA p. 296). He recommended physical therapy for her, which the claimant declined. (Id.) Dr. Svazas conclude by stating that she was fit for full duty as a truck driver that she was at MMI, he increased her rating to 6%. He completed a Form 14B on her finding that she could return to work without restrictions. (APA p. 300).

The Claimant continued to work full time as a driver for Palmetto State. Palmetto State is not a "forced dispatch" company—the Claimant was not required to take every run or job that was offered to her. (H.T. 55-57). She was free to turn down any runs she desired and work as much, or as little, as she wanted. (H.T. 55-57). She admitted it was rare she would be forced to move any freight. (H.T. p. 49). Despite this, she testified that she not only continued to work, but also took every run offered to her from 2012 until 2016. (H.T. 55-57).

On April 27, 2015, Dr. Cobb found the Claimant to be at MMI with the following impairment ratings: 4% interincisal range of Motion- 30mm, 3% lateral excursion range of motion 5-6mm, 2% facial disorder for a scar, 1% to the facial nerve. Her diet was to consist of 85% normal foods and 15% soft or semi-solid foods. (APA p. 301-302).

On July 5, 2015 Dr. Fowler performed surgery for removal of some of the hardware in her jaw. In August 2015, Dr. Fowler released her to return to work without restrictions.

Dr. Ridgell completed a Form 14B on the Claimant on April 9, 2015, and noted that she could return to work without restrictions. (APA p. 299).

In October 2015, Claimant went from "team driving" to single driving because the route she had run as a team driver was lost by Palmetto State and was no longer available. (H.T. 16:17-25; 35:16-23). Notwithstanding the preceding statements, on approximately March 3, 2016, the Claimant reported that she had "pain all over" and was unable to work. Claimant confirmed that she had suffered no new injury that caused her to suffer "pain all over." Claimant later alleged that her pain came from fatigue which originated from malnourishment which came from her inability to eat the prescribed diet of 85% of a normal food and 15% semi-soft foods. She alleged her fatigue was all the result of her injury and loss of weight.

At the Hearing, the Claimant testified that she had lost a significant amount of weight and loss of energy due to the accident. (H.T. 23:1-21:24:10-21). She also claimed to suffer from fatigue and weight loss that was preventing her from being able to perform her job duties. (H.T. 33:11-24). Claimant acknowledged being treated for depression prior to this incident. (H.T. 27:23 – 28:5). On cross examination, the Claimant admitted her weight was not significantly lower than it had been prior to the accident and that she had gained weight during her physical therapy in 2016. (H.T. 33:25-34:25; 39:6 – 19; 40:17 – 24; 45:3 – 23; 46: 4 – 12).

Claimant acknowledged that she was released to full duty without restrictions in November 2012, and then periodically thereafter by various physicians associated with her care. (H.T. 35:4-9). Claimant acknowledged that upon her return to work, she returned to being a tandem driver and that she drove 10 hours per day per D.O.T. regulations, and that as a solo driver, her driving hours were the same. (H.T. 36:14 – 37:5) She also acknowledged that in the years after the accident, she earned nearly the same or slightly more money than prior to the accident. (H.T. 38:1 – 4; 16 – 25:39:1-4). Claimant also admitted that despite doing the same work she was doing prior to the accident, and being offered similar work through Palmetto

Transport, Claimant took herself out of work and refused to return. (H.T. 41:8 – 22; 48:12 – 17). Prior to taking herself out of work in 2016, Claimant never turned down a run and even did extra runs, despite the fact she could turn down any run she wanted. (H.T. 55:1 – 13; 56:1-3).

In 2013, the Claimant earned $57,602.75, which was near her average income for a full year. (APA p. 372-375). In 2014, the Claimant earned $75,464.77, above her normal average. (APA p. 372-375). In 2015, the Claimant earned $63,693.25 with Palmetto State, which was in the normal range of what she had made over the course of her employment. (APA p. 326-339).

## STANDARD OF REVIEW

The Full Commission is the ultimate fact finder in Workers' Compensation cases and is not bound by the Single Commissioner's findings of fact. See Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (1989); see also Hoxit v. Michelin Tire Corp., 304 S.C. 461, 405 S.E.2d 407 (1991) (Full Commission is fact finder).

The Full Commission is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (1992); see also Brayboy v. Clark Heating Co., 306 S.C. 56, 409 S.E.2d 767 (1991) (Full Commission may review award of Single Commissioner and make its own findings of fact and conclusions of law). The final determination of witness credibility and the weight to be accorded evidence is reserved to the Full Commission. Ross, 298 S.C. at 492, 381 S.E.2d at 730; Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 440 S.E.2d 401 (Ct. App. 1994).

Where there are conflicts in the evidence over a factual issue, the findings of the Full Commission shall be conclusive. Rogers, 312 S.C. at 380, 440 S.E.2d at 403; see also Stokes v. First Natl Bank, 306 S.C. 46, 410 S.E.2d 248 (1991) (regardless of a conflict in the evidence,

either of different witnesses or of the same witness, a finding of fact by the Commission is conclusive).

## LAW/ANALYSIS

The Defendants argue that the Claimant failed to prove that she was permanently and totally disabled and that permanency in this case should have been awarded to the Claimant pursuant to South Carolina Code Section 42-9-30. We agree.

South Carolina Code Section 42-9-10 provides for permanent and total disability "when the incapacity for work resulting from an injury is total." A claim can be pursued for permanent and total disability under this section when a claimant has suffered injury to more than one body under South Carolina Code section 42-9-30. When proceeding under Section 42-9-10, however, a claimant must establish his disability, as it is not presumed as it is under Section 42-9-30. See Brown v. Owen Steel Co., 316 S.C. 278, 280, 450 S.E.2d 57, 58 (Ct. App. 1994). "Disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment. S.C. Code Ann. § 42-1-120.

The extent of disability is a question of fact to be proved as any other fact is proved. In Wynn v. Peoples Natural Gas Co. of S. C., 238 S.C. 1, 11–12, 118 S.E.2d 812, 817–18 (1961), our Supreme Court stated:

> Disability in compensation cases is to be measured by loss of earning capacity. Total disability does not require complete helplessness.... The generally accepted test of total disability is inability to perform services other than those that are "so limited in quality, dependability, or quantity that a reasonably stable market for them does not exist."

Wynn v. Peoples Natural Gas Co. of S. C., 238 S.C. at 11–12, 118 S.E.2d at 817–18 (1961). An award cannot rest on surmise, conjecture or speculation; it must be founded on evidence of

sufficient substance to afford a reasonable basis for it. Id. citing Revers v. V. P. Loftis Co., 214 S.C. 162, 51 S.E.2d 510.

If a claimant is attempting to establish causation of a medically complex condition, expert medical testimony is generally required. Brown v. La France Indus., 286 S.C. 319, 333 S.E.2d 348 (Ct. App. 1985); McLeod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984) (noting that depression was a medically complex issue). While the lack of medical causation may be overcome in some cases with competent evidence, The Appellate Panel is given discretion to weigh and consider all the evidence, both lay and expert, when deciding whether causation has been established. Ballenger v. S. Worsted Corp., 209 S.C. 463, 467, 40 S.E.2d 681, 685 (1946). McLeod provides the Appellate Panel with the ability to ascertain the proficiency of an expert and to decide whether a "higher degree of expertise" is needed regarding an award. Id. at 280 S.C. at 471, 313 S.E.2d at 41 (holding the award should be remanded for redetermination when an alleged defect and injury sustained by the claimant concerned a complicated area of the body requiring a higher degree of expertise than provided to the Appellate Panel).

As noted by the Supreme Court in Wynn v. Peoples Natural Gas Co. of S. C., 118 S.E.2d 812, 238 S.C. 1 (1961), "reliance on lay testimony and administrative expertise is not justified when the medical question is no longer an uncomplicated one and carries the fact-finders into realms which are properly within the province of medical experts.... The increasing tendency to accept awards unsupported by medical testimony should not be allowed to obscure the necessity of establishing medical causation by expert testimony in all but the simple and routine cases." Id. citing Larson's Workmen's Compensation Law, Section 79.54. Moreover, the Court in Wynn

further rejected the exact same proposition advanced here: that a claimant's own statement that she is unable to work is sufficient to support an award of permanent and total disability. Id.

The underlying Order bases permanent and total disability on the Claimant's weight in 2016, her testimony she was fatigued and unable to work, and reliance upon Dr. Ellis and Dr. Brabham. Our review of the record, however, does not supporting a finding of permanent and total disability, factually or causally.

Claimant's allegations in this case were that she had become malnourished, that her malnourishment caused her to suffer fatigue, and that her fatigue rendered her to be permanently and totally disabled, while Defendants argued that Claimant (a) failed to prevent sufficient evidence to establish these facts and (b) provided no medical evidence to support her claim.

A review of the record reveals that the Claimant provided no medical testimony or evidence to support her allegations of malnourishment, resulting in fatigue, rendering her permanently and totally disabled. None of the authorized treating physicians placed any restrictions on Claimant's ability to work, let alone opined that the Claimant was totally and permanently disabled. To the contrary, the authorized treating physicians all opined that the Claimant could return to work full duty following her accident: (1) On November 9, 2012, Dr. Stacy Newsom stated she could return to work without restriction and gave her a 2% rating to the shoulder (APA p. 285); (2) Dr. Cobb rated the Claimant in April 2015 and stated that she could return to work without restriction. (APA p. 302); (3) Dr. Svazas increased her impairment rating to the left shoulder to 6%, but found "that she is fit for full duty as a truck driver"; (4) Dr. Ridgell noted on his Form 14B that the Claimant could return to work without restrictions in April 2015. (APA p. 299).

In addition, Claimant did not complain to any of these physicians that she was suffering malnourishment or fatigue or ever registered a complaint that she was unable to work. While certainly the Claimant reported some issues with numbness of her facial nerve and some loss of function that impacted her diet, these issues were present from the outset when Claimant returned to work from 2012 until 2016. Moreover, these issues are reflected in the impairment ratings she received from her authorized treating physicians.

The Hearing Commissioner's Order relied upon the records of Dr. Ellis to support the decision that claimant was permanently and totally disabled. Dr. Ellis' records show, however, that she was written back to work by Dr. Ellis. Dr. Ellis never opined that the Claimant was permanently and totally disabled or opined on issues of causation other than to state her issues were not causally-related to her accident, or at best, were multi-factorial.

On March 3, 2016, the Claimant reported to Dr. Ellis that she was becoming mentally and physically fatigued. This was the first report of fatigue reported by the Claimant to any doctor. Dr. Ellis continued to see the Claimant in March 2016, April 2016, and May 2016. On April 22, 2016, Dr. Ellis noted that she believed the Claimant's weight loss and fatigue was "multifactorial." However, Dr. Ellis never identified the factors she felt were contributing to the Claimant's current status. Dr. Ellis did not opine to a reasonable degree of medical certainty that the Claimant's current condition (1) was causally related to her injury or (2) that Claimant was unable to return to work.

By May 9, 2016, Claimant reported that her energy level was improving. Dr. Ellis stated that she was "unable to continue to recommend [Claimant] out of [work] without clear deadline. [A]grees would be reasonable to return to work if maintains currents (sic) level of weight." Thus, as of May 9, 2016, Dr. Ellis opined that the Claimant had no restrictions that prevented her

from returning to work. On May 23, 2016, it was noted that the Claimant weighed 109.6 pounds and Dr. Ellis wrote her back to work. Claimant did not return to see Dr. Ellis after this visit returning her to work.

Dr. Ellis also completed disability paperwork for Claimant. (APA p. 322). Dr. Ellis wrote that the Claimant's primary condition was fatigue and weakness and a secondary condition of weight loss. (Id.) Dr. Ellis indicated that she expected significant improvement in the Claimant's medical condition in 1-2 months with a return to work date of May 30, 2016. (Id.) Dr. Ellis further indicated that the Claimant had no permanent restrictions preventing her from returning to work. (Id.) Finally, Dr. Ellis wrote that the Claimant's condition was not due to an accident. (Id.)

Based upon our review of the record, we find that Dr. Ellis' records do not support a finding of permanent and total disability, and to the contrary, support the fact that the Claimant was cleared to work without restrictions in May 2016. Dr. Ellis' records further support that rather than Claimant being permanently and totally disabled, the condition from which she was suffering, even if it was causally related, was short-term and did not result in total disability.

The Hearing Commissioner also relied upon Dr. Brabham's report to support a finding of permanent and total disability, which the Defendants contend was erroneous. We agree.

Dr. Brabham's report documenting his understanding of the Claimant's work history following the accident is clearly erroneous. In reciting her post-accident work history, Dr. Brabham states "[t]o her credit, Ms. Cox tried to return to work, and actually drove a one-week 'run.' However, she was 'exhausted' while doing so, and since that time, she has been unable to return to any gainful employment whatsoever, as a result of her on-the-job injuries on 5-31-12." (APA p. 274). Nowhere else in his report does Dr. Brabham recite any facts or information that

would lead us to believe that he was aware she worked full-time from January 2013 through March 3, 2016 and earning those amounts that were around or above her normal income. This lack of knowledge of the Claimant's work history undermines Dr. Brabham's report and its conclusions and do not provide a basis for determining that the Claimant is permanently and totally disabled. Alternatively, Dr. Brabham's report is outcome determinative.

Additionally, Dr. Brabham is not a medical doctor who was qualified to establish to a reasonable degree of medical certainty that Claimant's alleged fatigue that developed in 2016 was causally related to her work-related injury suffered in May 2012, or that any alleged fatigue would have rendered her permanently and totally disabled. Although Dr. Brabham cites portions of medical notes from the Claimant's authorized treating physicians and her treatment history, he does not cite any medical records from Claimant's authorized treating physicians that indicate the claimant has restrictions, let alone was unable to work. All the treating physicians in this case indicate that the Claimant could return to work without restrictions; accordingly, Dr. Brabham's conclusion that she is permanently and totally disabled is not supported by the opinions of the treating physicians.

Finally, we note that Dr. Brabham's conclusions about the Claimant's inability to perform activity because she is "unable to sustain much activity, due to pain" and that she must recline 2-3 hours of her day, to be in conflict with the record in this case. Claimant's medical records do not support any such complaints, let alone to be so great as to render her unable to work. Dr. Ellis' records reveal no such complaints of pain. There is no evidence the Claimant sought out any treatment for complaints of pain. The Claimant was not prescribed medicine for pain. Claimant testified what shoulder pain she may have was alleviated by Tylenol and/or SalonPas patches, and in 2014, Claimant rejected an offer to return to physical therapy on her

shoulder per Dr. Svazas. Moreover, Dr. Brabham's report is inconsistent with Claimant's testimony that from 2013 to 2016,. she drove 10-hour runs across country in 2014, 2015, and 2016, from Greenville, South Carolina to Brownsville, Texas. She drove this route nonstop, but for gas and food, starting her first run on a Monday and ending on a Wednesday and making a second run on Thursday and ending on a Saturday. (Cox 8/23/16 depo., p. 17).

Based upon a review of the record, the briefs, and the oral arguments of this matter, the Appellate Panel **REVERSES AND REMANDS** the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, and below, shall become, and hereby are, the law of the case.

## FINDINGS OF FACT:

1. The Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial nerve, as well as scarring to her chin.
2. The Claimant received medical care under with Dr. Cobb, Dr. Ridgell, Dr. Fowler, Dr. Cofer, Dr. Newsom, and Dr. Svazas for her injuries.
3. Upon being released by each of the authorized treating physicians, the Claimant was released to work full duty with no restrictions on her ability to perform her duties as an over-the-road truck driver.
4. Following her accident, the Claimant returned to work in November 2012 and shortly thereafter resumed her normal job as an OTR truck driver.
5. Claimant continued to work full-time as an OTR in 2013, 2014, 2015, save for those periods of time when she was undergoing further care.

6. In March 2016, Claimant took herself out of work, stating she was tired and unable to work due to fatigue secondary to malnourishment that was alleged to have resulted from her injuries.
7. Claimant saw her family physician, Dr. Ellis, in March 2016 for her complaints.
8. While Dr. Ellis treated the Claimant for weight loss and reported fatigue, by May 9, 2016, Dr. Ellis reported that the Claimant could return to work as a OTR truck driver. Dr. Ellis reiterated that opinion on May 23, 2016.
9. Dr. Ellis further completed a disability application for the Claimant, which stated that the Claimant's weight loss and reported fatigue were temporary in nature, lasted one to two months, and were not related to her accident.
10. At no point did Dr. Ellis opine as to the causation of Claimant's complaints; nor did Dr. Ellis opine that these complaints resulted in any permanent disability or even restrictions on Claimant's ability to work.
11. Dr. Cobb, Dr. Ridgell, Dr. Fowler, Dr. Cofer, Dr. Newsom, and Dr. Svazas, the authorized treating physicians, all released the Claimant to return to work full duty over the course of their treatment of the Claimant.
12. Claimant admits that she took every run offered to her between 2012 and 2016 and did not turn down any jobs until March 2016.
13. Claimant admitted, and her records, revealed that her weight throughout her recovery period fluctuated and that by May 2016, Dr. Ellis opined, and the Claimant agreed, that her weight was sufficient for her to return to work.

14. Claimant admitted that she was offered a tandem job by her employer, which she believed would allow her to return to work, but she declined to take her employer up on that offer to drive as a team driver and declined to return to work.
15. The Claimant provided no medical evidence to support her contention that she suffered from malnourishment or fatigue causally related to her 2012 injury.
16. The Claimant provided no medical evidence establishing that she was on restrictions or was permanently and totally disabled secondary to malnourishment.

## CONCLUSIONS OF LAW

1. That under S.C. Code Ann. § 42-3-20 and § 42-3-180 (1985), the Commission has jurisdiction over the parties to hear the issues in dispute.
2. That under S.C. Code Ann. § 42-1-130, the Claimant is a covered employee.
3. That under S.C. Code Ann. § 42-1-140, Palmetto Transportation Company is a covered employer.
4. That under S.C. Code Ann. § 42-1-150, there was an employer/employee relationship between the parties at the time in question.
5. That the burden of establishing total and permanent disability, or any benefit, is on the Claimant. Lee v. Bondex, Inc., 406 S.C. 97, 749 S.E.2d 155 (Ct. App. 2013).
6. That under S.C. Code Ann. § 42-9-10, Claimant failed to meet her burden of proving permanent and total disability and is not entitled to permanent and total disability award under S.C. Code Ann. § 42-9-10.
7. That as Claimant failed to prove that she was permanently and totally disabled, the Claimant is not entitled to a lump sum award of permanent and total disability. S.C. Code Ann. § 42-9-10.

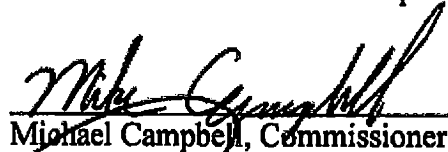
8. That the Claimant failed to establish by medical evidence, stated to a reasonable degree of medical certainty, that she suffered malnourishment resulting in fatigue or any alleged causal relationship to her May 30, 2012 accident. Brown v. La France Indus., 286 S.C. 319, 333 S.E.2d 348 (Ct. App. 1985); McLeod v. Piggly Wiggly Carolina Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984).
9. That the Claimant is not permanently and totally disabled as a result of her May 30, 2012, accident. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (1992) (the Full Commission is empowered to make its own findings of fact and to reach its own conclusions of law consistent or inconsistent with those of the Single Commissioner); Brayboy v. Clark Heating Co., 306 S.C. 56, 409 S.E.2d 767 (1991) (Full Commission may review award of Single Commissioner and make its own findings of fact and conclusions of law).
10. That the Claimant is entitled to treatment for her work injuries pursuant to S.C. Code Ann. § 42-15-60 including lifetime repair, replacement and/or removal of any retained hardware.
11. That the Claimant shall be awarded compensation pursuant to S.C. Code Ann. § 42-9-30 and S.C. Reg. 67-1101 for any disability suffered as a result of her May 31, 2012 injury, as shall be determined by a Hearing Commissioner on remand.
12. This matter shall not be remanded to the Hearing Commissioner who heard this matter initially on February 2, 2017, but to another Commissioner.
13. The Claimant is not permanently and totally disabled.

**ORDER**

**IT IS, THEREFORE, ORDERED** that the Order of the Hearing Commissioner filed in the above-captioned matter on May 23, 2017, is hereby Reversed as to all Findings of Fact and Conclusions of Law related to the finding of permanent and total disability. Pursuant to this Order, a Hearing Commissioner should determine Claimant's permanency award for her compensable injuries sustained because of her May 31, 2012 injury, pursuant to this Order.

**AND IT IS SO ORDERED.**

South Carolina Workers' Compensation Commission



Michael Campbell, Commissioner

Avery Wilkerson, Commissioner

Susan S. Barden, Commissioner

CERTIFICATE OF SERVICE

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

***By Eugenia on May 21, 2018***

**DECISION AND ORDER**

**OF THE**

**SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION**

**W.C.C. FILE NUMBER 1206236**

**Jennie Cox, EMPLOYEE,**

**versus**

**Palmetto State Transportation, EMPLOYER**

**and**

**Cherokee Insurance Company, CARRIER**

| | |
|---|---|
| **HEARING:** | **Held on Tuesday, February 12, 2019 in Spartanburg, South Carolina** |
| **APPEARANCES:** | **Claimant represented by Juliette B. Mims of The Mims Law Firm, 100 E. Poinsett Street, Greer, South Carolina 29651.** |
| | **Defendants represented by George D. Gallagher of Speed, Seta, Martin, Trivett & Stubley, LLC, P.O. Box 11669, Columbia, SC 29211.** |
| **PURPOSE OF HEARING:** | **Remand on issues as set forth by Full Commission Order.** |
| **DECISION AND ORDER BY:** | **The Honorable T. Scott Beck** |
| **FILED:** | **May 21, 2019** |

## STIPULATIONS

Counsel for the parties stipulated to the following at the Hearing:

1) Jennie Cox ("Claimant") sustained compensable facial, dental, and shoulder injuries arising out of and in the course of her employment as a truck driver for Palmetto State Transportation ("Palmetto") on May 31, 2012. Palmetto's carrier, Cherokee Insurance Company ('Cherokee") accepted compensability of the claim and provided medical and compensation benefits in accordance with the Act. Therefore, the South Carolina Worker's Compensation Commission ("Commission") has jurisdiction to adjudicate all disputed issues presented in this claim.
2) The purpose of the current Hearing is to determine all issues pursuant to the Full Commission Appellate Panel's ("Panel") Order dated May 21, 2018. Specifically, the Panel REVERSED the Order of Commissioner Aisha Taylor awarding Claimant permanent and total disability under S.C. Code §42-9-10 and REMANDED the case to a jurisdictional commissioner for entry of an award of permanent partial disability benefits ("PPD") for specifically enumerated scheduled members pursuant to S.C. Code §42-9-30 and WCC Regulation 67-1101.
3) Counsel for the parties received timely and proper Notice of the Hearing.
4) There is no objection to venue in Spartanburg County, South Carolina.
5) Claimant's average weekly wage ("AWW") and applicable compensation rate are $1327.69 and $725.47, respectively.
6) Defendants stipulate to remain financially responsible for causally related maintenance and replacement of all prosthetic devices and retained hardware Claimant possesses because of her injuries, including dental implants and the prosthetic devices to repair her broken jaw for the remainder of her lifetime per S.C. Code §42-15-60 (C), as well as physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

## APA SUBMISSIONS

Pursuant to the S.C. Administrative Procedures Act ("APA") and WCC Regulation 67-612, the following medical records and other documentary evidence were admitted into the Record without objection for purposes of this Hearing:[1]

1. [1] Defendants objected to Claimant's proposed submission of evidence generated after the original Hearing, specifically, an addendum from the Claimant's vocational expert and medical records from providers with dates of service after the original Hearing. Defendants contend the undersigned Commissioner must render an award per the Panel's remand instructions based on the existing Record at the time of the Panel's decision. The objection was sustained. Robert Brabham's report dated 7/16/2018 and records from Claimant's primary care provider, Dr. Ellis, generated after the original Hearing were

| Provider | Dates | Pages |
|---|---|---|
| Robert E. Brabham, Ph.D. | 7/16/18 | 385-386 |
| Jennifer T. Ellis, MD | 5/9/16-8/2/18 | 408-447 |
| Occupational Health | 11/9/12-3/10/16 | 448-451 |
| Piedmont Oral Surgery | 1/31/13-4/30/15 | 452-459 |
| Piedmont Oral Surgery Questionnaire | 2/23/16 | 460 |
| Center for Health & Occupational Services | 10/6/14-6/29/15 | 461-464 |
| Impairment Ratings-Form 14Bs | 4/9/15-4/30/15 | 465-468 |
| Exhibits: | | |
| Full WCC Appellate Order | 5/21/18 | 469-496 |
| The Honorable Aisha Taylor, Commissioner | 5/23/17 | 497-508 |

## STATEMENT OF THE CASE

Pursuant to the Panel's Order, the only issue before the undersigned is entry of a PPD award for the enumerated scheduled members. Specifically, the Panel sates, in pertinent part, on page 24 of its Order that it "**REVERSES AND REMANDS** the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, shall become, and hereby are, the law of the case." The Panel further states in its Finding of Fact # 1 that "Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial nerve, as well as scarring to her chin." Finally, the Panel ordered that a "Hearing Commissioner should determine Claimant's permanency award for her compensable injuries sustained because of her May 31, 2012 injury pursuant to this Order."

Despite this mandate, Claimant seeks additional relief not addressed by the Panel's Order, specifically, an order for psychological evaluation and treatment. Defendants counter the Panel clearly

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specifically excluded. However, Claimant's counsel was granted leave to proffer additional evidence that was not part of the original Record. The undersigned Commissioner only considered relevant portions of the original Record necessary to comply with the Panel's instructions that were resubmitted by the parties as APA Submissions for purposes of this Hearing.

reversed <u>ALL</u> the original Hearing Commissioner's findings, orders, and award, including her finding of a compensable psychological overlay injury. The Panel, as the ultimate fact finder, then found that the scope of Claimant's compensable injuries is limited to those enumerated in its Find of Fact # 1- teeth, mandible, left shoulder, facial nerve, and scarring to her chin. Therefore, Defendants urge that the undersigned has no authority to order further psychological evaluation/treatment. In reply, Claimant argues that the Panel did not make a specific finding denying compensability of Claimant's psychological injury; therefore, that issue remains unresolved and enables the undersigned to grant their requested relief.

## EVIDENCE OF THE CASE

For the undersigned's convenience and to expedite a timely adjudication of the current action, the parties have agreed to resubmit only portions from the original Record relevant to the determination of issues in accordance with the Panel's remand instructions. The original Record contains voluminous medical records and materials that were relevant to the issues already decided by the Panel but not to the issues on remand. The Commission's file is also incorporated into the Record of this case and for the current action.

### A. Claimant's Testimony

Claimant testified at the Hearing. She is currently 65 years old. She graduated from High School and attended a truck driving school to obtain her CDL. She has worked primarily as a truck driver since 1985. She worked for Palmetto based out of Greenville, SC for approximately 10 years. She previously worked briefly in the textile industry.

Claimant briefly described her accident, injuries, and subsequent course of treatment. Regarding the accident, Claimant explained she was unloading freight from her trailer at a facility in Georgia when a machine fell on top of her, knocked her to the floor of the loading dock where she struck her jaw and mouth, and pinned her underneath. Her primary injuries were a broken jaw and several missing teeth. She later was treated for shoulder pain. She was transported via EMS to an Emergency Room in Atlanta. After her condition was stabilized, she was transferred to the hospital in Greenville. She underwent surgery to repair a broken jaw and her mouth was wired shut for several weeks. She still has a prosthetic device/appliance in her jaw. She had a prominent laceration on her chin that required stitches.

Claimant acknowledged that she had several missing teeth prior to this accident but cannot recall the exact amount. Claimant thinks she lost 13 total teeth as a direct result of her accident- teeth either knocked out in the original accident and/or teeth later extracted to repair her jaw and treat her other dental injuries. Claimant recounted numerous residual issues related to her jaw and dental injuries, including the

following: difficulty with speech, difficulty chewing, and weight loss due to inability to eat all solid foods. The undersigned personally observed minor visible scarring on Claimant's chin.

Regarding her left shoulder injury, Claimant confirmed she did not undergo surgery and was only treated conservatively. She describes frequent residual pain, difficulty sleeping, limited overhead range of motion, and difficulty lifting. Claimant ultimately returned to work at full duty in November 2012. She last worked for Palmetto in 2016.

B. **Medical Evidence**

Following emergency treatment of her broken jaw, Claimant was treated in follow up by numerous medical providers with multiple specialties, including a plastic surgeon (Dr. Fowler); an oral surgeon (Dr. Cobb), a prosthodontist (Dr. Ridgell); and occupational medicine (Dr. Newsome and Dr. Svazas). Claimant has maxillary and mandibular appliances in her jaw that may require replacement or revision. (Defense APA p. 450). Regarding her shoulder, Dr. Newsome noted on 11/9/2012 that "she states she has had a lot of improvement. She is not having any pain and not requiring any pain medications. She states she is continuing her physical therapy exercises at home and feels able to return to work." (APA p. 448). On physical exam, Dr. Newsom found the following: full range of motion of bilateral upper extremities, mild weakness with external rotation of the left shoulder, internal rotation and supraspinatus testing within normal limits, and excellent grip strength. She was released to return to work without restriction.

Dr. Svazas saw Claimant for a reevaluation on 10/6/2014 (APA pp. 461-462). Claimant's subjective complaints and physical exam noted by Dr. Svazas essentially mirror Dr. Newsom's findings. Dr. Newsom states "I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career."

After being released at maximum medical improvement ("MMI") by the authorized treating providers, Claimant was assigned the following impairment ratings: 2% to the left shoulder per Dr. Newsom dated 11/9/2012; 6% to the shoulder per Dr. Svazas dated 4/8/2015; 7% to the mandible per Dr. Cobb dated 4/30/2015; 2% facial nerve disorder per Dr. Cobb dated 4/30/2015; and 11 lost teeth as documented by Dr. Cobb at various times throughout his treatment notes. Claimant was also referred by his counsel for an orthopedic IME with Dr. Grady on July 25, 2016. Dr. Grady assigned a 28% rating to the left shoulder.

## FINDINGS OF FACT

After hearing Claimant's testimony, review of all records relevant to the issues presented on remand, and consideration of able arguments from counsel for the parties, the undersigned hereby makes the following findings of fact in accordance with Panel's instructions:

1) The remand order specifically instructs me to determine permanency on the following compensable body parts specifically delineated in the Panel's order: teeth, mandible, left shoulder, facial nerve, and scarring to the chin.
2) Because I am constrained by the Panel's specific instructions to only enter an award for PPD to the enumerated body parts, I cannot order Defendants to provide Claimant with further psychological evaluation and treatment.
3) The Panel has at least implicitly found Claimant to be at MMI via their finding that an award of permanency is ripe for determination; therefore, I cannot order additional medical or psychological treatment to purportedly attain MMI. Again, Claimant has already been adjudicated to have reached MMI by the Panel and I cannot overrule the Panel since Full Commission is the ultimate fact finder in workers compensation matters under the applicable standard of review.
4) Likewise, I cannot order additional psychological evaluation or treatment as post-MMI palliative care per S.C. Code §42-15-60 (B) at this juncture when a) the Panel's Order does not empower me to do so; and b) the issue of whether the Panel intended to deny compensability of the alleged psychological claim in its 5/12/2018 Order requires further clarification.
5) Defendants have stipulated to responsibility for causally related replacement and maintenance of Claimant's dental implants and prosthetic appliances in her jaw for her lifetime and physical therapy for the left shoulder, if necessary.
6) Claimant could not pinpoint the number of teeth she lost secondary to this accident, and conceded she was missing teeth prior to her injury. The objective medical records confirm that Claimant had the following teeth extracted and/or replaced with implants following the accident: tooth #'s 3, 5, 6, 11, 12, 14, 20, 23, 25, 27 and 30. Claimant is therefore entitled to 22 weeks of compensation for these 11 lost teeth (2 weeks per tooth per Regulation 67-1101). An award for additional lost teeth would be based purely on speculation.
7) The undersigned observed a very faint scar in two locations on Claimant's chin for which she is awarded 1 week of compensation.
8) Regarding an award of compensation for injury to Claimant's facial nerve, WCC Regulation 67-1101 states such award shall be made in accordance with the AMA Guides to the Evaluation of Permanent Impairment. ("Guides"). The applicable sections of the Guides 13.4e and table 13-12.

Dr. Cobb assigned a 1% rating to the facial nerve, which corresponds to a Class I Impairment under the Guides. Claimant is hereby awarded 2 weeks of compensation for the facial nerve injury.

9) Claimant was assigned a 7% rating to the mandible by Dr. Cobb. Pursuant to WCC R. 67-1101 the minimum number of weeks of compensation due for a permanent mandibular injury is 25 weeks. Claimant's residual problems with chewing is clear evidence of a permanent injury. As such, she is hereby awarded 25 weeks of PPD benefits for her jaw injury.

10) Regarding PPD compensation for the left shoulder injury, the undersigned finds that Claimant has sustained a 15% specific loss of use the left shoulder and is therefore entitled to 45 weeks of compensation. The undersigned gives more weight to the opinions and ratings of Dr. Svazas than the rating from Dr. Grady.

11) Any Appeal to the Full Commission from this Decision and Order should be heard by the same Panel in order to clarify issues regarding the alleged psychological condition and any other issues not addressed in the remand instructions. All other issues, if any, not specifically addressed herein are only addressable by the Panel.

## CONCUSIONS OF LAW

The issues presented in the current action before the undersigned are governed by the following provisions of applicable law:

1) Under the South Carolina Workers Compensation Act the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. *See* Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (SC 1992).

2) Upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50. Inherent in the Panel's jurisdiction to "amend the award" is the authority to delegate the matter to a single commissioner for further findings if it so chooses. *See* S.C. Code §42-17-40 ("The commission or any of its members shall hear the parties at issue ... and shall determine the dispute in a summary manner.") However, the single commissioner is obviously bound by the duties delegated to him or her by the Panel, and the single commissioner may not rule on issues beyond the scope of the Panel's remand instructions.

3) MMI is the point at which, in the commission's opinion, no further medical treatment will tend to lessen the degree of claimant's impairment. O'Banner v. Westinghouse, 319 S.C. 24, 459 S.E.2d 324 (Ct. App. 1995). Once a claimant has been adjudged to have reached MMI, entitlement to permanent disability compensation is ripe for determination. *See* Curiel v. Environmental Management Systems, 655 S.E.2d 482 (Ct. App. 2007).
4) S.C. Code § 42-9-30 (14) governs the award of PPD compensation for loss of use of the shoulder up to a maximum of 300 weeks.
5) S.C. Code § 42-9-30 (23) governs proper and equitable compensation for visible scarring and disfigurement to members exposed in the workplace up to a maximum of 50 weeks.
6) WCC Regulation 67-1101 governs compensation for loss of other scheduled members and body parts not specifically enumerated in § 42-9-30, including the mandible, facial nerve, and teeth.
7) S.C. Code § 42-15-60 provides for maintenance and replacement of prosthetic devices and ongoing/future medical treatment.

## ORDER AND AWARD

**IT IS HEREBY ORDERED, ADJUDGED AND DECREED** that in accordance with the Panel's remand instructions, Claimant is entitled to the following weeks of permanent partial disability compensation at the stipulated compensation rate of $725.47:

a) 45 weeks of compensation ($32,646.15) for 15% loss of use of the shoulder;
b) 25 weeks of compensation ($18,136.75) for injury to the mandible;
c) 22 weeks of compensation ($15,960.34) for loss of 11 teeth;
d) 2 weeks of compensation ($1450.94) for injury to the facial nerve; AND
e) 1 week of compensation ($725.47) for scarring/disfigurement to the chin.

**IT IS FURTHER ORDERED, ADJUDGED AND DECREED** that Defendants shall tender this award of compensation to Claimant in a non-commuted lump sum per WCC Regulation 67-1605.

**IT IS FINALLY ORDERED, ADJUDGED AND DECREED** that Defendants shall be financially responsible for causally related maintenance and replacement, if necessary, of Claimant's prosthetic devices secondary to the accident and injuries referenced herein, specifically, the 11 dental implants and appliances in her jaw for her lifetime per S.C. Code §42-15-60 (C) , and physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

**IT IS SO ORDERED!**

**T. Scott Beck, Commissioner**

**CERTIFICATE OF SERVICE**

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

**May 21, 2019**

**By: Shawnee DeBruhl, Administrative Assistant to Commissioner Beck**

DECISION AND ORDER OF THE
SOUTH CAROLINA WORKERS' COMPENSATION
COMMISSION APPELLATE PANEL

| | | |
|---|---|---|
| Jennie Cox,<br><br>Employee,<br>vs.<br><br>Palmetto State Transportation,<br><br>Employer,<br><br>and<br><br>Cherokee Insurance Company,<br><br>Carrier,<br><br>Defendants | )<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>)<br>) | WCC FILE NO: 1206236<br><br><br><br>**FULL COMMISSION APPELLATE PANEL ORDER** |

HEARING DATE: August 19, 2019, in Columbia, South Carolina.

APPEARANCES: Claimant represented by Juliette B. Mims, Esquire and Henry J. Mims, Esquire of the Mims Law Firm and Adrianne Turner, Esquire of Columbia, South Carolina.

Defendants represented by George D. Gallagher, Esquire of Columbia, South Carolina.

PANEL: Commissioner Susan S. Barden, Chair
Commissioner Avery B. Wilkerson
Commissioner R. Michael Campbell

FILED: October 18, 2019

## STATEMENT OF THE CASE

Jennie Cox ("Claimant") sustained compensable facial, dental, and shoulder injuries arising out of and in the course of her employment as a truck driver for Palmetto State Transportation ("Palmetto") on May 31, 2012. Specifically, Claimant was unloading freight from her trailer at a facility in Georgia when a machine fell on top of her, knocked her to the floor of the loading dock where she struck her jaw and mouth, and pinned her underneath. Her primary injuries were a broken jaw and several missing teeth for which she received emergency treatment and extensive follow up treatment with multiple dental and facial reconstruction specialists. She later developed shoulder pain, which was treated conservatively. Palmetto's carrier, Cherokee Insurance Company ('Cherokee") accepted compensability of the claim and provided medical and compensation benefits in accordance with the Act. Claimant was paid approximately 48 weeks of temporary total disability benefits (TTD) before ultimately returning to full duty work as a truck driver. She remained gainfully employed until June of 2016 when she resigned her employment, citing inability to continue working due to chronic pain, fatigue, and malnourishment.

This matter initially came before Commissioner Aisha Taylor for Hearing on February 2, 2017 pursuant to Forms 50 and 51. Claimant alleged entitlement to permanent and total disability benefits (PTD) under S.C. Code §42-9-10 secondary to her work injuries. Defendants disputed her PTD claim but acknowledged her entitlement to scheduled disability compensation under §42-9-30 and WCC R. 67-1101. By Order dated May 23, 2017 Commissioner Taylor found, *inter alia*, that Claimant's accident and injuries aggravated her preexisting depression and awarded her PTD. Defendants appealed Commissioner Taylor's findings and PTD award to the Full Commission Appellate Panel ("Panel"), citing numerous factual and legal errors.

By Order dated May 21, 2018 the Panel reversed Commissioner Taylor's entire Order and remanded the case to a jurisdictional commissioner for entry of an award of permanent partial disability benefits ("PPD") for specifically enumerated scheduled members pursuant to S.C. Code §42-9-30 and WCC Regulation 67-1101. Specifically, the Panel sated, in pertinent part, on page 24 of its Order that it "**REVERSES AND REMANDS** the Decision and Order of the Hearing Commissioner dated May 23, 2017. The Findings of Fact and Conclusions of Law set forth herein, shall become, and hereby are, the law of the case." The Panel further states in its Finding of Fact # 1 that "Claimant did sustain compensable injuries to her teeth, mandible, left shoulder, and facial

nerve, as well as scarring to her chin." Finally, the Panel ordered that a "Hearing Commissioner should determine Claimant's permanency award for her compensable injuries sustained because of her May 31, 2012 injury pursuant to this Order."

This matter was then heard by Commissioner Scott Beck on February 12, 2019 pursuant to the Panel's remand instructions. Despite the Panel's clear mandate, Claimant sought additional relief not addressed by the Panel's Order, specifically, an order for psychological evaluation and treatment. Defendants countered that the Panel clearly reversed ALL the original Hearing Commissioner's findings, orders, and award, including her finding of a compensable psychological overlay injury. The Panel, as the ultimate fact finder, then found that the scope of Claimant's compensable injuries was limited to those enumerated in its Finding of Fact # 1- teeth, mandible, left shoulder, facial nerve, and scarring to her chin. In reply, Claimant argued that the Panel did not make a specific finding denying compensability of Claimant's psychological injury; therefore, that issue remains unresolved and enabled Commissioner Beck to grant their requested relief. [1]

In addition, Claimant sought to introduce additional evidence generated after the original Hearing before Commissioner Taylor, specifically, an addendum from the Claimant's vocational expert and medical records from providers with dates of service after the original Hearing. Defendants objected to these submissions, contending that Commissioner Beck must render an award per the Panel's remand instructions based on the existing Record at the time of the Panel's decision. The objection was sustained. Robert Brabham's report dated 7/16/2018 and records from Claimant's primary care provider, Dr. Ellis, generated after the original Hearing were specifically excluded. However, Claimant's counsel was granted leave to proffer additional evidence that was not part of the original Record.

By Order dated May 21, 2019 Commissioner Beck awarded the following PPD compensation per the Panel's remand instructions:

a) 45 weeks of compensation ($32,646.15) for 15% loss of use of the shoulder;

---

[1] Although not specifically referenced in the Panel's remand instructions, S.C. Code §42-15-60 (B)(2) requires the Commission to determine a claimant's entitlement to ongoing and/or reasonably anticipated future medical treatment along with any permanency award. Per this statutory mandate, Defendants stipulated at the Remand Hearing to provide lifetime repair, replacement, and/or removal of Claimant's mandibular appliance and dental implants, as well as physical therapy for Claimant's shoulder, if necessary. Commissioner Beck accepted the stipulation.

b) 25 weeks of compensation ($18,136.75) for injury to the mandible;

c) 22 weeks of compensation ($15,960.34) for loss of 11 teeth;

d) 2 weeks of compensation ($1450.94) for injury to the facial nerve; AND

e) 1 week of compensation ($725.47) for scarring/disfigurement to the chin.

Commissioner Beck denied Claimant's request for further psychological evaluation/treatment on grounds that such relief was not permitted by the Panel's Order, which specifically only instructed him to enter scheduled disability awards for the specifically delineated injured body parts. Commissioner Beck also reasoned that he could not order additional psychological evaluation/treatment because the Panel found, at least implicitly, that Claimant was at MMI by determining that entry of a permanency award was ripe. Finally, Commissioner Beck stated, "[a]ny Appeal to the Full Commission from this Decision and Order should be heard by the same Panel in order to clarify issues regarding the alleged psychological condition and any other issues not addressed in the remand instructions. All other issues, if any, not specifically addressed herein are only addressable by the Panel."

Claimant appealed Commissioner Beck's Order back to the Panel. Claimant raised numerous exceptions to the Order, but her grounds for appeal can essentially be consolidated as follows: 1) Commissioner Beck erred by denying her request for further psychological evaluation/treatment; 2) Commissioner Beck erred by excluding evidence from consideration at the remand Hearing that was not part of the existing Record; AND 3) Commissioner Beck erred in limiting his permanency award according to the Panel's instructions and by not finding her permanently and totally disabled.

## STANDARD OF REVIEW

It is elementary that when an appellate tribunal remands a case, the lower tribunal has only the jurisdiction and authority mandated by the higher tribunal. Prince v. Beaufort Memorial Hospital, 392 S.C. 599, 709 S.E.2d 122 (Ct. App. 2011). Therefore, matters heard and decided by the higher tribunal cannot be reheard, reconsidered, or relitigated in the lower tribunal. Ackerman v. McMillan, 324 S.C. 440, 477 S.E.2d 267 (Ct. App. 1996). Under the South Carolina Workers Compensation Act, the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. *See* Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is

empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (SC 1992). Finally, upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50.

## FINDINGS OF FACT

This matter was reheard by the Panel at the Review Hearing on August 19, 2019. After careful consideration of able arguments by counsel for the parties and review of the evidentiary Record and applicable law, the Panel concludes that Commissioner Beck's Order is legally and factually correct as stated and his Award is supported by the preponderance of the evidence in the record. As such, the Order is hereby **AFFIRMED WITH AMENDMENTS.** Specifically, the Panel makes the following Findings of Fact independent of Commissioner Beck's findings and conclusions:

1) Commissioner Beck properly followed this Panel's remand instructions to determine Claimant's entitlement to PPD compensation benefits for the following compensable body parts as found in the Panel's prior order: teeth, mandible, left shoulder, facial nerve, and scarring to the chin.
2) Because Commissioner Beck was constrained by the Panel's specific instructions to only enter an award for PPD to the enumerated body parts, he correctly concluded that he was not authorized to order Defendants to provide Claimant with further psychological evaluation and treatment.
3) In response to Commissioner Beck's prayer for clarification of the Panel's intentions regarding the alleged psychological claim, the Panel reiterates that Claimant's alleged psychological injury is DENIED, which was the express intent of the Panel when it REVERSED the Decision and Order of Commissioner Taylor dated May 23, 2017. This constitutes a complete reversal of Commissioner Taylor's findings regarding the alleged psychological injury.
4) To further clarify our original Order, the Panel also finds that Claimant has reached maximum medical improvement (MMI) for all compensable injuries stemming from her May 31, 2012 accident.

5) For these reasons, Commissioner Beck correctly declined Claimant's request for further psychological evaluation and treatment.

6) Commissioner Beck properly excluded and rejected consideration of evidence proffered by Claimant, including an addendum from the Claimant's vocational expert and medical records from providers with dates of service after the first Hearing in this matter. The Panel did not intend for the remand Hearing before Commissioner Beck to be *de novo*. As such, Commissioner Beck was proper in only considering relevant portions of the original Record necessary to comply with the Panel's instructions that were resubmitted by the parties as APA Submissions for purposes of the remand Hearing.

7) Moreover, the Panel did not consider Claimant's proffered evidence on the grounds that it is irrelevant to the issues currently before the Commission in light of the Panel's prior Order. Specifically, additional vocational evidence from Claimant's expert is not relevant to the issue of PPD compensation based on medical impairment and/or loss of use of the individual compensable injuries found. Likewise, evidence from Claimant's primary care provider generated after the original Hearing is not relevant because its probative value only goes to the alleged psychological injury, which as noted earlier, was found to be not compensable by the Panel.

8) Defendants stipulated to responsibility for causally related replacement and maintenance of Claimant's dental implants and prosthetic appliances in her jaw for her lifetime, as well as physical therapy for the left shoulder if necessary.

9) Claimant could not pinpoint the number of teeth she lost secondary to this accident, and conceded she was missing teeth prior to her injury. The objective medical records confirm that Claimant had the following teeth extracted and/or replaced with implants following the accident: tooth #'s 3, 5, 6, 11, 12, 14, 20, 23, 25, 27 and 30. Claimant is therefore entitled to 22 weeks of compensation for these 11 lost teeth (2 weeks per tooth per Regulation 67-1101). An award for additional lost teeth would be based purely on speculation.

10) Commissioner Beck noted on the record that he observed a very faint scar in two locations on Claimant's chin for which he awarded 1 week of compensation. There is no evidence in the Record indicating this award was insufficient.

11) Regarding Commissioner Beck's award of compensation for injury to Claimant's facial nerve; WCC Regulation 67-1101 states such award shall be made in accordance with the AMA Guides to the Evaluation of Permanent Impairment. ("Guides"). The applicable sections of the Guides 13.4e and table 13-12. Dr. Cobb assigned a 1% rating to the facial nerve, which corresponds to a Class I Impairment under the Guides. Therefore, the award of 2 weeks of compensation for the facial nerve injury is proper and supported by evidence in the Record.

12) Claimant was assigned a 7% rating to the mandible by Dr. Cobb. Pursuant to WCC R. 67-1101 the minimum number of weeks of compensation due for a permanent mandibular injury is 25 weeks. Claimant's residual problems with chewing is clear evidence of a permanent injury. As such, Commissioner Beck properly awarded 25 weeks of PPD benefits for Claimant's jaw injury.

13) Regarding PPD compensation for the left shoulder injury, the Panel finds that Claimant has sustained a 15% specific loss of use the left shoulder and is therefore entitled to 45 weeks of compensation. The Panel gives more weight to the opinions and ratings of Dr. Svazas as the authorized treating physician than the rating from Claimant's IME provider, Dr. Grady.

## CONCUSIONS OF LAW

The issues presented in the current action before the Panel are governed by the following provisions of applicable law:

1) Under the South Carolina Workers Compensation Act, the Full Commission Appellate Panel is the ultimate finder of fact and arbiter of the claim and is not bound by a single commissioner's findings of fact and conclusions of law. *See* Ross v. American Red Cross, 298 S.C. 490, 381 S.E.2d 728 (SC 1989). The Panel is empowered to make its own findings and conclusions consistent or inconsistent with those of the single commissioner. McGuffin v. Schlumberger-Sangamo, 307 S.C. 184, 414 S.E.2d 162 (SC 1992).

2) Upon review of a single commissioner's Order and award, the panel may "reconsider the evidence, receive further evidence, rehear the parties or their representatives and, if proper, amend the award." S.C. Code §42-17-50. Inherent in the Panel's jurisdiction to

"amend the award" is the authority to delegate the matter to a single commissioner for further findings if it so chooses. *See* S.C. Code §42-17-40 ("The commission or any of its members shall hear the parties at issue ... and shall determine the dispute in a summary manner.") However, the single commissioner is obviously bound by the duties delegated to him or her by the Panel, and the single commissioner may not rule on issues beyond the scope of the Panel's remand instructions.

3) MMI is the point at which, in the commission's opinion, no further medical treatment will tend to lessen the degree of claimant's impairment. O'Banner v. Westinghouse, 319 S.C. 24, 459 S.E.2d 324 (Ct. App. 1995). Once a claimant has been adjudged to have reached MMI, entitlement to permanent disability compensation is ripe for determination. *See* Curiel v. Environmental Management Systems, 655 S.E.2d 482 (Ct. App. 2007).

4) S.C. Code § 42-9-30 (14) governs the award of PPD compensation for loss of use of the shoulder up to a maximum of 300 weeks.

5) S.C. Code § 42-9-30 (23) governs proper and equitable compensation for visible scarring and disfigurement to members exposed in the workplace up to a maximum of 50 weeks.

6) WCC Regulation 67-1101 governs compensation for loss of other scheduled members and body parts not specifically enumerated in § 42-9-30, including the mandible, facial nerve, and teeth.

7) S.C. Code § 42-15-60 provides for maintenance and replacement of prosthetic devices and ongoing/future medical treatment.

## ORDER AND AWARD

**IT IS HEREBY ORDERED, ADJUDGED AND DECREED** that Commissioner Becks' award of PPD benefits is hereby **AFFIRMED.** Specifically, Claimant is entitled to the following weeks of permanent partial disability compensation at the stipulated compensation rate of $725.47:

a) 45 weeks of compensation ($32,646.15) for 15% loss of use of the shoulder;

b) 25 weeks of compensation ($18,136.75) for injury to the mandible;

c) 22 weeks of compensation ($15,960.34) for loss of 11 teeth;

d) 2 weeks of compensation ($1450.94) for injury to the facial nerve; AND

e) 1 week of compensation ($725.47) for scarring/disfigurement to the chin.

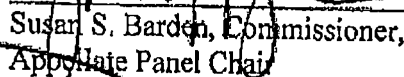
**IT IS FURTHER ORDERED, ADJUDGED AND DECREED** that Defendants shall tender this award of compensation to Claimant in a non-commuted lump sum per WCC Regulation 67-1605.

**IT IS FURTHER ORDERED ADJUDGED AND DECREED** that Claimant's prayer for additional evaluation and treatment of her alleged psychological injury is hereby **DENIED.**

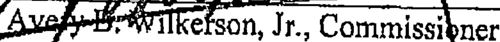
**IT IS FINALLY ORDERED, ADJUDGED AND DECREED** that Defendants shall be financially responsible for causally related maintenance and replacement, if necessary, of Claimant's prosthetic devices secondary to the accident and injuries referenced herein, specifically, the 11 dental implants and appliances in her jaw for her lifetime per S.C. Code §42-15-60 (C), and physical therapy for the left shoulder, if necessary, per S.C. Code §42-15-60 (B).

**IT IS SO ORDERED!**

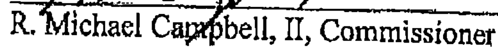
SOUTH CAROLINA WORKERS'COMPENSATION COMMISSION



Susan S. Barden, Commissioner,
Appellate Panel Chair



Avery B. Wilkerson, Jr., Commissioner



R. Michael Campbell, II, Commissioner

CERTIFICATE OF SERVICE

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

***By Eugenia Hollmon on October 18, 2019***

**South Carolina Workers' Compensation Commission**
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675 www.wcc.sc.gov

# PRE-HEARING BRIEF
# WCC File No: 1206236

Claimant's Name: Jennie Cox
Address: 222 W. Chapman Road
City: Belton State: SC Zip: 29627
Home Phone: (864) 243-0032 Work Phone: ( ) -
Preparer's Name: Juliette B. Mims

Employer's Name: Palmetto State Transportation
Address: 1050 Park West Blvd.
City: Greenville State: SC Zip: 29611
Carrier: Cherokee Insurance Company
Preparer's Phone #: (864) 877-0463

**A claim for workers' compensation benefits is made based on the following grounds:**
☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $1,327.69 2. AWW: $725.47 **Date of Injury:** 05/31/12
3. Type of injury and body part(s): Head, neck, cognitive brain and traumatic brain dysfunction, jaw, teeth, soft tissue, nerves, left shoulder, chest, mid back, low back problems breathing, depression and severe weight loss
4. Facts in controversy: Claimant is at maximum medical improvement? To what extent is Claimant's permanent impairment? Whether Claimant is entitled to repayment of Temporary Today Disability?
5. Legal issues involved: Whether the Claimant has reached maximum medical improvement? Whether the Claimant is permanently disabled? Whether the Claimant is entitled to additional medical care? Whether Claimant is entitled to payment of Temporary Today Disability from March 3, 2016 through May 31, 2016 and June 14, 2016 to the present?
6. Unusual aspects: None
7. Witnesses (designate if expert):* Claimant
8. Exhibits: The Claimant's medical records. The Claimant reserves the right to offer additional evidence in response to any testimony or evidence by the Defendants in their Pre-Hearing Brief of APA Submissions.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): See attached Notice of Witnesses and Medical Reports to be Introduced as Evidence on Behalf of the Claimant. Claimant reserves The right to add additional records upon receipt pursuant to Morgan v. JPS. Regulation 67-613.
10. Name, address, and specialty, if any, of the treating physician: James L. Fowler, III, M.D, GHS Plastic Surgery & Aesthetics, Greenville, SC Larry Cobb, DMD, Piedmont Oral Surgery, PA, Greenville, SC; Jennifer T. Ellis, M.D., Hillcrest Family Practice, Simpsonville, SC; Donald L. Ridgell, DMD, Upstate Prosthodontics, Greenville, SC.
11. Impairment rating(s); body part(s); physician and date of opinion: Stacey Newsom, M.D., 2% left upper extremity on 11/09/12; Brian Svazas, M.D, 6% to left shoulder on 04/08/15; Donald Ridgell, M.D. medical opinion as to future medical care/maintenance on 04/09/15; Larry Cobb, DMD, 15%-diet limited to soft or semi solid foods- 85% of normal function, 4% interincisal range of Motion- 30mm, 3$ lateral excursion range of motion0 5-6mm, 2% facial disorder- scar, 1% nerve disorder- permanent numbness of lower lip and chin on left side, 25% whole person on 04/30/15; Walter Grady,, DO, 17% left upper extremity, 28% to left shoulder impairment, 10% whole person on 07/25/16; and Robert E. Brabham, Ph.D. Psychological and Vocational Evaluation on 08/08/16.
12. I am amending my Form 50/51 in the following manner: N/A

☒ **Mediation**

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

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

**I certify I have served this document pursuant to Reg. 67-211 by delivering a copy to Robert E. Horner, Esquire Address Speed, Seta, Martin, Trivett & Stubley, PO Box 11669, Columbia, SC 29211 on the 5th day of December 2016, by:**
☒ **first class postage** ☐ **certified mail** ☐ **personal service** ☒ **electronic service**

**I verify the contents of this form are accurate and true to the best of my knowledge.**
Signature: s/Juliette B. Mims Email: jbmims@themimslawfirm.com
Date of hearing: December 20, 2016 Time needed for hearing: 45 minutes

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

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

| | | |
|---|---|---|
| JENNIE COX,<br>Employee<br>Claimant,<br><br>vs.<br><br>PALMETTO STATE TRANSPORTATION,<br><br>Employer<br><br>AND<br><br>CHEROKEE INSURANCE COMPANY,<br><br>Carrier<br><br>Defendants. | } | **NOTICE OF WITNESS AND WRITTEN MEDICAL REPORTS TO BE INTRODUCED AS DIRECT EVIDENCE ON BEHALF OF OF CLAIMANT** |

**TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND ROBERT HORNER, ESQUIRE, ATTORNEY FOR DEFENDANTS:**

**YOU ARE HEREBY NOTIFIED THAT THE CLAIMANT,** pursuant to the provisions of the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330 (1976, as amended), herewith submits the following medical reports as direct evidence on behalf of the Claimant above named, to wit:

| | NAME OF PROVIDER/OTHER | DATE(S) OF RECORD(S) | NUMBER OF PAGES |
|---|---|---|---|
| APA #1 | Grady Hospital | 05/31/12 | 1-33 |
| APA #2 | American Medical Response of Georgia | 05/31/12 | 34-39 |
| APA #3 | Greenville Memorial | 06/01/12 & 06/02/12 | 40-42 |
| APA #4 | James Fowler, M.D.<br>GHS Plastic Surgery & Aesthetics | 06/01/12-10/12/15 | 43-70 |
| APA #5 | GHS Center for Health & Occupational Services | 06/12/12-04/08/15 | 71-95 |
| APA #6 | Innervision MRI & Imaging | 07/06/12 & 07/17/12 | 96-97 |
| APA #7 | Proaxis Therapy | 08/21/12-11/29/12 | 98-181 |
| APA #8 | Jennifer T. Ellis, M.D.<br>Hillcrest Family Practice | 08/28/12-09/22/16 | 182-226 |
| APA #9 | Donald L. Ridgell, DMD<br>Upstate Prosthodontics, LLC | 10/04/12-10/28/15 | 227-235 |
| APA #10 | Larry W. Cobb, DMD<br>Upstate Prosthodontics, LLC | 10/30/12-10/27/16 | 236-265 |
| APA #11 | William A. Cofer, DMD | 04/14/16 | 266 |
| APA #12 | Walter Grady, D.O | 07/25/16 | 267-273 |
| APA #13 | Robert E. Brabham, Ph.D. | 08/05/16 | 274-284 |

**YOU ARE FURTHER NOTIFIED** that you have the right of cross-examination; and, should you desire to exercise said right, you are to forthwith schedule the depositions of any of the physicians whose reports submitted for the purposes of cross-examination.

**YOU ARE FURTHER NOTIFIED** that the originals of the documents referred to herein, or photocopies received from said physicians/others, are being herewith forwarded to the South Carolina Workers' Compensation Commission for insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence on behalf of the Claimant/Employee.

**YOU ARE FURTHER NOTIFIED** that the following witnesses may be called on behalf of the Claimant/Employee: Jennie Cox

**THE MIMS LAW FIRM**


**s/Juliette B. Mims**
**Juliette B. Mims**
**100 E. Poinsett Street**
**Greer, SC 29651-3404**
**(864)877-0463**
**ATTORNEY FOR CLAIMANT**


**Greer, South Carolina**

**December 5, 2016**

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO: 1206236

| | |
|---|---|
| JENNIE COX,<br>Employee<br>Claimant,<br><br>vs.<br><br>PALMETTO STATE<br>TRANSPORTATION,<br>Employer<br><br>AND<br><br>CHEROKEE INSURANCE COMPANY,<br>Carrier<br><br>Defendants. | **APA SUBMISSIONS** |

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| APA #13 | Robert E. Brabham, Ph.D. | 274-284 |

APA #1
GRADY HOSPITAL
05/31/12

## ED Arrival Information

| Expected | Arrival | Acuity | Means of Arrival | Escorted By | Service | Admission Type |
|---|---|---|---|---|---|---|
| - | 5/31/2012 15:35 | Emergent | Grady Ambulance | Self | Emergency Medicine (Non-admitting) | Emergency |

## Chief Complaint

**Fall [160198]** per EMS pt at work and piece of equipment fell on her and knocked her to the floor. c/o right rib, face, mid back pain

## Diagnosis

**Closed fracture of unspecified part of ramus of mandible**

## ED Events

| Date/Time | Event | User | Comments |
|---|---|---|---|
| 05/31/12 1535 | Patient arrived in ED | HARRIS, PAULINE | |
| 05/31/12 1535 | Patient expected in ED | HARRIS, PAULINE | |
| 05/31/12 1535 | | HARRIS, PAULINE | |
| 05/31/12 1535 | | HARRIS, PAULINE | |
| 05/31/12 1538 | Patient transferred | HEMMINGS, COLETTE | From room EDWR1 to room EDWR2 |
| 05/31/12 1544 | Triage Completed | HEMMINGS, COLETTE | |
| 05/31/12 1551 | Patient roomed in ED | GRIFFIN, PEGGY | To room Trauma6 |
| 05/31/12 1554 | Assign Nurse | PEDRO, OYINKANSOLA | PEDRO, O assigned as Registered Nurse |
| 05/31/12 1603 | Assign Mid-level | GARDNER, KEMBERLY | GARDNER, K assigned as Resident |
| 05/31/12 1603 | Assign Physician | GARDNER, KEMBERLY | |
| 05/31/12 1604 | Assign Attending | HUOT, CHAD | HUOT, C assigned as Attending |
| 05/31/12 1604 | Assign Physician | HUOT, CHAD | |
| 05/31/12 1605 | Lab Ordered | GARDNER, KEMBERLY | LIPASE-SERUM, URINALYSIS, COMPLETE, TYPE AND SCREEN ONLY, PT WITH INR ONLY, ETHANOL-SERUM, CHEM 8, METABOLIC PANEL, CBC, PLAT, WBC DIFF, APTT |
| 05/31/12 1605 | XR Ordered | GARDNER, KEMBERLY | XR CHEST PA OR AP, XR PELVIS LIMITED |
| 05/31/12 1605 | Imaging Exam Ordered | GARDNER, KEMBERLY | |
| 05/31/12 1605 | CT Ordered | GARDNER, KEMBERLY | CT HEAD WO CONTRAST, CT MAXILLOFACIAL WO CONTRAST |
| 05/31/12 1605 | Imaging Exam Ordered | GARDNER, KEMBERLY | |
| 05/31/12 1606 | Imaging Exam Started | BRAY, JENNIFER | |
| 05/31/12 1606 | Imaging Exam Started | BRAY, JENNIFER | |
| 05/31/12 1618 | Imaging Exam Ended | BRAY, JENNIFER | |
| 05/31/12 1618 | Imaging Exam Ended | BRAY, JENNIFER | |
| 05/31/12 1621 | CT Ordered | ELLIS, MELBA | CT BRAIN FACE WO CONTRAST |
| 05/31/12 1621 | Imaging Exam Ordered | ELLIS, MELBA | |
| 05/31/12 1624 | CT Ordered | GARDNER, KEMBERLY | CT CHEST W CONTRAST, CT CERVICAL SPINE WO CONTRAST |
| 05/31/12 1624 | Imaging Exam Ordered | GARDNER, KEMBERLY | |
| 05/31/12 1624 | Imaging Preliminary | EDI, RAD RESULTS IN | |

**ED Events**

| Date/Time | Event | User | Comments |
|---|---|---|---|
| | Result | | |
| 05/31/12 1624 | XRay Preliminary Result | EDI, RAD RESULTS IN | (Preliminary result) XR CHEST PA OR AP |
| 05/31/12 1626 | CT Ordered | ELLIS, MELBA | CT BRAIN C SPINE FACE WO CONTRAST |
| 05/31/12 1626 | Imaging Exam Ordered | ELLIS, MELBA | |
| 05/31/12 1626 | Imaging Preliminary Result | EDI, RAD RESULTS IN | |
| 05/31/12 1626 | XRay Preliminary Result | EDI, RAD RESULTS IN | (Preliminary result) XR PELVIS LIMITED |
| 05/31/12 1635 | Xray Final Result | EDI, RAD RESULTS IN | (Final result) XR CHEST PA OR AP |
| 05/31/12 1635 | Xray Final Result | EDI, RAD RESULTS IN | (Final result) XR PELVIS LIMITED |
| 05/31/12 1657 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) CHEM 8, METABOLIC PANEL |
| 05/31/12 1657 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) LIPASE-SERUM |
| 05/31/12 1705 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) ETHANOL-SERUM |
| 05/31/12 1705 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) LIPASE-SERUM |
| 05/31/12 1705 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) CHEM 8, METABOLIC PANEL |
| 05/31/12 1706 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) CBC, PLAT, WBC DIFF |
| 05/31/12 1711 | Imaging Exam Started | ELLIS, MELBA | |
| 05/31/12 1711 | Imaging Exam Started | ELLIS, MELBA | |
| 05/31/12 1727 | Imaging Exam Ended | ELLIS, MELBA | |
| 05/31/12 1728 | Imaging Exam Ended | ELLIS, MELBA | |
| 05/31/12 1728 | Lab Resulted | EDI, LAB IN HLSEVEN | (Preliminary result) PT WITH INR ONLY |
| 05/31/12 1731 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) PT WITH INR ONLY |
| 05/31/12 1731 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) APTT |
| 05/31/12 1738 | Registration Completed | HARRIS, PAULINE | |
| 05/31/12 1932 | Lab Resulted | EDI, LAB IN HLSEVEN | (Final result) TYPE AND SCREEN ONLY |
| 05/31/12 1944 | Assign Nurse | PEDRO, OYINKANSOLA | FELIZ-GUILLEN, L assigned as Registered Nurse |
| 05/31/12 1944 | Remove Nurse | PEDRO, OYINKANSOLA | PEDRO, O removed as Registered Nurse |
| 05/31/12 2220 | Transfer Disposition Selected | GARDNER, KEMBERLY | ED Disposition set to Transfer to Another Facility |
| 05/31/12 2220 | Disposition Selected | GARDNER, KEMBERLY | |
| 05/31/12 2235 | Charting Complete | HUOT, CHAD | |
| 05/31/12 2235 | Physician LOS Filed | HUOT, CHAD | LOS Code 99285 filed |
| 05/31/12 2240 | Patient transferred to OTF | KALOZ, CHRISTY | |
| 05/31/12 2240 | Patient transferred | KALOZ, CHRISTY | From room Trauma6 to room OTF1 |
| 05/31/12 2308 | Remove Nurse | FELIZ-GUILLEN, LOIDA | FELIZ-GUILLEN, L removed as Registered Nurse |
| 05/31/12 2308 | Patient discharged | PROFFITT, WINDY | |
| 05/31/12 2308 | Patient departed from ED | PROFFITT, WINDY | |
| 05/31/12 2309 | Team Member Removed | GARDNER, KEMBERLY | GARDNER, K removed as Resident |
| 06/01/12 0000 | ED Census | TABER, JOSHUA | |
| 06/01/12 0902 | Remove Attending | TABER, JOSHUA | HUOT, C removed as Attending |
| 06/01/12 1138 | Imaging Preliminary Result | EDI, RAD RESULTS IN | |

**ED Events**

| Date/Time | Event | User | Comments |
|---|---|---|---|
| 06/01/12 1138 | CT Preliminary Result | EDI, RAD RESULTS IN | (Preliminary result) CT CHEST W CONTRAST |
| 06/01/12 1408 | CT Final Result | EDI, RAD RESULTS IN | (Final result) CT CHEST W CONTRAST |
| 06/01/12 1808 | Imaging Preliminary Result | EDI, RAD RESULTS IN | |
| 06/01/12 1808 | CT Preliminary Result | EDI, RAD RESULTS IN | (Preliminary result) CT BRAIN C SPINE FACE WO CONTRAST |
| 06/01/12 1832 | CT Final Result | EDI, RAD RESULTS IN | (Final result) CT BRAIN C SPINE FACE WO CONTRAST |
| 06/02/12 1847 | | PROFFITT, WINDY | |
| 05/31/12 1605 | | GARDNER, KEMBERLY | |
| 05/31/12 1624 | | GARDNER, KEMBERLY | |

**ED Treatment Team**

| Provider | Role | From | To | Phone | Pager |
|---|---|---|---|---|---|
| **Huot, Chad P., MD** | **Attending Provider** | **05/31/12 1604** | **06/01/12 0902** | **404-778-2624** | |
| **Pedro, Oyinkansola, RN** | **Registered Nurse** | **05/31/12 1554** | **05/31/12 1944** | | |
| **Gardner, Kimberly R., MD** | **Resident** | **05/31/12 1603** | **05/31/12 2309** | **404-616-5800** | **PIC 18552** |
| **Feliz-Guillen, Loida, RN (Inactive)** | **Registered Nurse** | **05/31/12 1944** | **05/31/12 2308** | | |

**Discharge Orders**

None

**ED Notes**

**ED Notes by Pedro, Oyinkansola, RN at 5/31/2012 4:52 PM** Version 1 of 1

Author: Pedro, Oyinkansola, RN Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 4:54 PM Note Time: 5/31/2012 4:52 PM Status: Signed
Editor: Pedro, Oyinkansola, RN (Registered Nurse)

59 y/o female to ED s/p GLF on face. -LOC. Alert and Oriented x 4. Breathing even and non-labored. C-collar intact. Pt reports a machine fell on her back and caused her to fall on the floor face first. Bleeding in controlled. Cardiac monitor in place. Awaiting CT. Will continue to monitor.

Signed by Pedro, Oyinkansola, RN on 5/31/2012 4:54 PM

**ED Notes by Feliz-Guillen, Loida at 5/31/2012 7:53 PM** Version 1 of 1

Author: Feliz-Guillen, Loida Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 7:54 PM Note Time: 5/31/2012 7:53 PM Status: Signed
Editor: Feliz-Guillen, Loida

ENT consult MD Calligas at bedside for Chin LAC repair.

Signed by Feliz-Guillen, Loida on 5/31/2012 7:54 PM

**ED Notes by Feliz-Guillen, Loida at 5/31/2012 8:00 PM** Version 1 of 1

Author: Feliz-Guillen, Loida Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 8:00 PM Note Time: 5/31/2012 8:00 PM Status: Signed
Editor: Feliz-Guillen, Loida

Family at bedside.

**ED Notes (continued)**

**ED Notes by Feliz-Guillen, Loida at 5/31/2012 8:00 PM** Version 1 of 1

Signed by Feliz-Guillen, Loida on 5/31/2012 8:00 PM

**ED Notes by Feliz-Guillen, Loida at 5/31/2012 7:35 PM** Version 1 of 1

Author: Feliz-Guillen, Loida Service: (none) Author Type: Registered Nurse
Filed: 5/31/2012 8:08 PM Note Time: 5/31/2012 7:35 PM Status: Signed
Editor: Feliz-Guillen, Loida

Initial contact with patient, care assumed with patient lying supine on stretcher alert and oriented with family at bedside, patient is missing some upper and lower teeth, patient await's ENT consult for dispo. Patient voices no complaints at this time. RN will continue to monitor for changes.

Signed by Feliz-Guillen, Loida on 5/31/2012 8:08 PM

**ED Notes by Dorsett, Tamiko, MSW at 5/31/2012 9:36 PM** Version 1 of 1

Author: Dorsett, Tamiko, MSW Service: (none) Author Type: Social Worker
Filed: 5/31/2012 9:49 PM Note Time: 5/31/2012 9:36 PM Status: Signed
Editor: Dorsett, Tamiko, MSW (Social Worker)

Social Services was requested by Dr. Huot to assist patient and family with transportation for a transfer to Greenville, South Carolina. Social worker provided the family with a list of transportation providers. Patient's family was able to schedule transportation with AMR. Social worker informed Dr. Huot of the transportation arrangements made by patient's family. Social Services will assist further as needed.

Signed by Dorsett, Tamiko, MSW on 5/31/2012 9:49 PM

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1

Author: Gardner, Kimberly R., MD Service: (none) Author Type: Resident
Filed: 5/31/2012 10:21 PM Note Time: 5/31/2012 4:33 PM Status: Signed
Editor: Gardner, Kimberly R., MD (Resident)
Related Notes: Cosigned by Huot, Chad P., MD (Physician) filed at 5/31/2012 10:35 PM

**Chief Complaint**

Patient presents with

- Fall

  *per EMS pt at work and piece of equipment fell on her and knocked her to the floor. c/o right rib, face, mid back pain*

**HISTORY OF PRESENT ILLNESS**

**HPI Comments:** 59 yo female presents after fall. Patient unloading a truck at a loading dock. States a heavy piece of equipment (~200lbs) fell and hit her in the back. Largest point of impact between shoulder blades- per patient. Patient states she was pinned beneath the equipment. Did hit her chin and teeth. Now presents complaining of mouth pain, left shoulder and scapula pain and right sided lower rib pain. Denies any abdominal pain. No LOC.

Patient is a 59 y.o. female presenting with trauma and fall. The history is provided by the patient.

**Trauma**

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1

The incident occurred just prior to arrival. There has been chest pain and difficulty breathing. There has been no fever, no abdominal pain, no diarrhea, no vomiting, no headaches and no cough. There were no sick contacts. She has received no recent medical care.

**Fall**

The accident occurred less than 1 hour ago. The fall occurred while standing. She fell from a height of 3 to 5 ft. She landed on a hard floor. The volume of blood lost was minimal. Point of impact: chin/face. The pain is moderate. She was not ambulatory at the scene. There was entrapment after the fall. There was no drug use involved in the accident. There was no alcohol use involved in the accident. Pertinent negatives include no fever, no abdominal pain, no vomiting and no headaches. Treatment on scene includes a c-collar and a backboard. She has tried nothing for the symptoms.

## PAST MEDICAL HISTORY

*The information below is populated from the nursing note but has been reviewed by the provider. Discrepancies will be noted in the HPI above*

History reviewed. No pertinent past medical history.
History reviewed. No pertinent past surgical history.
No family history on file.

**History**

Social History

- Marital Status: N/A
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: None
- Alcohol Use: No
- Drug Use: No
- Sexually Active:

| Other Topics | Concern |
|---|---|
| • None | |

Social History Narrative

- None

**SBIRT**

*Information below is populated from nursing, Right-click refreshes data*

Tobacco: Yes
Women: Drinks: 0 (never)
Drugs: No

## REVIEW OF SYSTEMS

Review of Systems

**ED Notes (continued)**

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1

Constitutional: Negative for fever and chills.
Respiratory: Negative for cough.
Cardiovascular: Positive for chest pain.
Gastrointestinal: Negative for vomiting, abdominal pain and diarrhea.
Musculoskeletal: Positive for back pain, joint swelling and arthralgias.
Skin: Positive for wound.
Neurological: Negative for dizziness, speech difficulty, weakness and headaches.
Psychiatric/Behavioral: Negative for confusion and agitation.
[all other systems reviewed and are negative

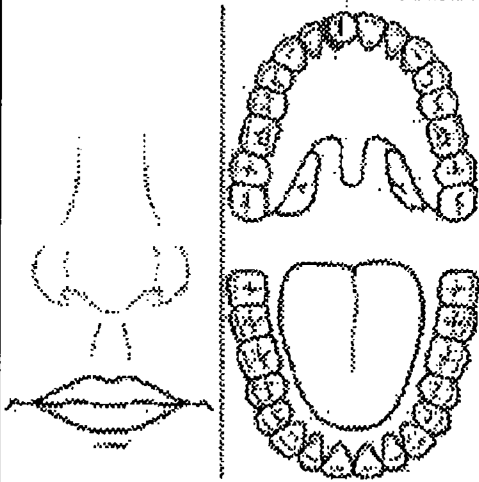
**Initial Vital Signs**
Temp: 35.7 °C (96.3 °F)
Heart Rate: 85
Resp: 20
BP: 105/64 mmHg
SpO2: 98 %

PHYSICAL EXAM

Physical Exam
[vitalsreviewed.
Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished. No distress. Cervical collar and backboard in place.
**A- intact**
**B- equal bilaterally**
**C- 2+ radial/2+DP pulses**
**D- pupils 3mm reactive, GCS 15**
HENT:
Head: Atraumatic.
Mouth/Throat: Oropharynx is clear and moist. Abnormal dentition.

**ED Notes (continued)**

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1



1: impacted tooth

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Neck supple.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. She exhibits no distension. There is no tenderness. There is no rebound and no guarding.
Musculoskeletal: She exhibits no edema.
Neurological: She is alert and oriented to person, place, and time. She has normal strength. No cranial nerve deficit.
Skin: Skin is warm and dry. Laceration noted.
**2cm laceration to chin**

**Procedures**
*Information below is documented by providers, but will be empty if no procedures were performed*
Procedures

**EM Work-up**
**MDM**
Number of Diagnoses or Management Options
Diagnosis management comments: 59 yo female presents after fall secondary to heavy equipment landing on her.

-Primary survey intact
-Secondary survey significant for impacted tooth and chin lac
-FAST negative
-CXR and pelvis XR
-CT head and face
-cbc, chem, ua, lipase, pt/inr

4:49 PM
Patient without midline ttp on clearance of backboard. However patient continues to complain of left

**ED Notes (continued)**

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1

shoulder pain- will also CT chest. EKG with old anterior Q waves. Otherwise unremarkable.

**MEDICAL DECISION MAKING**

**NARRATIVE:**

CT head negative. CT face- communited fracture of the mandible. Primarily left symphaseal. Extends bilaterally- left angle of the mandible, bilateral ramus. Right greater wing of sphenoid. No cspine fracture. CT chest- nothing acute - emphysema. No fractures. No PTX.

7:24 PM
Patient clinically cleared from c-collar. ENT at bedside to evaluate for facial fractures and laceration repair.

10:20 PM
Patient wishes to be transferred to another facility. Accepted by trauma surgeon in Greenville, SC. Transport at bedside. Will transfer now.

**DISPOSITION**

**Most Recent Vitals**
*Right-click to refresh data below for latest vital signs*
Temp: 35.7 °C (96.3 °F)
Heart Rate: 73
Resp: 19
BP: 150/84 mmHg
SpO2: 99 %

**Diagnosis(es):**
1. Mandible fracture

**Condition:**
unchanged

**Disposition:**
Transfer to Other Facility

**Provider:** ***Kimberly R. Gardner, MD***
**Supervision:** ***Initial plan discussed with Dr Huot***

Gardner, Kimberly R., MD
Resident
05/31/12 2221

Huot, Chad P., MD
05/31/12 2235

**ED Notes (continued)**

**ED Provider Notes by Gardner, Kimberly R., MD at 5/31/2012 4:33 PM** Version 1 of 1

Signed by Gardner, Kimberly R., MD on 5/31/2012 10:21 PM

**ED Provider Notes by Huot, Chad P., MD at 5/31/2012 4:33 PM** Version 1 of 1

Author: Huot, Chad P., MD Service: Emergency Medicine (Non-admitting) Author Type: Physician
Filed: 5/31/2012 10:35 PM Note Time: 5/31/2012 4:33 PM Status: Signed
Editor: Huot, Chad P., MD (Physician)
Related Notes: Related Note by Gardner, Kimberly R., MD (Resident) filed at 5/31/2012 10:21 PM

Chad P. Huot, MD I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note.

Huot, Chad P., MD
05/31/12 2235

Signed by Huot, Chad P., MD on 5/31/2012 10:35 PM

**ED Orders**

| Start | | Status | Ordering Provider |
|---|---|---|---|
| 05/31/12 2230 | **fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg** ONCE | Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 2220 | GARDNER, KIMBERLY R. |
| 05/31/12 2100 | **clindamycin (cleocin) 900 mg/50 mL D5W IVPB 900 mg** ONCE | Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 2045 | GARDNER, KIMBERLY R. |
| 05/31/12 1930 | **lidocaine-EPINEPhrine 1 %-1:100000 injection 10 mL** ONCE | Last MAR action: Given - by FELIZ-GUILLEN, LOIDA on 05/31/12 at 1955 | GARDNER, KIMBERLY R. |
| 05/31/12 1900 | **fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg** ONCE | Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1906 | GARDNER, KIMBERLY R. |
| 05/31/12 1800 | **fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg** ONCE | Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1758 | GARDNER, KIMBERLY R. |
| 05/31/12 1630 | **fentaNYL (SUBLIMAZE) 0.05 mg/mL injection 50 mcg** ONCE | Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1627 | GARDNER, KIMBERLY R. |
| 05/31/12 1630 | **0.9% sodium chloride (NS) IV fluid** ONCE | Last MAR action: Given - by PEDRO, OYINKANSOLA on 05/31/12 at 1627 | GARDNER, KIMBERLY R. |

**ED Orders**

| Start | | Status | Ordering Provider |
|---|---|---|---|
| 05/31/12 1627 | **CT Brain C Spine Face wo Contrast** 1 TIME IMAGING | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1626 | **EKG 12 lead** ONE TIME | Preliminary result | GARDNER, KIMBERLY R. |
| 05/31/12 1625 | **CT chest with contrast** 1 TIME IMAGING | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1606 | **Lipase** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **APTT** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **CBC, Platelets, WBC Differential** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **Chem 8, Metabolic Panel** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **Ethanol - serum** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **PT with INR only** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **Type and Screen** ONE TIME | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **XR pelvis 1 View** 1 TIME IMAGING | Final result | GARDNER, KIMBERLY R. |
| 05/31/12 1604 | **XR Chest PA or AP** 1 TIME IMAGING | Final result | GARDNER, KIMBERLY R. |

## Lab Results (05/31/12 - 05/31/12)

**APTT [40573720]**

Resulted: 05/31/12 1731, Result Status: Final result

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| APTT | 29.4 | 26.8 - 35.6 SEC | | - | GRALAB |

**PT with INR only [40573724] (Abnormal)**

Resulted: 05/31/12 1731, Result Status: Final result

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| PROTHROMBIN TIME | 10.9 | 11.0 - 13.4 SEC | L | - | GRALAB |
| INR | 1.0 | | | | GRALAB |

Comment:

INR IS USEFUL FOR MONITORING COUMADIN THERAPHY.
THERAPEUTIC RANGES FOR THE INR VARY WITH CLINICAL STATE.

FOR PREVENTION OF EMBOLISM, PROPHYLAXIS OF VENOUS EMBOLISM, OR TREATMENT OF DEEP VEIN THROMBOSES: INR=2.0-3.0

FOR MECHANICAL HEART VALVE OR RECURRENT SYSTEMIC EMBOLISM: INR=2.5-3.5

**PT with INR only [40573724] (Abnormal)**

Resulted: 05/31/12 1728, Result Status: Preliminary result

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| PROTHROMBIN TIME | 10.9 | 11.0 - 13.4 SEC | L | - | GRALAB |
| INR | 1.0 | | | | GRALAB |

Comment:

INR IS USEFUL FOR MONITORING COUMADIN THERAPHY.
THERAPEUTIC RANGES FOR THE INR VARY WITH CLINICAL STATE.

FOR PREVENTION OF EMBOLISM, PROPHYLAXIS OF VENOUS EMBOLISM, OR TREATMENT OF DEEP VEIN THROMBOSES: INR=2.0-3.0

FOR MECHANICAL HEART VALVE OR RECURRENT SYSTEMIC

## Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1728, Result Status: Preliminary result

**PT with INR only [40573724] (Abnormal)**

EMBOLISM: INR=2.5-3.5

Resulted: 05/31/12 1706, Result Status: Final result

**CBC, Platelets, WBC Differential [40573721]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| WBC COUNT-BLOOD | 7.3 | 4.0 - 8.5 K/mcL | | - | GRALAB |
| % Neutrophils-Blood | 55 | 25 - 62 % | | - | GRALAB |
| % Monocytes-Blood | 5 | 2 - 11 % | | - | GRALAB |
| % Eosinophil-Blood | 2 | < 9 % | | - | GRALAB |
| % Basophil-Blood | 1 | < 3 % | | - | GRALAB |
| % Lymphoctyes-Blood | 37 | 20 - 53 % | | - | GRALAB |
| RBC COUNT-BLOOD | 4.68 | 3.90 - 5.20 M/mcL | | - | GRALAB |
| HEMOGLOBIN-BLOOD | 15.4 | 11.5 - 15.5 GM/DL | | - | GRALAB |
| HEMATOCRIT-BLOOD | 43.8 | 35.0 - 45.0 % | | - | GRALAB |
| RBC MCV | 94 | 80 - 97 fL | | - | GRALAB |
| RBC MCHC | 35.2 | 32.0 - 36.0 % | | - | GRALAB |
| RBC RDW | 13.1 | 11.5 - 14.5 % | | - | GRALAB |
| PLATELET COUNT-BLOOD | 244 | 140 - 440 K/mcL | | - | GRALAB |
| # Neutrophils-Blood | 4.0 | K/mcL | | - | GRALAB |
| # Lymphocytes-Blood | 2.7 | 0.5 - 4.5 K/mcL | | - | GRALAB |
| # Monocytes-Blood | 0.4 | < 1.2 K/mcL | | - | GRALAB |
| # Eosinophils-Blood | 0.2 | < 0.8 K/mcL | | - | GRALAB |
| # Basophils-blood | 0.1 | < 0.3 K/mcL | | - | GRALAB |
| # NEUT (Seg+Band+Meta)-Blood | 4.0 | 1.8 - 7.3 K/mcL | | - | GRALAB |

Resulted: 05/31/12 1705, Result Status: Final result

**Chem 8, Metabolic Panel [40573722] (Abnormal)**

## Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1705, Result Status: Final result

**Chem 8, Metabolic Panel [40573722] (Abnormal)**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| UREA NITROGEN-SERUM | 12 | 8 - 22 MG/DL | | - | GRALAB |
| GLUCOSE,CASUAL-SERUM | 87 | 70 - 125 MG/DL | | | GRALAB |
| Comment: IMPAIRED GLUCOSE CONTROL: 126-199 PROVISIONAL DIAGNOSIS OF DIABETES: >= 200 | | | | | |
| SODIUM-SERUM | 137 | 132 - 144 MEQ/L | | - | GRALAB |
| POTASSIUM-SERUM | 4.3 | 3.4 - 5.1 MEQ/L | | - | GRALAB |
| CHLORIDE-SERUM | 102 | 101 - 111 MEQ/L | | - | GRALAB |
| CO2 CONTENT-SERUM | 24 | 22 - 32 MEQ/L | | - | GRALAB |
| ANION GAP | 11 | 1 - 13 | | - | GRALAB |
| OSMO,CALCULATED | 273 | 275 - 300 MOSM/L | L | - | GRALAB |
| CREATININE-SERUM | 0.9 | 0.4 - 1.0 MG/DL | | - | GRALAB |
| GLOMERULAR FILTRATION RATE CALC | INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR. | >60 | | INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR. | |
| CALCIUM,TOTAL SERUM | 9.7 | 8.9 - 10.3 MG/DL | | - | GRALAB |
| CALCIUM,ALBUMIN ADJUSTED | 9.7 | 8.9 - 10.3 MG/DL | | - | GRALAB |
| ALBUMIN,BCG-SERUM | 4.7 | 3.5 - 5.0 GM/DL | | - | GRALAB |

Resulted: 05/31/12 1705, Result Status: Final result

**Ethanol - serum [40573723]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| ETHANOL-SERUM | < 10 | MG/DL | | - | GRALAB |

Resulted: 05/31/12 1705, Result Status: Final result

**Lipase [40573729]**

## Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1705, Result Status: Final result

**Lipase [40573729]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 — Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| LIPASE-SERUM | 52 | 16 - 62 U/L | | - | GRALAB |

Resulted: 05/31/12 1657, Result Status: Final result

**Chem 8, Metabolic Panel [40573722] (Abnormal)**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 — Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| UREA NITROGEN-SERUM | 12 | 8 - 22 MG/DL | | - | GRALAB |
| GLUCOSE,CASUAL-SERUM | 87 | 70 - 125 MG/DL | | | GRALAB |
| Comment: IMPAIRED GLUCOSE CONTROL: 126-199 PROVISIONAL DIAGNOSIS OF DIABETES: >= 200 | | | | | |
| SODIUM-SERUM | 137 | 132 - 144 MEQ/L | | - | GRALAB |
| POTASSIUM-SERUM | 4.3 | 3.4 - 5.1 MEQ/L | | - | GRALAB |
| CHLORIDE-SERUM | 102 | 101 - 111 MEQ/L | | - | GRALAB |
| CO2 CONTENT-SERUM | 24 | 22 - 32 MEQ/L | | - | GRALAB |
| ANION GAP | 11 | 1 - 13 | | - | GRALAB |
| OSMO,CALCULATED | 273 | 275 - 300 MOSM/L | L | - | GRALAB |
| CREATININE-SERUM | 0.9 | 0.4 - 1.0 MG/DL | | - | GRALAB |
| GLOMERULAR FILTRATION RATE CALC | INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR. | >60 | | INSUFFICIENT CLINICAL DATA TO CALCULATE ESTIMATED GFR. | |
| CALCIUM,TOTAL SERUM | 9.7 | 8.9 - 10.3 MG/DL | | - | GRALAB |
| CALCIUM,ALBUMIN ADJUSTED | 9.7 | 8.9 - 10.3 MG/DL | | - | GRALAB |
| ALBUMIN,BCG-SERUM | 4.7 | 3.5 - 5.0 GM/DL | | - | GRALAB |

Resulted: 05/31/12 1657, Result Status: Final result

**Lipase [40573729]**

## Lab Results (05/31/12 - 05/31/12) (continued)

Resulted: 05/31/12 1657, Result Status: Final result

**Lipase [40573729]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

| Component | Value | Ref Range | Flag | Comment | Lab |
|---|---|---|---|---|---|
| LIPASE-SERUM | 52 | 16 - 62 U/L | | - | GRALAB |

Resulted: 05/31/12 1606, Result Status: In process

**APTT [40573720]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

Resulted: 05/31/12 1606, Result Status: In process

**CBC, Platelets, WBC Differential [40573721]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

Resulted: 05/31/12 1606, Result Status: In process

**Chem 8, Metabolic Panel [40573722]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

Resulted: 05/31/12 1606, Result Status: In process

**Ethanol - serum [40573723]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

Resulted: 05/31/12 1606, Result Status: In process

**PT with INR only [40573724]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

Specimen Collection: Blood - Venous 05/31/12 1604

Resulted: 05/31/12 1606, Result Status: In process

**Lipase [40573729]**

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605 Resulting Lab: GRADY MAIN LABORATORY

## Lab Results (05/31/12 - 05/31/12) (continued)

**Lipase [40573729]** — Resulted: 05/31/12 1606, Result Status: In process

Specimen Collection: Blood - Venous 05/31/12 1604

**Testing Performed By**

| Lab - Abbreviation | Name | Director | Address | Valid Date Range |
|---|---|---|---|---|
| **7 - GRALAB** | GRADY MAIN LABORATORY | Andrew N Young M.D. | 80 Jesse Hill Jr. Drive Atlanta GA 30303 | 12/07/09 1428 - 06/28/12 1113 |

### EKG Results

**EKG 12 lead (Preliminary result)** — **Result time: 05/31/12 16:33:14**

**Preliminary result**

Narrative:
Heart Rate 68
QRS Interval 84 ms
QT Interval 392 ms
QTC Interval 417 ms
P Axis 84 deg
QRS Axis -58 deg
T Wave Axis 55 deg
P-R Interval 132 msec
- ABNORMAL ECG -
SINUS ARRHYTHMIA, RATE 63-80
VENTRICULAR PREMATURE COMPLEX
LEFT AXIS DEVIATION
PROBABLE ANTEROSEPTAL INFARCT, AGE INDETERM

### ED Current OP Medications

None

Medications not reviewed this encounter

### Medication Comments

**** No Medication Comments Found ****

### ED Prescriptions

None

### Allergies as of 5/31/2012

Reviewed on: **5/31/2012**

No Known Allergies

### Discharge Instructions

Cox, Jennie (MR # 100071167)

None

**All Flowsheet Data (05/31/12 0000--05/31/12 2359)**

Data

| | 05/31/12 2220 | 05/31/12 1935 | 05/31/12 1906 | 05/31/12 1806 | 05/31/12 1758 |
|---|---|---|---|---|---|
| **Vitals** | | | | | |
| BP | | 140/72 mmHg -LF | | 132/73 mmHg -OP | |
| Pulse | | 88 -LF | | 92 -OP | |
| Resp | | 25 -LF | | 19 -OP | |
| SpO2 | | 97 % -LF | | 95 % -OP | |
| **OTHER** | | | | | |
| I have documented the pain assessment | Yes -LF | | Yes -OP | | Yes -OP |

| | 05/31/12 1627 | 05/31/12 1604 | 05/31/12 1603 | 05/31/12 1541 | |
|---|---|---|---|---|---|
| **Vitals** | | | | | |
| BP | | 150/84 mmHg -OP | | 105/64 mmHg -CH | |
| Temp | | | | 35.7 °C (96.3 °F) -CH | |
| Temp src | | | | Oral -CH | |
| Pulse | | 73 -OP | | 85 -CH | |
| Resp | | 19 -OP | | 20 -CH | |
| SpO2 | | 99 % -OP | | 98 % -CH | |
| Height | | | 1.702 m (5' 7") -OP | | |
| Weight | | | | 52.164 kg (115 lb) -CH | |
| **OTHER** | | | | | |
| I have documented the pain assessment | Yes -OP | | | | |

Custom Formula Data

| | 05/31/12 1603 | 05/31/12 1541 | | | |
|---|---|---|---|---|---|
| **OTHER** | | | | | |
| Percent Weight Change Since Birth | | 0 -CH | | | |
| IBW/kg (Calculated) Male | 66.1 kg -OP | | | | |
| Low Range Vt 6cc/kg MALE | 396.6 mL -OP | | | | |
| Adult Moderate Range Vt 8cc/kg MA | 528.8 mL -OP | | | | |
| Adult High Range Vt 10cc/kg MALE | 661 mL -OP | | | | |
| IBW/kg (Calculated) FEMALE | 61.6 kg -OP | | | | |
| Low Range Vt 6cc/kg FEMALE | 369.6 mL -OP | | | | |

| | |
|---|---|
| Adult Moderate Range vt 8cc/kg FEMALE | 492.8 mL -OP |
| IBW/kg (Calculated) | 61.6 -OP |
| Low Range Vt 6cc/kg | 369.6 mL -OP |
| Adult Moderate Range Vt 8cc/kg | 492.8 mL -OP |
| Adult High Range Vt 10cc/kg | 616 mL -OP |

**Relevant Labs and Vitals**

| | |
|---|---|
| Temp (in Celsius) | 35.7 -CH |

Secondary Assessement

| | 05/31/12 1649 |
|---|---|
| **FAST** | |
| ABD FAST | Negative -OP |
| **Secondary Assessment** | |
| Head | -- Avulsion to chin. Impacted and missing teeth -OP |
| Eyes | WDL -OP |
| Ears | WDL -OP |
| Mouth/Throat | WDL -OP |
| Neck/Back | -- C-collar intact. C-spine tenderness. -OP |
| Chest | WDL -OP |
| Cardiac | WDL -OP |
| Abdomen | WDL -OP |
| Pelvis/GU | WDL -OP |
| Extremities | WDL -OP |

Triage Plan

| | 05/31/12 1543 |
|---|---|
| **Triage Plan** | |
| Triage Level | 2 -CH |
| ED Destination | ZONE -CH |

SBIRT

| | 05/31/12 1603 |
|---|---|
| **SBIRT** | |
| Tobacco | Yes -OP |
| Women: Drinks | 0 (never) -OP |
| Drugs | No -OP |

Vital Signs

| | 05/31/12 1935 | 05/31/12 1806 | 05/31/12 1604 | 05/31/12 1603 | 05/31/12 1541 |
|---|---|---|---|---|---|
| **Vital Signs** | | | | | |
| Temp | | | | | 35.7 °C (96.3 °F) -CH |
| Temp src | | | | | Oral -CH |
| Pulse | 88 -LF | 92 -OP | 73 -OP | | 85 -CH |
| Pulse Source | Monitor;Pulse Ox -LF | | | | Monitor -CH |
| Resp | 25 -LF | 19 -OP | 19 -OP | | 20 -CH |
| BP | 140/72 mmHg -LF | 132/73 mmHg -OP | 150/84 mmHg -OP | | 105/64 mmHg -CH |
| MAP (mmHg) | 87 -LF | 87 -OP | | | |
| BP Location | Left arm -LF | | | | Right arm -CH |
| Patient Position | Supine -LF | | | | Supine -CH |
| SpO2 | 97 % -LF | 95 % -OP | 99 % -OP | | 98 % -CH |
| Patient Currently in Pain | Denies -LF | | Yes -OP | | Yes -CH |
| **Pain Assessment Scale** | | | | | |
| Pain Assessment Scale | | | Verbal Analog (0-10) -OP | | Verbal Analog (0-10) -CH |
| Patient-Stated Pain Level | | | 10 -OP | | 7 -CH |
| Patient's Stated Pain Goal | | | | | No pain -CH |
| Pain Type | | | Acute pain -OP | | Acute pain -CH |
| Pain Location | | | Mouth -OP | | Face -CH |
| Pain Descriptors | | | | | Aching -CH |
| Pain Frequency | | | | | Continuous -CH |
| Pain Onset | | | | | -- x one hour -CH |
| Multiple Pain Sites | | | | | Yes -CH |
| **Pain 2** | | | | | |
| Pain Rating 2 | | | | | 7 -CH |
| Pain Type 2 | | | | | Acute pain -CH |
| Pain Location 2 | | | | | Back -CH |
| Pain Orientation 2 | | | | | Mid -CH |
| Pain Descriptors 2 | | | | | Aching -CH |
| Pain Frequency 2 | | | | | Continuous -CH |
| Patient's Stated Pain Goal 2 | | | | | No pain -CH |
| **Height and Weight** | | | | | |
| Height | | | | 1.702 m (5' 7") -OP | |
| Height Method | | | | Stated -OP | |
| Weight | | | | | 52.164 kg (115 lb) -CH |
| Weight Method | | | | | Stated -CH |

Primary Assessment

| | 05/31/12 1935 | 05/31/12 1649 | | | |
|---|---|---|---|---|---|
| **Airway** | | | | | |
| Obstructed? | | Patent -OP | | | |
| **Breathing** | | | | | |
| Breathing Effort | | Spontaneous -OP | | | |
| Trachea | | Midline -OP | | | |
| Chest Wall | | WDL -OP | | | |
| Breath Sounds Right | | Clear -OP | | | |
| Breath Sounds Left | | Clear -OP | | | |
| **Circulation** | | | | | |
| Skin | | WDL -OP | | | |
| Uncontrolled Bleeding | | No -OP | | | |
| **Disability** | | | | | |
| Responsivenes s | | Alert -OP | | | |
| Loss of Consciousness (LOC) | | No -OP | | | |
| Eye Opening | 4 -LF | 4 -OP | | | |
| Best Verbal Response | 5 -LF | 5 -OP | | | |
| Best Motor Response | 6 -LF | 6 -OP | | | |
| Glasgow Coma Scale Score | 15 -LF | 15 -OP | | | |

Anthropometrics

| | 05/31/12 1603 | 05/31/12 1541 | | | |
|---|---|---|---|---|---|
| **Anthropometrics** | | | | | |
| Height | 1.702 m (5' 7") -OP | | | | |
| Weight | | 52.164 kg (115 lb) -CH | | | |
| Weight Change | 0 -CH | | | | |

Focused Assessment

| | 05/31/12 1935 | 05/31/12 1806 | 05/31/12 1649 | 05/31/12 1604 | 05/31/12 1544 |
|---|---|---|---|---|---|
| **Airway** | | | | | |
| Airway (WDL) | | | | | WDL -CH |
| Obstructed? | | | Patent -OP | | |
| **Breathing** | | | | | |
| Breathing (WDL) | | | | | WDL -CH |
| SpO2 | 97 % -LF | 95 % -OP | | 99 % -OP | |
| **Circulation** | | | | | |
| Circulation (WDL) | | | | | WDL -CH |
| **Disability** | | | | | |

| Disability (WDL) | | | | | WDL -CH |
|---|---|---|---|---|---|
| | 05/31/12 1541 | | | | |
| **Breathing** | | | | | |
| SpO2 | 98 % -CH | | | | |

Neurological

| | 05/31/12 1935 | | | | |
|---|---|---|---|---|---|
| **Neurological** | | | | | |
| Neuro (WDL) | WDL -LF | | | | |

Respiratory

| | 05/31/12 1935 | | | | |
|---|---|---|---|---|---|
| **Respiratory** | | | | | |
| Respiratory (WDL) | WDL -LF | | | | |

Cardiac/Telemetry

| | 05/31/12 1935 | | | | |
|---|---|---|---|---|---|
| **Cardiac** | | | | | |
| Cardiac (WDL) | WDL -LF | | | | |
| Cardiac Regularity | Regular -LF | | | | |
| Cardiac Rhythm | NSR -LF | | | | |
| Telemetry Monitor On | Yes -LF | | | | |
| Telemetry Audible | Yes -LF | | | | |
| Telemetry Alarms Set | Yes -LF | | | | |

Arrival Documentation

| | 05/31/12 1935 | 05/31/12 1806 | 05/31/12 1604 | 05/31/12 1541 | 05/31/12 1540 |
|---|---|---|---|---|---|
| **Means of Arrival** | | | | | |
| Means of Arrival | | | | | A -CH |
| **Prehospital Treatment** | | | | | |
| Prehospital Treatment | | | | | Yes -CH |
| **Prehospital Care** | | | | | |
| Backboard | | | | | Long Board -CH |
| Cervical Collar | | | | | Yes -CH |
| SpO2 | 97 % -LF | 95 % -OP | 99 % -OP | 98 % -CH | |

Care Handoff

| | 05/31/12 2307 | | | | |
|---|---|---|---|---|---|
| **Care Handoff** | | | | | |
| Report Given to | Given to other (Comment) pt transfered to other hospital via AMR transportation -LF | | | | |

Suicide Risk

| | 05/31/12 1603 | | | | |
|---|---|---|---|---|---|
| **Suicide Risk** | | | | | |
| Do you have any thoughts of hurting yourself or others? | No -OP | | | | |

GCS

| | 05/31/12 1935 | 05/31/12 1649 | | | |
|---|---|---|---|---|---|
| **Glasgow Coma Scale** | | | | | |
| Eye Opening | 4 -LF | 4 -OP | | | |
| Best Verbal Response | 5 -LF | 5 -OP | | | |
| Best Motor Response | 6 -LF | 6 -OP | | | |
| Glasgow Coma Scale Score | 15 -LF | 15 -OP | | | |

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key

| Initials | Name | Effective Dates |
|---|---|---|
| CH | Hemmings, Colette, RN | 09/09/10 - |
| OP | Pedro, Oyinkansola, RN | 09/24/10 - |
| LF | Feliz-Guillen, Loida | - |

## Admission Information - Patient Record Only

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Arrival Date/Time: | 05/31/2012 3:35 PM | Admit Date/Time: | 05/31/2012 3:51 PM | IP Adm. Date/Time: | None |
| Admission Type: | Emergency | Point of Origin: | Self Referral | Admit Category: | None |
| Means of Arrival: | Grady Ambulance | Primary Service: | Emergency Medicine (Non-admitting) | Secondary Service: | N/A |
| Transfer Source: | None | Service Area: | Grady Health System Service Area | Unit: | Ghs Emergency |
| Admit Provider: | None | Attending Provider: | Huot, Chad P., MD | Referring Provider: | None |

## Radiology Results (06/01/12 - )

Resulted: 06/01/12 1831, Result Status: Final result

**CT Brain C Spine Face wo Contrast [40573742]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Krishnan, Arun R., MD<br>McDermott, Matthew C., MD |
| Performed: | 05/31/12 1710 - 05/31/12 1726 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1710 | | |

Narrative:

Patient Name: COX, JENNIE
DOB: Aug 14, 1952 SEX: F
Ordering Physician: HUOT, CHAD

HEAD CT WITHOUT IV CONTRAST

## Radiology Results (06/01/12 - ) (continued)

Resulted: 06/01/12 1831, Result Status: Final result

**CT Brain C Spine Face wo Contrast [40573742]**

CT OF THE FACIAL BONES WITHOUT IV CONTRAST
CERVICAL SPINE CT WITHOUT IV CONTRAST

INDICATION: Pain following trauma. Large object fell on top of patient. Patient is bleeding from the oropharynx and impacted tooth.

TECHNIQUE: Axial CT images from skull base to vertex without IV contrast. Multiple-row detector helical CT examination of the facial bones and mandible without IV contrast. Axial, sagittal, and coronal reconstructed images. Multiple-row detector helical
CT examination of the cervical spine without IV contrast. Axial, sagittal, and coronal reconstructed images.

COMPARISON: None.

FINDINGS:
HEAD CT:
No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities in the right anterior limb of the internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular
spaces. Mild periventricular the scattered white matter hypodensities also nonspecific, but likely represent microangiopathic white matter changes. No evidence of acute large territory infarction. Density in the larger dural venous sinuses is grossly
normal. There is calcified atherosclerotic plaque of the intracranial internal carotid arteries.

No hydrocephalus.

No displaced skull base or calvarium fractures identified, but there is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent
involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of frontal sinuses. Mastoid air cells are clear. There is soft tissue density in the bilateral external auditory canals, which is likely cerumen.

FACE CT:
Complex and comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth, where there are periapical abscesses about the central and lateral left mandibular incisors,
with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess. The fracture also involves the left body of the mandible, and the left inferior alveolar nerve canal. There are additional bilateral condylar neck and ramus
fractures, both with apex lateral angulation. The temporomandibular joints are not involved bilaterally. There is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the
sphenoid sinus. There is no apparent involvement of the carotid canal. Other facial bones show no additional fractures or dislocation. No aggressive osseous lesions.

The globes are normal. The extraocular muscles, intraconal fat, and extraconal fat are within normal limits. The lacrimal glands appear normal. The orbital walls and optic canals are normal.

No lesion of the imaged skull base or calvarium is present. Air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of

**Radiology Results (06/01/12 - ) (continued)**

Resulted: 06/01/12 1831, Result Status: Final result

**CT Brain C Spine Face wo Contrast [40573742]**

frontal sinuses. Mastoid air cells are clear.

CSPINE CT:
No evidence of acute fracture or subluxation, with likely degenerative minimal retrolisthesis of C6 on C7. The cervical spine demonstrates normal alignment. Vertebral body heights are maintained. No aggressive osseous lesions are identified.
Intervertebral disc space heights are maintained. There are mild degenerative changes of the cervical spine and anterior osteophyte at C4, posterior osteophytes at C4, C5 and C7.

No abnormality of the cranio-cervical junction.

Evaluation of the individual levels demonstrates no disc herniation, or central spinal canal stenosis. Facet and uncovertebral hypertrophy cause moderate bilateral neuroforaminal stenosis at C6-C7. No other neural foraminal narrowing.

There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma. The prevertebral and paraspinal soft tissues demonstrate no abnormality. Visualized lung apices show bilateral
consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

IMPRESSION:
1. No intracranial hemorrhage or abnormal extra-axial fluid collection.
2. Focal hypodensities in the right anterior limb internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces.
3. Mild periventricular and scattered white matter hypodensities likely represent microangiopathic white matter changes.
4. Soft tissue density in the bilateral external auditory canals, likely cerumen. Correlation with otoscopic exam is recommended.
5. Comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left body of the mandible and involves the inferior alveolar nerve
canal.
6. Periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess.
7. Left mandibular ramus fracture with apex lateral angulation. TMJ uninvolved.
8. Right mandibular ramus with minimal apex lateral angulation. TMJ uninvolved.
9. Suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal.
10. No acute abnormality of the cervical spine, with degenerative changes, noted above, including facet and uncovertebral hypertrophy causing moderate bilateral neuroforaminal stenosis at C6-C7.
11. Abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, especially given reported bleeding from oropharynx.

Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on top of patient. --- COMP: [] --- PRELIMINARY READ: HEAD: No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities

## Radiology Results (06/01/12 - ) (continued)

Resulted: 06/01/12 1831, Result Status: Final result

**CT Brain C Spine Face wo Contrast [40573742]**

within the right anterior limb internal capsule and right thalamus are nonspecific and may represent dilated perivascular spaces or age-indeterminate lacunar infarctions. Mild periventricular and subcortical white matter hypodensity, nonspecific. No acute calvarial fractures. Soft tissue density within the bilateral external auditory canals likely represents cerumen. C-spine: No acute fracture or subluxation of the cervical spine. There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, although attention on follow-up and/or direct visual inspection is recommended to exclude underlying neoplasm. After speaking with clinician, patient is bleeding from the oro pharynx and impacted tooth in this may explain the findings. Face: There is a comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left angle of the mandible. There is fracture with apex lateral angulation of the left mandibular ramus proximal to the TMJ joint. There is fracture of the right mandibular ramus with minimal apex lateral angulation as well. Fracture extends through the inferior alveolar nerve canal on the left. There is an additional minimally displaced fracture of the left greater wing of the sphenoid. Scattered mucosal thickening within the bilateral frontal sinuses ethmoid air cells. Foamy debris within the left sphenoid chamber is nonspecific. No obvious skull base fracture. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

The final report essentially agrees with the preliminary report.

AK

These images were reviewed and interpreted by Arun Krishnan, MD.

Resulted: 06/01/12 1757, Result Status: Preliminary result

**CT Brain C Spine Face wo Contrast [40573742]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Krishnan, Arun R., MD<br>McDermott, Matthew C., MD |
| Performed: | 05/31/12 1710 - 05/31/12 1726 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1710 | | |

Narrative:

Patient Name: COX, JENNIE
DOB: Aug 14, 1952 SEX: F
Ordering Physician: HUOT, CHAD

HEAD CT WITHOUT IV CONTRAST
CT OF THE FACIAL BONES WITHOUT IV CONTRAST
CERVICAL SPINE CT WITHOUT IV CONTRAST

INDICATION: Pain following trauma. Large object fell on top of patient. Patient is bleeding from the oropharynx and impacted tooth.

TECHNIQUE: Axial CT images from skull base to vertex without IV contrast. Multiple-row detector helical CT examination of the facial bones and mandible without IV contrast. Axial, sagittal, and coronal reconstructed images. Multiple-row detector helical CT examination of the cervical spine without IV contrast. Axial, sagittal, and coronal reconstructed images.

COMPARISON: None.

## Radiology Results (06/01/12 - ) (continued)

Resulted: 06/01/12 1757, Result Status: Preliminary result

**CT Brain C Spine Face wo Contrast [40573742]**

FINDINGS:
HEAD CT:
No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities in the right anterior limb of the internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular
spaces. Mild periventricular the scattered white matter hypodensities also nonspecific, but likely represent microangiopathic white matter changes. No evidence of acute large territory infarction. Density in the larger dural venous sinuses is grossly
normal. There is calcified atherosclerotic plaque of the intracranial internal carotid arteries.

No hydrocephalus.

No displaced skull base or calvarium fractures identified, but there is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent
involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of frontal sinuses. Mastoid air cells are clear. There is soft tissue density in the bilateral external auditory canals, which is likely cerumen.

FACE CT:
Complex and comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth, where there are periapical abscesses about the central and lateral left mandibular incisors,
with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess. The fracture also involves the left body of the mandible, and the left inferior alveolar nerve canal. There are additional bilateral condylar neck and ramus
fractures, both with apex lateral angulation. The temporomandibular joints are not involved bilaterally. There is a suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the
sphenoid sinus. There is no apparent involvement of the carotid canal. Other facial bones show no additional fractures or dislocation. No aggressive osseous lesions.

The globes are normal. The extraocular muscles, intraconal fat, and extraconal fat are within normal limits. The lacrimal glands appear normal. The orbital walls and optic canals are normal.

No lesion of the imaged skull base or calvarium is present. Air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal. There is also patchy opacification of ethmoid sinuses, mucosal thickening of
frontal sinuses. Mastoid air cells are clear.

CSPINE CT:
No evidence of acute fracture or subluxation, with likely degenerative minimal retrolisthesis of C6 on C7. The cervical spine demonstrates normal alignment. Vertebral body heights are maintained. No aggressive osseous lesions are identified.
Intervertebral disc space heights are maintained. There are mild degenerative changes of the cervical spine and anterior osteophyte at C4, posterior osteophytes at C4, C5 and C7.

No abnormality of the cranio-cervical junction.

Evaluation of the individual levels demonstrates no disc herniation, or central spinal canal stenosis. Facet and uncovertebral hypertrophy cause moderate bilateral neuroforaminal stenosis at C6-C7. No other neural foraminal narrowing.

## Radiology Results (06/01/12 - ) (continued)

**CT Brain C Spine Face wo Contrast [40573742]** Resulted: 06/01/12 1757, Result Status: Preliminary result

There is abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma. The prevertebral and paraspinal soft tissues demonstrate no abnormality. Visualized lung apices show bilateral
consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

IMPRESSION:
1. No intracranial hemorrhage or abnormal extra-axial fluid collection.
2. Focal hypodensities in the right anterior limb internal capsule and right thalamus are nonspecific and may represent prior lacunar infarction or dilated perivascular spaces.
3. Mild periventricular and scattered white matter hypodensities likely represent microangiopathic white matter changes.
4. Soft tissue density in the bilateral external auditory canals, likely cerumen. Correlation with otoscopic exam is recommended.
5. Comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends along the left body of the mandible and involves the inferior alveolar nerve
canal.
6. Periapical abscesses about the central and lateral left mandibular incisors, with both buccal and lingual breakthrough, but no noncontrast evidence of soft tissue abscess.
7. Left mandibular ramus fracture with apex lateral angulation. TMJ uninvolved.
8. Right mandibular ramus with minimal apex lateral angulation. TMJ uninvolved.
9. Suspected nondisplaced fracture of the greater wing of the left sphenoid, as evidenced by an air-fluid level in the left chamber of the sphenoid sinus. There is no apparent involvement of the carotid canal.
10. No acute abnormality of the cervical spine, with degenerative changes, noted above, including facet and uncovertebral hypertrophy causing moderate bilateral neuroforaminal stenosis at C6-C7.
11. Abnormal soft tissue and fluid density within the hypopharynx and larynx which is nonspecific and may represent debris posttrauma, especially given reported bleeding from oropharynx.

Visualized lung apices show bilateral consolidations and paraseptal emphysema, but for complete intrathoracic findings please see separately dictated report for CT of the chest.

---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on top of patient. --- COMP: [] --- PRELIMINARY READ: HEAD: No acute intracranial hemorrhage or abnormal extra-axial fluid collections. Focal hypodensities
within the right anterior limb internal capsule and right thalamus are nonspecific and may represent dilated perivascular spaces or age-indeterminate lacunar infarctions. Mild periventricular and subcortical white matter hypodensity, nonspecific. No
acute calvarial fractures. Soft tissue density within the bilateral external auditory canals likely represents cerumen. C-spine: No acute fracture or subluxation of the cervical spine. There is abnormal soft tissue and fluid density within the
hypopharynx and larynx which is nonspecific and may represent debris posttrauma, although attention on follow-up and/or direct visual inspection is recommended to exclude underlying neoplasm. After speaking with clinician, patient is bleeding from the
oro pharynx and impacted tooth in this may explain the findings. Face: There is a comminuted fracture of the mandible involving the left parasymphyseal region extending vertically to involve the root of several mandibular teeth. Fracture line extends
along the left angle of the mandible. There is fracture with apex lateral angulation of the left mandibular ramus proximal to the TMJ joint. There is fracture of the right mandibular ramus with

## Radiology Results (06/01/12 - ) (continued)

Resulted: 06/01/12 1757, Result Status: Preliminary result

**CT Brain C Spine Face wo Contrast [40573742]**

minimal apex lateral angulation as well. Fracture extends
through the inferior alveolar nerve canal on the left. There is an additional minimally displaced fracture of the left greater wing of the sphenoid. Scattered mucosal thickening within the bilateral frontal sinuses ethmoid air cells. Foamy debris within
the left sphenoid chamber is nonspecific. No obvious skull base fracture. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

The final report essentially agrees with the preliminary report.

AK

[Sign Diagnostic]

Resulted: 06/01/12 1407, Result Status: Final result

**CT chest with contrast [40573738]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1624 | Resulted by: | Berkowitz, Eugene A., MD<br>Henson, Nicholas Levi, MD<br>Tigges, Stefan, MD |
| Performed: | 05/31/12 1711 - 05/31/12 1727 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1711 | | |
| Narrative: | CT CHEST WITH CONTRAST | | |

CLINICAL INDICATION: Trauma. Chest pain. Large object fell on patient's back.

TECHNIQUE: Written informed consent was obtained. Noncardiac-gated spiral axial 2.0 mm images of the chest were obtained with intravenous contrast. There were no immediate reported complications.

COMPARISON: No direct comparison available. Portable chest x-ray dated 5/31/2012.

FINDINGS:

LOWER NECK:
Grossly Unremarkable

HEART/MEDIASTINUM:
Aorta: Within normal limits in size.
Heart: Within normal limits in size.
Mediastinal Lymph Nodes: Not Enlarged

LUNGS/PLEURA:
Mild upper lobe predominant centrilobular comparison emphysematous change. Mild bibasilar atelectasis. No lobar consolidation, pleural effusion, or pneumothorax. Upper lobe nodularity and mild pleural thickening likely representing scarring. 4 mm
peripheral noncalcified pulmonary nodule in the right lower lobe (image 197 of 316). The tracheobronchial tree is patent.

VISUALIZED ABDOMEN:
Ill-defined left adrenal nodule measuring approximately 18 x 9 mm with an average attenuation of 20 HU, not clearly an adenoma.

## Radiology Results (06/01/12 - ) (continued)

Resulted: 06/01/12 1407, Result Status: Final result

**CT chest with contrast [40573738]**

SOFT TISSUES/BONE:
No aggressive bone lesions. No acute fractures.

IMPRESSION:

1. No acute intrathoracic abnormality.

2. Mild bibasilar atelectasis.

3. Mild biapical probable scarring.

4. Mild emphysema.

5. Noncalcified upper lobe 4 mm pulmonary nodule. Recommend followup noncontrast CT in 12 months.

6. Indeterminate left adrenal nodule. Routine CT of the abdomen, adrenal mass protocol is suggested to further evaluate.

The final report agrees with the preliminary report by the on-call radiology resident below.

Preliminary findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Final report dictated by Dr. Nicholas L. Henson, the radiology resident on service.

This study has been personally reviewed by the attending Stefan Tigges MD.

---

Patient:COX JENNIE
MRN:100071167
Accession:B5435341
Procedure:CT CHEST W CONTRAST
---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on patient"s back. --- COMP: [] --- PRELIMINARY READ: There is moderate emphysema bilaterally with predominantly posterior and biapical scarring. No acute traumatic abnormality within the chest. No displaced fractures. A left adrenal nodule is nonspecific, although primarily low density likely representing an adenoma. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Resulted: 06/01/12 1136, Result Status: Preliminary result

**CT chest with contrast [40573738]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1624 | Resulted by: | Berkowitz, Eugene A., MD<br>Henson, Nicholas Levi, MD<br>Tigges, Stefan, MD |
| Performed: | 05/31/12 1711 - 05/31/12 1727 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1711 | | |
| Narrative: | CT CHEST WITH CONTRAST | | |

CLINICAL INDICATION: Trauma. Chest pain. Large object fell on patient's back.

**Radiology Results (06/01/12 - ) (continued)**

Resulted: 06/01/12 1136, Result Status: Preliminary result

**CT chest with contrast [40573738]**

TECHNIQUE: Written informed consent was obtained. Noncardiac-gated spiral axial 2.0 mm images of the chest were obtained with intravenous contrast. There were no immediate reported complications.

COMPARISON: No direct comparison available. Portable chest x-ray dated 5/31/2012.

FINDINGS:

LOWER NECK:
Grossly Unremarkable

HEART/MEDIASTINUM:
Aorta: Within normal limits in size.
Heart: Within normal limits in size.
Mediastinal Lymph Nodes: Not Enlarged

LUNGS/PLEURA:
Mild upper lobe predominant centrilobular comparison emphysematous change. Mild bibasilar atelectasis. No lobar consolidation, pleural effusion, or pneumothorax. Upper lobe nodularity and mild pleural thickening likely representing scarring. 4 mm
peripheral noncalcified pulmonary nodule in the right lower lobe (image 197 of 316). The tracheobronchial tree is patent.

VISUALIZED ABDOMEN:
Ill-defined left adrenal nodule measuring approximately 18 x 9 mm with an average attenuation of 20 HU, not clearly an adenoma.

SOFT TISSUES/BONE:
No aggressive bone lesions. No acute fractures.

IMPRESSION:

1. No acute intrathoracic abnormality.

2. Mild bibasilar atelectasis.

3. Mild biapical probable scarring.

4. Mild emphysema.

5. Noncalcified upper lobe 4 mm pulmonary nodule. Recommend followup noncontrast CT in 12 months.

6. Indeterminate left adrenal nodule. Routine CT of the abdomen, adrenal mass protocol is suggested to further evaluate.

The final report agrees with the preliminary report by the on-call radiology resident below.

Preliminary findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant

**Radiology Results (06/01/12 - ) (continued)**

Resulted: 06/01/12 1136, Result Status: Preliminary result

**CT chest with contrast [40573738]**

Webber.

Final report dictated by Dr. Nicholas L. Henson, the radiology resident on service.

[ST]

---

Patient:COX JENNIE
MRN:100071167
Accession:B5435341
Procedure:CT CHEST W CONTRAST
---INITIAL FINDINGS AND COMMUNICATION--- ADDITIONAL HX: Status post trauma. Large object fell on patient"s back. --- COMP: [] --- PRELIMINARY READ: There is moderate emphysema bilaterally with predominantly posterior and biapical scarring. No acute traumatic abnormality within the chest. No displaced fractures. A left adrenal nodule is nonspecific, although primarily low density likely representing an adenoma. --- The above findings were called to Dr. Kimberly Gardner at 1745 hours on 5/31/12 by Dr. Grant Webber.

Resulted: 05/31/12 1633, Result Status: Final result

**XR pelvis 1 View [40573727]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1606 | | |

Narrative: Clinical Indication: Pain following trauma

Technique: AP view view of the pelvis.

Comparison: None available.

Findings:

BONES: There is no evidence of an acute, displaced fracture or dislocation. The symphysis pubis does not appear widened. The hip joint spaces are maintained. Air filled bowel loops obscure assessment of the SI joints.

SOFT TISSUES: No focal abnormality is appreciated.

Impression:
No acute osseous abnormality of the pelvis.

The images were reviewed and interpreted by Dr. Faisal Khosa.

Resulted: 05/31/12 1633, Result Status: Final result

**XR Chest PA or AP [40573728]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1606 | | |

Narrative: PROCEDURE: SINGLE AP VIEW OF THE CHEST

## Radiology Results (06/01/12 - ) (continued)

Resulted: 05/31/12 1633, Result Status: Final result

**XR Chest PA or AP [40573728]**

CLINICAL INDICATION: Pain following trauma

COMPARISON: None.

FINDINGS: The cardiomediastinal silhouette is within normal limits. There are no focal pulmonary consolidations or pleural effusions. There is no evidence of pneumothorax. There are no acute osseous abnormalities.

IMPRESSION:
No acute cardiopulmonary disease.

The images were reviewed and interpreted by Dr. Faisal Khosa.

Resulted: 05/31/12 1623, Result Status: Preliminary result

**XR pelvis 1 View [40573727]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1606 | | |

Narrative:

Clinical Indication: Pain following trauma

Technique: AP view view of the pelvis.

Comparison: None available.

Findings:

BONES: There is no evidence of an acute, displaced fracture or dislocation. The symphysis pubis does not appear widened. The hip joint spaces are maintained. Air filled bowel loops obscure assessment of the SI joints.

SOFT TISSUES: No focal abnormality is appreciated.

Impression:
No acute osseous abnormality of the pelvis.

{FK}

Resulted: 05/31/12 1621, Result Status: Preliminary result

**XR Chest PA or AP [40573728]**

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Resulting Lab: | GRADY RADIOLOGY |
| Specimen Collection | 05/31/12 1606 | | |

Narrative:

PROCEDURE: SINGLE AP VIEW OF THE CHEST

CLINICAL INDICATION: Pain following trauma

COMPARISON: None.

## Radiology Results (06/01/12 - ) (continued)

**XR Chest PA or AP [40573728]** — Resulted: 05/31/12 1621, Result Status: Preliminary result

FINDINGS: The cardiomediastinal silhouette is within normal limits. There are no focal pulmonary consolidations or pleural effusions. There is no evidence of pneumothorax. There are no acute osseous abnormalities.

IMPRESSION:
No acute cardiopulmonary disease.

{FK}

**XR pelvis 1 View [40573727]** — Resulted: 0000, Result Status: In process

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Specimen Collection | 05/31/12 1606 |

**XR Chest PA or AP [40573728]** — Resulted: 0000, Result Status: In process

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Khosa, Faisal, MD<br>Rampure, Jaideep M., MD |
| Performed: | 05/31/12 1606 - 05/31/12 1610 | Specimen Collection | 05/31/12 1606 |

**CT Face w/o Contrast [40573730]** — Resulted: 0000, Result Status: In process

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605

**CT BRAIN FACE WO CONTRAST [40573734]** — Resulted: 0000, Result Status: In process

Ordering provider: Gardner, Kimberly R., MD 05/31/12 1605

**CT chest with contrast [40573738]** — Resulted: 0000, Result Status: In process

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1624 | Resulted by: | Berkowitz, Eugene A., MD<br>Henson, Nicholas Levi, MD<br>Tigges, Stefan, MD |
| Performed: | 05/31/12 1711 - 05/31/12 1727 | Specimen Collection | 05/31/12 1711 |

**CT Brain C Spine Face wo Contrast [40573742]** — Resulted: 0000, Result Status: In process

| | | | |
|---|---|---|---|
| Ordering provider: | Gardner, Kimberly R., MD 05/31/12 1605 | Resulted by: | Krishnan, Arun R., MD<br>McDermott, Matthew C., MD |
| Performed: | 05/31/12 1710 - 05/31/12 1726 | Specimen Collection | 05/31/12 1710 |

**Testing Performed By**

| Lab Abbreviation | Name | Director | Address | Valid Date Range |
|---|---|---|---|---|
| **9 - GRADYRAD** | GRADY RADIOLOGY | Unknown | Unknown | 12/11/09 1042 - Present |

**END OF REPORT**

APA #2
AMERICAN MEDICAL RESPONSE OF GEORGIA
05/31/12

# ATLANTA
# AMERICAN MEDICAL RESPONSE
# OF GEORGIA
## Patient Care Report

**Case #:** 60195177 **Unit ID:** 204 **Date:** 5/31/2012

## Dispatch Information 60195177

**Time Call Received:** 21:20:18
**Time Dispatched:** 21:31:04
**Time Enroute:** 21:33:35
**Time at Scene:** 22:12:00
**Time at Pt Side:** 22:12:00

**Time Transporting:** 22:43:00
**Time Transport Arrived:** 01:05:00
**Time Available:** 01:18:00
**Final Response Mode:**
**Final Transport Mode:**

**Disposition:** -Hospital to Hospital Transport
**From Location:**

80 JESSE HILL JR DR SE, ATLANTA, GA 30303
**Incident Location Type:** Medical - Hospital

**To Location:**

Greenville Memorial Hospital

701 grove rd, greenville, SC 29605
**Destination Type:** Medical - Hospital

**Caller Name:** 3RD PARTY

**ALS Assessment:** AMR Paramedic

## Patient Demographics 60195177

**Name:** COX, JENNIE
**Address:** 222 w chapman rd
**City, State, Zip:** greenville, SC 29627
**Phone:** (864)243-0032 **Cell:** (864)243-0032
**SSN:** xxxx-xx-8760
**Pt. #** 1 of 1

**DOB:** 8/14/1952
**Age:** 59 years
**Gender:** Female
**Weight:** 0
**Ethnicity:** Caucasian

## Transfer 60195177

**Reason for Transport:** Other Non-Emergency Impression

**Underlying Medical Condition:** -

**Transfer Reasons:**
**Was Specialized Observation Required?**
**Was Pt Able to Sit in W/C During Trans?**
**Was There Existing Tx To Be Monitored?**
**Was Special Positioning Required?**
**Was Patient on Psych Hold?**
**Was Oxygen Used During Transport?**

## Physical Findings 60195177

Face: Deformity

Face Remarks: pt had possible fractured jaw.

Chin: Laceration

## History Of Present Illness 60195177

**Chief Complaint:**

**Physician:**

**Safety Equipment:**

**History Obtained From:** Patient
**History:** None Stated
**Allergies:** None ,
**Medications:** NONE STATED

**Advanced Directives:**

## Narrative 60195177

RESPONDED ON A CALL TO GRADY MEMORIAL HOSPITAL FOR A PT BEING DISCHARGED TO A HOSPITAL CLOSER TO HOME. PT WAS 59 Y/O FEMALE. PT WAS WORKING WHEN HEAVY EQUIPMENT FELL ON HER. PT HAD DCAP-BTLS TO HER FACE AND HEAD.

UPON OUR ARRIVAL TO THE SCENE THE PT WAS CA&OX4. PT APPEARED TO BE IN NO DISTRESS. PT STATED SHE HAD PAIN TO HER FACE. PT STATED PAIN WAS ABOUT A 6 ON THE PAIN SCALE. PT WAS PLACED ON THE STRETCHER VIA A DRAWSHEET. PT WAS PLACED IN A POSITION OF COMFORT AND SECURED ON BY SAFETY BELTS. PT HAD 18G IV AND 1000ML OF NS RUNNING. PT WAS BEING TRANSPORTED TO GREENVILLE SC TO A HOSPITAL CLOSER TO HER HOME.

PT SLEPT THE MAJORITY OF THE TRANSPORT. NO FURTHER CHANGES NOTED.

## Vitals

| Time | BP | Pulse | RR | SPo2 % | GCS | Performed By |
|---|---|---|---|---|---|---|
| 22:51 | 116/74 (88) | 88 | 18 | | | ANDERSON, CHASE,AMR |
| 23:10 | 117/80 (92) | 85 | 18 | | | ANDERSON, CHASE,AMR |
| 23:55 | 115/75 (88) | 85 | 18 | | | ANDERSON, CHASE,AMR |

## Treatment and Response 60195177

| PTA | Time | Medic | Procedure |
|---|---|---|---|
| | 22:51:00 | ANDERSON, CHASE,AMR | Monitor Other Existing Treatment - Peripheral IV , Result: Unchanged . . |
| | 22:51:00 | ANDERSON, CHASE,AMR | Vital Signs - Blood Pressure Method: Manual Cuff , BP: 116 / 74 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 88 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal , . |
| | 23:10:00 | ANDERSON, CHASE,AMR | Vital Signs - Blood Pressure Method: Automated Cuff , BP: 117 / 80 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 85 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal , . |
| | 23:55:00 | ANDERSON, CHASE,AMR | Vital Signs - Blood Pressure Method: Automated Cuff , BP: 115 / 75 , Patient Position: Semi-Fowlers . Pulse at: Radial , Pulse Rate: 85 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 18 , Respiration Depth: Normal , Respiration Effort: Normal , . |

## Patient Disposition 60195177

**Mileage Scene:** 0.0
**Mileage Hospital:** 161.5
**Total Mileage:** 161.5

**Destination Decis:** Patient/Family Request

**Transfer Time:**

## Patient Medical Insurances 60195177

SELF PAY Policy#:self pay,

**Guarantor:**
Self
COX, JENNIE
222 w chapman rd, greenville, SC 29627

**Employer:**

**1st Attendant:** ANDERSON, CHASE,AMR

**Number:** 10491
**Certification:** Paramedic

**2nd Attendant:** ONEILL, BRYAN,AMR

**Number:** 44557
**Certification:** EMT Intermediate

**Hospital Signature:**

# American Medical Response

Run Number 60195177 Date and Time of Transport 5/31/2012 at 22:43:00

Patient Name COX, JENNIE

Destination: , 701 grove rd, greenville, SC 29605

I acknowledge that I am legally responsible for the ambulance services provided to me. I request and assign payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to AMR directly for any ambulance services and supplies furnished to me by AMR, whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now, or in the future. I agree to cooperate with AMR or its agent in collecting any such benefits. I acknowledge that I have been provided with a copy of AMR's Notice of Privacy Practices. I expressly authorize AMR or its agents or associates to contact me or any responsible party at any phone number provided, including any cellular phone number provided, for the purpose of resolving any unpaid balances or other pertinent issues. Nothing herein shall relieve me from direct financial responsibility for any charges not paid by an insurer. I further agree to send promptly to AMR any payments that an insurer forwards to me.

Signature of Patient Date

## REPRESENTATIVE SIGNATURE

Reason Patient could not Sign: Sedated

By signing below, I certify that I am one of the following individuals and that I am authorized to sign on the patient's behalf (check one):

Relative or other person who arranges patient's treatment or manages the patient's affairs (42 CFR 424.36(b)(3))

Joyce Johnson joyce 6/1/2012

Signature of Representative Printed Name of Representative Date

## FACILITY SIGNATURE

**Complete this section only if you are unable to obtain the signature of the patient or authorized representative listed above.**

*Reason Patient could not Sign:* Sedated

By signing below, I certify that the above named patient was physically or mentally incapable of signing at the time of transport and that none of the individuals listed in 42 C.F.R. $424.36(b)(1)-(3) was available or willing to sign the claim on behalf of the beneficiary.

Crew Signature Crew Date

*This section is to be complete by a representative of the receiving facility, whenever you are unable to obtain the signature of the patient or an authorized representative. Note: The crew must also complete the "Crew Signature" Section above.*

Name and Location of Facility

The above named patient, as described by AMR, was received by our facility, which provided care or assistance to the patient, on the date and time set forth above.

Signature of Receiving Representative Date

Printed Name of Receiving Facility Representative Title

***AMR is required to obtain this form in order to submit a claim for payment to Medicare or other third party payer. This Signature is not an acceptance of financial responsibility for the patient.***

| Supply Descripton | Quantity | |
|---|---|---|
| Pulse Ox | 1 | 3092 |
| Linen-disposable | 1 | 3056 |
| Gloves / cleaning supplies | 1 | 3013 |

APA #3
GREENVILLE MEMORIAL
06/01/12 & 06/12/12

| Pt Name: | COX, JENNIE C | MRN: | 971202636 |
|---|---|---|---|
| Pt ID: | 20102920969 | Acct No: | 03014432629 |
| DOB: | 08/14/1952 | Age/Sex: | 59Y/F |
| Adm DTime: | 01/05/2012 11:30 | Atn Dr: | Ellis, Jennifer MD |
| Nurse Sta: | | Rm/Bed: | |
| Dx: | | | |
| Alrg: | Milk of Magnesia, No Known Food Allergies | | |

| Order Name: | CT Head W/O Contrast | Observation Dtime: | 06/01/2012 02:20 |
|---|---|---|---|
| Result Name: | CT Head | Result Status: | Final Result |

IMPRESSION: NEGATIVE NONCONTRAST HEAD CT EXAM.
ADDENDUM: I have located an old head CT exam of 10/12/06 and I don't see a significant change in the examination in comparison with that study.
ORDERING MD:YULIYA YURKOOP LOCATION:ETC CRITICAL CARE
, ,
RC120300 - CT HEAD W/O CONTRAST 6/1/2012 2:20 AMEXAM#: 12481979
ORDERED BY: Dr. YULIYA YURKO
REASON FOR EXAM: HEAD INJURY/FALLTRAUMA PROTOCOL---TRAUMA PROTOCOL---
RESULT:COX, JENNIE
CT HEAD WITHOUT CONTRAST 6/01/12
CLINICAL: Fall with pain.
Skull base to vertex noncontrast head CT images. No comparison exam. Exam demonstrates no evidence of an acute intracranial hemorrhage, localized mass effect of shift of the midline. The ventricles and other CSF spaces appear normal. No changes of infarction are seen at this time. No abnormalities of the skull are noted.
TRANSCRIPTIONIST:KATHY YARLETT
TRANSCRIBE TIME/DATE:6/1/2012 8:27:00 AM
READ BY:MICHAEL EVERT, MD,
SIGNED BY:
0 ELECTRONIC SIGNATURE / EVERT, MD,MICHAEL

**Comments**

Result Comments: GCT0112GDT

Requisition Comments:

| Ordering Dr: | Yurko Yuliya Y | Order Date/Time: | 06/01/2012 02:20 |
|---|---|---|---|
| | | Ord#/Occurrence#: | 8675145 / 11427588 |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| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 03014432629 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 59Y/F |
| **Adm DTime:** | 01/05/2012 11:30 | **Atn Dr:** | Ellis, Jennifer MD |
| **Nurse Sta:** | | **Rm/Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

****** Stat Result *******

| | | | |
|---|---|---|---|
| **Order Name:** | DX Chest Single View | **Observation Dtime:** | 06/01/2012 01:59 |
| **Result Name:** | Chest PA | **Result Status:** | Final Result |

ORDERING MD:JOHN RINKLIFF, MDOP LOCATION:
UMG - GENERAL SURGERY
35 MEDICAL RIDGE DRIVE
GREENVILLE, SC, 29605
RX410200 - CHEST SINGLE VIEW 6/1/2012 1:59 AMEXAM#: 12481972
ORDERED BY: Dr. JOHN RINKLIFF, MD
REASON FOR EXAM: fall* fall---* fall---
PATIENT - JENNIE MAE COX
PROCEDURE:ONE VIEW CHEST, 6/1/12.
History: Fall.
Findings: Time of study is 2:11 a.m. and comparison is with
8/16/04. Heart size is stable. Pulmonary vasculature is normal. I
see no consolidation and no pneumothorax.
TRANSCRIPTIONIST:GLORIA PARKER
TRANSCRIBE TIME/DATE:6/1/2012 9:50:00 AM
READ BY:STEVEN C. LOWE, MD,
SIGNED BY:
0 ELECTRONIC SIGNATURE / LOWE, MD,STEVEN C.

**Comments**

Result Comments: GRD0129GDT

Requisition Comments:

| | | | |
|---|---|---|---|
| Ordering Dr: | Rinkliff John | Order Date/Time: | 06/01/2012 01:59 |
| | | Ord#/Occurrence#: | 8675286 / 11428046 |


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| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 03014432629 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 59Y/F |
| **Adm DTime:** | 01/05/2012 11:30 | **Atn Dr:** | Ellis, Jennifer MD |
| **Nurse Sta:** | | **Rm/Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | DX Shoulder AP Lat | **Observation Dtime:** | 06/02/2012 09:59 |
| **Result Name:** | Shoulder Ap&Lat | **Result Status:** | Final Result |

IMPRESSION:
UNREMARKABLE EXAM.
ORDERING MD:JASON WELLSOP LOCATION:NS VASCULAR
, ,
RX495577L - LEFT SHOULDER AP/LAT/AXILARY 6/2/2012 9:59 AMEXAM#:
12484265
ORDERED BY: Dr. JASON WELLS
REASON FOR EXAM: left shoulder painleft shoulder pain left shoulder
xray---left shoulder pain left shoulder xray---
RESULT:
JENNIE MAE COX
LEFT SHOULDER, 6/2/2012:
Internal and external rotation views of the left shoulder as well as
an axillary view are submitted. The clinical history is that of left
shoulder pain. No soft tissue or bony abnormality was identified.
TRANSCRIPTIONIST:J. DAN HIPPS
TRANSCRIBE TIME/DATE:6/2/2012 7:23:00 PM
READ BY:D. MACK THOMASON, MD,
SIGNED BY:
0 ELECTRONIC SIGNATURE / THOMASON, MD,D. MACK

**Comments**

Result Comments: GRD0249GDT

Requisition Comments:

| | | | |
|---|---|---|---|
| Ordering Dr: | Wells Jason T | Order Date/Time: | 06/02/2012 09:59 |
| | | Ord#/Occurrence#: | 8703082 / 11469897 |



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APA #4
JAMES L. FOWLER, M.D.
GHS Plastic Surgery & Aesthetics
06/01/12-10/12/15

| Pt Name: | COX, JENNIE C | MRN: | 971202636 |
|---|---|---|---|
| Pt ID: | 20102920969 | Acct No: | 08015693988 |
| DOB: | 08/14/1952 | Age/Sex: | 62Y/F |
| Adm DTime: | 07/05/2012 09:35 | Atn Dr: | Fowler, James MD |
| Nurs Sta: | GMH OP Dept | Rm & Bed: | |
| Dx: | | | |
| Alrg: | Milk of Magnesia, No Known Food Allergies | | |

| Order Name: | | Observation Dtime: | 06/01/2012 08:00 |
|---|---|---|---|
| Result Name: | OP Notes/GI Lab | Result Status: | Final Result |

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: COX, JENNIE MAE Patient Location: 083C3329AM
PATIENT MR#: 000-971-20-2636 Billing NO: 080015539394
DATE OF PROCEDURE: 06/01/2012

PREOPERATIVE DIAGNOSES:
1. Bilateral subcondylar mandible fractures.
2. Left body comminuted mandible fracture.
3. Avulsed maxillary and mandibular teeth.

POSTOPERATIVE DIAGNOSES:
1. Bilateral subcondylar mandible fractures.
2. Left body comminuted mandible fracture.
3. Avulsed maxillary and mandibular teeth.

PROCEDURE:
1. Maxillomandibular fixation with intramaxillary fixation screws.
2. Open reduction and internal fixation left body mandible fracture.
3. Dental tooth extraction: Left mandibular and maxillary central and lateral incisors, right mandibular and maxillary central incisor.

ATTENDING SURGEON: James L. Fowler, III, M.D.
ANESTHESIA: General endotracheal anesthesia per nasotracheal RAE tube.
ESTIMATED BLOOD LOSS: 50 mL.
SPECIMENS: None.
COMPLICATIONS: None.
INDICATIONS: Status post blunt trauma after falling onto a concrete loading dock. The patient sustained mandible fractures x3. The plan is for maxillomandibular fixation, removal of avulsed teeth, which had several dental caries and are in need of removal. The patient has no dentition distal to the bicuspids on the maxilla or mandible. Therefore, plan is for maxillomandibular fixation with very few points of contact for occlusion and open reduction and internal fixation of the body fracture of the mandible to allow early mobilization, and closed reduction of the subcondylar fractures. The risks and benefits were discussed with the patient and patient's family. They understand and they wish to proceed.
DESCRIPTION OF PROCEDURE: The patient was brought to the operating room after informed consent was obtained. General endotracheal anesthesia was administered per nasotracheal RAE tube. The face was prepped with Betadine and draped with sterile towels and sterile drapes. A time-out was held. The self-retaining lip retractor was placed. The throat pack was placed under direct vision. The pharynx appeared without edema or swelling, no


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| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 08015693968 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 62Y/F |
| **Adm DTime:** | 07/05/2012 09:35 | **Atn Dr:** | Fowler, James MD |
| **Nurs Sta:** | GMH OP Dept | **Rm & Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | | **Observation Dtime:** | 06/01/2012 08:00 |
| **Result Name:** | OP Notes/GI Lab | **Result Status:** | Final Result |

epistaxis or blood was noted in the pharynx after nasotracheal intubation. The mouth was irrigated copiously with Peridex. The dentition was examined and multiple teeth were found to be very loose, mobile, and holding on by gingival attachments only. The Freer was used to extract the six teeth described above. This left bipolar bicuspid and canine teeth for occlusion between the maxilla and the mandible. Next, 8 mm intramaxillary fixation screws were placed between the canine and bicuspid of the mandible and maxilla bilaterally. The remaining dentition was readily brought into occlusion. The fracture and the left body of the mandible were injected with 1% Xylocaine containing epinephrine. The Bovie cautery was used to incise through the mucosa and the muscular attachments including the periosteum. Subperiosteal dissection revealed a comminuted fracture of the mandible over the left body, which extended from the parasymphyseal region and the menton to the posterior body of the mandible. There was a long oblique fracture low on the mandible and to series of comminuted fractures towards the previous alveolus distal to the bicuspid on the left mandible. Loose, devitalized bone fragments were d brided in this area. The fracture was irrigated copiously with normal saline. The fracture was readily reduced. A four-hole tension band was applied across the superior fracture just below the area of comminution and just above the mental nerve. The mental nerve was readily identified and preserved. The monocortical screws were utilized for the tension band. Once the tension band was in place, bigonial pressure was able to be applied and a six-hole 2.0 Synthes titanium plate was fashioned over a template, which was placed spanning the mandibular margins from the parasymphyseal region to the mid body, spanning the fracture. The plate was affixed using bicortical screws holding bigonial pressure. Good reduction resulted. Occlusion remained stable. The dissection was irrigated with thrombin spray. Closure was performed with musculomucosal interrupted sutures of 3-0 Vicryl. The gingiva over the areas of avulsed teeth was loosely approximated using interrupted 3-0 chromic sutures. Again, the mouth was irrigated with Peridex. The occlusal wires were removed. The mandible was arranged. Reduction maneuver was performed with inferior and anterior rotation of the mandible cleaning it back into occlusion after the throat pack had been removed. Occlusal wires were replaced. The patient tolerated the procedure well and a lip retractor was removed. The patient was successfully extubated after passage of a nasogastric tube to allow aspiration of the pharynx and stomach prior to emergence. The patient emerged pain-free and was transferred to the hospital stretcher for transfer to the recovery room, for subsequent admission to the hospital.


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| | | | |
|---|---|---|---|
| Pt Name: | COX, JENNIE C | MRN: | 971202636 |
| Pt ID: | 20102920960 | Acct No: | 08015693968 |
| DOB: | 08/14/1952 | Age/Sex: | 62Y/F |
| Adm DTime: | 07/06/2012 09:35 | Atn Dr: | Fowler, James MD |
| Nurs Sta: | GMH OP Dept | Rm & Bed: | |
| Dx: | | | |
| Alrg: | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| Order Name: | | Observation Dtime: | 06/01/2012 08:00 |
| Result Name: | OP Notes/GI Lab | Result Status: | Final Result |

```
James L. Fowler, III, MD
cc:  James L. Fowler, III, MD
D: 06/01/2012 02:12 P              T: 06/02/2012 07:27 A        zst
DVI: 536063         C/S#: 3631856
```

**Comments**

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /



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**Outpatient Notes Results Report**

| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 06015693968 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 62Y/F |
| **Adm DTime:** | 07/05/2012 09:35 | **Atn Dr:** | Fowler, James MD |
| **Nurs Sta:** | GMH OP Dept | **Rm & Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | | **Observation Dtime:** | 06/11/2012 08:00 |
| **Result Name:** | Outpatient Notes | **Result Status:** | Final Result |

PATIENT: COX, JENNIE
MRN: 971202636
June 11, 2012
She presents today in follow up of ORIF of comminuted symphyseal mandible fracture and closed reduction of two subcondylar fractures.
PHYSICAL EXAMINATION: She remains wired and of good occlusion of four teeth that remain. The incision is closed, hygiene is good. She is taking protein supplements. She is able to eat grits as she has a large space anteriorly and posteriorly through which pureed fractured jaw diet may pass. Pain has been controlled, swelling is decreased considerably.
ASSESSMENT/PLAN: The plan is for continued good oral hygiene in a levered and wired occlusion for one more week. She will follow up next week at which time we will clip the wires.

James L. Fowler III, M.D.

JLF/abc
T: 6/12/2012

**Comments**

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /



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**Outpatient Notes Results Report**

| | | | |
|---|---|---|---|
| Pt Name: | COX, JENNIE C | MRN: | 971202636 |
| Pt ID: | 20102920969 | Acct No: | 08015693968 |
| DOB: | 08/14/1952 | Age/Sex: | 62Y/F |
| Adm DTime: | 07/05/2012 09:35 | Atn Dr: | Fowler, James MD |
| Nurs Sta: | GMH OP Dept | Rm & Bed: | |
| Dx: | | | |
| Alrg: | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| Order Name: | | Observation Dtime: | 06/18/2012 08:00 |
| Result Name: | Outpatient Notes | Result Status: | Final Result |

PATIENT: COX, JENNIE
MRN: 971202636
June 18, 2012
She is status post ORIF of mandible. She had bilateral subcondylar mandible fractures as well as left body comminuted mandible fracture. She had ORIF of the body fracture and has been in occlusion with IMF screws. She had multiple tooth extractions and had four teeth to occlude. She has had decrease in pain, she is not complaining of pain at all today. Swelling has completely resolved and she has some hollowing of the cheeks. She has no mandibular pain, either in the TMJ's or the left body.
PHYSICAL EXAMINATION: Incision interorally remains closed, the occlusal wires are removed. She has 2 cm of interincisal opening. She is healing well.
ASSESSMENT/PLAN: Plan is to schedule her for removal of IMF screws. She is to remain on soft diet for two additional weeks and we will schedule her for the IMF screw removal in the next week.

James L. Fowler III, M.D.

JLF/sbc
T: 6/19/2012

**Comments**

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /


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**OP Notes/GI Lab Results Report**

| Pt Name: | COX, JENNIE C | MRN: | 971202636 |
|---|---|---|---|
| Pt ID: | 20102920968 | Acct No: | 08015693968 |
| DOB: | 08/14/1952 | Age/Sex: | 62Y/F |
| Adm DTime: | 07/05/2012 09:35 | Atn Dr: | Fowler, James MD |
| Nurs Sta: | GMH OP Dept | Rm & Bed: | |
| Dx: | | | |
| Alrg: | Milk of Magnesia, No Known Food Allergies | | |

| Order Name: | | Observation Dtime: | 07/05/2012 08:00 |
|---|---|---|---|
| Result Name: | OP Notes/GI Lab | Result Status: | Final Result |

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
GREENVILLE MEMORIAL HOSPITAL
MEDICAL RECORD

NAME: COX, JENNIE C Patient Location: 080D1001AM
PATIENT MR#: 000-971-20-2636 Billing NO: 080015693968
DATE OF PROCEDURE: 07/05/2012
PREOPERATIVE DIAGNOSIS: Mandible fracture.
POSTOPERATIVE DIAGNOSIS: Mandible fracture.
PROCEDURE: Removal of IMF screws.
SURGEON: Dr. James L. Fowler, III.
ASSISTANT: None.
ANESTHESIA: Intravenous sedation and 1% Xylocaine with epinephrine 5 mL injected.
ESTIMATED BLOOD LOSS: Less than 1 mL.
COMPLICATIONS: None.
INDICATIONS: Status post open reduction internal fixation, mandible fracture with maxillomandibular fixation with IMF screws. Patient had the occlusal wires removed as jaw has remained stable. She has good range of motion. She has lost multiple teeth, but does have the ability to chew, and the mandible has remained stable with maintaining her current occlusal pattern with her few remaining teeth. The plan is for removal of IMF screws. Risks and benefits were discussed, and the patient wishes to proceed.
DESCRIPTION OF PROCEDURE: The patient was brought to the operating room after informed consent was obtained. The patient was placed supine on the operating room table. The face was prepped with PHisoHex and draped with sterile towels and a sterile drape. Time-out was held. A self-retaining lip retractor was placed. The mucosa was prepped with Peridex. Each screw insertion site was injected with 1 mL of 1% Xylocaine with epinephrine. Each screw was removed using the screwdriver without complications. Pressure was held. Peridex was used to re-prep and cleanse the mucosa. Previous gingivobuccal mucosal closures remained intact. The mandible demonstrated normal range of motion. The mandible was stable to compression and testing with range of motion. The lip retractor was removed after the oral cavity was
suctioned, and the patient as transferred to the recovery room hemodynamically stable and awake, tolerating secretions and swallowing well. The patient is given follow up in my office in one month. IMF screws were removed x4.
James L. Fowler, III, MD


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| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 08015693968 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 62Y/F |
| **Adm DTime:** | 07/05/2012 09:35 | **Atn Dr:** | Fowler, James MD |
| **Nurs Sta:** | GMH OP Dept | **Rm & Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | | **Observation Dtime:** | 07/05/2012 08:00 |
| **Result Name:** | OP Notes/GI Lab | **Result Status:** | Final Result |

cc: James L. Fowler, III, MD
D: 07/05/2012 04:56 P T: 07/06/2012 06:58 A zjt
DVI: 554298 C/S#: 3656035

**Comments**

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /



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**Outpatient Notes Results Report**

| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920969 | **Acct No:** | 08015693968 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 62Y/F |
| **Adm DTime:** | 07/05/2012 09:35 | **Atn Dr:** | Fowler, James MD |
| **Nurs Sta:** | GMH OP Dept | **Rm & Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | | **Observation Dtime:** | 08/03/2012 08:00 |
| **Result Name:** | Outpatient Notes | **Result Status:** | Final Result |

PATIENT: COX, JENNIE C.
MRN: 971202636
August 3, 2012
She presents today after mandible fracture. She has had the IMF screws removed. She has healed those areas. She does not have any jaw pain, she has good range of motion without clicking, popping or subluxation of TMJ's. Occlusion has remained stable.
PHYSICAL EXAMINATION: On examination there is no malocclusion and interincisal opening is normal. She has no pain at the TMJ or over the left body of the mandible.
ASSESSMENT/PLAN: She has seen Dr. Cobb for dental restoration. He has identified the plates and identified the tension and on the left as a potential problem regrinding denture fit and I am able to take that out if need be. Otherwise the plate would be to stay in place. She may return to a completely normal diet. She is not impaired from a jaw standpoint and she will follow up in our office in three months.

James L. Fowler III, M.D.

JLF/abc
T: 8/6/2012

**Comments**

Result Comments:

Requisition Comments:

Ordering Dr:

Order Date/Time:
Ord#/Occurrence#: /


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**Outpatient Notes Results Report**

| | | | |
|---|---|---|---|
| **Pt Name:** | COX, JENNIE C | **MRN:** | 971202636 |
| **Pt ID:** | 20102920989 | **Acct No:** | 08015693988 |
| **DOB:** | 08/14/1952 | **Age/Sex:** | 62Y/F |
| **Adm DTime:** | 07/05/2012 09:35 | **Atn Dr:** | Fowler, James MD |
| **Nurs Sta:** | GMH OP Dept | **Rm & Bed:** | |
| **Dx:** | | | |
| **Alrg:** | Milk of Magnesia, No Known Food Allergies | | |

| | | | |
|---|---|---|---|
| **Order Name:** | | **Observation Dtime:** | 11/05/2012 08:00 |
| **Result Name:** | Outpatient Notes | **Result Status:** | Final Result |

PATIENT: COX, JENNIE
MRN: 971202636
November 5, 2012
She presents today after ORIF of mandible. She has been seen by a prosthodontist and is scheduled for dental restoration.
PHYSICAL EXAMINATION: On examination the incisions are healed, the swelling is gone. She has a little bit of deviation of the mandible with maximal opening. No pain, no clicking, no popping, no subluxation of the TMJ's.
ASSESSMENT/PLAN: She has done well. She reports that her nutrition has been affected in that she is having to work to get enough nutrition in, particularly when she is on the job. She is eating pureed foods. She does report getting a pork tenderloin the other week and was able to eat it once cut into small bites. We have recommended softer food diet and maintaining her nutrition as needed with calorie supplements including Ensure or Carnation Instant Breakfast. She has not acknowledged any need for a nutritional consult at this time and she will proceed with her dental restoration and she will follow up in this office prn.

James L. Fowler III, M.D.

JLF/sbc
T: 11/6/2012

**Comments**

Result Comments:

Requisition Comments:

| | | | |
|---|---|---|---|
| Ordering Dr: | | Order Date/Time: | |
| | | Ord#/Occurrence#: | / |


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GREENVILLE HEALTH SYSTEM

# COX, JENNIE C

**62 Y old Female, DOB: 08/14/1952**
**Account Number: 971202636**
**222 W CHAPMAN RD, BELTON, SC-29627**
**Home: 864-243-0032**
**Guarantor: COX, JENNIE C Insurance: SELF PAY**
**Appointment Facility: GHS Plastic Surgery**

**06/08/2015** **PROGRESS NOTE: James L. Fowler, MD**

## Current Medications

**Taking**

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

## Surgical History

Hysterectomy and lap lysis of adhesions 4/2001
ORIF of mandible 6/1/12
Removal of MMF screws 7/5/12

## Social History

Alcohol women 18 yrs and older Assessment completed: **today**, Alcohol intake: **patient does not drink alcohol screening complete**.
Smoking Status > 13 years old Are you a: **Current smoker**, Pt counseled on the dangers of tobacco use and urged to quit. **06/08/2015**.

## Allergies

Magnesium

## Hospitalization/Major Diagnostic Procedure

See surgery history

## Reason for Appointment

1. EST MANDIBLE FX DOI 5.31.12

## Assessments

1. Mandible fracture - 802.20 (Primary)

Nonunion of the body of an atrophic mandible.
We will obtain a CT scan. We will attempt to obtain copies of Dr. Cobb's panoramic views. She will follow-up in a week. We have discussed surgery with removal of hardware as necessary, bone biopsy, and possible staged approach with bone grafting as necessary. She will follow-up next week.
James L. Fowler, III, M.D./pan.

## Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds **Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.**
Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

## Follow Up

1 Week

## History of Present Illness

SPLA HPI:

She presents today status post ORIF of the mandible in 2012. She has recently had dental restoration with Dr. Cobb and he has done some nice work with a mandibular dental prosthesis that is fixed into place. He has done panoramics and has noted some scabbing at the body of the mandible on the left side. She has been able to eat and has done fairly well without discomfort to the jaw specifically. She reports the scab not getting better over time. She denies any fever or chills or chronic drainage from the area.

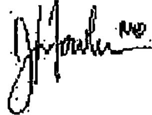
## Vital Signs

Wt lbs 113, Wt kg 51.26, BP 122/75, HR 81.

## Examination

SPLA-Examination:

On physical exam, she appears to be a thin, pleasant, Caucasian female in no acute distress. Alert and oriented. The face demonstrates lax, loose, inelastic skin with thin features. There is a 3 mm eschar at the inferior body of the left mandible. There is no erythema, no induration, no drainage. Intraorally there is a fixed, mandibular, dental prosthesis and the appliance is firmly affixed and not loose. Intraoral incisions appear to have healed well. There are no ulcerations there. Range of motion of the mandible is normal.



**Electronically signed by James Fowler , MD on 06/30/2015 at 02:39 PM EDT**

**Sign off status: Completed**

**GHS Plastic Surgery**
**200 Patewood Dr, Suite B480**
**Greenville, SC 29615**
**Tel: 864-454-4570**
**Fax: 864-241-9270**

### Current Medications

**Taking**

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

### Past Medical History

No Medical History.

### Surgical History

Hysterectomy and lap lysis of adhesions 4/2001
ORIF of mandible 6/1/12
Removal of MMF screws 7/5/12

### Family History

No Family History documented.

### Social History

Alcohol women 18 yrs and older Assessment completed: **today**, Alcohol intake: **patient does not drink alcohol screening complete**.
Smoking Status > 13 years old Are you a: **Current smoker**, Pt counseled on the dangers of tobacco use and urged to quit. **06/08/2015**.

### Allergies

Magnesium

### Hospitalization/Major Diagnostic Procedure

See surgery history

### Reason for Appointment

1. RECK/LT MANDIBLE FX/1 WEEK/DOI 5.31.12

### Assessments

1. Mandible fracture - 802.20 (Primary)

### Treatment

**1. Mandible fracture**

Notes: ASSESSMENT: Exposure of left mandibular plate. I have recommended removal of the indwelling device of the mandibular bone and along with removal of plate and screws in then operating room. Risks and benefits have been discussed. She understands that we could obtain a bone culture at surgery that would show osteomyelitis in which case she may need prolonged IV antibiotics and possibly a fixator device. We discussed atrophic mandible and the loss of size and strength of that bone and suggested that she might need to abort an implanted device of the mandible. She understands these risks and we will schedule in the next scheduling with Dr. Cobb's removal of the dental prosthesis and the surgery to remove the plate and screws.
James L. Fowler, III, M.D./mad.

### Preventive Medicine

MED RECONCILIATION: Pt. Ed: Current Meds **Verified: Current meds/immunizations reviewed, including purpose with pt. Med Recon list given to pt/family. Pt advised to discard old med lists and provide all providers with current list at each visit and carry list with them in case of emergency.**
Patient is to continue all medications as directed by prescribing physicians. Continuations on today's visit are made based on the patient's report of current medications.

### Follow Up

prn

### History of Present Illness

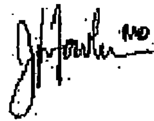
SPLA HPI:

HPI: She presents with a draining sinus to the left jaw in the region of a previous ORIF and plate and screw placement for a compound fracture of an atrophic mandible. The patient was seen by Dr. Cobb in oral surgery and had implanted dental restoration with screw placement in the mandibular bone. The patient reports having some

pressure applied to the mandible during placement of this device over the area of the plate with some pain. She later presented to him with a draining sinus and she was referred here for evaluation for possible infection. She denies fevers or chills, nausea or vomiting. There is no erythema. There is no purulence. She was sent for a CT scan and was found to have osseous healing with a point of prominence of the plate over the body on the left side. This corresponds to the point of drainage. CT reports no evidence of osteomyelitis. No soft tissue gas and the bone does not appear to have findings consistent with osteomyelitis. She is currently not on an antibiotic.

**Vital Signs**

Ht 67, Ht Cm 170.18, Wt lbs 113, Wt kg 51.26, BMI 17.70, BP 139/84, HR 99.



**Electronically signed by James Fowler , MD on 06/30/2015 at 02:39 PM EDT**

**Sign off status: Completed**

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

GREENVILLE HEALTH SYSTEM

# COX, JENNIE C

62 Y old Female, DOB: 08/14/1952
Account Number: 971202636
222 W CHAPMAN RD, BELTON, SC-29627
Home: 864-243-0032
Guarantor: COX, JENNIE C Insurance: SELF PAY
Appointment Facility: GHS Plastic Surgery

**06/29/2015** **Progress Note: James L. Fowler, MD**

### Current Medications

**Taking**

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)
- Medication List reviewed and reconciled with the patient

### Past Medical History

No Medical History.

### Surgical History

Hysterectomy and lap lysis of adhesions 4/2001
ORIF of mandible 6/1/12
Removal of MMF screws 7/5/12

### Family History

No Family History documented.

### Social History

Alcohol women 18 yrs and older Assessment completed: **today**, Alcohol intake: **patient does not drink alcohol screening complete**.
Smoking Status > 13 years old Are you a: **Current smoker**, Pt counseled on the dangers of tobacco use and urged to quit. **06/08/2015**.

### Allergies

Magnesium

### Hospitalization/Major Diagnostic Procedure

See surgery history

### Reason for Appointment

1. POV

### Assessments

1. Mandible fracture - 802.20 (Primary)

Plan is for no dentures for a total of one month. She wishes to remain out of work for the period that she cannot wear dentures. She will continue to rinse with Listerine, which is her preferred mouthwash and she is completing the postoperative oral antibiotic course. Once that is completed, she will discontinue antibiotics. She will follow-up in the office for any kind of recurrent swelling in the area and will otherwise follow-up in two weeks. I recommended that she just leave the bone anchors in place for the time being.
James L. Fowler, III, M.D./pan.

### Preventive Medicine

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

### Follow Up

1 Week

### History of Present Illness

SPLA HPI:

She presents today postop from removal of mandibular plates and screws. The denture anchors remain in place. Cultures from the removal of the plate, the cortical bone, did not grow anything but sparse skin flora. Clinically she did not have any purulent infection and had complete osseous healing.

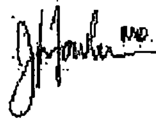
### Vital Signs

BP 141/90, HR 70, Pain score 0.

### Examination

SPLA-Examination:

The sutures of the skin remain. The closure intraorally remains closed.



**Electronically signed by James Fowler , MD on 07/16/2015 at 04:58 PM EDT**

**Sign off status: Completed**


**GHS Plastic Surgery**
**200 Patewood Dr, Suite B480**
**Greenville, SC 29615**
**Tel: 864-454-4570**
**Fax: 864-241-9270**

GREENVILLE
HEALTH SYSTEM

Plastic Surgery & Aesthetics
200 Patewood Drive Suite B480
Greenville, SC 29615
864-454-4570 Fax: 864-454-4575

**RETURN TO WORK STATUS**

Patient Name: Jennie Coy was seen in our

office on 6/29/15

Date of Birth: 8/14/52

□ May return to Work on 7/20/15 with no restrictions

□ May return to Work with RESTRICTIONS From: ______ To: ______

□ Unable to Work From: ______ To: ______

- □ Limit standing to no more than ______ hr/day.
- □ Limit sitting to no more than ______ hr/day.
- □ Limit walking to no more than ______ hr/day.
- □ No lifting over ______ pounds.
- □ No climbing of stairs/ladders.
- □ No reaching above shoulder level.
- □ No squatting.
- □ No bending or stooping.
- □ No use of R / L / Both hands.
- □ Other restrictions ______

Follow-up Appointment Date: ______

Dr. Fowler / E. Akerson RN — Physician's Signature

6-29-15 — Date

Wesley Culpepper, MD
Carl de Brux, MD
James Fowler, MD
John Jarrell, MD

GREENVILLE HEALTH SYSTEM

# COX, JENNIE C

62 Y old Female, DOB: 08/14/1952
Account Number: 971202636
222 W CHAPMAN RD, BELTON, SC-29627
Home: 864-243-0032
Guarantor: COX, JENNIE C Insurance: SELF PAY
Appointment Facility: GHS Plastic Surgery

**07/06/2015** **Progress Note: NURSE, SPLA**

## Current Medications

Taking

- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)

## Allergies

Magnesium

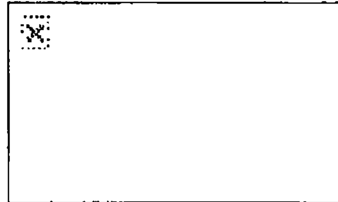
## Reason for Appointment

1. NURSE CHECK/SUTURE REMOVAL

## Treatment

**1. Others**

Notes: Pt returns to office today to have sutures removed from left side of jaw per Dr. Fowler. Sutures removed with no difficulty, pt tolerated well. No signs of redness, area well approximated, no s/sx of infection noted. Pain under control. Pt has no c/o at this time. Pt to return next week to see Dr. Fowler. E. Akens RN.



**Electronically signed by Paula Brown RN on 07/21/2015 at 02:52 PM EDT**

**Sign off status: Completed**

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

## Visit Summary

**Reason for Visit**

**Post-op** mandible fracture

**Diagnoses**

**Mandible open fracture, sequela** - Primary

**Reviewed** On: **7/17/2015** By: **Etienne Michelle Akens, RN**

**Allergies as of 7/17/2015**

| Allergen | Noted | Reaction Type | Reactions | Deletion Reason |
|---|---|---|---|---|
| **Magnesium** | 07/17/2015 | | Shortness Of Breath | |

Most recent update: 7/17/2015 3:00 PM by Etienne Michelle Akens, RN

**Vital Signs**

| BP | Pulse | Temp(Src) | Ht | Wt | BMI |
|---|---|---|---|---|---|
| 98/58 mmHg | 93 | 97.9 °F (36.6 °C) (Temporal) | 5' 7" (1.702 m) | 108 lb (48.988 kg) | 16.91 kg/m2 |

Patient History

**Medical as of 7/17/2015**

| Past Medical History | Date | Comments | Source |
|---|---|---|---|
| Mandible fracture | | | Provider |

**Surgical as of 7/17/2015**

| Past Surgical History | Laterality | Date | Comments |
|---|---|---|---|
| HYSTERECTOMY | | 4/2001 | lap lysis of adhesions |
| ORIF MANDIBULAR FRACTURE | | 6/1/12 | ORIF of mandible |
| OTHER SURGICAL HISTORY | | 7/5/12 | Removal of MMF screws |

**Family as of 7/17/2015**

| Problem | Relation | Name | Age of Onset | Comments | Source |
|---|---|---|---|---|---|
| Hypertension | Brother | | | | Provider |

**Family Status as of 7/17/2015** ****None****

**Tobacco Use as of 7/17/2015**

| Smoking Status | Source | Types | Packs/day | Years Used | Comments | Smoking Start Date | Smoking Quit Date | Smokeless Tobacco Status | Smokeless Tobacco Quit Date |
|---|---|---|---|---|---|---|---|---|---|
| Current Every Day Smoker | Provider | | 0.0 | 0.0 | urged to quit, 8/8/2015 | | | Unknown | |

**Alcohol Use as of 7/17/2015**

| Alcohol Use | Source | Drinks/Week | Alcohol/Wk | Comments |
|---|---|---|---|---|
| No | Provider | 0 Not specified | 0.0 oz | |

**Drug Use as of 7/17/2015**

| Drug Use | Source | Types | Frequency | Comments |
|---|---|---|---|---|
| Not Asked | Provider | | 0.00 | |

**Sexual Activity as of 7/17/2015**

| Sexually Active | Source | Birth Control | Partners | Comments |
|---|---|---|---|---|
| Not Asked | Provider | | | |

**Social ADL as of 7/17/2015**

| ADL Question | Response | Comments | Source |
|---|---|---|---|
| ****None**** | | | |

## Visit Summary (continued)

**Occupational** as of 7/17/2015 — ****None****

**Socioeconomic** as of 7/17/2015

| Marital Status | Spouse Name | Num of Children | Years Education | Source |
|---|---|---|---|---|
| Divorced | | | | |

| Preferred Language | Ethnicity | Race |
|---|---|---|
| English | Non-Hispanic or Non-Latino | White or Caucasian |

## Medications

### Medications the Patient Reported Taking

| | Disp | Refills | Start | End |
|---|---|---|---|---|

**HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet (Taking)**
Sig: Take by mouth every 6 (six) hours as needed for moderate pain.
Class: Historical Med
Route: Oral

**temazepam (RESTORIL) 30 mg capsule (Taking)**
Sig: Take nightly.
Class: Historical Med
Route: Oral

## Telephone Encounter

### Call Information

| | Provider | Department | Center |
|---|---|---|---|
| 7/17/2015 2:50 PM | James Lyman Fowler, MD | Plastic Surg-Patewood | PTWD CENTERS |

### Reason for Call

**Post-op** — mandible fracture

### Call Documentation

No notes of this type exist for this encounter.

### Care Advice Given

No Care Advice given for this encounter.

## Orders

### All Orders and Results Except Lab and Imaging

No orders and results found

## Result Summary

### All Lab and Imaging Orders and Results

No orders and results found

## Progress Notes

**Progress Notes (continued)**

**James Lyman Fowler, MD at 7/17/2015 3:04 PM**

Author Type: Physician   Status: Signed

**Office Visit Note**

7/17/2015

**Subjective:**

Jennie C Cox is a 62 y.o. female.

**Chief Complaint**

Patient presents with:

- Post-op
  *mandible fracture*

**HPI**

Ms. Cox presents today postop from removal of hardware from the mandible after exposure. She reports decreased pain and swelling. She has not replaced the lower denture at our request. Been off work due to her restriction of a soft diet without this denture.

Review of Systems

**Objective:**

BP 98/58 mmHg | Pulse 93 | Temp(Src) 97.9 °F (36.6 °C) (Temporal) | Ht 5' 7" (1.702 m) | Wt 108 lb (48.988 kg) | BMI 16.91 kg/m2

Physical Exam

On physical exam H EEE NT: The swelling over the mandible has fully resolved. Her intraoral incision appears healed without dehiscence. She has mild edema that remains at the incision site. There is no fluctuance purulence or instability. Range of motion of the mandible is normal. By gonial pressure does not reveal any instability.

Assessment

**Assessment/Plan:**

**Problem List Items Addressed This Visit**

None

Status post exposure of mandibular plate and screws following ORIF. Cortical mandibular integrity was confirmed at the time of surgery. She is to remain on a soft diet for 2 more weeks. I have recommended returning for replacement of her denture at 6 weeks from the time of surgery. She has indicated an interest in returning to work August 1. She is cleared to do so.

## Progress Notes (continued)

**James Lyman Fowler, MD at 7/17/2015 3:04 PM (continued)**

Electronically signed by James Lyman Fowler, MD on 7/17/2015 4:27 PM

**Etienne Michelle Akens, RN at 7/17/2015 3:03 PM**

Author Type: Registered Nurse    Status: Signed

Electronically signed by Etienne Michelle Akens, RN on 7/17/2015 4:27 PM

**H&P Notes**

No notes of this type exist for this encounter.

**Follow-up and Disposition History**

| User | Date & Time |
|---|---|
| FOWLER, JAMES | 7/17/2015 4:03 PM |

**Disposition:**

Return in about 3 months (around 10/17/2015) for Recheck.

**Follow-up:**

N/A

**Instructions:**

N/A

**Check-out Note:**

N/A

**Send Reminder:**

N/A

**Encounter-Level Documents:**

There are no encounter-level documents.

**Order-Level Documents:**

There are no order-level documents.

GREENVILLE
HEALTH SYSTEM

**COX, JENNIE C**
62 Y old Female, DOB: 08/14/1952
Account Number: 971202636
222 W CHAPMAN RD, BELTON, SC-29627
Home: 864-243-0032
Guarantor: COX, JENNIE C Insurance: SELF PAY
Appointment Facility: GHS Plastic Surgery

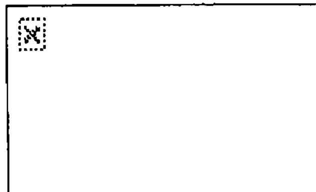
07/06/2015 Progress Note: NURSE, SPLA

### Current Medications
Taking
- Restoril 30 mg capsule 1 cap(s) once a day (at bedtime)

### Allergies
Magnesium

### Reason for Appointment
1. NURSE CHECK/SUTURE REMOVAL

### Treatment
**1. Others**
Notes: Pt returns to office today to have sutures removed from left side of jaw per Dr. Fowler. Sutures removed with no difficulty, pt tolerated well. No signs of redness, area well approximated, no s/sx of infection noted. Pain under control. Pt has no c/o at this time. Pt to return next week to see Dr. Fowler. E. Akens RN.



**Electronically signed by Paula Brown RN on 07/21/2015 at 02:52 PM EDT**

**Sign off status: Completed**

GHS Plastic Surgery
200 Patewood Dr, Suite B480
Greenville, SC 29615
Tel: 864-454-4570
Fax: 864-241-9270

GREENVILLE
HEALTH SYSTEM

Plastic Surgery & Aesthetics
200 Patewood Drive Suite B480
Greenville, SC 29615
864-454-4570 Fax: 864-454-4575

**RETURN TO WORK STATUS**

Patient Name: Jennie Coy was seen in our office on 7-17-15

Date of Birth: 8-14-52

☒ May return to Work on Aug 1, 2015 with no restrictions

☐ May return to Work with RESTRICTIONS From: ______ To: ______

☐ Unable to Work From: ______ To: ______

- ☐ Limit standing to no more than ______ hr/day.
- ☐ Limit sitting to no more than ______ hr/day.
- ☐ Limit walking to no more than ______ hr/day.
- ☐ No lifting over ______ pounds.
- ☐ No climbing of stairs/ladders.
- ☐ No reaching above shoulder level.
- ☐ No squatting.
- ☐ No bending or stooping.
- ☐ No use of R / L/ Both hands.
- ☐ Other restrictions ______

Follow-up Appointment Date: ______

Dr Fowler / E Akens RN
Physician's Signature

7-17-15
Date

Wesley Culpepper, MD
Carl de Brux, MD
~~James Fowler, MD~~
John Jarrell, MD

## Visit Summary

**Reason for Visit**

**Follow-up**

**Diagnoses**

**Open fracture of body of mandible, sequela** - Primary

**Problem List as of 10/12/2015** Date Reviewed: **10/12/2015**

None

**Reviewed** On: **10/12/2015** By: **James Lyman Fowler, MD**

**Allergies as of 10/12/2015**

| Allergen | Noted | Reaction Type | Reactions | Deletion Reason |
|---|---|---|---|---|
| **Magnesium** | 07/17/2015 | | Shortness Of Breath | |

Most recent update: 10/12/2015 8:45 AM by Etienne Michelle Akens, RN

**Vital Signs**

| BP | Pulse | Ht | Wt | BMI |
|---|---|---|---|---|
| 118/80 mmHg | 87 | 5' 7" (1.702 m) | 112 lb (50.803 kg) | 17.54 kg/m2 |

Patient History

**Medical as of 10/12/2015**

| Past Medical History | Date | Comments | Source |
|---|---|---|---|
| Mandible fracture | | | Provider |

**Surgical as of 10/12/2015**

| Past Surgical History | Laterality | Date | Comments |
|---|---|---|---|
| HYSTERECTOMY | | 4/2001 | lap lysis of adhesions |
| ORIF MANDIBULAR FRACTURE | | 6/1/12 | ORIF of mandible |
| OTHER SURGICAL HISTORY | | 7/5/12 | Removal of MMF screws |

**Family as of 10/12/2015**

| Problem | Relation | Name | Age of Onset | Comments | Source |
|---|---|---|---|---|---|
| Hypertension | Brother | | | | Provider |

**Family Status as of 10/12/2015** **None**

**Tobacco Use as of 10/12/2015**

| Smoking Status | Source | Types | Packs/day | Years Used | Comments | Smoking Start Date | Smoking Quit Date | Smokeless Tobacco Status | Smokeless Tobacco Quit Date |
|---|---|---|---|---|---|---|---|---|---|
| Current Every Day Smoker | Provider | | 0.0 | 0.0 | urged to quit. 6/8/2015 | | | Unknown | |

**Alcohol Use as of 10/12/2015**

| Alcohol Use | Source | Drinks/Week | Alcohol/Wk | Comments |
|---|---|---|---|---|
| No | Provider | 0 Not specified | 0.0 oz | |

**Drug Use as of 10/12/2015**

| Drug Use | Source | Types | Frequency | Comments |
|---|---|---|---|---|
| Not Asked | Provider | | 0.00 | |

**Sexual Activity as of 10/12/2015**

| Sexually Active | Source | Birth Control | Partners | Comments |
|---|---|---|---|---|
| Not Asked | Provider | | | |

## Visit Summary (continued)

| **Social ADL** as of 10/12/2015 | ADL Question | Response | Comments | Source |
|---|---|---|---|---|
| | **None** | | | |

**Occupational** as of 10/12/2015 **None**

| **Socioeconomic** as of 10/12/2015 | Marital Status | Spouse Name | Num of Children | Years Education | Source |
|---|---|---|---|---|---|
| | Divorced | | | | |
| | Preferred Language | Ethnicity | Race | | |
| | English | Non-Hispanic or Non-Latino | White or Caucasian | | |

## Medications

### Medications the Patient Reported Taking

| | Disp | Refills | Start | End |
|---|---|---|---|---|

**temazepam (RESTORIL) 30 mg capsule (Taking)**
Sig: Take nightly.
Class: Historical Med
Route: Oral

### Medications at Start of Encounter

| | Disp | Refills | Start | End |
|---|---|---|---|---|

**temazepam (RESTORIL) 30 mg capsule (Taking)**
Sig - Route: Take nightly. - Oral
Class: Historical Med

**HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet**
Sig - Route: Take by mouth every 6 (six) hours as needed for moderate pain. - Oral
Class: Historical Med

## Telephone Encounter

### Call Information

| | Provider | Department | Center |
|---|---|---|---|
| 10/12/2015 9:40 AM | James Lyman Fowler, MD | Plastic Surg-Patewood | PTWD CENTERS |

### Reason for Call

**Follow-up**

### Call Documentation

No notes of this type exist for this encounter.

### Care Advice Given

No Care Advice given for this encounter.

## Orders

## Orders (continued)

**All Orders and Results Except Lab and Imaging**

No orders and results found

## Result Summary

**All Lab and Imaging Orders and Results**

No orders and results found

## Progress Notes

**James Lyman Fowler, MD at 10/12/2015 8:46 AM**

Author Type: Physician Status: Signed

Subjective

Reason for Visit:

**Chief Complaint**

| Patient presents with |
|---|
| • Follow-up |

HPI

Jennie C Cox is a 63 y.o. female who presents with his removal of hardware from the left mandible. She has a healed mandible fracture with an endoprosthesis secured with screws into the mandible. She has healed her incision. She reports some soreness over the area of the left body of the mandible. She reports eating normal regular diet and does not report any pain with eating. She does report some numbness over the chin and the left lower lip..

Review of Systems

**Allergies**

| Allergen | Reactions |
|---|---|
| • Magnesium | Shortness Of Breath |

has a current medication list which includes the following prescription(s): temazepam and hydrocodone-acetaminophen.

**Past Medical History**

| Diagnosis | Date |
|---|---|
| • Mandible fracture | |

Past Surgical History

| Procedure | Laterality | Date |
|---|---|---|
| • Hysterectomy<br>*lap lysis of adhesions* | | 4/2001 |
| • Orif mandibular fracture<br>*ORIF of mandible* | | 6/1/12 |
| • Other surgical history<br>*Removal of MMF screws* | | 7/5/12 |

**History**

**Progress Notes (continued)**

**James Lyman Fowler, MD at 10/12/2015 8:48 AM (continued)**

Social History

- **Marital Status:** Divorced
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Current Every Day Smoker
- Smokeless tobacco: None
  - *Comment: urged to quit. 6/8/2015*
- Alcohol Use: No
- Drug Use: None
- Sexual Activity: None

| Other Topics | Concern |
|---|---|
| • None | |

Social History Narrative

Objective

Physical Exam
HEENT: Swelling has completely resolved. The implantable denture is in place with screws into the mandible including 1 in the left body. The incision is healed. There is no swelling or drainage. By gonial pressure is applied to the mandible and there is no instability. Range of motion of the mandible is normal with good occlusion of the denture. She has tenderness over the body of left mandible. There is no palpable mass, induration, over the left mandible.

BP 118/80 mmHg | Pulse 87 | Ht 5' 7" (1.702 m) | Wt 112 lb (50.803 kg) | BMI 17.54 kg/m2

Assessment

**Problem List Items Addressed This Visit**

None

Plan

Healed after removal of hardware from the left mandible. The bony integrity of the left mandible was intact at the time of the removal of hardware. The mandible remained stable. She has an implantable denture in place with a screw in the area of the previous fracture that is holding stable. She has residual numbness from the left mental nerve which may be permanent. We should be able to to determine that at 12-18 months from her last surgery. Discussed that this could be permanent. She will follow-up in the office as

## Progress Notes (continued)

**James Lyman Fowler, MD at 10/12/2015 8:46 AM (continued)**

needed.

Electronically signed by James Lyman Fowler, MD on 10/12/2015 5:04 PM

**H&P Notes**

No notes of this type exist for this encounter.

**Follow-up and Disposition History**

| User | Date & Time |
|---|---|
| FOWLER, JAMES | 10/12/2015 9:18 AM |

**Disposition:**

Return if symptoms worsen or fail to improve.

**Follow-up:**

N/A

**Instructions:**

N/A

**Check-out Note:**

N/A

**Send Reminder:**

N/A

**Encounter-Level Documents:**

There are no encounter-level documents.

**Order-Level Documents:**

There are no order-level documents.

**END OF REPORT**

APA #5
GHS CENTER FOR HEALTH AND OCCUPATIONAL SERVICES
06/12/12-04/08/15

# GHS Center for Health and Occupational Services

Phone (864) 455-2300 1020 Grove Road, Greenville, SC 29605 Fax (864) 455-2399

## Consent for Occupational Health and Medical Services

Patient Name (PRINT) Last Cox First Jannie M C Sex M (F) Race W

Social Security 250-94-3648 Date of Birth 8/14/52 Marital Status D Pref Language Eng.

Are you a Veteran? Y / (N) Ethnicity: O Hispanic/Latino O Non-Hispanic/Non-Latino O Refuse/Decline

Home Address 222 W. Chapman Rd Belton SC 29627
Street City State Zip Code

County Greenville Home # 864-243-0032 Cell (or Primary) # ______

Employer Palmetto State Trans ~~Full Time~~/ Part Time Occupation Truck Driver Length of Employment: 7yr

Emergency Contact Tammy Healy Relationship to Patient Daughter Primary Tel # 864 630-5004

Guarantor Name ______ SS# ______ Address: ______
*(If patient is under the age of 18)*

The following are the conditions for services by GHS Center for Health and Occupational Services (CHOS) for the patient whose name appears above.

**Medical Consent-** I consent to all occupational health and medical services, evaluation, and treatment given under the general and special instructions of the physician and/or nurse practitioner, as requested by me, by my employer, and/or as required by municipal, state, or federal statutes that govern my occupation. Services may include, but are not limited to, diagnostic and screening procedures, administration of anesthetics, use of prescribed medication, medical services, the collection and evaluation of cultures and laboratory specimens, and referral to specialty services for radiology, physical therapy, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the physician or designees.

If a health care worker comes in direct contact with my blood or body fluids, I understand that my blood may be tested for Hepatitis B virus, Hepatitis C virus, or HIV (Human Immunodeficiency Virus) to determine whether or not the viruses are present, endangering the health care worker (IN ACCORDANCE WITH South Carolina State Statute title 44, chapter 29, section 44-29-230). The results of testing will be made available to me.

**Financial Agreement-** I understand that, if my employer requires me to pay for the requested services, then I am required to make full payment at the time service is rendered. Any agreement for reimbursement of these payments is held strictly between the employer and me.

**Disclosure / Use of Health Information / Authorization for Release of Medical Information-** I request that CHOS provide any health information gathered as a result of the services received to the employer requesting the service, to the insurance company, or to a valid representative of the payor; for purposes of payment for the services provided and to assist me to meet the medical requirements of my employer. I also authorize CHOS to provide health information to other physicians and healthcare facilities for continuing care. I further agree that CHOS can use the health information for operations such as peer review and outcome analysis. My initials here [initials] will acknowledge that I have received a copy of the CHOS Notice of Privacy Practices. I will be provided with a copy of this signed authorization, at my request.

This authorization for release of information expires 24 months from date of my signature. I may revoke the authorization at any time by writing *Center for Health and Occupational Services, Attention: Office Manager, 1020 Grove Road, Greenville, SC 29605.* However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation.

I may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. *Note:* There may be a processing fee charged to me, to cover labor, copying, and supplies used to reproduce medical records.

**Signatures-** I hereby authorize the treatment and the disclosure of personal health information as described above. I understand that this authorization is voluntary. However, if I do not sign this authorization, services will not be provided. Refusing to sign this authorization will *not* affect any other services I may receive at CHOS. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Patient Signature Jannie Cox Date 6/12/12

Guarantor Name ______ Relationship to Patient ______ Date ______
*(If Different from Patient)*
Guarantor Signature ______

Witness [signature] Date 6/12/12

**GHS Center for Health and Occupational Services**
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Cox SS# 250-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

**Diagnosis:** Mandible fracture; chest wall contusions; shoulder pain/weakness

**Medications:** Lortab at bedtime

**Work Status:** May return to work on 6/12/12

- ☐ Full Duty
- ☑ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]
  - ☑ Lift, push or pull no more than 5 lbs. [ O ]
  - ☐ Bend or Twist [ ]
  - ☐ Walk and Stand [ ]
  - ☐ Sit/Stand as needed
  - ☑ Sedentary Work, change positions as needed
  - ☐ No use of ______
  - ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
  - ☐ Overhead use of (right/left) arm [ ]
  - ☐ Squat or kneel [ ]
  - ☐ Climb or work at heights [ ]
  - ☐ Awkward or Static postures [ ]
  - ☑ No operating heavy machinery or Commercial Motor Vehicle
  - ☐ Elevate affected area ______
  - ☐ Use crutches as needed for ambulation
  - ☐ Use ______ splint as needed
  - ☐ Other ______

Restrictions are for the chestwall and shoulder injury — other restrictions per. Dr. Fowler [signature]

**Instructions:**

- ☐ Stay active during your recovery.
- ☑ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☑ Report any problems with medications to your provider.
- ☑ Apply ice or heat to the affected areas as needed.
- ☑ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☑ Wash wound with soap and water 1 times per day.
- ☑ May apply antibiotic ointment.
- ☑ Keep bandage clean and dry.
- ☑ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☑ Other: deep breathing 4x/day

**Follow Up:** after MRI or sooner for any problems

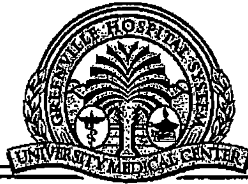
- ☐ Appointment Date: ______ Time: ______ Provider: ______
- ☐ Maximum Medical Improvement; Contact your employer prior to making further appointments.
- ☑ Referral to MRI (L) shoulder. You will be contacted with an appointment.

Physician/NP: [signature] Date: 6-12-12



return yellow copy to your employer

Revised 3/09



# UNIVERSITY MEDICAL GROUP

**Center for Health and Occupational Services**

**OUTPATIENT VISIT**

Name: Jennie Cox — Date of Service: 06-12-12
SSN: 250-94-3648 — Date of Injury: 05-31-12

SUBJECTIVE: Patient is a tractor-trailer driver with Palmetto State Transportation for seven years who comes to clinic today for follow up of chest wall pain. She was in an accident on 05-31-12 where she had a piece of equipment fall on her. She was seen in Grady Memorial Hospital and was diagnosed with a mandibular fracture. She is under the care of plastic surgery for her facial injuries. She is here today for chest wall pain and left shoulder pain. She rates the pain as 5/10. She denies any breathing difficulties. No shortness of breath. She denies any previous problems with her chest or shoulder. Review of available records is notable for negative noncontrast head CT. Left shoulder x-ray without sign of fracture or dislocation. Chest x-ray was unremarkable.

PAST MEDICAL HISTORY: Denies.

MEDICATIONS: None.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative.

OBJECTIVE: General: Patient is a pleasant female. She ambulates in the clinic without difficulty. Vital signs are stable. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: There is bruising to the anterior chest wall which is resolving. No midline tenderness to the cervical, thoracic or lumbar spine. She has tenderness over the left anterior and lateral chest wall. Also tender over the right lateral chest wall. There are two small abrasions to the right flank without sign of infection. Inspection of the left shoulder reveals no bruising, swelling or deformity. There is tenderness to the anterior and lateral aspect. She has range of motion to 120 degrees. There is weakness with external rotation and supraspinatus testing.

IMPRESSION:

1. Chest wall contusions.
2. Left shoulder contusion with weakness and possible rotator cuff injury.

PLAN:

1. May continue with Lortab for pain. She is given a refill for Lortab 7.5/500 one po qhs prn pain, dispense 15 with no refill.
2. She is instructed on deep breathing exercises.
3. Recommend MRI of the left shoulder.
4. Return to clinic after imaging is completed or sooner for any problems or concerns.

WORK STATUS:

1. Sedentary work.
2. Lift no more than 5 lbs.
3. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH — SN/llr 06-14-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Boulevard, Greenville, SC 29611

JUN 18 2012

GHS Center for Health and Occupational Services
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jensie Cox SS# 250-94-3648
Company Palmetto State Transportation
Date of Injury 5-31-12

**Diagnosis:** Chest wall Contusion
**Medications:** Lortab 7.5mg PRN

**Work Status:** May return to work on ____________

☐ Full Duty
☐ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☒ Lift, push or pull no more than 5 lbs. [ O ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed
- ☒ Sedentary Work, change positions as needed
- ☐ No use of ____________
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Climb or work at heights [ ]
- ☐ Awkward or Static postures [ ]
- ☒ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area ____________
- ☐ Use crutches as needed for ambulation
- ☐ Use ____________ splint as needed
- ☐ Other ____________

other Restrictions per Dr. Fowler.

**Instructions:**

- ☐ Stay active during your recovery.
- ☒ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☒ Report any problems with medications to your provider.
- ☒ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☒ Other: Deep breathing 4x day.

**Follow Up:** 8/7/12 or sooner for any problems.

- ☐ Appointment Date: ____________ Time: ________ Provider: ____________
- ☐ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to ____________. You will be contacted with an appointment.

Physician/NP: [signature], APRN Date: 7/17/12



return yellow copy to your employer

Revised 3/09

UNIVERSITY MEDICAL GROUP

**Center for Health and Occupational Services**

## OUTPATIENT VISIT

| Name: | Jennie Cox | Date of Service: | 07-17-12 |
|---|---|---|---|
| SSN: | 250-94-3648 | Date of Injury: | 05-31-12 |

SUBJECTIVE: Patient is a tractor-trailer driver with Palmetto State Transportation for the past 7 years. She is here today for follow up to an accident that occurred on the 31st of May this year and follow up to her MRI report. Findings of the MRI were reviewed with patient. She states that she still has some left shoulder discomfort with certain movements and some left chest pain with palpation over clavicle and upper chest area and some right-sided posterior back pain. Pain is managed with medication she received from another physician, Dr. Fowler, plastic surgeon as this was a significant injury that caused a fractured mandible and loss of some of her teeth. Musculoskeletal is improving well. See previous dictation for past medical history and specifics of initial injury.
ALLERGIES: She is allergic to Ativan.
REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative.
Cardiovascular: Negative. GI: Negative. Musculoskeletal: Findings as above. We reviewed her MRI from July 6, 2012 that showed degenerative changes with mild tendinopathy of the supra and infraspinatus tendons but no findings to suggest a full thickness rotator cuff tendon tear.
OBJECTIVELY: Patient is a pleasant 59-year old female who moves in the clinic without difficulty. Vital signs are stable. BP: 107/60. HR: 98. T: 98.0 and has 0 complaint of pain at present. Heart: Regular rate and rhythm without murmurs, gallop or rub. Chest clear to auscultation. Ecchymosis, bruising that was noted on previous exam has now resolved. The two small abrasions to the right flank have resolved. There still remains tenderness to the anterior lateral aspect of the left upper chest. Patient has full range of motion of the left arm and shoulder. No weakness noted on external rotation. Patient did relate that she has decreased hearing and feels that the left is worse than the right and decreased sense of smell. I examined both ear canals and they are occluded by cerumen. Unable to visualize TMs. Patient has an appointment with Dr. Fowler on August 3, 2012 and will definitely discuss with him the loss of smell. Advised it could be the result of inflammation of the nerves from the fracture and should resolve. She will also ask Dr. Fowler about cleaning out the impacted ear wax. She denies any dizziness. She is alert and oriented times three. No aphasia, dysarthria. Patient also has an appointment with an orthodontist on July 24, 2012 to discuss replacement of the teeth that she lost in this accident.
DIAGNOSIS: Chest wall contusions resolving. Left shoulder contusion improving.
PLAN: She will continue with her pain medication as prescribed by Dr. Fowler and work restrictions as dictated to her by Dr. Fowler. She is instructed to continue doing the deep breathing exercises as previously recommended and she is to return to the clinic after her next appointment with Dr Fowler. I recommended she make the appointment for around August 7, 2012 or sooner if any problems arise. Work status remains sedentary work, lifting no more than 5 pounds and no operating of commercial vehicle. Patient verbalized understanding of these instructions.

Lizanne Olyarchuk, APRN LO/llr 07-18-12
C: Palmetto State Transportation, Scott Justice, 1050 Park West Boulevard, Greenville, SC 29611



JUL 24 2012

GHS Center for Health and Occupational Services
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Cox SS# 250-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

Diagnosis: (L) Shoulder weakness / tendinosis ; Chest wall contusion

Medications:

**Work Status:** May return to work on 8/7/12

☐ Full Duty

☑ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☑ Lift, push or pull no more than 15 lbs. [ O ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of ____
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Climb or work at heights [ ]
- ☐ Awkward or Static postures [ ]
- ☑ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area ____
- ☐ Use crutches as needed for ambulation
- ☐ Use ____ splint as needed
- ☐ Other ____

**Instructions:**

- ☑ Stay active during your recovery.
- ☑ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☑ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water ____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☑ Other: Slowly start aerobic exercise - walking

**Follow Up:** 3wks or sooner for any problems

- ☐ Appointment Date: ____ Time: ____ Provider: ____
- ☐ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to physical therapy. You will be contacted with an appointment.

Physician/NP: [signature] Date: 8-7-12

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-0143-

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UNIVERSITY MEDICAL GROUP

Center for Health and Occupational Services

**OUTPATIENT VISIT**

| Name: | Jennie Cox | Date of Service: | 08-07-12 |
|---|---|---|---|
| SSN: | 250-94-3648 | Date of Injury: | 05-31-12 |

SUBJECTIVE: Patient follows up in clinic for her left shoulder pain and chest wall contusion. She states that she has had some improvement. She rates her pain as 0/10. She reports feeling weakness in the shoulder. She states that she has a physical job to return to as a commercial motor vehicle driver.

We reviewed the MRI of her left shoulder dated 07-06-12. The report is notable for degenerative changes and mild tendinopathy in the supra and infraspinatus tendons. No findings to suggest full thickness rotator cuff tear.

MEDICATIONS: None.
ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. HEENT: Reports some improvement in jaw range of motion, although she still has some limitations there. Respiratory: Negative. Cardiovascular: Negative. GI: Negative.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in the clinic without difficulty. Chest clear to auscultation. No chest wall tenderness. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: No tenderness to the left shoulder. Good range of motion. She continues to have decreased strength in external rotation and supraspinatus testing. Distal sensation, motor and circulation in the extremities are intact.

IMPRESSION:
1. Left shoulder weakness and tendinosis.
2. Chest wall contusion.

PLAN:
1. Tylenol as needed.
2. Recommend physical therapy referral for strengthening prior to return to full duty.
3. Return in 3 weeks or sooner for any problems or concerns.

WORK STATUS: May return to work on 08-07-12 with the following restrictions:
1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH SN/llr 08-13-12
C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611



AUG 15 2012

Justice 934 612-3816

FAXED 8/28/12


**GHS Center for Health and Occupational Services**
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399


Name Jennie Mae Coy SS# 252-94-3648

Company Palmetto State Transportation

Date of Injury 5-31-12

**Diagnosis:** (L) shoulder weakness/tendinosis; chest wall contusion

**Medications:** Tylenol OTC

**Work Status:** May return to work on 8/28/12

- ☐ Full Duty
- ☑ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]
  - ☑ Lift, push or pull no more than 15 lbs. [ O ]
  - ☐ Bend or Twist [ ]
  - ☐ Walk and Stand [ ]
  - ☐ Sit/Stand as needed
  - ☐ Sedentary Work, change positions as needed
  - ☐ No use of ______
  - ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
  - ☐ Overhead use of (right/left) arm [ ]
  - ☐ Squat or kneel [ ]
  - ☐ Climb or work at heights [ ]
  - ☐ Awkward or Static postures [ ]
  - ☑ No operating heavy machinery or Commercial Motor Vehicle
  - ☐ Elevate affected area ______
  - ☐ Use crutches as needed for ambulation
  - ☐ Use ______ splint as needed
  - ☐ Other ______

**Instructions:**

- ☐ Stay active during your recovery.
- ☑ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☑ Report any problems with medications to your provider.
- ☑ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water ____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: Continue PT

**Follow Up:** 3-4wks or sooner for any problems

- ☐ Appointment Date: ______ Time: ______ Provider: ______
- ☐ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to Continue PT x6. You will be contacted with an appointment.

Physician/NP: [signature] Date: 8/28/12

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UNIVERSITY MEDICAL GROUP
Center for Health and Occupational Services

**OUTPATIENT VISIT**

| Name: | Jennie Cox | Date of Service: | 08-28-12 |
|---|---|---|---|
| SSN: | 250-94-3648 | Date of Injury: | 05-31-12 |

SUBJECTIVE: Patient follows up in clinic for her left shoulder tendinosis, weakness and chest wall contusion. She states that she has had a little improvement. She denies any pain today. She states that she has been going to physical therapy and has been noting some improvement in strength. She has follow up with the oral surgeon scheduled for September 4. No new complaints today.

MEDICATIONS: Tylenol.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female. She ambulates in the clinic without difficulty. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Left shoulder is nontender to palpation. She has full range of motion. There is weakness with external rotation. Distal strength and grip strength is improved. Neurologic Exam: Alert and oriented. Grossly nonfocal.

IMPRESSION: Left shoulder weakness and tendinosis.

PLAN:
1. Tylenol as needed.
2. She is making good progress in physical therapy. Would recommend an additional six visits to continue strengthening and conditioning.
3. Return to clinic in 3 weeks or sooner for any problems or concerns.

WORK STATUS: May return to work on 08-28-12 with the following restrictions:
1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH　　　　SN/llr 08-29-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611



AUG 31 2012

GHS Center for Health and Occupational Services
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Mae Cox SS# 250-94-3648
Company Palmetto State Transportation
Date of Injury 5-31-12

Diagnosis: (L) Shoulder weakness
Medications: —

**Work Status:** May return to work on 9/27/12

☐ Full Duty
☑ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☑ Lift, push or pull no more than 15 lbs. [ O ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of ______
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Climb or work at heights [ ]
- ☐ Awkward or Static postures [ ]
- ☑ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area ______
- ☐ Use crutches as needed for ambulation
- ☐ Use ______ splint as needed
- ☐ Other ______

**Instructions:**

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: ______

**Follow Up:** 1 month — will need to consider functional test if unable to return to full duty by next visit

- ☐ Appointment Date: ______ Time: ______ Provider: ______
- ☐ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to ______. You will be contacted with an appointment.

Physician/NP: [signature] Date: 9/27/12

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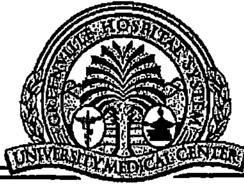


# UNIVERSITY MEDICAL GROUP

**Center for Health and Occupational Services**

**OUTPATIENT VISIT**

| Name: | Jennie Cox | Date of Service: | 09-27-12 |
|---|---|---|---|
| SSN: | 250-94-3648 | Date of Injury: | 05-31-12 |

SUBJECTIVE: Patient follows up in clinic for her left shoulder weakness and chest wall contusion. She denies any pain today. She states that she has been attending physical therapy and that therapy is going well. She currently does not feel able to pull pins on trailers as she states this is a very forceful activity. Discussed her progress with her physical therapist who states that she is continuing to make progress and that an additional two visits a week for four weeks is recommended. Patient states that she continues to await further treatment with the oral surgeon and that they are waiting for further healing before moving forward with her dental implants.

MEDICATIONS: Tylenol.
ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. HEENT: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in clinic without difficulty. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Neck and shoulders have full range of motion. She continues with weakness in external rotation.

IMPRESSION:
1. Left shoulder weakness.
2. Chest wall contusion.

PLAN:
1. Tylenol on an as needed basis.
2. Continue with physical therapy.
3. Follow up in one month or seek care sooner for any problems or concerns. At follow up visit if she continues to have significant weakness and potential limitation for her work duties we may need to consider a functional capacity test to clarify her safe lifting, pushing and pulling limitations.

WORK STATUS: May return to work on 09-27-12 with the following restrictions:
1. Lift, push or pull no more than 15 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH SN/llr 09-28-12
C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

1020 Grove Road • Greenville, SC 29605 • (864) 455-2300 • Fax (864) 455-2399

OCT 02 2012

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 27, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Plan of Care

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## Assessment

**Presentation:**

- Improved AROM, improved SA stregnth, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilzer weakness.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*LTG Achieve by Oct 02, 2012.*

**Symptomatic Improvements:**

- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 25, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #3***

| Range of Motion: Shoulder: Pre-Treatment. | Left AROM | Left PROM | Right AROM |
|---|---|---|---|
| • Abduction(no pain with overpressure 9/18) | 180 | | 180 |
| • Flexion(no pain with overpressure 9/18) | 175 | 180 | 180 |
| • Horizontal Adduction(9/18) | 50 | 60 | |

*Goal Achieved Sep 27, 2012.*

| Range of Motion Improvements to: Shoulder: | Left AROM |
|---|---|
| • Flexion | 170 |
| • Abduction | 170 |

***Problem #4***

| Muscle Testing: Upper Extremity MMT. | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder External Rotation(at side 4-/5; at 45 4/5) | -4/5 | -4/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |

*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

**Musculoskeletal Improvements In: Shoulder Muscle Strength to:** **Left**

### Please sign and return

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

**Comments/Revisions**

[signature] 10/1/12 S. Newsom

**Physician/NPP Signature** **Date** **Print Name and Credentials**

Document ID: 00114D94.013
Mason Rockwell,PT(SC Lic: 5456)

Status: Signed off (secure electronic signature)



To Proaxis
1-Stove 10-1-12

proaxistherapy



| | |
|---|---|
| • Gross Assessment | +4/5 |

***Problem #5*** **Questionnaires: Additional.**

| | |
|---|---|
| • Assessment | Reassessment |
| • Date | 09/27/2012 |
| • Score 1 | pain 8/30 |
| • Score 2 | function 35/60 |
| • Test Name | Penn SHoulder Score |
| • Total | 64/100 |

*LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's*

**Questionnaire Improvements: Additional:**

| | |
|---|---|
| • Test Name | Penn Shoulder Score |
| • Assessment | Reassessment |
| • Total | 80/100 |
| • Score 1 | pain decrease by 3 points or greater |
| • Score 2 | function score improve by 10 points or more |

| ***Problem #6*** **Muscle Testing: Shoulder.** | **Left** | **Right** |
|---|---|---|
| • Serratus Anterior(improved) | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | +4/5 |
| • Trapezius, Middle | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

| **Musculoskeletal Improvements In: Shoulder Muscle Strength to:** | **Left** |
|---|---|
| • Gross Assessment | -5/5 |

# Plan

**Amount, Frequency and Duration:**
- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Daily Plan:**
- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

**Therapeutic Contents:**
- RTC and scapular strengthening and functional activites at shoulder level and overhead.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 27, 2012 14:17:24

Scott Justice 866-900-9381

FAXED 10-26-12

**GHS Center for Health and Occupational Services**
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name: Jennie Cox SS#: 3648
Company: Palmetto State Transportation
Date of Injury: 5/3/12

**Diagnosis:** (L) shoulder weakness s/p fall
**Medications:** —

**Work Status:** May return to work on 10/26/12

☐ Full Duty
☑ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☑ Lift, push or pull no more than 25 lbs. [ O ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of ______
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Climb or work at heights [ ]
- ☐ Awkward or Static postures [ ]
- ☑ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area ______
- ☐ Use crutches as needed for ambulation
- ☐ Use ______ splint as needed
- ☐ Other ______

Please fax a job description to CHOS at 455-2335. She is approaching MMI and a functional test is needed to determine if she can safely return to the essential functions of her job.

**Instructions:**

- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water ____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: ______

**Follow Up:** 2wks

- ☐ Appointment Date: ______ Time: ______ Provider: ______
- ☐ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to FCE ______. You will be contacted with an appointment.

Physician/NP: [signature] Date: 10/26/12

84

-0151-

return yellow copy to your employer

Revised 3/09

# UNIVERSITY MEDICAL GROUP

**Center for Health and Occupational Services**

**OUTPATIENT VISIT**

| Name: | Jennie Cox | Date of Service: | 10-26-12 |
|---|---|---|---|
| SSN: | 250-94-3648 | Date of Injury: | 05-31-12 |

SUBJECTIVE: Patient returns to clinic for follow up of her left shoulder. She states that her shoulder is doing well. She feels that she is making improvements in physical therapy. She denies any pain. She is still concerned about her ability to do heavy pushing and pulling required at her job. She states that she is concerned about being reinjured when she returns to full duty.

MEDICATIONS: Ibuprofen.

ALLERGIES: Ativan.

REVIEW OF SYSTEMS: Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. GI: Negative. Musculoskeletal: Per HPI.

OBJECTIVE: General: Patient is a pleasant female in no distress. She ambulates in clinic without difficulty and moves easily about the exam room. Chest clear to auscultation. Cardiovascular: Regular rate and rhythm without murmurs, rubs or gallops. Musculoskeletal: Cervical spine is nontender and has full range of motion. Shoulders are nontender and have good range of motion. She has some mild weakness in external rotation on the left as compared to the right. She has good grip strength. Full range of motion of the lumbar spine and lower extremities. Sensation and circulation in the extremities are intact.

IMPRESSION: Left shoulder weakness after a fall.

PLAN:
1. Finish two remaining approved physical therapy visits and transition to home exercise program.
2. Recommend a functional capacity test to determine her ability to safely return to the essential functions of her job.
3. Follow up in two weeks or seek care sooner for any problems or concerns.

WORK STATUS: May return to work on 10-26-12 with the following restrictions:
1. Lift, push or pull no more than 25 pounds occasionally.
2. No operating commercial motor vehicle.

Stacey Newsom, M. D., MPH SN/llr 10-29-12

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd., Greenville, SC 29611

1020 Grove Road • Greenville, SC 29605 • (864) 455-2300 • Fax (864) 455-2399

NOV 01 2012

Scott Justice 466-4?? 9381

FAXED 11-9-12

**GHS Center for Health and Occupational Services**
1020 Grove Road
Greenville, SC 29605
Phone (864) 455-2300
Fax (864) 455 2399

Name Jennie Mae Cox SS# 250 94 3648
Company Palmetto State Transportation
Date of Injury 5-31-12

**Diagnosis:** shoulder weakness improved
**Medications:** —

**Work Status:** May return to work on 11/9/12
☒ Full Duty
☐ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☐ Lift, push or pull no more than ____ lbs. [ ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed
- ☐ Sedentary Work, change positions as needed
- ☐ No use of ____
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Climb or work at heights [ ]
- ☐ Awkward or Static postures [ ]
- ☐ No operating heavy machinery or Commercial Motor Vehicle
- ☐ Elevate affected area ____
- ☐ Use crutches as needed for ambulation
- ☐ Use ____ splint as needed
- ☐ Other ____

**Instructions:**
- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water ____ times per day.
- ☐ May apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain or drainage.
- ☐ Other: ____

**Follow Up:**
- ☐ Appointment Date: ____ Time: ____ Provider: ____
- ☒ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to ____. You will be contacted with an appointment.

Physician/NP: [signature] Date: 11/9/12



return yellow copy to your employer

Revised 3/09

UNIVERSITY MEDICAL GROUP
**Center for Health and Occupational Services**

**OUTPATIENT VISIT**

| **Patient:** | Jennie Cox | **Date:** | 11/09/12 |
|---|---|---|---|
| **MRN:** | 250-94-3648 | **DOI:** | 5/31/12 |

**Subjective:** Patient follows up in clinic for her right shoulder. She states that she has had a lot of improvement. She is not having any pain and not requiring any pain medications. She states that she is continuing her physical therapy exercises as home and feels able to return to work.

We reviewed the job description sent by the company. There was a lifting requirement of 100 lbs. Ms. Cox stated that the amount was much more than she was required to lift at work. This was discussed with Scott Justice of the company who concurred that maximum lifting would be approximately 35 lbs.

**Medications:** Ibuprofen.
**Allergies:** Ativan.

**Review of Systems:** Constitutional: Negative. Musculoskeletal: Per HPI.

**Objective:** General: Patient is a pleasant female. She ambulates in the clinic without difficulty and moves easily about the exam room. Full range of motion of bilateral extremities. She continues to have some mild weakness with external rotation of the left shoulder. Internal rotation and supraspinatus testing within normal limits. She has excellent grip strength. Sensation and circulation in the arms are intact.

**Impression:** Left shoulder injury at MMI.

**Plan:**
1. Continue exercises at home.
2. Impairment rating for the left shoulder best fits in class I in the shoulder regional grid on page 401 in the *Guides to the Evaluation of Permanent Impairment, 6th Edition.* There was a shoulder contusion with soft tissue injury. There are residual symptoms and consistent objective findings at MMI. Impairment rating of the left shoulder is 2%.

**Work Status:** May return to work on 11/09/12 without restriction.

Stacey Newsom, M.D., MPH SN/md 11/12/12
C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611



NOV 1 3 2012

## CHS Center for Health and Occupational Services

Phone: (864) 455-2300 | 1526 [illegible] Road Greenville, SC 29605 | Fax: (864) 455-2339

### Consent for Occupational Health and Medical Services

Patient Name (First, Last): ____________________

Social Security #: ____________ Date of Birth: ____________ [illegible]: ____________

[illegible]

Home Address: ____________________
Street City State Zip Code

County: ____________ Home #: ____________ Cell (or) Pager #: ____________

Primary Care Physician: ____________________

Employer: ____________ Full Time/Part Time: ____________ Occupation: ____________ Length of Employment: ____________

Emergency Contact: ____________ Relationship to Patient: ____________ Primary Tel #: ____________

The following are the conditions for services by CHS Center for Health and Occupational Services (CHOS) or the physicians who practice therein.

**Medical Consent:** I consent to all occupational health and medical services, evaluation, and treatment [illegible]

[illegible]

**Employer Agreement:** I understand that, if my employer [illegible]

**Disclosure / Use of Health Information / Authorization for Release of Medical Information:** [illegible]

[illegible]

**Signatures:** [illegible]

Patient Signature: ____________________ Date: ____________

Witness: ____________________ Date: ____________

**GHS Center for Health and Occupational Services**
1020 Grove Road
Greenville, SC 29605
Phone (864)455-2300
Fax (864) 455-2399

Name Jennie Cox DOB 8-14-52
Company Palmetto State Transportation
Date of Injury 5-31-12

**Diagnosis:** (L) Shoulder Contusion
**Medications:** Tylenol OTC

**Work Status:** May return to work on 6 OCT 2014
☒ Full Duty
☐ Modified Duty: [None = N] [Rarely = R] [Occasional = O] [Frequently = F] [As Tolerated = AT]

- ☐ Lift, push or pull no more than ______ lbs. [ ]
- ☐ Bend or Twist [ ]
- ☐ Walk and Stand [ ]
- ☐ Sit/Stand as needed.
- ☐ No climbing ladders or work at unprotected heights.
- ☐ Forceful or Repetitive use of (right/left) hand and arm [ ]
- ☐ Overhead use of (right/left) arm [ ]
- ☐ Squat or kneel [ ]
- ☐ Awkward or Static postures [ ]
- ☐ No use of ______
- ☐ No operating heavy machinery or Commercial Motor Vehicle.
- ☐ Elevate affected area ______
- ☐ Use crutches as needed.
- ☐ Use ______ splint.
- ☐ Other ______

**Instructions:**
- ☐ Stay active during your recovery.
- ☐ Use over the counter pain relievers by package directions and/or follow prescription directions.
- ☐ Report any problems with medications to your provider.
- ☐ Apply ice or heat to the affected areas as needed.
- ☐ Begin gentle stretches as demonstrated in clinic or in your self care handout.
- ☐ Elevate the affected area to reduce swelling.
- ☐ Wash wound with soap and water _____ times per day.
- ☐ Apply antibiotic ointment.
- ☐ Keep bandage clean and dry.
- ☐ Seek care for any signs of infection including increasing redness, swelling, pain, or drainage.
- ☐ Other: ______

**Follow Up:**
- ☐ Appointment Date: ______ Time: ______ Provider: ______
- ☒ Maximum Medical Improvement : Contact your employer prior to making further appointments.
- ☐ Referral to ______. You will be contacted with and appointment.

Physician/NP: [signature] Date: 10-6-14

**Return Yellow Copy to your Employer** Revised 1/24/14

GREENVILLE
HEALTH SYSTEM

Center for Health &
Occupational Services

1020 Grove Road
Greenvillle, SC 29605
(864) 455-2300 P
(864) 455-2399 F
ghs.org

**OUTPATIENT VISIT**

Name: Jennie Cox
DOB: 08/14/52

Date of Service: 10/06/14

SUBJECTIVE: Ms. Cox is being sent today for reevaluation of her left shoulder. She states that she has some residual difficulties in the left shoulder and wishes for these to be noted. The difficulties that she is having is in the lateral aspect of the left shoulder blade. She points to this location. Aggravating factors are when she reaches behind her or when she drives her zero-clearance lawnmower (she does have a sizable property that she mows). She states that after mowing for an hour in this capacity she will have some difficulties in this same area. In terms of her range of motion and strength, she is agreeable that these are doing quite well. She states that she has been sore after some of her long truck runs because she uses the left hand to secure the steering wheel while reaching up to flip switches or doing gear shifts with her right hand. She says that she will be quite sore in this area after one of these long road trips. When asked about sleeping on that side, she states that she typically does not sleep on that side. She says if she has to sleep in her truck berth she does not sleep on the left side due to difficulties with pain in her left jaw. She otherwise has no other difficulties with the left shoulder area. Of note, on this visit she does talk about some difficulties with the left ear, with intermittent hearing diminution. She gives the example of singing in church last night, being able to hear her voice in her right ear but not hearing on the left side. This prompted her to have a relative who is in the medical profession flush her left ear. She states some improvement after that, but has noted intermittent difficulties with the left ear on occasion.

PAST MEDICAL HISTORY: No significant factors identified.

MEDICATIONS: She is just taking over-the-counter Tylenol for her cervical pain and the left shoulder pain.

REVIEW OF SYSTEMS: Negative in terms of any respiratory complaints. Denies any cough or any wheezes. Does not have any effect on the left scapular region with deep breathing. Cardiovascular: She does not have any chest pain. No shortness of breath. GI: She has no complaints in this regard. As mentioned in the ENT arena, she does complain of some difficulties with occasional perceived left hearing loss, as if the left ear is clogged.

OBJECTIVE: On examination of the left shoulder, she is able to put the shoulder through full range of motion, both actively and passively. Crossover arm stretch does not elicit any pain. She is pain-free on both supraspinatus and infraspinatus testing. There is no weakness noted with these maneuvers. She demonstrates that when she reaches behind her the left lateral scapular border is painful. When performing this maneuver I hear an audible click and also can palpate a click within the soft tissue in this region. Performed provocative maneuvers for latissimus dorsi and these did not elicit any pain or click. Again, on external abduction and external rotation, another click was elicited in the same area of the scapular region. When palpating the lateral scapular border, no pain is elicited. The tissues do appear to be somewhat sinewy, that is less supple than on the unaffected right side. Lungs are clear to auscultation. Heart S1, S2. No murmurs or extra sounds. Abdomen is soft. Bowel sounds are positive. Ears canals patent bilaterally. TM's mobile with valsalva.



OCT 08 2014

| Name: | Jennie Cox | Date of Service: | 10/06/14 |
|---|---|---|---|
| DOB: | 08/14/52 | Page 2 | |

ASSESSMENT:
1. Individual with residual symptoms to the left shoulder region. I do believe that the complaints she has in the left scapular border are likely related to her previous injury to the shoulder.
2. Upon review of the chart, there was similar complaints of hearing loss on the left side.

PLAN:
1. I did advise Ms. Cox that, should she wish to pursue the left ear issues, she should request to see an ENT physician.
2. I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.
3. The left shoulder still appears to be somewhat problematic for this individual. I did suggest that physical therapy may help clear some of the soft tissue areas. Ms. Cox did express some reluctance to enter into physical therapy again, as she had a quite extensive course post injury. As the pain appears to be amenable to Tylenol over-the-counter, she should continue with this for symptomatic treatment.

WORK STATUS: I do find that she is fit for full duty as a truck driver. I find her at MMI. Due to the ongoing issues with the left shoulder, this clinic previously rated her at 2%. I would rate her at 6%, as she may need some ongoing therapy to this shoulder going forward.

Brian C. Svazas, MD, MPH BCS/bts/nw 10/07/14

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611

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

# Physician's Statement

Claimant's Name: Jennie Cox
Physician's Name: Stacey Newsom md
Practice/Clinic: OHS
Preparer's Name: ______
Phone: ( ___ ) ______ - ______

Employer's Name: Palmetto State Transportation
Insurance Carrier: ______
SCWCC File No: ______

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

**Date of Injury or Illness:** ______

Date of first office visit: 9/27/12 Date of last visit: 11/9/12

Diagnosis or nature of injury or illness: chest and (L) shoulder contusions

Body part(s) injured: chest, (L) shoulder Body part(s) affected: chest, (L) shoulder

Date of **Maximum Medical Improvement:** 11/9/12

Based on the **AMA Guidelines**, the claimant has sustained a 2 **% medical impairment** to (L) upper extremity injured body part(s) and a 0 **% medical impairment** to chest ______ other affected body part(s).

X The claimant is **able to return to work** without restriction.

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

______

______

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

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

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

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

______

______

______

Treating Physician [signature] Newsom.    Date 11/9/12

GREENVILLE
HEALTH SYSTEM

Center for Health &
Occupational Services

1020 Grove Road
Greenville, SC 29605
(864) 455-2300 P
(864) 455-2399 F
ghs.org

WC34197

**OUTPATIENT VISIT**

Name: Jennie Cox  Date of Service: 10/06/14
DOB: 08/14/52

SUBJECTIVE: Ms. Cox is being sent today for reevaluation of her left shoulder. She states that she has some residual difficulties in the left shoulder and wishes for these to be noted. The difficulties that she is having is in the lateral aspect of the left shoulder blade. She points to this location. Aggravating factors are when she reaches behind her or when she drives her zero-clearance lawnmower (she does have a sizable property that she mows). She states that after mowing for an hour in this capacity she will have some difficulties in this same area. In terms of her range of motion and strength, she is agreeable that these are doing quite well. She states that she has been sore after some of her long truck runs because she uses the left hand to secure the steering wheel while reaching up to flip switches or doing gear shifts with her right hand. She says that she will be quite sore in this area after one of these long road trips. When asked about sleeping on that side, she states that she typically does not sleep on that side. She says if she has to sleep in her truck berth she does not sleep on the left side due to difficulties with pain in her left jaw. She otherwise has no other difficulties with the left shoulder area. Of note, on this visit she does talk about some difficulties with the left ear, with intermittent hearing diminution. She gives the example of singing in church last night, being able to hear her voice in her right ear but not hearing on the left side. This prompted her to have a relative who is in the medical profession flush her left ear. She states some improvement after that, but has noted intermittent difficulties with the left ear on occasion.

PAST MEDICAL HISTORY: No significant factors identified.

MEDICATIONS: She is just taking over-the-counter Tylenol for her cervical pain and the left shoulder pain.

REVIEW OF SYSTEMS: Negative in terms of any respiratory complaints. Denies any cough or any wheezes. Does not have any effect on the left scapular region with deep breathing. Cardiovascular: She does not have any chest pain. No shortness of breath. GI: She has no complaints in this regard. As mentioned in the ENT arena, she does complain of some difficulties with occasional perceived left hearing loss, as if the left ear is clogged.

OBJECTIVE: On examination of the left shoulder, she is able to put the shoulder through full range of motion, both actively and passively. Crossover arm stretch does not elicit any pain. She is pain-free on both supraspinatus and infraspinatus testing. There is no weakness noted with these maneuvers. She demonstrates that when she reaches behind her the left lateral scapular border is painful. When performing this maneuver I hear an audible click and also can palpate a click within the soft tissue in this region. Performed provocative maneuvers for latissimus dorsi and these did not elicit any pain or click. Again, on external abduction and external rotation, another click was elicited in the same area of the scapular region. When palpating the lateral scapular border, no pain is elicited. The tissues do appear to be somewhat sinewy, that is less supple than on the unaffected right side. Lungs are clear to auscultation. Heart S1, S2. No murmurs or extra sounds. Abdomen is soft. Bowel sounds are positive. Ears canals patent bilaterally. TM's mobile with valsalva.

ASSESSMENT:
1. Individual with residual symptoms to the left shoulder region. I do believe that the complaints she has in the left scapular border are likely related to her previous injury to the shoulder.
2. Upon review of the chart, there was similar complaints of hearing loss on the left side.

PLAN:
1. I did advise Ms. Cox that, should she wish to pursue the left ear issues, she should request to see an ENT physician.
2. I do find that the patient is functioning at 100%, as she has returned to her truck driver position and is thriving in this career.
3. The left shoulder still appears to be somewhat problematic for this individual. I did suggest that physical therapy may help clear some of the soft tissue areas. Ms. Cox did express some reluctance to enter into physical therapy again, as she had a quite extensive course post injury. As the pain appears to be amenable to Tylenol over-the-counter, she should continue with this for symptomatic treatment.

WORK STATUS: I do find that she is fit for full duty as a truck driver. I find her at MMI. Due to the ongoing issues with the left shoulder, this clinic previously rated her at 2%. I would rate her at 6%, as she may need some ongoing therapy to this shoulder going forward.

Brian C. Svazas, MD, MPH BCS/bts/nw 10/07/14

C: Palmetto State Transportation, Scott Justice, 1050 Park West Blvd, Greenville, SC 29611

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

# Physician's Statement

Claimant's Name: Jennie Cox

Employer's Name: Palmetto State Transportation

Physician's Name: Brian Svazas, M.D., MPH, FACOEM

Insurance Carrier: Cherokee Insurance Company

Practice/Clinic: Center for Health & Occupational Services

SCWCC File No: 1206236

Preparer's Name: ______

Phone: ______

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

**Date of Injury or Illness:** May 31, 2012

Date of first office visit: 6 OCT 2014 Date of last visit: 6 OCT 2014

Diagnosis or nature of injury or illness: (L) Shoulder

Body part(s) injured: (L) Shoulder Body part(s) affected: ______

**Date of Maximum Medical Improvement:** 6 OCT 2014

Based on the **AMA Guidelines**, the claimant has sustained a 6 % **medical impairment** to (L) Shoulder injured body part(s) and a ______ % **medical impairment** to ______ other affected body part(s).

X The claimant is **able to return to work** without restriction.

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

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

___ Claimant **possesses retained hardware** casually related to this injury.

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

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

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

Physical Therapy

[signature]
Treating Physician

8 Apr 2015
Date

APA #6
INNVERSION MRI & IMAGING
07/06/12 & 07/17/12

Innervision
Innervision at Grove
Open MRI of Simpsonville

# *INNERVISION MRI & IMAGING*

**Grove** One Cannon Drive Greenville, SC 29605 Phone (864) 242-4011 Fax (864) 233-2677

**PATIENT:** Cox, Jennie
**DOB:** 8/14/1952
**MRN:** 850738
**PATIENT PHONE:** 864-243-0032
**PHYSICIAN:** Stacey Newsom, MD
**DATE:** 7/6/2012

**EXAM: MRI OF THE LEFT SHOULDER WITHOUT CONTRAST**

**HISTORY:** Left shoulder pain and weakness.

**TECHNIQUE:** Multisequential, multiplanar MRI of the left shoulder performed without contrast.

**COMPARISON:** There is no previous available for comparison.

**FINDINGS:** Acromion is flat. Mild acromioclavicular joint hypertrophy appreciated. There is tendinopathy appreciated within the supra and infraspinatus tendons. There are no findings to suggest a full-thickness tear. No significant rotator cuff muscular atrophy. There are mild degenerative changes appreciated in the lateral aspect of the humeral head. Marrow signal intensities in the imaged humerus and bony glenoid are otherwise unremarkable. Mild AC joint hypertrophy. Cartilaginous labrum and biceps labral anchor appear grossly unremarkable. Imaged biceps tendon is appreciated within its groove.

**IMPRESSION:** Degenerative changes and mild tendinopathy in the supra and infraspinatus tendons. No findings to suggest full-thickness rotator cuff tendon tear.

**Christopher Sidden, M.D.**
CS / lb

**DD:** 7/6/2012
**DT:** 7/6/2012
**Job:** 15460259

M 7/9/12

This document has been electronically reviewed and signed by Christopher Sidden, M.D.

# INNERVISION MRI & IMAGING

Innervision
Innervision at Grove
Open MRI of Simpsonville

Grove
One Cannon Drive Greenville, SC 29605 Phone (864) 242-4011 Fax (864) 233-2677


**PATIENT:** Cox, Jennie
**DOB:** 8/14/1952
**MRN:** 850738
**PATIENT PHONE:** 864-243-0032
**PHYSICIAN:** Stacey Newsom, MD
**DATE:** 7/17/2012

**EXAM: X-RAY OF THE CHEST, TWO VIEWS**

**HISTORY:** Chest wall contusion.

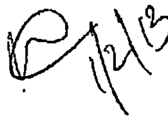
**FINDINGS:** PA and lateral views of the chest show heart size within normal limits. There are some atherosclerotic changes of the aortic arch. The lungs show hyperaeration indicative of COPD with associated retrosternal airspace increase and flattening of the hemidiaphragms. No effusion or pneumothorax.

**IMPRESSION:** COPD without acute findings.

Perry Edenfield, MD
WE / ab

DD: 7/17/2012
DT: 7/17/2012
Job: 15516220

This document has been reviewed and electronically signed.



APA #7
PROAXIS THERAPY
08/21/12-11/29/12

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Aug 21, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 1
CxI/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Initial Evaluation

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**The patient's medical history has been verbally reviewed with the patient by the evaluating therapist. The medical history questionnaire bas been completed and signed by the patient, reviewed by the evaluating therapist, and is on file. The patient has read and signed the Patient Rights and Consent for Treatment forms, they have been reviewed by the evaluating therapist, and are on file.**

**ADL / Functional Status:**
- Premorbid status:
  - Basic care: Independent Without Difficulty. Work status: Full time / Full duty.
- Current status:
  - Basic care: Independent With Increased Time. Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Extremity Dominance:**
- Right.

**Questionnaires: Additional:**
- Test Name — Penn SHoulder Score
- Date — 08/21/2012
- Assessment — Initial
- Total — 65/100
- Score 1 — pain 9/30
- Score 2 — function 38/60

**Questionnaires: Fear Avoidance:**
- Date — 08/21/2012

- Assessment — Initial
- Physical Activity Score — 8

# Objective Examination

| **Functional Tests: Apley's Scratch Test:** | **Left** | **Right** |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |
| • IR - Combined | To T6 | To T5 |

**Muscle Testing:**
- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation | 4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |

| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
|---|---|---|
| • Flexion(no pain with overpressure) | 142 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |

# Treatments

**Exercise Activities: Isotonics:**

- Isotonic Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Tubing/Bands:**

- ER 0 deg — Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- IR 0 deg — Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1 — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Therapeutic Activities, Billing Code: 97530.

**Pt./Family Education:**

- Pathology/Involved Anatomy — Time Elapsed: 5 Minutes, Additional Detail: RTC, impingement, scapular position., Charge As: Therapeutic Exercise, Billing Code: 97110.
- Written Home Exercise Program — Time Elapsed: 4 Minutes, Activity: Provided & Reviewed, Description: Diagnosis Specific, Charge As: Therapeutic Exercise, Billing Code: 97110.

## Assessment

**In my professional opinion, this client requires skilled physical therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is excellent. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 6 weeks. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits fair understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.**

**Presentation:**

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Shoulder: scapular stabilizer and RTC ER weakness.

**Treatment Emphasis to focus on:**

- Postural Improvements. Muscle Function Improvements. Enhanced Dynamic Stability.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*LTG Achieve by Oct 02, 2012.*

**Symptomatic Improvements:**

- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 02, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #3*** **Range of Motion: Shoulder: Pre-Treatment.**

*LTG Achieve by Oct 02, 2012.*

| **Range of Motion Improvements to: Shoulder:** | **Left AROM** |
|---|---|
| • Flexion | 170 |
| • Abduction | 170 |

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

*LTG Achieve by Oct 02, 2012.*

**Musculoskeletal Improvements In: Shoulder Muscle Strength to:** **Left**

- Gross Assessment +4/5

***Problem #5*** **Questionnaires: Additional.**

*LTG Achieve by Oct 02, 2012. improve strength for painfree ADL's*

**Questionnaire Improvements: Additional:**

- Test Name: Penn Shoulder Score
- Assessment: Reassessment
- Total: 80/100
- Score 1: pain decrease by 3 points or greater
- Score 2: function score improve by 10 points or more

***Problem #6*** **Muscle Testing: Shoulder.**

*LTG Achieve by Oct 02, 2012.*

**Musculoskeletal Improvements In: Shoulder** **Left**

**Musele Strength to:**

- Gross Assessment -5/5

# Plan

**The goals and plan were discussed with the patient and/or family and they concur. The patient and/or family were instructed to call therapist regarding problems or questions. The patient was instructed in the independent performance of a home exercise program that addresses the problems and aehieving the goals outlined in the plan of care.**

**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 3 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Therapeutic Contents:**

- Active Range of Motion Activities. Client Education. Aerobic Conditioning: Upper Body Ergometer. Home Exercise Program. Proprioceptive/Closed Kinetic Chain Activities. Therapeutic Activities.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 21, 2012 19:55:40

proaxistherapy

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Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

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Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
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Pol/Claim#: WC34192

Visit Date: **Aug 21, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 1
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Plan of Care

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## Assessment

**In my professional opinion, this client requires skilled physical therapy in conjunction with a home exercise program to address the problems and achieve the goals outlined below. Overall rehabilitation potential is excellent. The expected length of this episode of skilled therapy services required to address the patient's condition is estimated to be 6 weeks. The patient and/or family were educated regarding their diagnosis, prognosis and related pathology. The client exhibits fair understanding and performance of the therapeutic activity and instructions outlined in this skilled rehabilitation session.**

**Presentation:**

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Shoulder: scapular stabilizer and RTC ER weakness.

**Treatment Emphasis to focus on:**

- Postural Improvements. Muscle Function Improvements. Enhanced Dynamic Stability.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*LTG Achieve by Oct 02, 2012.*

**Symptomatic Improvements:**

- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 02, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #3*** **Range of Motion: Shoulder: Pre-Treatment.**

| | Left AROM | Right AROM |
|---|---|---|
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Flexion(no pain with overpressure) | 142 | 180 |

*LTG Achieve by Oct 02, 2012.*

| Range of Motion Improvements to: Shoulder: | Left AROM |
|---|---|
| • Flexion | 170 |
| • Abduction | 170 |

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

| | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |

### Please sign and return

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

**Comments/Revisions**

**Physician/NPP Signature** **Date** **Print Name and Credentials**

Document ID: 00114D94.002
Mason Rockwell,PT(SC Lic: 5456)

Status: Signed off (secure electronic signature)

| | | Left | Right |
|---|---|---|---|
| | • Shoulder External Rotation | -4/5 | -4/5 |
| | • Shoulder Flexion | 4/5 | -5/5 |
| | • Shoulder Internal Rotation | 4/5 | -5/5 |

*LTG Achieve by Oct 02, 2012.*

**Musculoskeletal Improvements In: Shoulder** **Left**
**Muscle Strength to:**
- Gross Assessment +4/5

***Problem #5*** **Questionnaires: Additional.**
- Assessment: Initial
- Date: 08/21/2012
- Score 1: pain 9/30
- Score 2: function 38/60
- Test Name: Penn SHoulder Score
- Total: 65/100

*LTG Achieve by Oct 02, 2012. improve strength for painfree ADL's*

**Questionnaire Improvements: Additional:**
- Test Name: Penn Shoulder Score
- Assessment: Reassessment
- Total: 80/100
- Score 1: pain decrease by 3 points or greater
- Score 2: function score improve by 10 points or more

***Problem #6*** **Muscle Testing: Shoulder.**

| | Left | Right |
|---|---|---|
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

*LTG Achieve by Oct 02, 2012.*

**Musculoskeletal Improvements In: Shoulder** **Left**
**Muscle Strength to:**
- Gross Assessment -5/5

# Plan

**The goals and plan were discussed with the patient and/or family and they concur. The patient and/or family were instructed to call therapist regarding problems or questions. The patient was instructed in the independent performance of a home exercise program that addresses the problems and achieving the goals outlined in the plan of care.**

**Amount, Frequency and Duration:**
- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 3 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Therapeutic Contents:**
- Active Range of Motion Activities. Client Education. Aerobic Conditioning: Upper Body Ergometer. Home Exercise Program. Proprioceptive/Closed Kinetic Chain Activities. Therapeutic Activities.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 21, 2012 19:55:40

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Aug 24, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 2
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Able to sleep on left side but really weak with left arm use.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation | 4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
| • Flexion(no pain with overpressure) | 142 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • Prone Extension. | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 1 | Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Description: prone scapular set over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg | Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • IR 0 deg | Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Tubing/Bands 1 | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Acrobic Conditioning:**

| | |
|---|---|
| • Upper Body Ergometer | Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Pulleys: Upper Extremity:**

- G-H Flexion — Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Therapeutic Activities, Billing Code: 97530.

**Therapy Session Time**

- Total Therapy Session Time 44 Minutes

## Assessment

**The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.**

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 24, 2012 15:05:25

proaxistherapy

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1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
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Acct #: 314925
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Clinician: Mason Rockwell
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Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Aug 28, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 3
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments: Report of outcome from Doctors visit:**
- Continue with rehab. Was pleased with progress. Follow-up in 3-4 weeks with Dr.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| **Functional Tests: Apley's Scratch Test:** | **Left** | **Right** |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |

**Muscle Testing:**
- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation | 4/5 | -5/5 |

| **Muscle Testing: Shoulder:** | **Left** | **Right** |
|---|---|---|
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| **Palpatiou: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper | 1=Complaint of pain |

| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
|---|---|---|
| • Flexion(no pain with overpressure) | 142 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Horizontal Adduction | 30 | |

| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** |
|---|---|
| • Adduction(improved after stretching) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension. | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 1 | Time Elapsed: 4 Minutes, Repetitions: 30, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg(This visit) | Did Not Perform: This visit |
| • Tubing/Bands 1(This visit) | Did Not Perform: This visit |

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion — Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**
- Upper Trapezius — Time Elapsed: 8 Minutes, Tx Depth: Moderate, Technique: Sustained Pressure, Assisting Technique: after sustained pressure with strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**
- Total Therapy Session Time 62 Minutes

# Assessment

**The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.**

**Impairments Identified:**
- Weakness with RTC Primarily ER.

# Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 28, 2012 12:23:28

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Visit Date: **Aug 30, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 4
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHè suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Feels better but still very weak.

**Questionnaires: Additional:**
- Test Name — Penn SHoulder Score
- Date — 08/21/2012
- Assessment — Initial
- Total — 65/100
- Score 1 — pain 9/30
- Score 2 — function 38/60

**Questionnaires: Fear Avoidance:**
- Date — 08/21/2012
- Assessment — Initial
- Physical Activity Score — 8

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper | 1=Complaint of pain | |
| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
| • Flexion(no pain with overpressure) | 160 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Horizontal Adduction | 30 | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Adduction(improved after stretching) | 41 | |

# Treatments

| | |
|---|---|
| **Exercise Activities: Isotonics:** | |
| • External Rotation Sidelying.(This visit) | Did Not Perform: This visit |
| • Prone Extension. | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row.(This visit) | Did Not Perform: This visit |
| • Supine Punch(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 1(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |
| **Exercise Activities: Tubing/Bands:** | |
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg(This visit) | Did Not Perform: This visit |
| • Pull Downs | Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scapular Retraction | Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |

- Tubing/Bands 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion — Time Elapsed: 4 Minutes, Repetitions: 0, Sets: 0, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**
- Upper Trapezius — Time Elapsed: 8 Minutes, Tx Depth: Moderate, Technique: Sustained Pressure, Assisting Technique: after sustained pressure with strumming, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**
- Total Therapy Session Time 54 Minutes

# Assessment

**Assessment of Improvement:**
- Improved FE.

**Impairments Identified:**
- weakness (L) ER and scapular stabilizers.

**Presentation:**
- No winging, anterior tilt with prone extension, rows or scapular reverse punches prone.

# Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Aug 30, 2012 15:30:23

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 06, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 5
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis
Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- No changes to report with left shoulder and jaw, teeth surgery delayed until more bone healing.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper | 1=Complaint of pain | |
| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
| • Flexion(no pain with overpressure) | 160 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Horizontal Adduction | 30 | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Adduction(improved after stretching) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension.(6 reps with 2 # before compensation) | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 1(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg | Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |

- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Aerobic Conditioning:**

- Upper Body Ergometer — Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**

- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**

- Stabilization Training 1(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**

- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**

- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**

- Total Therapy Session Time 50 Minutes

## Assessment

**Presentation:**

- Symptoms consistent with referring diagnosis.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 06, 2012 15:04:50

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

| | | | |
|---|---|---|---|
| Acct #: | 314925 | | |
| Patient: | JENNIE M. COX | | |
| DOB: | Aug 14, 1952 | Visit Date: | Sep 11, 2012 |
| Physician: | STACY NEWSOM | Phys Phone: | (864) 455-2300 |
| Phys Fax: | (864) 455-2399 | SSN: | XXX-XX-XXXX |
| Physician: | Not Specified | Inj. Date: | May 31, 2012 |
| Clinician: | Mason Rockwell | Surg. Date: | |
| FSC: | Workers Compensation | Visits: | 6 |
| Case Mgr: | SCOTT JUSTICE | Cxl/Ns: | 0 |
| Payor: | | Employer: | |
| Pol/Claim#: | WC34192 | Insured: | PALM STATE TRANS |

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- soreness in left shoulder and tired feeling when driving.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper | 1=Complaint of pain | |
| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
| • Flexion(no pain with overpressure) | 160 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Horizontal Adduction | 30 | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Adduction(improved after stretching) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension.(6 reps with 2 # before compensation) | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scaption/External Rotation. | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 1(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg | Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |

- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Aerobic Conditioning:**

- Upper Body Ergometer — Time Elapsed: 9 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**

- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**

- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**

- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**

- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**

- Total Therapy Session Time 58 Minutes

# Assessment

**Presentation:**

- Symptoms consistent with referring diagnosis.

# Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 11, 2012 14:59:40

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 14, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 7
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Soreness in the left side of the shoudler.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper | 1=Complaint of pain | |
| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Right AROM** |
| • Flexion(no pain with overpressure) | 160 | 180 |
| • Abduction(no pain with overpressure) | 160 | 180 |
| • Horizontal Adduction | 30 | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Adduction(improved after stretching) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension. | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scaption/External Rotation. | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch | Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 1(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg(This visit) | Did Not Perform: This visit |
| • Pull Downs(This visit) | Did Not Perform: This visit |

- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**
- Deltoid — Time Elapsed: 8 Minutes, Tx Depth: Superficial, Technique: Strumming, Additional Detail: middle deltoid, Charge As: Manual Therapy Techniques, Billing Code: 97140.
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 56 Minutes

# Assessment

**Presentation:**
- Symptoms consistent with referring diagnosis.

# Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 14, 2012 15:09:56

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 18, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 8
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis
Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Pain in the shoulder not as sore this week. She still reports reaching around the hook/unhook bra is painful and describes as a dull ache.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper | 1=Complaint of pain | |

| **Range of Motion: Shoulder: Pre-Treatment:** | **Left AROM** | **Left PROM** | **Right AROM** |
|---|---|---|---|
| • Flexion(no pain with overpressure 9/18) | 160 | 175 | 180 |
| • Abduction(no pain with overpressure 9/18) | 180 | | 180 |
| • Horizontal Adduction(9/18) | 50 | 60 | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | | |
| • Adduction(improved after stretching) | 41 | | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension. | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scaption/External Rotation. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch(Tbis visit) | Did Not Perform: This visit |
| • Isotonic Activity 1 | Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

- IR 0 deg — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint — Time Elapsed: 5 Minutes, Grade: II/III, Body Position: supine, Pressure: Oscillatory, Technique 1: horizontal adduction stretch, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Soft Tissue:**
- Deltoid(This visit) — Did Not Perform: This visit
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 55 Minutes

# Assessment

**Continued weakness with ER but no scapular winging during prone scaption. Added PNF with minimal verbal and tactile cues to prevent biceps compensation.**

# Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program. Assess soreness after PNF added.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 18, 2012 15:03:02

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 20, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 9
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis
Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach | Posterior Opposite Shoulder | Lateral Opposite Shoulder |
| • ER - Combined | To T4 | To T4 |
| • IR - Combined | To T6 | To T5 |

**Muscle Testing:**

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| Muscle Testing: Upper Extremity MMT: | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |

| Muscle Testing: Shoulder: | Left | Right |
|---|---|---|
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| Palpation: Musculature: Tenderness: | Left |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper | 1=Complaint of pain |

| Range of Motion: Shoulder: Pre-Treatment: | Left AROM | Left PROM | Right AROM |
|---|---|---|---|
| • Flexion(no pain with overpressure 9/18) | 160 | 175 | 180 |
| • Abduction(no pain with overpressure 9/18) | 180 | | 180 |
| • Horizontal Adduction(9/18) | 50 | 60 | |

| Range of Motion: Shoulder: Post-Treatment: | Left AROM |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension. | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scaption/External Rotation. | Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Supine Punch(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 1 | Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

- IR 0 deg — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Therapeutic Activities, Billing Code: 97530.
- Stabilization Training 2 — Time Elapsed: 4 Minutes, Repetitions: 15, Additional Detail: BOING, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint(This visit) — Did Not Perform: This visit

**Manual Interventions: Soft Tissue:**
- Deltoid(This visit) — Did Not Perform: This visit
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 58 Minutes

## Assessment

**The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.**
**Improved tolerance with scapular strengthening and less medial angle winging.**

## Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 20, 2012 14:48:39

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 25, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 10
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Total | 65/100 |
| • Score 1 | pain 9/30 |
| • Score 2 | function 38/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 08/21/2012 |
| • Assessment | Initial |
| • Physical Activity Score | 8 |

## Objective Examination

| **Functional Tests: Apley's Scratch Test:** | **Left** | **Right** |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T6 | To T5 |

**Muscle Testing:**

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| Muscle Testing: Upper Extremity MMT: | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |

| Muscle Testing: Shoulder: | Left | Right |
|---|---|---|
| • Serratus Anterior | +3/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 |
| • Trapezius, Middle | 4/5 | 4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| Palpation: Musculature: Tenderness: | Left |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper | 1=Complaint of pain |

| Range of Motion: Shoulder: Pre-Treatment: | Left AROM | Left PROM | Right AROM |
|---|---|---|---|
| • Flexion(no pain with overpressure 9/18) | 160 | 175 | 180 |
| • Abduction(no pain with overpressure 9/18) | 180 | | 180 |
| • Horizontal Adduction(9/18) | 50 | 60 | |

| Range of Motion: Shoulder: Post-Treatment: | Left AROM |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Prone Extension. — Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
- Prone Row. — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scaption/External Rotation. — Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Supine Punch(This visit) — Did Not Perform: This visit
- Isotonic Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Isotonic Activity 2 — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

**Exercise Activities: Tubing/Bands:**

- IR 0 deg — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Neuromuscular Reeducation, Billing Code: 97112.
- Stabilization Training 2(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Upper Quarter Joint Complex:**
- Glenohumeral Joint(This visit) — Did Not Perform: This visit

**Manual Interventions: Soft Tissue:**
- Deltoid(This visit) — Did Not Perform: This visit
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 54 Minutes

# Assessment

**Presentation:**
- weakness with ER but no compensation during RS and PNF on left.

# Plan

**Daily Plan:**
- Reassess objective measurements next visit. (patient given Penn outcome to return).

**Therapeutic Contents:**
- RTC and scapular strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 25, 2012 14:25:41

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 27, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Re-Evaluation

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Pain has: Pain 2/10 on average.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Total | 64/100 |
| • Score 1 | pain 8/30 |
| • Score 2 | function 35/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score | 17 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |

| | | | | |
|---|---|---|---|---|
| • IR - Combined(equal and symmetrical) | To T6 | | To T5 | |

**Muscle Testing:**

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| | Aug 21, 2012 | | Sep 27, 2012 | |
|---|---|---|---|---|
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 | 4/5 | -5/5 |
| • Shoulder External Rotation(at side 4-/5; at 45 4/5) | -4/5 | -4/5 | -4/5 | -4/5 |
| • Shoulder Internal Rotation(improved) | 4/5 | -5/5 | +4/5 | -5/5 |

| | Aug 21, 2012 | | Sep 27, 2012 | |
|---|---|---|---|---|
| **Muscle Testing: Shoulder:** | **Left** | **Right** | **Left** | **Right** |
| • Serratus Anterior(improved) | +3/5 | +4/5 | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | 4/5 | -4/5 | +4/5 |
| • Trapezius, Middle | 4/5 | 4/5 | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 | 5/5 | 5/5 |

| | |
|---|---|
| **Palpation: Musculature: Tenderness:** | **Left** |
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| | Aug 21, 2012 | | Sep 27, 2012 | | |
|---|---|---|---|---|---|
| **Range of Motion: Shoulder: Pre-Treatment:** | **L. Act.** | **R. Act.** | **L. Act.** | **Pas.** | **R. Act.** |
| • Flexion(no pain with overpressure 9/18) | 142 | 180 | 175 | 180 | 180 |
| • Abduction(no pain with overpressure 9/18) | 160 | 180 | 180 | | 180 |
| • Horizontal Adduction(9/18) | | | 50 | 60 | |

| | Sep 27, 2012 |
|---|---|
| **Range of Motion: Shoulder: Post-Treatment:** | **L. Act.** |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Prone Extension. — Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
- Prone Row. — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scaption/External Rotation. — Time Elapsed: 4 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 10, Sets: 3, Position: prone over bolster, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Supine Punch(This visit) — Did Not Perform: This visit
- Isotonic Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 30, Side: Bilateral, Additional Detail: In front of mirror, Description: scapular retraction bent arm, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Isotonic Activity 2 — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

**Exercise Activities: Tubing/Bands:**
- IR 0 deg(This visit) — Did Not Perform: This visit
- IR 90 deg Slow — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scapular Retraction(This visit) — Did Not Perform: This visit

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1(This visit) — Did Not Perform: This visit
- Stabilization Training 2(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 10 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Soft Tissue:**
- Deltoid(This visit) — Did Not Perform: This visit
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 54 Minutes

# Assessment

**Presentation:**
- Improved AROM, improved SA stregnth, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilzer weakness.

# Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side hut can't pick anything up heavy. SHe currently describes pain as 2/10.**

*LTG Achieve by Oct 02, 2012.*

**Symptomatic Improvements:**
- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 25, 2012.*

**Functional Improvements In:**
- Work Capacity, Returning to: Modified Duty.

***Problem #3*** **Range of Motion: Shoulder: Pre-Treatment.**
*Goal Achieved Sep 27, 2012.*

| **Range of Motion Improvements to: Shoulder:** | **Left AROM** |
|---|---|
| • Flexion | 170 |
| • Abduction | 170 |

***Problem #4*** **Muscle Testing: Upper Extremity MMT.**
*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

| **Musculoskeletal Improvements In: Shoulder Muscle Strength to:** | **Left** |
|---|---|
| • Gross Assessment | +4/5 |

***Problem #5*** **Questionnaires: Additional.**
*LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's*

| **Questionnaire Improvements: Additional:** | |
|---|---|
| • Test Name | Penn Shoulder Score |
| • Assessment | Reassessment |
| • Total | 80/100 |
| • Score 1 | pain decrease by 3 points or greater |
| • Score 2 | function score improve by 10 points or more |

***Problem #6*** **Muscle Testing: Shoulder.**
*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

| **Musculoskeletal Improvements In: Shoulder Muscle Strength to:** | **Left** |
|---|---|
| • Gross Assessment | -5/5 |

# Plan

**Amount, Frequency and Duration:**
- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Daily Plan:**
- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

**Therapeutic Contents:**
- RTC and scapular strengthening and functional activites at shoulder level and overhead.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 27, 2012 14:17:24

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Sep 27, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 11
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Plan of Care

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## Assessment

**Presentation:**

- Improved AROM, improved SA stregnth, ER at 45 degrees, decreased pain but continued RTC ER and scapular stabilzer weakness.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*LTG Achieve by Oct 02, 2012.*

**Symptomatic Improvements:**

- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 25, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #3***

| Range of Motion: Shoulder: Pre-Treatment. | Left AROM | Left PROM | Right AROM |
|---|---|---|---|
| • Abduction(no pain with overpressure 9/18) | 180 | | 180 |
| • Flexion(no pain with overpressure 9/18) | 175 | 180 | 180 |
| • Horizontal Adduction(9/18) | 50 | 60 | |

*Goal Achieved Sep 27, 2012.*

| Range of Motion Improvements to: Shoulder: | Left AROM |
|---|---|
| • Flexion | 170 |
| • Abduction | 170 |

***Problem #4***

| Muscle Testing: Upper Extremity MMT. | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder External Rotation(at side 4-/5; at 45 4/5) | -4/5 | -4/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |

*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

**Musculoskeletal Improvements In: Shoulder Muscle Strength to:** **Left**

### Please sign and return

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

**Comments/Revisions**

**Physician/NPP Signature** **Date** **Print Name and Credentials**

| | | Left | Right |
|---|---|---|---|
| | • Gross Assessment | +4/5 | |
| ***Problem #5*** | **Questionnaires: Additional.** | | |
| | • Assessment | Reassessment | |
| | • Date | 09/27/2012 | |
| | • Score 1 | pain 8/30 | |
| | • Score 2 | function 35/60 | |
| | • Test Name | Penn SHoulder Score | |
| | • Total | 64/100 | |

*LTG Achieve by Oct 25, 2012. Progress: No change. improve strength for painfree ADL's*

**Questionnaire Improvements: Additional:**

| | |
|---|---|
| • Test Name | Penn Shoulder Score |
| • Assessment | Reassessment |
| • Total | 80/100 |
| • Score 1 | pain decrease by 3 points or greater |
| • Score 2 | function score improve by 10 points or more |

| | | Left | Right |
|---|---|---|---|
| ***Problem #6*** | **Muscle Testing: Shoulder.** | **Left** | **Right** |
| | • Serratus Anterior(improved) | +4/5 | +4/5 |
| | • Trapezius, Lower | -4/5 | +4/5 |
| | • Trapezius, Middle | +4/5 | +4/5 |
| | • Trapezius, Upper | 5/5 | 5/5 |

*LTG Achieve by Oct 25, 2012. Progress: Some progress.*

| **Musculoskeletal Improvements In: Shoulder Muscle Strength to:** | **Left** |
|---|---|
| • Gross Assessment | -5/5 |

# Plan

**Amount, Frequency and Duration:**
- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Daily Plan:**
- Continue w/ Current Rehabilitation Program. Progression Under Current Plan. Advance as tolerated.

**Therapeutic Contents:**
- RTC and scapular strengthening and functional activites at shoulder level and overhead.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Sep 27, 2012 14:17:24

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 12, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 12
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Total | 64/100 |
| • Score 1 | pain 8/30 |
| • Score 2 | function 35/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score | 17 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T6 | To T5 |

**Muscle Testing:**

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| Muscle Testing: Upper Extremity MMT: | Left | Right |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12) | 4/5 | 4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior(improved) | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | +4/5 |
| • Trapezius, Middle | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper(improved) | 0=No tenderness noted | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Prone Extension. — Time Elapsed: 4 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530.
- Prone Row. — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Scaption/External Rotation.(This visit) — Did Not Perform: This visit
- Supine Punch — Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Isotonic Activity 1(This visit) — Did Not Perform: This visit
- Isotonic Activity 2 — Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over bolster, Charge As: Therapeutic Activities, Billing Code: 97530.

**Exercise Activities: Tubing/Bands:**

- ER 0 deg — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Redx15, yellow 2x10, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- IR 0 deg(This visit) — Did Not Perform: This visit
- IR 90 deg Slow(This visit) — Did Not Perform: This visit
- Pull Downs — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Additional Detail: pinches, Charge As: Therapeutic Exercise, Billing Code: 97110.

- Scapular Retraction — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1 — Time Elapsed: 4 Minutes, Level: 30 second bouts, Additional Detail: wall pluses at 90 FE, Charge As: Neuromuscular Reeducation, Billing Code: 97112.
- Stabilization Training 2 — Time Elapsed: 4 Minutes, Repetitions: 15, Additional Detail: BOING, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 12 Minutes, Technique: Rhythmic Stab., Position: Supine PNF D1 flexion, Additional Detail: 90 FE and scapular plane ER/IR, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Soft Tissue:**
- Deltoid(This visit) — Did Not Perform: This visit
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 55 Minutes

# Assessment

**Presentation:**
- Improved ER at side and 45 degrees without scapular winging.

# Plan

**Client tolerated longer session due to early arrival.**

**Daily Plan:**
- Continue w/ Current Rehabilitation Program. 2-3 times a week for 8 sessions for RTC and scapular strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 12, 2012 10:04:47

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Timothy Marinelli
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 15, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 13
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Patient states that her shoulder is feeling a little sore today.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Total | 64/100 |
| • Score 1 | pain 8/30 |
| • Score 2 | function 35/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score | 17 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined(equal and symmetrical) | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12) | 4/5 | 4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior(improved) | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | +4/5 |
| • Trapezius, Middle | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper(improved) | 0=No tenderness noted | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 4 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Prone Extension. | Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Activities, Billing Code: 97530. |
| • Prone Row. | Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Scaption/External Rotation.(This visit) | Did Not Perform: This visit |
| • Supine Punch(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 1(This visit) | Did Not Perform: This visit |
| • Isotonic Activity 2 | Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Description: prone scapular set over holster, Charge As: Therapeutic Activities, Billing Code: 97530. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • ER 0 deg(This visit) | Did Not Perform: This visit |
| • IR 0 deg(This visit) | Did Not Perform: This visit |
| • IR 90 deg Slow(This visit) | Did Not Perform: This visit |
| • Pull Downs(This visit) | Did Not Perform: This visit |
| • Scapular Retraction(This visit) | Did Not Perform: This visit |

**Exercise Activities: Aerobic Conditioning:**

| | |
|---|---|
| • Upper Body Ergometer | Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Pulleys: Upper Extremity:**
- G-H Flexion(This visit) — Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Standing Position:**
- Stabilization Training 1(This visit) — Did Not Perform: This visit
- Stabilization Training 2(This visit) — Did Not Perform: This visit

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization(This visit) — Did Not Perform: This visit

**Manual Interventions: Soft Tissue:**
- Deltoid — Time Elapsed: 8 Minutes, Tx Depth: Superficial, Technique: Strumming, Additional Detail: middle deltoid, Charge As: Manual Therapy Techniques, Billing Code: 97140.
- Upper Trapezius(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 30 Minutes

# Assessment

**Tolerance:**
- Patient tolerated exercises well. Resistance was progressed with shoulder strengthening/rotator cuff strengthening exercises.

# Plan

**Recommendations:**
- Progress next visit with shoulder strengthening/stabilization activities as tolerated.

Timothy Marinelli, PT(SC Lic: 6704)
Signed on Oct 15, 2012 14:32:48

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeffery Gearhart
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 17, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 14
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Overall Condition is: Client reports that she continues to have soreness, primarily lateral and superior shoulder. Client reports overall that her shoulder continues to improve.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Total | 64/100 |
| • Score 1 | pain 8/30 |
| • Score 2 | function 35/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 09/27/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score | 17 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |

| | | |
|---|---|---|
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T6 | To T5 |

**Muscle Testing:**

- Strong and painless biceps; Weak and painless shoulder ABD and ER.

| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
|---|---|---|
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12) | 4/5 | 4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |

| **Muscle Testing: Shoulder:** | **Left** | **Right** |
|---|---|---|
| • Serratus Anterior(improved) | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | +4/5 |
| • Trapezius, Middle | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 8 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • D1 Flexion/Extension. | Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Extension, Shoulder | Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Rows | Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Aerobic Conditioning:**

| | |
|---|---|
| • Upper Body Ergometer | Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

| | |
|---|---|
| • Rhythmic Stabilization | Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112. |

**Manual Interventions: Upper Quarter Joint Complex:**

- Scapulothoracic Joint — Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**

- Total Therapy Session Time 50 Minutes

# Assessment

**Tolerance:**

- Client reported decreased soreness with treatment. Client required verbal cues for posture and form. Client continues to have strength and muscle endurance deficits. She would benefit from progression of strength and posture.

# Plan

**Daily Plan:**

- Progress with strength and muscle endurance. Progress with posture.

Jeffery Gearhart, PT(SC Lic: 5945)
Signed on Oct 17, 2012 15:25:01

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeffery Gearhart
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 19, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 15
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Daily Comments:**
- Overall Condition is: Client reports that overall her shoulder continues to improve.

**Questionnaires: Additional:**

| | |
|---|---|
| Test Name | Penn SHoulder Score |
| Date | 09/27/2012 |
| Assessment | Reassessment |
| Total | 64/100 |
| Score 1 | pain 8/30 |
| Score 2 | function 35/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| Date | 09/27/2012 |
| Assessment | Reassessment |
| Physical Activity Score | 17 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| ER - Combined(equal and symmetrical) | To T4 | To T4 |

| | | |
|---|---|---|
| • IR - Combined(equal and symmetrical) | To T6 | To T5 |
| **Muscle Testing:** | | |
| • Strong and painless biceps; Weak and painless shoulder ABD and ER. | | |
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** |
| • Scaption | 4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 |
| • Shoulder Flexion | 4/5 | -5/5 |
| • Shoulder External Rotation(improved @ 0 and 45 ABD 10/12/12) | 4/5 | 4/5 |
| • Shoulder Internal Rotation(improved) | +4/5 | -5/5 |
| **Muscle Testing: Shoulder:** | **Left** | **Right** |
| • Serratus Anterior(improved) | +4/5 | +4/5 |
| • Trapezius, Lower | -4/5 | +4/5 |
| • Trapezius, Middle | +4/5 | +4/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper(improved) | 0=No tenderness noted | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 2 Minutes, Weight - Pounds: 0 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • D1 Flexion/Extension. | Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • D2 Flexion/Extension. | Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • ER 0 deg | Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Extension, Shoulder | Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • IR 0 deg | Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Rows | Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Aerobic Conditioning:**

- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Upper Quarter Joint Complex:**

- Scapulothoracic Joint — Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**

- Total Therapy Session Time 55 Minutes

# Assessment

**Tolerance:**

- Client continues to require verbal cues for posture and form. She continues to have strength deficits, specifically at or above shoulder height. Client would benefit from progression of range and strength.

# Plan

**Daily Plan:**

- Progress with strength and posture.

Jeffery Gearhart, PT(SC Lic: 5945)
Signed on Oct 19, 2012 14:18:19

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 22, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 16
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Re-Evaluation

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Chief Complaint:**
- Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**

• Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| | Sep 27, 2012 | | Oct 22, 2012 | |
|---|---|---|---|---|
| **Muscle Testing: Upper Extremity MMT:** | **Left** | **Right** | **Left** | **Right** |
| • Scaption(improved 10/22) | 4/5 | -5/5 | +4/5 | -5/5 |
| • Shoulder Abduction | 4/5 | -5/5 | +4/5 | -5/5 |
| • Shoulder Flexion(improved 10/22) | 4/5 | -5/5 | +4/5 | -5/5 |
| • Shoulder External Rotation(improved @ 0 and 45 ABD 10/22/12) | -4/5 | -4/5 | 4/5 | 4/5 |
| • Shoulder Internal Rotation(improved 10/22/12) | +4/5 | -5/5 | -5/5 | -5/5 |

| | Sep 27, 2012 | | Oct 22, 2012 | |
|---|---|---|---|---|
| **Muscle Testing: Shoulder:** | **Left** | **Right** | **Left** | **Right** |
| • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | -4/5 | +4/5 | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | +4/5 | +4/5 | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| | Sep 27, 2012 | Oct 22, 2012 |
|---|---|---|
| **Range of Motion: Shoulder: Post-Treatment:** | **L. Act.** | **L. Act.** |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | 41 |

# Treatments

**Exercise Activities: Isotonics:**

• External Rotation Sidelying.(This visit) — Did Not Perform: This visit

**Exercise Activities: Tubing/Bands:**

• D1 Flexion/Extension. — Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

• D2 Flexion/Extension. — Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.

• ER 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.

• ER 90 deg Slow — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.

• Extension, Shoulder — Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

- IR 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Rows — Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization — Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Upper Quarter Joint Complex:**
- Scapulothoracic Joint — Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**
- Total Therapy Session Time 54 Minutes

## Assessment

**Presentation:**
- Improving RTC strength and scapular stabilizer strength, continued endurance weakness.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*Goal Achieved Oct 12, 2012. able to sleep on left side without shoulder pain*

**Symptomatic Improvements:**
- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 27, 2012.*

**Functional Improvements In:**
- Work Capacity, Returning to: Modified Duty.

***Problem #3*** **Muscle Testing: Upper Extremity MMT.**

*Goal Achieved Oct 22, 2012. : 90% of Goal Met*

**Musculoskeletal Improvements In: Shoulder** Left

**Muscle Strength to:**
- Gross Assessment +4/5

***Problem #4*** **Questionnaires: Additional.**

*LTG Achieve by Oct 27, 2012. Progress: No change. 90% of Goal Met*

**Questionnaire Improvements: Additional:**

- Test Name — Penn Shoulder Score
- Assessment — Reassessment
- Total — 80/100
- Score 1 — pain decrease by 3 points or greater
- Score 2 — function score improve by 10 points or more

***Problem #5*** **Muscle Testing: Shoulder.**

*LTG Achieve by Oct 25, 2012. Progress: Some progress, partially met*

**Musculoskeletal Improvements In: Shoulder** **Left**

**Muscle Strength to:**

- Gross Assessment — -5/5

# Plan

**Daily Plan:**

- 2 more sessions remaining before MD follow-up.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 22, 2012 14:11:01

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 22, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 16
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Plan of Care

## Diagnosis
Left Shoulder 71941 JOINT PAIN-SHLDER

## Assessment

**Presentation:**
- Improving RTC strength and scapular stabilizer strength, continued endurance weakness.

## Problems & Goals

***Problem #1*** **Chief Complaint: Pain in the left shoulder and able to sleep on left side but can't pick anything up heavy. SHe currently describes pain as 2/10.**

*Goal Achieved Oct 12, 2012. able to sleep on left side without shoulder pain*

**Symptomatic Improvements:**
- Decreasing Pain: to 0/10.

***Problem #2*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Oct 27, 2012.*

**Functional Improvements In:**
- Work Capacity, Returning to: Modified Duty.

***Problem #3*** **Muscle Testing: Upper Extremity MMT.**

| | Left | Right |
|---|---|---|
| Scaption(improved 10/22) | +4/5 | -5/5 |
| Shoulder Abduction | +4/5 | -5/5 |
| Shoulder External Rotation(improved @ 0 and 45 ABD 10/22/12) | 4/5 | 4/5 |
| Shoulder Flexion(improved 10/22) | +4/5 | -5/5 |
| Shoulder Internal Rotation(improved 10/22/12) | -5/5 | -5/5 |

*Goal Achieved Oct 22, 2012. : 90% of Goal Met*

| **Musculoskeletal Improvements In: Shoulder Muscle Strength to:** | **Left** |
|---|---|
| Gross Assessment | +4/5 |

***Problem #4*** **Questionnaires: Additional.**

| | |
|---|---|
| Assessment | Reassessment |
| Date | 10/22/2012 |
| Score 1(goal met) | pain 6/30 |
| Score 2 | function 39/60 |
| Test Name | Penn SHoulder Score |

### Please sign and return

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

**Comments/Revisions**

**Physician/NPP Signature** **Date** **Print Name and Credentials**

| | | | |
|---|---|---|---|
| | • Total(improved) | 70/100 | |
| *LTG Achieve by Oct 27, 2012. Progress: No change. 90% of Goal Met* | | | |
| | **Questionnaire Improvements: Additional:** | | |
| | • Test Name | Penn Shoulder Score | |
| | • Assessment | Reassessment | |
| | • Total | 80/100 | |
| | • Score 1 | pain decrease by 3 points or greater | |
| | • Score 2 | function score improve by 10 points or more | |
| ***Problem #5*** | **Muscle Testing: Shoulder.** | **Left** | **Right** |
| | • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 |
| | • Trapezius, Lower(improved 10/22) | 4/5 | +4/5 |
| | • Trapezius, Middle(improved 10/22) | -5/5 | -5/5 |
| | • Trapezius, Upper | 5/5 | 5/5 |
| *LTG Achieve by Oct 25, 2012. Progress: Some progress. partially met* | | | |
| | **Musculoskeletal Improvements In: Shoulder** | **Left** | |
| | **Muscle Strength to:** | | |
| | • Gross Assessment | -5/5 | |

# Plan

**Daily Plan:**

- 2 more sessions remaining before MD follow-up.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 22, 2012 14:11:01

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 24, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 17
Cxl/Ns: 0
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**
- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| Muscle Testing: Shoulder: | Left | Right |
|---|---|---|

| | | |
|---|---|---|
| • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 |
| **Palpation: Musculature: Tenderness:** | **Left** | |
| • Teres Minor | 1=Complaint of pain | |
| • Trapezius, Upper(improved) | 0=No tenderness noted | |
| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** | |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 2 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Tubing/Bands:**

- D1 Flexion/Extension. — Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- D2 Flexion/Extension. — Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 90 deg Slow — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Extension, Shoulder — Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- IR 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Rows — Time Elapsed: 4 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1 — Time Elapsed: 3 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Description: forward punch, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**

- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Upper Quarter Joint Complex:**

- Scapulothoracic Joint — Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

# Assessment

**Tolerance:**

- Fatigue with sidelying ER. No abnormal scapular winging with ER or theraband. Compensation of elbow flexion with PNF patterns.

# Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program. one more session before MD appointment.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 24, 2012 14:28:35

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Oct 26, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 17
CxI/Ns: 1
Employer:
Insured: PALM STATE TRANS

# Cancel/No Show *Patient cancelled appointment*

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Cancel Reasoning:**

- SICK MICHELEG

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 26, 2012 10:48:51

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

| | | | |
|---|---|---|---|
| Acct #: | 314925 | | |
| Patient: | JENNIE M. COX | | |
| DOB: | Aug 14, 1952 | Visit Date: | Oct 30, 2012 |
| Physician: | STACY NEWSOM | Phys Phone: | (864) 455-2300 |
| Phys Fax: | (864) 455-2399 | SSN: | XXX-XX-XXXX |
| Physician: | Not Specified | Inj. Date: | May 31, 2012 |
| Clinician: | Mason Rockwell | Surg. Date: | |
| FSC: | Workers Compensation | Visits: | 18 |
| Case Mgr: | SCOTT JUSTICE | Cxl/Ns: | 1 |
| Payor: | | Employer: | |
| Pol/Claim#: | WC34192 | Insured: | PALM STATE TRANS |

# Daily Note

## Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Daily Comments: Report of outcome from Doctors visit:**
- Continue with rehab. asked for specific job descrpitions and follow-up November 9.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| **Muscle Testing: Shoulder:** | **Left** | **Right** |
|---|---|---|
| • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

| | |
|---|---|
| • External Rotation Sidelying. | Time Elapsed: 2 Minutes, Weight - Pounds: 1 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Isotonic Activity 1 | Time Elapsed: 4 Minutes, Weight - Pounds: 3 Pounds, Repetitions: 10, Sets: 3, Side: Left, Description: prone reverse punch, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Tubing/Bands:**

| | |
|---|---|
| • D1 Flexion/Extension. | Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • D2 Flexion/Extension.(This visit) | Did Not Perform: This visit |
| • ER 0 deg | Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • ER 90 deg Slow | Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Extension, Shoulder | Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • IR 0 deg | Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Rows | Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110. |
| • Tubing/Bands 1(This visit) | Did Not Perform: This visit |

**Exercise Activities: Aerobic Conditioning:**

| | |
|---|---|
| • Upper Body Ergometer | Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110. |

**Exercise Activities: Range of Motion:**

- ROM Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ROM Activity 2 — Time Elapsed: 4 Minutes, Repetitions: 15, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization — Time Elapsed: 8 Minutes, Additional Detail: 90 deg Forward Elevation, Charge As: Neuromuscular Reeducation, Billing Code: 97112.

**Manual Interventions: Upper Quarter Joint Complex:**

- Scapulothoracic Joint — Time Elapsed: 10 Minutes, Grade: II/III, Pressure: Oscillatory, Technique 1: All Glides, Charge As: Manual Therapy Techniques, Billing Code: 97140.

**Therapy Session Time**

- Total Therapy Session Time 59 Minutes

## Assessment

**Presentation:**

- Symptoms consistent with referring diagnosis.

## Plan

**Daily Plan:**

- Continue w/ Current Rehabilitation Program. Progression Under Current Plan.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Oct 30, 2012 12:38:56

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

| | | | |
|---|---|---|---|
| Acct #: | 314925 | | |
| Patient: | **JENNIE M. COX** | | |
| DOB: | Aug 14, 1952 | Visit Date: | **Nov 01, 2012** |
| Physician: | STACY NEWSOM | Phys Phone: | (864) 455-2300 |
| Phys Fax: | (864) 455-2399 | SSN: | XXX-XX-XXXX |
| Physician: | Not Specified | Inj. Date: | May 31, 2012 |
| Clinician: | Mason Rockwell | Surg. Date: | |
| FSC: | Workers Compensation | Visits: | 19 |
| Case Mgr: | SCOTT JUSTICE | Cxl/Ns: | 1 |
| Payor: | | Employer: | |
| Pol/Claim#: | WC34192 | Insured: | PALM STATE TRANS |

# Re-Evaluation *Progress Report (No Re-eval Charge)*

## Diagnosis Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Daily Comments:**
- Endurance level the problem when using left arm.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| **Functional Tests: Apley's Scratch Test:** | **Left** | **Right** |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| | Oct 22, 2012 | | Nov 01, 2012 | |
|---|---|---|---|---|
| **Muscle Testing: Shoulder:** | **Left** | **Right** | **Left** | **Right** |
| • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | 4/5 | +4/5 | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | -5/5 | -5/5 | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| | Oct 22, 2012 | Nov 01, 2012 |
|---|---|---|
| **Range of Motion: Shoulder: Post-Treatment:** | **L. Act.** | **L. Act.** |
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 | 41 |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 2 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Isotonic Activity 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Tubing/Bands:**

- D1 Flexion/Extension. — Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- D2 Flexion/Extension. — Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 90 deg Slow — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Extension, Shoulder — Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- IR 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Rows — Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1(This visit) — Did Not Perform: This visit

- Tubing/Bands 2 — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: lower trapezius wall slides, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**

- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Range of Motion:**

- ROM Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ROM Activity 2 — Time Elapsed: 4 Minutes, Repetitions: 5, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Functional/ADL Activities: Functional Task Training:**

- Overhead Reach — Time Elapsed: 8 Minutes, Weight - Pounds: 2.5 round and hexagon weights Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.
- Pulling/Pushing — Time Elapsed: 4 Minutes, Weight - Pounds: 1 rep max 30, 40, 50 Pounds, Repetitions: 10 reps for 35 feet, Additional Detail: sled with stop during push/pull for biceps curl movement, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**

- Rhythmic Stabilization(This visit) — Did Not Perform: This visit

**Manual Interventions: Upper Quarter Joint Complex:**

- Scapulothoracic Joint(This visit) — Did Not Perform: This visit

**Therapy Session Time**

- Total Therapy Session Time 55 Minutes

## Assessment

**The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.**

**Impairments Identified:**

- weakness with lower trapezius endurance durine wall slides but no scapular upward rotation or tilt with palpation.

## Problems & Goals

***Problem #1*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Nov 29, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #2*** **Questionnaires: Additional.**

*LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk*

**Questionnaire Improvements: Additional:**

- Test Name — Penn Shoulder Score

- Assessment — Reassessment
- Total — 80/100
- Score 1 — pain decrease by 3 points or greater
- Score 2 — function score improve by 10 points or more

***Problem #3*** **Muscle Testing: Shoulder.**

*LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met*

**Musculoskeletal Improvements In: Shoulder** **Left**

**Muscle Strength to:**

- Gross Assessment — -5/5

# Plan

**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Recommendations:**

- Awaiting approval for further sessions and possible functional capacity evaluation for objective data for return to work abilities.

**Therapeutic Contents:**

- scapular strengthening, RTC strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 01, 2012 13:01:32

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Jeremy W. Skoog
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Note Date: **Nov 01, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 19
Cxl/Ns: 1
Employer:
Insured: PALM STATE TRANS

# Expiration Override to Re-Evaluation from Nov 01, 2012 *Physician Script*

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## Justification

**Pending response.**

Jeremy W. Skoog, PT(SC Lic: 5127)
Signed on Nov 01, 2012 13:01:52

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: **Nov 01, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 19
CxI/Ns: 1
Employer:
Insured: PALM STATE TRANS

# Plan of Care

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## Assessment

**The client tolerated today's treatment/therapeutic activity with minimal complaints of pain and difficulty.**
**Impairments Identified:**
- weakness with lower trapezius endurance durine wall slides but no scapular upward rotation or tilt with palpation.

## Problems & Goals

***Problem #1*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Nov 29, 2012.*

**Functional Improvements In:**
- Work Capacity, Returning to: Modified Duty.

***Problem #2*** **Questionnaires: Additional.**

- Assessment — Reassessment
- Date — 10/22/2012
- Score 1(goal met) — pain 6/30
- Score 2 — function 39/60
- Test Name — Penn SHoulder Score
- Total(improved) — 70/100

*LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk*

**Questionnaire Improvements: Additional:**
- Test Name — Penn Shoulder Score
- Assessment — Reassessment
- Total — 80/100
- Score 1 — pain decrease by 3 points or greater
- Score 2 — function score improve by 10 points or more

***Problem #3*** **Muscle Testing: Shoulder.**

| Muscle | Left | Right |
|---|---|---|
| Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 |
| Trapezius, Lower(improved 10/22) | 4/5 | +4/5 |
| Trapezius, Middle(improved 10/22) | -5/5 | -5/5 |
| Trapezius, Upper | 5/5 | 5/5 |

*LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met*

**Musculoskeletal Improvements In: Shoulder** Left
**Muscle Strength to:**

### Please sign and return

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

**Comments/Revisions**

**Physician/NPP Signature** **Date** **Print Name and Credentials**

• Gross Assessment -5/5

# Plan

**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the client attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks. Interventions during the course of treatment will be directed toward addressing the problems and achieving the goals previously outlined.

**Recommendations:**

- Awaiting approval for further sessions and possible functional capacity evaluation for objective data for return to work abilities.

**Therapeutic Contents:**

- scapular strengthening, RTC strengthening.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 01, 2012 13:01:32

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: JENNIE M. COX
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Visit Date: Nov 06, 2012
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 20
Cxl/Ns: 1
Employer:
Insured: PALM STATE TRANS

# Daily Note

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Daily Comments:**
- Sees MD this Friday and reports no changes with pain in the left shoulder.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| **Functional Tests: Apley's Scratch Test:** | **Left** | **Right** |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**

- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| **Muscle Testing: Shoulder:** | **Left** | **Right** |
|---|---|---|
| • Serratus Anterior(improved 10/22/12) | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 |

| **Palpation: Musculature: Tenderness:** | **Left** |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| **Range of Motion: Shoulder: Post-Treatment:** | **Left AROM** |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Treatments

**Exercise Activities: Isotonics:**

- External Rotation Sidelying. — Time Elapsed: 2 Minutes, Weight - Pounds: 2 Pounds, Repetitions: 30, Sets: 3, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Isotonic Activity 1(This visit) — Did Not Perform: This visit

**Exercise Activities: Tubing/Bands:**

- D1 Flexion/Extension. — Time Elapsed: 6 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- D2 Flexion/Extension. — Time Elapsed: 3 Minutes, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Additional Detail: Modified Range, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ER 90 deg Slow — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 2, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: supported on pillow, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Extension, Shoulder — Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- IR 0 deg — Time Elapsed: 2 Minutes, Tubing/Band Color: Red, Resistance: Concentric/Eccentric, Additional Detail: Isometric Hold Step Out, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Rows — Time Elapsed: 4 Minutes, Tubing/Band Color: Green, Resistance: Concentric/Eccentric, Charge As: Therapeutic Exercise, Billing Code: 97110.
- Tubing/Bands 1(This visit) — Did Not Perform: This visit

- Tubing/Bands 2 — Time Elapsed: 3 Minutes, Repetitions: 10, Sets: 3, Tubing/Band Color: Yellow, Resistance: Concentric/Eccentric, Description: lower trapezius wall slides, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Aerobic Conditioning:**
- Upper Body Ergometer — Time Elapsed: 6 Minutes, Direction: forward & backward, Speed (rpm): 120, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Exercise Activities: Range of Motion:**
- ROM Activity 1 — Time Elapsed: 4 Minutes, Repetitions: 10, Sets: 3, Technique: Active, Hold.: 6 Seconds, Description: wall roller, Charge As: Therapeutic Exercise, Billing Code: 97110.
- ROM Activity 2 — Time Elapsed: 4 Minutes, Repetitions: 5, Sets: 2, Side: Left, Technique: Active, Description: prone hor abd at 90, Charge As: Therapeutic Exercise, Billing Code: 97110.

**Functional/ADL Activities: Functional Task Training:**
- Overhead Reach — Time Elapsed: 8 Minutes, Weight - Pounds: 2.5 round and hexagon weights Pounds, Charge As: Therapeutic Activities, Billing Code: 97530.
- Pulling/Pushing — Time Elapsed: 4 Minutes, Weight - Pounds: 1 rep max 30, 40, 50 Pounds, Repetitions: 10 reps for 35 feet, Additional Detail: sled with stop during push/pull for biceps curl movement, Charge As: Therapeutic Activities, Billing Code: 97530.

**Manual Interventions: Proprioceptive Neuromuscular Facilitation:**
- Rhythmic Stabilization(This visit) — Did Not Perform: This visit

**Manual Interventions: Upper Quarter Joint Complex:**
- Scapulothoracic Joint(This visit) — Did Not Perform: This visit

**Therapy Session Time**
- Total Therapy Session Time 55 Minutes

# Assessment

**Presentation:**
- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Improved strength and endurance with reaching and strengthening.

# Plan

**Daily Plan:**
- Continue w/ Current Rehabilitation Program.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 06, 2012 14:27:53

proaxistherapy

Greenville Proaxis Therapy
1020 Grove Road
Greenville, SC USA 29605
Phone: (864) 455-2319
Fax: (864) 455-2340

Acct #: 314925
Patient: **JENNIE M. COX**
DOB: Aug 14, 1952
Physician: STACY NEWSOM
Phys Fax: (864) 455-2399
Physician: Not Specified
Clinician: Mason Rockwell
FSC: Workers Compensation
Case Mgr: SCOTT JUSTICE
Payor:
Pol/Claim#: WC34192

Note Date: **Nov 29, 2012**
Phys Phone: (864) 455-2300
SSN: XXX-XX-XXXX
Inj. Date: May 31, 2012
Surg. Date:
Visits: 20
Cxl/Ns: 1
Employer:
Insured: PALM STATE TRANS

# Discharge Summary

## Diagnosis

Left Shoulder 71941 JOINT PAIN-SHLDER

## General Information

**Disease/Disorder/Condition:**
- Unremarkable. MRI negative for Left RTC tear.

**History of Injury:**
- Truck driver interstate when she was removing a piece of machinery and was pinned against the dock floor. SHe suffered facial fractures, chest contusion and left shoulder, rib pain.

**Occupation:**
- Truck driver interstate travel from Atlanta to Mexico.

## Subjective Examination

**CLient last seen 11/6/12.**

**ADL / Functional Status:**
- Current status: Work status: Unable to work secondary to dysfunction.

**Questionnaires: Additional:**

| | |
|---|---|
| • Test Name | Penn SHoulder Score |
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Total(improved) | 70/100 |
| • Score 1(goal met) | pain 6/30 |
| • Score 2 | function 39/60 |

**Questionnaires: Fear Avoidance:**

| | |
|---|---|
| • Date | 10/22/2012 |
| • Assessment | Reassessment |
| • Physical Activity Score(improved) | 11 |

## Objective Examination

| Functional Tests: Apley's Scratch Test: | Left | Right |
|---|---|---|
| • Cross Body Reach(improved left) | Posterior Opposite Shoulder | Posterior Opposite Shoulder |
| • ER - Combined(equal and symmetrical) | To T4 | To T4 |
| • IR - Combined(equal and symmetrical) | To T5 | To T5 |

**Muscle Testing:**
- Strong and painless biceps and shoulder abduction; Weak and painless shoulder ER at side.

| Muscle Testing: Shoulder: | Aug 21, 2012 Left | Right | Nov 06, 2012 Left | Right |
|---|---|---|---|---|
| • Serratus Anterior(improved 10/22/12) | +3/5 | +4/5 | +4/5 | +4/5 |
| • Trapezius, Lower(improved 10/22) | -4/5 | 4/5 | 4/5 | +4/5 |
| • Trapezius, Middle(improved 10/22) | 4/5 | 4/5 | -5/5 | -5/5 |
| • Trapezius, Upper | 5/5 | 5/5 | 5/5 | 5/5 |

| Palpation: Musculature: Tenderness: | Left |
|---|---|
| • Teres Minor | 1=Complaint of pain |
| • Trapezius, Upper(improved) | 0=No tenderness noted |

| Range of Motion: Shoulder: Post-Treatment: | Nov 06, 2012 L. Act. |
|---|---|
| • Horizontal Adduction(improved WNL after stretching 9/18) | 41 |

# Assessment

**Presentation:**

- Symptoms consistent with referring diagnosis. Displays signs and symptoms of: Improved strength and endurance with reaching and strengthening.

# Problems & Goals

***Problem #1*** **ADL / Functional Status: Current status: Work status: Unable to work secondary to dysfunction.**

*LTG Achieve by Nov 29, 2012.*

**Functional Improvements In:**

- Work Capacity, Returning to: Modified Duty.

***Problem #2*** **Questionnaires: Additional.**

*LTG Achieve by Nov 29, 2012. Progress: No change. allow getting into/out of trunk*

**Questionnaire Improvements: Additional:**

| | |
|---|---|
| • Test Name | Penn Shoulder Score |
| • Assessment | Reassessment |
| • Total | 80/100 |
| • Score 1 | pain decrease by 3 points or greater |
| • Score 2 | function score improve by 10 points or more |

***Problem #3*** **Muscle Testing: Shoulder.**

*LTG Achieve by Nov 10, 2012. Progress: Some progress. partially met*

| Musculoskeletal Improvements In: Shoulder | Left |
|---|---|
| **Muscle Strength to:** | |
| • Gross Assessment | -5/5 |

# Plan

**Discharge to Independent Home Exercise Program.**

**Discharge due to:**

- Physician Direction.

Mason Rockwell, PT(SC Lic: 5456)
Signed on Nov 29, 2012 10:59:59

# APA #8
# JENNIFER T. ELLIS, M.D.
# HILLCREST FAMILY PRACTICE
# 08/28/12-09/28/16

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | August 28, 2012 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main Street<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U Anxiety Disorder & Rx Refill

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been getting worse. She is currently taking the following prescription medications: Aprazolam 0.25mg and Restoril Oral Capsule 30 mg She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regimen. She feels like the following symptoms have improved: none have improved. And she feels like the following symptoms have worsened: depression. She is is currently experiencing loss of appetite and loss of interest in pleasurable activities . She denies difficulty concentrating and difficulty performing routine daily activities. She has the following issues going on that are affecting the condition: a recent accident at work = 6/2012- machine fell on her- see mandible fx notes and chest trauma. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdomina pain, nausea, diarrhea, and myalgias. She remains on dietary management alone for intervention and claims to be adhering wel to it thus far.
She does not exercise but is very active.
She is not fasting today.

## Past Medical History

Significant for Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Significant for Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; Lysis of adhesions; Tonsillectomy

## Medication List

Significant for Alprazolam Oral 0.5mg; pravastatin Oral Tablet 20 mg; Restoril Oral Capsule 30 mg

## Allergy List

Significant for Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Significant for Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

## Social History

Significant for Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies :** weight loss, weight gain, loss of appetite

**HENT**
- **Denies :** headaches

**Cardiovascular**
- **Denies :** chest pain, dyspnea on exertion

**Respiratory**
- **Denies** : shortness of breath

**Gastrointestinal**
- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies** : rash, itching

**Neurologic**
- **Denies** : tingling or numbness

**Musculoskeletal**
- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI $kg/m^2$ | BSA $m^2$ | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 08/28/2012 | 02:13 PM | 114/76 | Sitting | | | | | | 97.9 | 107lbs 8oz | 5' 6.5" | 17.09 | 1.51 | | |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**
- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
  - **Extremities** : no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination** :
  - **Orientation** : oriented
  - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

## Assessment

- Depression 311
- Insomnia 307.40
- Anxiety Disorder 300.00
- Hypercholesterolemia 272.0
  has been off medicine since CPE b/c labs were norma. will call with results

## Plan

**Orders**

- Hillcrest Profile (HCFP PRO) - - 09/04/2012
  - General health panel This panel must include the following: Comp (80050) - - 09/04/2012
  - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 09/04/2012

**Medications**

- Alprazolam Oral 0.5mg
  SIG: take 1 tablet by mouth three times daily prn anxiety
  DISP: (30) tablets with 0 refills
  **Adjusted on 08/28/2012**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- CPX
- Return Visit Request in/on 4 months +/- 2 days (28815).

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on August 28, 2012 02:48:30 PM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | July 15, 2013 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main Street<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- Pt would like to have medications refilled.

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: Alprazolam Oral 0.5mg, Restoril Oral Capsule 30 mg, and only uses alprazolam few q 1-2 months She is not taking any over the counter medications for the symptoms. She has not been compliant with the medication regiment. She feels like the following symptoms have improved: none have improved. And she feels like the following symptoms have worsened: none have worsened and but still having blue spells due to frustration over accident, tires easy. She is is currently experiencing fatigue, weight loss, loss of appetite, and gets hungry, tries to eat but hurts, does get lortab from surgeon . The patient reports losing 25 pounds loss over the past 1 year. She denies difficulty concentrating, difficulty performing routine daily activities, loss of interest in pleasurable activities, and does enjoy the new gbaby- her youngest daughter's baby. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdomina pain, nausea, diarrhea, and myalgias. She remains on dietary management alone for intervention and claims to be adhering well to it thus far.
She does not exercise but is very active.
She is not fasting today.

Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Significant for Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Significant for Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; Lysis of adhesions; Tonsillectomy

## Medication List

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Significant for Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

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- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/$m^2$ | BSA $m^2$ | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 07/15/2013 | 08:36 AM | 100/62 | Sitting | | | | | | 98.9 | 95lbs 6oz | 5' 6.25" | 15.28 | 1.42 | | |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

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## Assessment

- Depression 311
- Insomnia 307.40
- Anxiety Disorder 300.00
- Hypercholesterolemia 272.0

  has been off medicine since CPE 2011 b/c labs were normal. will call with results

## Plan

**Orders**

- Hillcrest Profile (HCFP PRO) - - 07/15/2013
  - General health panel This panel must include the following: Comp (80050) - - 07/15/2013
  - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 07/15/2013

**Medications**

- Alprazolam Oral

  SIG: take 1 tablet by mouth three times daily prn anxiety

  DISP: (30) tablets with 2 refills

  **Refilled on 07/15/2013**

- Restoril Oral capsule 30 mg

  SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days

  DISP: (30) capsules with 5 refills

  **Refilled on 07/15/2013**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- Appointment Requested (42647)

  Careprovider : Ellis, Jennifer T. MD (1007)

  Location : Hillcrest Family Practice

  Appointment : Follow Up / Office Visit

  Date : 6 months +/- 2 days

  Override : No

  Comments/Instructions :

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on July 15, 2013 09:10:12 AM

# LabCorp - Lab - General Lab

**Specimen #:** 196-076-5801-0 **Report Status:** Final Results

**Patient Information:**

| | | | | | |
|---|---|---|---|---|---|
| **Name:** | Cox, Jennie C | **PatientID:** 55780 | **Sex:** F | **DOB:** 08/14/1952 |
| **Address:** | 222 W Chapman Road<br>Belton, SC 29627- | **Phone #:** (864)243-0032 | **SSN:** | |

**Date of Specimen:** 07/15/2013 09:09 **Date Received:** 07/15/2013 21:33 **Specimen Source:**
**Date Reported:** 07/16/2013 11:38 **Physician:** Ellis, J **Information:** 1SST, 1LAV

| Test Name | Result | Flags | Reference Range | Lab |
|---|---|---|---|---|
| **Comments:** | | | | |
| **CMP12+LP+6AC+CBC/D/Plt+TSH+Fer** | | | | |
| Glucose, Serum | 92 mg/dL | | 65-99 mg/dL | BN |
| Uric Acid, Serum | 4.2 mg/dL | | 2.5-7.1 mg/dL | BN |
| Therapeutic target for gout patients: <6.0 | | | | |
| BUN | 9 mg/dL | | 8-27 mg/dL | BN |
| Creatinine, Serum | 0.84 mg/dL | | 0.57-1.00 mg/dL | BN |
| eGFR If NonAfricn Am | 76 mL/min/1.73 | | >59 mL/min/1.73 | BN |
| eGFR If Africn Am | 87 mL/min/1.73 | | >59 mL/min/1.73 | BN |
| Sodium, Serum | 137 mmol/L | | 134-144 mmol/L | BN |
| Potassium, Serum | 5.1 mmol/L | | 3.5-5.2 mmol/L | BN |
| Chloride, Serum | 98 mmol/L | | 97-108 mmol/L | BN |
| Calcium, Serum | 9.9 mg/dL | | 8.6-10.2 mg/dL | BN |
| Phosphorus, Serum | 3.9 mg/dL | | 2.5-4.5 mg/dL | BN |
| Protein, Total, Serum | 7.5 g/dL | | 6.0-8.5 g/dL | BN |
| Albumin, Serum | 4.5 g/dL | | 3.6-4.8 g/dL | BN |
| Globulin, Total | 3.0 g/dL | | 1.5-4.5 g/dL | BN |
| Bilirubin, Total | 0.2 mg/dL | | 0.0-1.2 mg/dL | BN |
| Alkaline Phosphatase, S | 99 IU/L | | 42-107 IU/L | BN |
| **Please note reference interval change** | | | | |
| LDH | 200 IU/L | | 0-214 IU/L | BN |
| AST (SGOT) | 20 IU/L | | 0-40 IU/L | BN |
| ALT (SGPT) | 9 IU/L | | 0-32 IU/L | BN |
| GGT | 25 IU/L | | 0-60 IU/L | BN |
| **Iron, Serum** | **34 ug/dL** | **L** | **35-155 ug/dL** | **BN** |
| Ferritin, Serum | 53 ng/mL | | 15-150 ng/mL | BN |
| **Cholesterol, Total** | **232 mg/dL** | **H** | **100-199 mg/dL** | **BN** |
| Triglycerides | 131 mg/dL | | 0-149 mg/dL | BN |
| HDL Cholesterol | 61 mg/dL | | >39 mg/dL | BN |
| According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD. | | | | |
| **LDL Cholesterol Calc** | **145 mg/dL** | **H** | **0-99 mg/dL** | **BN** |
| Comment: | | | | BN |
| T. Chol/HDL Ratio | 3.8 ratio units | | 0.0-4.4 ratio units | BN |
| Estimated CHD Risk | 0.7 times avg. | | 0.0-1.0 times avg. | BN |

T. Chol/HDL Ratio

| | Men | Women |
|---|---|---|
| 1/2 Avg.Risk | 3.4 | 3.3 |
| Avg.Risk | 5.0 | 4.4 |
| 2X Avg.Risk | 9.6 | 7.1 |
| 3X Avg.Risk | 23.4 | 11.0 |

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

| | | | | |
|---|---|---|---|---|
| TSH | 1.860 uIU/mL | | 0.450-4.500 uIU/mL | BN |
| WBC | 7.4 x10E3/uL | | 4.0-10.5 x10E3/uL | BN |
| RBC | 4.36 x10E6/uL | | 3.77-5.28 x10E6/uL | BN |

| | | | |
|---|---|---|---|
| Hemoglobin | 13.6 g/dL | 11.1-15.9 g/dL | BN |
| Hematocrit | 41.5 % | 34.0-46.6 % | BN |
| MCV | 95 fL | 79-97 fL | BN |
| MCH | 31.2 pg | 26.6-33.0 pg | BN |
| MCHC | 32.8 g/dL | 31.5-35.7 g/dL | BN |
| RDW | 13.5 % | 12.3-15.4 % | BN |
| Platelets | 398 x10E3/uL | 140-415 x10E3/uL | BN |
| Neutrophils | 59 % | 40-74 % | BN |
| Lymphs | 33 % | 14-46 % | BN |
| Monocytes | 4 % | 4-13 % | BN |
| Eos | 2 % | 0-7 % | BN |
| Basos | 2 % | 0-3 % | BN |
| Immature Cells | | | BN |
| Neutrophils (Absolute) | 4.4 x10E3/uL | 1.8-7.8 x10E3/uL | BN |
| Lymphs (Absolute) | 2.4 x10E3/uL | 0.7-4.5 x10E3/uL | BN |
| Monocytes(Absolute) | 0.3 x10E3/uL | 0.1-1.0 x10E3/uL | BN |
| Eos (Absolute) | 0.1 x10E3/uL | 0.0-0.4 x10E3/uL | BN |
| Baso (Absolute) | 0.1 x10E3/uL | 0.0-0.2 x10E3/uL | BN |
| Immature Granulocytes | 0 % | 0-2 % | BN |
| Immature Grans (Abs) | 0.0 x10E3/uL | 0.0-0.1 x10E3/uL | BN |
| NRBC | | | BN |
| Hematology Comments: | | | BN |

| | | | |
|---|---|---|---|
| **Lab Name:** | LabCorp Burlington (BN) | **Director:** | William F Hancock |
| **Address:** | 1447 York Court<br>Burlington, NC 27215-3361 | **Phone #:** | 8007624344 |

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | Apri 14, 2014 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main Street<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- Pt here for medication refills.

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: Alprazolam Oral 0.5mg, Restoril Oral Capsule 30 mg, and only uses alprazolam few q 1-2 months She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels l ke the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing out of control feelings and somewhat overwhelmed by keeping up with items at home . She denies difficulty concentrating, difficulty performing routine daily activities, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She remains on medication but does not follow the recommended diet.
She does not exercise but is very active.
She is not fasting today.

alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week; restoril takes prn- approx a wednesdays when home and weekend

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; Lysis of adhesions; Tonsillectomy

## Medication List

Alprazolam 0.5 MG; Restoril Oral capsule 30 mg

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute



## Social History

Chilcren; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies :** weight loss, weight gain, loss of appetite

**HENT**
- **Denies :** headaches

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- **Denies :** additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies :** polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies :** additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04/14/2014 | 08:45 AM | 96/72 | Sitting | | | | | | 98.1 | 101lbs 2oz | 5' 6" | 16.32 | 1.46 | | |

## Physical Examination

**Constitutional**
- **Appearance :** well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae :** conjunctiva normal
- **Sclerae :** sclera white
- **Pupils and Irises :** pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort :** breathing unlabored
- **Auscultation of Lungs :** normal breath sounds

**Cardiovascular**
- **Heart :**
  - **Auscultation of Heart :** regular rate and rhythm, no murmurs present
- **Peripheral Vascular System :**
  - **Extremities :** no edema or cyanosis

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## Assessment

- Depression Stable 311
- Insomnia Stable 307.40
- Anxiety Disorder Stable 300.00
- Hypercholesterolemia Stable 272.0
  has been off medicine since CPE 2011 b/c labs were normal. will call with results

## Plan

**Orders**

- Hillcrest Profile (HCFP PRO) - - 04/17/2014
  - General health panel This panel must include the following: Comp (80050) - - 04/17/2014
  - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 04/17/2014

**Medications**

- Alprazolam Oral 0.5 MG
  SIG: take 1 tablet by mouth three times daily prn anxiety
  DISP: (30) tablets with 2 refills
  **Refilled on 04/14/2014**

- Restoril oral capsule 30 mg
  SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
  DISP: (30) capsules with 5 refills
  **Refilled on 04/14/2014**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- CPX
- Return Visit Request in/on 1 month +/- 2 days (54114).

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on April 14, 2014 09:50:22 AM

# LabCorp - Lab - General Lab

**Specimen #:** 272-076-6872-0 **Report Status:** Final Results

**Patient Information:**

**Name:** Cox, Jennie C **PatientID:** 55780 **Sex:** F **DOB:** 08/14/1952
**Address:** 222 W CHAPMAN ROAD BELTON, SC 29627- **Phone #:** (864)243-0032 **SSN:** ###-##-3648

**Date of Specimen:** 09/29/2014 08:41 **Date Received:** 09/29/2014 22:18 **Specimen Source:**
**Date Reported:** 09/30/2014 08:42 **Physician:** ELLIS, J **Information:**

| Test Name | Result | Flags | Reference Range | Lab |
|---|---|---|---|---|
| **Comments:** Fasting=Y | | | | |
| **CMP12+LP+6AC+CBC/D/Plt+TSH+Fer** | | | | |
| Glucose, Serum | 90 mg/dL | | 65-99 mg/dL | BN |
| Uric Acid, Serum | 5.3 mg/dL | | 2.5-7.1 mg/dL | BN |
| Therapeutic target for gout patients: <6.0 | | | | |
| BUN | 10 mg/dL | | 8-27 mg/dL | BN |
| Creatinine, Serum | 0.85 mg/dL | | 0.57-1.00 mg/dL | BN |
| eGFR If NonAfricn Am | 74 mL/min/1.73 | | >59 mL/min/1.73 | BN |
| eGFR If Africn Am | 85 mL/min/1.73 | | >59 mL/min/1.73 | BN |
| Sodium, Serum | 140 mmol/L | | 134-144 mmol/L | BN |
| Potassium, Serum | 5.2 mmol/L | | 3.5-5.2 mmol/L | BN |
| Chloride, Serum | 100 mmol/L | | 97-108 mmol/L | BN |
| Calcium, Serum | 9.9 mg/dL | | 8.6-10.2 mg/dL | BN |
| Phosphorus, Serum | 3.4 mg/dL | | 2.5-4.5 mg/dL | BN |
| Protein, Total, Serum | 7.2 g/dL | | 6.0-8.5 g/dL | BN |
| Albumin, Serum | 4.7 g/dL | | 3.6-4.8 g/dL | BN |
| Globulin, Total | 2.5 g/dL | | 1.5-4.5 g/dL | BN |
| Bilirubin, Total | 0.3 mg/dL | | 0.0-1.2 mg/dL | BN |
| Alkaline Phosphatase, S | 101 IU/L | | 39-117 IU/L | BN |
| LDH | 210 IU/L | | 0-214 IU/L | BN |
| AST (SGOT) | 19 IU/L | | 0-40 IU/L | BN |
| ALT (SGPT) | 6 IU/L | | 0-32 IU/L | BN |
| GGT | 13 IU/L | | 0-60 IU/L | BN |
| Iron, Serum | 88 ug/dL | | 35-155 ug/dL | BN |
| Ferritin, Serum | 34 ng/mL | | 15-150 ng/mL | BN |
| **Cholesterol, Total** | **224 mg/dL** | **H** | **100-199 mg/dL** | **BN** |
| Triglycerides | 125 mg/dL | | 0-149 mg/dL | BN |
| HDL Cholesterol | 62 mg/dL | | >39 mg/dL | BN |
| According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD. | | | | |
| **LDL Cholesterol Calc** | **137 mg/dL** | **H** | **0-99 mg/dL** | **BN** |
| T. Chol/HDL Ratio | 3.6 ratio units | | 0.0-4.4 ratio units | BN |

T. Chol/HDL Ratio

| | Men | Women |
|---|---|---|
| 1/2 Avg.Risk | 3.4 | 3.3 |
| Avg.Risk | 5.0 | 4.4 |
| 2X Avg.Risk | 9.6 | 7.1 |
| 3X Avg.Risk | 23.4 | 11.0 |

| Test Name | Result | Flags | Reference Range | Lab |
|---|---|---|---|---|
| Estimated CHD Risk | 0.6 times avg. | | 0.0-1.0 times avg. | BN |

T. Chol/HDL Ratio

| | Men | Women |
|---|---|---|
| 1/2 Avg.Risk | 3.4 | 3.3 |
| Avg.Risk | 5.0 | 4.4 |
| 2X Avg.Risk | 9.6 | 7.1 |
| 3X Avg.Risk | 23.4 | 11.0 |

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

| Test Name | Result | Flags | Reference Range | Lab |
|---|---|---|---|---|
| TSH | 1.490 uIU/mL | | 0.450-4.500 uIU/mL | BN |

| | | | |
|---|---|---|---|
| WBC | 7.5 x10E3/uL | 3.4-10.8 x10E3/uL | BN |
| RBC | 4.38 x10E6/uL | 3.77-5.28 x10E6/uL | BN |
| Hemoglobin | 13.7 g/dL | 11.1-15.9 g/dL | BN |
| Hematocrit | 41.2 % | 34.0-46.6 % | BN |
| MCV | 94 fL | 79-97 fL | BN |
| MCH | 31.3 pg | 26.6-33.0 pg | BN |
| MCHC | 33.3 g/dL | 31.5-35.7 g/dL | BN |
| RDW | 13.9 % | 12.3-15.4 % | BN |
| Platelets | 283 x10E3/uL | 150-379 x10E3/uL | BN |
| Neutrophils | 65 % | | BN |
| Lymphs | 25 % | | BN |
| Monocytes | 6 % | | BN |
| Eos | 2 % | | BN |
| Basos | 2 % | | BN |
| Neutrophils (Absolute) | 4.9 x10E3/uL | 1.4-7.0 x10E3/uL | BN |
| Lymphs (Absolute) | 1.9 x10E3/uL | 0.7-3.1 x10E3/uL | BN |
| Monocytes(Absolute) | 0.5 x10E3/uL | 0.1-0.9 x10E3/uL | BN |
| Eos (Absolute) | 0.1 x10E3/uL | 0.0-0.4 x10E3/uL | BN |
| Baso (Absolute) | 0.1 x10E3/uL | 0.0-0.2 x10E3/uL | BN |
| Immature Granulocytes | 0 % | | BN |
| Immature Grans (Abs) | 0.0 x10E3/uL | 0.0-0.1 x10E3/uL | BN |

**Lab Name:** LabCorp Burlington (BN) **Director:** William F Hancock

**Address:** 1447 York Court **Phone #:** 8007624344

Burlington, NC 27215-3361

# History and Physical

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | November 10, 2014 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- Comprehesive Exam
- Pt declines flu vaccine.
- Pt declines to discuss smoking cessation.

labs in emr
vison checked yearly
last pap done 12/8/2011
needs order for mammogram

## History Of Present Illness

Jennie C. Cox is a 62 year old White female who presents for her annual comprehensive exam . It has been 1 year since her last check up. She is due for the following health maintenance items: DRE, EKG, fasting labs, hemoccult testing, mammogram, pap smear, urinalysis, and visual exam.

**Exercise History**
She does not exercise regularly but is very active.

**Dietary Habits**
She provided the following examples for meals on an average day. A typical breakfast might consists of some or all of the following: fast food biscuit or breakfast sandwich. Lunch is usually comprised of some or all of the following: fruit and some vegetables. Some examples of typical supper food would be some or all of the following: fast food. She does not eat desert very often. Typical beverages consumed throughout the day include coffee and regular sodas. She regularly consumes sugar-sweetened beverages. On a typical day she might consume one sweet drink. She does not drink alcohol.

**Tobacco History**
She uses cigarettes 2 pack/s per day.

**Current Medical Problems Followed by Us**
She is followed by us for hyperlipidemia and an anxiety disorder. The patient's mixed lipid levels have been poorly controlled with diet alone and are detailed in the laboratory reports. The anxiety disorder has been essentially unchanged since the last visit and waxing and waning in severity.

Jennie C. Cox is a 62 year old White female who presents for her annual exam. She is a GRAVIDA PARA who underwent a TAH/BSO 25 years ago for menorrhagia
Since her last visit, there have been no significant changes in her health history.

She has no current complaints.

The patient is not taking HRT medication. She is having no vasomotor symptoms.
She has has not had a recent mammogram. A screening mammogram has been ordered.
She does not perform self breast exams.
The patient has no maternal family history of breast cancer.
She is currently single.

cvs moonville 2990234

## Past Medical History

| Disease Name | Date Onset | Notes |
|---|---|---|
| Abdominal Radiologic Abnormality | 3/5/08 | see CT report- L adrenal gland abnormality |
| Anxiety Disorder | -- | -- |
| Bone Infection | 2001 | Dr. devault- I & D ? R hamstring insertion/ infection. a/w overuse unloading hand truck. infxn noted upon re-attachment of hamstring per pt? |
| Hypercholesterolemia | 11/26/2010 | h/o given. willing to work on diet/ exercise. re check 4 mos. Did |

| | | |
|---|---|---|
| | | not tolerate simvastatin- felt "sick," malaise |
| Insomnia | -- | -- |
| Irritable Bowel Syndrome | 2004-2007 | w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007 |
| Joint Pain | -- | -- |
| Low Back Pain | -- | ? HNP L5/s1 |

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Adenoidectomy | -- | -- |
| Appendectomy | ? at time of ooph | -- |
| Colonoscopy | 8/16/04 | int/ext hemmorhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wtih emesis) |
| EGD | 10/04 | mild erythema |
| hystw/oooph | age 20s/ 1990s | hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery |
| jaw surgery | 5/2012- multiple surgerie | Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist |
| Lysis of adhesions | 1990s | bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Blouin and May |
| Tonsillectomy | -- | -- |

## Medication List

| Name | Date Started | Instructions |
|---|---|---|
| alprazolam oral tablet 0.5 mg | 10/17/2014 | take 1 tablet (0.5 mg) by oral route 3 times per day |
| Restoril oral capsule 30 mg | 10/17/2014 | take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days |

## Allergy List

| Allergen Name | Date | Reaction | Notes |
|---|---|---|---|
| Magnesium | -- | -- | -- |
| Nickel | -- | ?metal allergy? | -- |
| Simvastatin | -- | malaise | -- |
| Ultram | -- | -- | -- |

## Family Medical History

| Disease Name | Relative/Age | Notes |
|---|---|---|
| Alzheimer's Disease | / Aunt/ Grandmother (maternal)/ Mother/ | -- |
| DM Type II | / Aunt/ Uncle/ | -- |
| Myocardial Infarction, Acute | / Father/70 | -- |

## Social History

| Finding | Status | Start/Stop | Quantity | Notes |
|---|---|---|---|---|
| Children | -- | --/-- | -- | 2 daughters |
| Divorced | -- | --/-- | -- | -- |
| Grandchildren | -- | --/-- | -- | 5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthew and Meghan), older brother died- Michael -was at 16 yo from MVA |

| | | | | |
|---|---|---|---|---|
| Nondrinker | -- | --/-- | -- | -- |
| Smoker | -- | --/-- | 2 ppd | -- |
| Tobacco | Current every day | 18/-- | 2 PPD | -- |
| Truck Driver | -- | --/-- | -- | -- |

## Review of Systems

**Constitutional**
- **Denies** : fatigue, fever, chills, weight loss, weight gain

**Eyes**
- **Denies** : double vision, changes in vision, floaters

**HENT**
- **Denies** : headaches, nose bleeding, hearing loss, tinnitus, snoring, hoarseness

**Breasts**
- **Denies** : lumps, tenderness, nipple discharge, masses, skin changes

**Cardiovascular**
- **Denies** : chest pain, dyspnea on exertion, orthopnea, lower extremity edema, palpitations

**Respiratory**
- **Admits** : cough- slight recent with drainage
- **Denies** : shortness of breath, hemoptysis

**Gastrointestinal**
- **Denies** : nausea, vomiting, change in bowel habits, dysphagia, heartburn, frequent heartburn, abdominal pain, blood in stools

**Genitourinary**
- **Denies** : urgency, frequency, dysuria, nocturia, hematuria, incontinence, decreased stream, decreased libido

**Integument**
- **Denies** : rash, new skin lesions, changes to existing skin lesions or moles

**Neurologic**
- **Denies** : tingling or numbness, memory difficulties, tremors

**Musculoskeletal**
- **Denies** : joint pain, joint swelling, muscle pain

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance, weight gain

**Psychiatric**
- **Denies** : anxiety, depression, difficulty sleeping

**Heme-Lymph**
- **Denies** : easy bleeding, easy bruising, lymph node enlargement or tenderness

**Allergic-Immunologic**
- **Denies** : sinus allergy symptoms

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m$^2$ | BSA m$^2$ | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11/10/2014 | 10:50 AM | 112/70 | Sitting | | | | 88 - R | | 98.5 | 110lbs 8oz | 5' 6.25" | 17.7 | 1.53 | | |

## Physical Examination

**Constitutional**
- **Appearance** : *thin*, well developed, alert, in no acute distress, appears about reported age

**Head and Face**
- **Head** :
  - **Inspection** : atraumatic, normocephalic
  - **Palpation** : no tenderness or masses present
- **Face** :
  - **Inspection** : no facial lesions

**Eyes**
- **Vision** :
  - **Acuity** : visual acuity grossly normal at distance O.U., near vision grossly intact O.U.
- **Conjunctivae** : conjunctiva normal

- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally
- **Ophthalmoscopic Exam** : retinas are normal without hemorrhage or exudate, no AV crossing changes, optic disk normal with normal cup to disk ratio
- **Corneas** : no lesions present
- **Eyelids/Ocular Adnexae** : eyelid appearance normal, no erythema or lesions noted

**Ears, Nose, Mouth and Throat**

- **Ears** :
  - **External Ears** : appearance within normal limits, no lesions present
  - **Otoscopic Examination** : tympanic membrane appearance within normal limits bilaterally without perforations, mobility normal
  - **Hearing** : intact to conversational voice both ears
- **Nose** :
  - **External Nose** : appearance normal
  - **Intranasal Exam** : mucosa within normal limits, no intranasal lesions present
  - **Nasopharynx** : no lesions or inflammation
- **Oral Cavity** :
  - **Oral Mucosa** : no worrisome oral lesions present
  - **Lips** : lip appearance normal
  - **Teeth** : normal dentition for age
  - **Gums** : gums pink, no lesions
  - **Tongue** : tongue appearance normal, no lesions
  - **Palate** : hard palate normal, soft palate appearance normal
- **Throat** :
  - **Oropharynx** : no inflammation or lesions present
  - **Hypopharynx** : appearance within normal limits, no erythema or lesions

**Neck**

- **Inspection/Palpation** : normal appearance, no masses or tenderness, trachea midline
- **Range of Motion** : cervical range of motion within normal limits
- **Thyroid** : not enlarged, no nodules, non-tender

**Respiratory**

- **Respiratory Effort** : breathing unlabored
- **Inspection of Chest** : normal appearance, no retractions
- **Auscultation of Lungs** : clear and equal bilaterally

**Cardiovascular**

- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no appreciable murmurs, rubs or gallops
  - **Palpation of Heart** : normal apical impulse, no cardiac thrill present
- **Peripheral Vascular System** :
  - **Carotid Arteries** : no appreciable bruits present
  - **Abdominal Aorta** : aortic pulse normal without bruits
  - **Femoral Arteries** : normal femoral pulses, no appreciable bruits
  - **Pedal Pulses** : normal dorsalis pedis and posterior tibial pulses bilaterally
  - **Extremities** : no clubbing, cyanosis or edema

**Breasts**

- **Inspection of Breasts** : no dimpling, retractions or other skin changes
- **Palpation of Breasts, Axillae** : no masses, tenderness or adenopathy noted on palpation

**Gastrointestinal**

- **Abdominal Examination** : bowel sounds positive, non-distended, no appreciable masses or tenderness
- **Liver and spleen** : no appreciable hepatomegaly present, liver nontender to palpation, spleen not palpable
- **Hernias** : no appreciable hernias present

**Genitourinary**

- **External Genitalia** : no inflammation, no lesions present
- **Vagina** : normal vaginal vault, no discharge present, no inflammatory lesions present, no masses present
- **Urethra** : no inflammation, no lesions
- **Bladder** : nontender to palpation
- **Cervix** : *cervix not present*, no lesions present, nontender to palpation, no discharges, no bleeding present, normal midline position
- **Uterus** : *surgically absent*, no masses present, position midline/midplane, size normal
- **Adnexa** : no tenderness or masses present on bimanual examination
- **Anus** : no inflammation or lesions present
- **Perineum** : perineum within normal limits
- **Digital Rectal Examination** : normal sphincter tone, no rectal masses present

- **Occult Blood In Stool** : Hemoccult test negative, normal appearing stool present on glove

**Lymphatic**

- **Neck** : no lymphadenopathy present
- **Axilla** : no lymphadenopathy present
- **Groin** : no lymphadenopathy present
- **Supraclavicular Nodes** : no supraclavicular nodes
- **Preauricular Nodes** : no preauricular nodes present

**Musculoskeletal**

- **Spine** :
  - **Inspection/Palpation** : no spinal tenderness, scoliosis or kyphosis present
- **Right Upper Extremity** :
  - **Inspection/Palpation** : no atrophy or deformity noted, no edema, swelling or erythema present, no ecchymosis, no tenderness to palpation
  - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Left Upper Extremity** :
  - **Inspection/Palpation** : no atrophy or deformity noted, no edema swelling or erythema present, no ecchymosis, no tenderness to palpation
  - **Range of Motion** : full passive range of motion, full active range of motion, no joint crepitus present
- **Right Lower Extremity** :
  - **Inspection/Palpation** : no atrophy or deformity noted, no edema,swelling, or erythema present, no ecchymosis, no tenderness to palpation
  - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion
- **Left Lower Extremity** :
  - **Inspection/Palpation** : no atrophy or deformity noted, no edema,swelling, or erythema present, no ecchymosis, no tenderness to palpation
  - **Range of Motion** : range of motion normal, no joint crepitus present, no pain on motion

**Skin and Subcutaneous Tissue**

- **General Inspection** : no rashes or worrisome lesions present
- **General Palpation** : no skin or subcutaneous tissue masses present, no tenderness to palpation, skin turgor normal
- **Body Hair** : scalp palpation normal, hair normal for age, general body hair distribution normal for age
- **Digits and Nails** : no clubbing or cyanosis, normal appearing nails

**Neurologic**

- **Mental Status Examination** :
  - **Orientation** : grossly oriented to person, place and time
  - **Memory** : intact in that we were able to conduct the interview
- **Cranial Nerves** : cranial nerves intact and symmetric throughout
- **Motor Examination** : grossly normal
- **Reflexes** : DTR's 2 bilaterally
- **Sensation** : grossly intact
- **Gait and Station** : normal gait, able to stand without difficulty

**Psychiatric**

- **Judgement and Insight** : judgment and insight intact
- **Thought Processes** : rate of thoughts normal, thought content logical, abstract reasoning within normal limits
- **Mood and Affect** : mood normal, affect appropriate
- **Presence of Abnormal Thoughts** : no hallucinations, no delusions present, no psychotic thoughts

## In Office Procedure Results

**Urinalysis - Clinitek Status w/o Micro (81003)**

- Albumin: N/A
- Bilirubin: Small
- Creatinine: N/A
- Glucose: Negative
- Ketone: Trace
- Leukocyte: Negative
- Nitrite: Negative
- Blood: Small
- pH: 5.5
- Protein: Negative
- Specific Gravity: 1.020
- Urobilinogen: 0.2 E.U./dL
- Albumin:Creatinine Ratio: N/A

- Protein:Creatinine Ratio: N/A
- Color: yellow
- Clarity: clear

## Assessment

- General Medical Exam, Adult V70.0
- Pap Smear V76.2
- Insomnia 307.40
  Stable
- Anxiety Disorder 300.00
  Only rare use of Xanax- q few weeks.
- Hypercholesterolemia 272.0
  Did not tolerate simvastatin- felt "sick," malaise. trial low dose atorvastatin.
- Microscopic hematuria 599.72
  urology for persistent hematuria. lost to FU in past. discussed risk of bladder cancer.
- Abdominal Radiologic Abnormality 793.6
  see CT report- L adrenal gland abnormality- CT to review along with above.

## Plan

**Orders**

- ECG (12-lead electrocardiogram) (93000) - - 11/10/2014
- Hillcrest Profile (HCFP PRO) - - 08/16/2015
  - General health panel This panel must include the following: Comp (80050) - - 08/16/2015
  - Lipoprotein, direct measurement; high density cholesterol (HDL c (83718) - - 08/16/2015
- Urine culture (87086) - - 11/10/2014

**Instructions**

- Recommend regular exercise
- Recommend working on weight loss as we discussed
- Recommend a heart healthy diet
- Schedule screening mammogram
- The labs you had drawn today should be back within 3 business days. We will call you only if there are abnormalities that we need to discuss.

**Disposition**

- Return Visit Request in/on 3 months +/- 2 days (63255).

**Correspondence**

- Screening Mammogram Order GHS/FHv1 (Jennie C. Cox) - 11/10/2014
- Screening Mammogram Order GHS/FHv1 (Jennie C. Cox) - 02/16/2015

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on February 16, 2015 09:35:19 AM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | February 16, 2015 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- f/u anxiety and medication
- declined flu shot
- pt. is still smoking- not interested in smoking cessation

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing out of control feelings and somewhat overwhelmed by keeping up with items at home . She denies difficulty concentrating, difficulty performing routine daily activities, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias. She is not on any therapy or diet
She does not exercise but is very active.
She is not fasting today.

alprazolam expelred- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

## Medication List

alprazolam oral tablet 0.5 mg; Restoril oral capsule 30 mg

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute



[Digital Signature Validated]

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies :** weight loss, weight gain, loss of appetite

**HENT**
- **Denies :** headaches

**Cardiovascular**
- **Denies :** chest pain, dyspnea on exertion

**Respiratory**
- **Denies :** shortness of breath

**Gastrointestinal**
- **Denies :** nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies :** rash, itching

**Neurologic**
- **Denies :** tingling or numbness

**Musculoskeletal**
- **Denies :** additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies :** polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies :** additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 02/16/2015 | 08:56 AM | 106/47 | Sitting | | | | 82 - R | | 97.8 | 108lbs 6oz | 5' 6" | 17.49 | 1.51 | | |

## Physical Examination

**Constitutional**
- **Appearance :** well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae :** conjunctiva normal
- **Sclerae :** sclera white
- **Pupils and Irises :** pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort :** breathing unlabored
- **Auscultation of Lungs :** normal breath sounds

**Cardiovascular**
- **Heart :**
  - **Auscultation of Heart :** regular rate and rhythm, no murmurs present
- **Peripheral Vascular System :**
  - **Extremities :** no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination :** non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection :** no rashes present, no lesions present, no areas of discoloration present
- **General Palpation :** no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination :**
  - **Orientation :** oriented
  - **Memory :** memory intact
- **Cranial Nerves :** cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight :** judgement and insight intact
- **Mood and Affect :** normal, appropriate

## Assessment

- Depression Stable 311
- Insomnia Stable 307.40
- Anxiety Disorder Stable 300.00
- Hypercholesterolemia Stable 272.0
  has been off medicine since CPE 2011 b/c labs were normal. will call with results
- Tobacco Abuse 305.1

## Plan

**Medications**

- alprazolam oral tablet 0.5 mg
  SIG: take 1 tablet (0.5 mg) by oral route 3 times per day
  DISP: (30) tablets with 2 refills
  **Refilled on 02/16/2015**

- Restoril oral capsule 30 mg
  SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
  DISP: (30) capsules with 5 refills
  **Refilled on 02/16/2015**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- CPX
- Return Visit Request in/on 9 months +/- 2 days (67329).

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on February 16, 2015 09:45:41 AM


[Digital Signature Validated]

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | August 24, 2015 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- Pt needs medications refilled.
- Pt declines to discuss smoking cessation.

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.
She does not exercise but is very active.
She is not fasting today.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; usiing alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Adenoidectomy | -- | -- |
| Appendectomy | ? at time of ooph | -- |
| Colonoscopy | 8/16/04 | int/ext hemmorhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wtih emesis) |
| EGD | 10/04 | mild erythema |
| hystw/oooph | age 20s/ 1990s | hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery |
| jaw surgery | 5/2012- multiple surgerie | Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist |
| Lysis of adhesions | 1990s | bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Blouin |

and May

| Tonsillectomy | -- | -- |
|---|---|---|

## Medication List

alprazolam oral tablet 0.5 mg; Restoril oral capsule 30 mg

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies** : weight loss, weight gain, loss of appetite

**HENT**
- **Denies** : headaches

**Cardiovascular**
- **Denies** : chest pain, dyspnea on exertion

**Respiratory**
- **Denies** : shortness of breath

**Gastrointestinal**
- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies** : rash, itching

**Neurologic**
- **Denies** : tingling or numbness

**Musculoskeletal**
- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m$^2$ | BSA m$^2$ | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 08/24/2015 | 08:30 AM | 103/67 | Sitting | | | | 97 - R | | 97.8 | 109lbs 6oz | | | | | |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**
- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present

- **Peripheral Vascular System :**
  - **Extremities :** no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination :** non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection :** no rashes present, no lesions present, no areas of discoloration present
- **General Palpation :** no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination :**
  - **Orientation :** oriented
  - **Memory :** memory intact
- **Cranial Nerves :** cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight :** judgement and insight intact
- **Mood and Affect :** normal, appropriate

## Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia Stable 272.0/E78.0
  has been off medicine since CPE 2011 b/c labs were normal. will call with results
- Tobacco Abuse 305.1/Z72.0

## Plan

**Medications**
- alprazolam oral tablet 0.5 mg
  SIG: take 1 tablet (0.5 mg) by oral route 3 times per day
  DISP: (30) tablets with 3 refills
  **Refilled on 08/24/2015**

- Restoril oral capsule 30 mg
  SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
  DISP: (30) capsules with 5 refills
  **Refilled on 08/24/2015**

**Instructions**
- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**
- CPX
- Return Visit Request in/on 6 months +/- 2 days (76317).

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on August 24, 2015 09:07:17 AM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | March 3, 2016 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U Depression
- Anxiety

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.
She does not exercise but is very active.
She is not fasting today.

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchaged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; using alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low back pain

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Adenoidectomy | -- | -- |
| Appendectomy | at time of ooph | -- |
| Colonoscopy | 8/16/04 | int/ext hemmorhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wtih emesis) |
| EGD | 10/04 | mild erythema |
| hystw/oooph | age 20s/ 1990s | hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery |

| | | |
|---|---|---|
| jaw surgery | 5/2012- multiple surgerie | Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr CObb- oral surgeon, Dr Ridgill prosthetic orthodontist |
| Lysis of adhesions | 1990s | bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May |
| Tonsillectomy | -- | -- |

## Medication List

| Name | Date Started | Instructions |
|---|---|---|
| alprazolam 0.5 mg oral tablet | 08/24/2015 | take 1 tablet (0.5 mg) by oral route 3 times per day |
| Restoril 30 mg oral capsule | 08/24/2015 | take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days |

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies** : weight loss, weight gain, loss of appetite

**HENT**
- **Denies** : headaches

**Cardiovascular**
- **Denies** : chest pain, dyspnea on exertion

**Respiratory**
- **Denies** : shortness of breath

**Gastrointestinal**
- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies** : rash, itching

**Neurologic**
- **Denies** : tingling or numbness

**Musculoskeletal**
- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 03/03/2016 | 12:43 PM | 104/68 | Sitting | | | | 81 - R | | 94.8 | 101lbs 6oz | | | | | |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal

- **Sclerae :** sclera white
- **Pupils and Irises :** pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort :** breathing unlabored
- **Auscultation of Lungs :** normal breath sounds

**Cardiovascular**
- **Heart :**
  - **Auscultation of Heart :** regular rate and rhythm, no murmurs present
- **Peripheral Vascular System :**
  - **Extremities :** no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination :** non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection :** no rashes present, no lesions present, no areas of discoloration present
- **General Palpation :** no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination :**
  - **Orientation :** oriented
  - **Memory :** memory intact
- **Cranial Nerves :** cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight :** judgement and insight intact
- **Mood and Affect :** normal, appropriate

## Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40/F51.9
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia Stable 272.0/E78.0
  has been off medicine since CPE 2011 b/c labs were normal. will call with results
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
  routine cancer screening- mammo, chest CT. add remeron for appetite. will be out of work this week to see how responds to meds prior to resume driving.

## Plan

**Orders**
- General health panel This panel must include the following: Comp (80050, 80050) - - 03/03/2016

**Medications**
- mirtazapine 7.5 mg oral tablet
  SIG: take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks
  DISP: (60) tablets with 5 refills
  **Prescribed on 03/03/2016**

- Restoril 30 mg oral capsule
  SIG: take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days
  DISP: (30) capsules with 5 refills
  **Refilled on 03/03/2016**

**Instructions**
- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**
- Return Visit Request in/on 1 month +/- 2 days (85474).

**Correspondence**
- Work/School Excuse (Pain v3.6)FHv1 (Jennie C. Cox) - 03/03/2016

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on March 3, 2016 01:39:50 PM


[Digital Signature Validated]

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | March 11, 2016 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U to discuss lab and CT Scan results.

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is not currently experiencing any additional or new symptoms. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, and loss of interest in pleasurable activities. She has no current issues exacerbating the condition. She is not currently seeing a therapist. This patient feels that she is able to care for himself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.
She does not exercise but is very active.
She is not fasting today.

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.
ate more this week since home.
mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchaged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; usilng alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

## Medication List

| Name | Date Started | Instructions |
|---|---|---|
| alprazolam 0.5 mg oral tablet | 08/24/2015 | take 1 tablet (0.5 mg) by oral route 3 times per day |
| mirtazapine 7.5 mg oral tablet | 03/03/2016 | take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks |
| Restoril 30 mg oral capsule | 03/03/2016 | take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days |

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

| Disease Name | Relative/Age | Notes |
|---|---|---|
| Alzheimer's Disease | / Aunt/ Grandmother (maternal)/ Mother/ | -- |
| DM Type II | / Aunt/ Uncle/ | -- |
| Myocardial Infarction, Acute | / Father/70 | -- |

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**
- **Denies :** weight loss, weight gain, loss of appetite

**HENT**
- **Denies :** headaches

**Cardiovascular**
- **Denies :** chest pain, dyspnea on exertion

**Respiratory**
- **Denies :** shortness of breath

**Gastrointestinal**
- **Denies :** nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies :** rash, itching

**Neurologic**
- **Denies :** tingling or numbness

**Musculoskeletal**
- **Denies :** additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies :** polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies :** additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/$m^2$ | BSA $m^2$ | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 03/11/2016 | 03:53 PM | 88/54 | Sitting | | | | 86 - R | | 98.2 | 103lbs 8oz | 5' 6" | 16.71 | 1.48 | | |



[Digital Signature Validated]

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**
- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
  - **Extremities** : no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination** :
  - **Orientation** : oriented
  - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

## Assessment

- Depression Stable 311/F32.9
- Insomnia Stable 307.40/F51.9
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia 272.0/E78.0
  willing to resume statin.
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
  routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can continue to gain weight off work x 1 more week. will refer back to surgeon.

  DR Fowler

## Plan

**Orders**
- General health panel This panel must include the following: Comp (80050, 80050, 80050) - - 06/11/2016

**Medications**
- atorvastatin 40 mg oral tablet
  SIG: take 1/2 tablet daily, increase after 2 weeks to 1 full tablet qhs if tolerated
  DISP: (30) tablets with 11 refills
  **Prescribed on 03/11/2016**

**Instructions**
- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**
- CPX
- Two appointments:
- Return Visit Request in/on 3 months +/- 2 days (85862).

**Correspondence**

- Work/School Excuse (Pain v3.6)FHv1 (Jennie C. Cox) - 03/11/2016

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on March 11, 2016 05:23:25 PM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | March 22, 2016 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U on Weight Loss

## History Of Present Illness

The patient returns for follow up of Her depression and Insomnia Since the last visit She has been doing about the same. She is currently taking the following prescription medications: alprazolam oral tablet 0.5 mg, Restoril oral capsule 30 mg, and as below She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety and sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing depression, insomnia, irritability, out of control feelings, fatigue, weight loss, loss of appetite, and loss of interest in pleasurable activities. The patient reports losing 25 pounds loss over the past 2 years- gradually gaining back, slowly, still difficulty eating. She denies difficulty concentrating and difficulty performing routine daily activities. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.
She does not exercise but is very active.
She is not fasting today.

3/21/16: does not feel she have the energy to return to work; feels overwhelmed

Feels she cannot work becuase does not have the energy; reports she can do the driving; out/ in the truck, opening/ closing doors, securing the freight;

decreased endurance / strenght to maintain position

If runs to Florida, takes 10-11 hrs driving straight, get freight off, empty, hand out 5-6 hours; go to Savannah, then return to Greeville; in 7 days, take 34 hour break;

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.
ate more this week since home.
mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchaged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; usilng alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours. no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

## Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**

- **Denies** : weight loss, weight gain, loss of appetite

**HENT**
- **Denies** : headaches

**Cardiovascular**
- **Denies** : chest pain, dyspnea on exertion

**Respiratory**
- **Denies** : shortness of breath

**Gastrointestinal**
- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies** : rash, itching

**Neurologic**
- **Denies** : tingling or numbness

**Musculoskeletal**
- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**
- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
  - **Extremities** : no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination** :
  - **Orientation** : oriented
  - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

## Assessment

- Depression Worsening 311/F32.9
  Suspect contributing to appetite issues / wt loss. agreeable to adding fluoxetine. feels unable to maintain current intensity of job due to lost endurance, strength with low weight.
- Insomnia Worsening 307.40/F51.9
  wants to consider changing med to Lunesta- will reassess at FU.
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia 272.0/E78.0
  willing to resume statin.
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
  routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can

continue to gain weight off work x 1 more week. will refer back to surgeon.

DR Fowler

## Plan

**Orders**

- General health panel This panel must include the following: Comp (80050, 80050, 80050, 80050) - - 03/22/2016 - - (Future Order)

**Medications**

- fluoxetine 20 mg oral tablet
  SIG: take 1 tablet (20 mg) by oral route once daily for 30 days
  DISP: (30) tablets with 11 refills
  **Prescribed on 03/22/2016**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- Return Visit Request in/on 2 weeks +/- 2 days (86404).

**Correspondence**

- Work/School Excuse (Pain v3.6)FHv1 (Jennie C. Cox) - 03/22/2016

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on March 22, 2016 05:44:40 PM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | April 7, 2016 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U to discuss Depression and Anxiety Disorder.
- Pt declines to discuss smoking cessation.

## History Of Present Illness

The patient returns for follow up of Her depression and insomnia Since the last visit She has been doing better She is currently taking the following prescription medications: alprazolam 0.5 mg oral tablet, fluoxetine 20 mg oral tablet, Restoril 30 mg oral capsule, and taking Prozac and Restoril daily; no Xanax She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: anxiety, sadness, and weight loss. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing fatigue, loss of appetite, and loss of interest in pleasurable activities. She denies difficulty concentrating, difficulty performing routine daily activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: a chronic medical illness. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

She also returns today for routine follow-up of lipid issues. Overall, the patient states she is doing well and has no complaints at this time. She specifically denies chest pain, abdominal pain, nausea, diarrhea, and myalgias.
She does not exercise but is very active.
She is not fasting today.

4/7: tried to wean out restoril. did not sleep for 3 days strainght. nausea with onset of prozac, now appetite starting to return. believes she will begin to gain weight. believes she will never be able to push like she used to, does hope to return to work. before would come home, go right back out and cut the lawn. believes she was in the middle of nervous breakdown, finally coming to terms with her accident.

3/21/16: does not feel she have the energy to return to work; feels overwhelmed

Feels she cannot work becuase does not have the energy; reports she can do the driving; out/ in the truck, opening/ closing doors, securing the freight;

decreased endurance / strenght to maintain position

if runs to Florida, takes 10-11 hrs driving straight, get freight off, empty, hand out 5-6 hours; go to Savannah, then return to Greeville; in 7 days, take 34 hour break;

3/11/2016: trouble chewing; throughout mouth, L side feels numb, R side primary used for chewing; still using ensure 1-3 bottles/ day.
ate more this week since home.
mammo not done yet

CVS augusta

3/2016: went from running team driving, now single since Oct 2015. Physically/ mentally wearing her out. Input unchaged from prior. Still uncomfortable to eat- teeth not lined up. Eats lots of mashed potatoes, grilled chicken, green beans. 1 meals/ day. Only ensure remainder of day.

8/2015: takes restoril when has at least 10-12 hours off, partner drives; usiing alprazolam few times/ week

May 2012, 2 plates in mandible, when put studs in for teeth and removed plates, new knot last October, oral surgeon Dr Cobb sent to Dr Fowler, took out the plate in June

previous visit: alprazolam expeired- has been out x 1 month; normally usues 1-2 x/week- usu on Wenesdays to unwind or on Saturday if kids pushing her. ; restoril takes nightly. 10 hours + off between driving, usu 14 hours . no grogginess.

previous visit: Oral surgery this thursday- 6 studs in upper plate

Has lost sign amount weight

Broke jaw wired mouth shut- 5/31/2012

## Past Medical History

| Disease Name | Date Onset | Notes |
|---|---|---|
| Abdominal Radiologic Abnormality | 3/5/08 | see CT report- L adrenal gland abnormality |
| Anxiety Disorder | -- | -- |
| Bone Infection | 2001 | Dr. devault- I & D ? R hamstring insertion/ infection. a/w overuse unloading hand truck. infxn noted upon re-attachment of hamstring per pt? |
| Hypercholesterolemia | 11/26/2010 | h/o given. willing to work on diet/ exercise. re check 4 mos. Did not tolerate simvastatin- felt "sick," malaise |
| Insomnia | -- | -- |
| Irritable Bowel Syndrome | 2004-2007 | w/u by GI Assoc- for IBS- Hartley- upper GI, small bowe series, U/S, HIDA Scan 2004-2007 |
| Joint Pain | -- | -- |
| Low Back Pain | -- | ? HNP L5/s1 |

## Past Surgical History

| Procedure Name | Date | Notes |
|---|---|---|
| Adenoidectomy | -- | -- |
| Appendectomy | ? at time of ooph | -- |
| Colonoscopy | 8/16/04 | int/ext hemmorhoids; tortuous colon- Dr. Hartley- FU 10 yrs. (Refuses more scopes, b/c hospitalized after wtih emesis) |
| EGD | 10/04 | mild erythema |

| | | |
|---|---|---|
| hystw/ooph | age 20s/ 1990s | hyst for bleeding; took out ovaries later b/c of adhesions to colon and previous tubal surgery |
| jaw surgery | 5/2012- multiple surgerie | Lower jaw crushed in accident (machine fell off truck onto her) 5/2012- plate, studs, screws- Dr Folwer + Dr COBb- oral surgeon, Dr Ridgill prosthetic orthodontist |
| Lysis of adhesions | 1990s | bladder adhesions to colon after hyst/ ooph surgeries- x3 Dr Biouin and May |
| Tonsillectomy | -- | -- |

## Medication List

| Name | Date Started | Instructions |
|---|---|---|
| alprazolam 0.5 mg oral tablet | 03/14/2016 | take 1 tablet (0.5 mg) by oral route 3 times per day |
| atorvastatin 40 mg oral tablet | 03/11/2016 | take 1/2 tablet daily, increase after 2 weeks to 1 full tablet qhs if tolerated |
| fluoxetine 20 mg oral tablet | 03/22/2016 | take 1 tablet (20 mg) by oral route once daily for 30 days |
| mirtazapine 7.5 mg oral tablet | 03/03/2016 | take 1 tablets by oral route Qhs, increase to 2 tabs if tolerated after 1-2 weeks |
| Restoril 30 mg oral capsule | 03/03/2016 | take 1 capsule (30 mg) by oral route once daily at bedtime as needed for 30 days |

## Allergy List

| Allergen Name | Date | Reaction | Notes |
|---|---|---|---|
| Magnesium | -- | -- | -- |
| Nickel | -- | ?metal allergy? | -- |
| Simvastatin | -- | malaise | -- |
| Ultram | -- | -- | -- |

## Family Medical History

| Disease Name | Relative/Age | Notes |
|---|---|---|
| Alzheimer's Disease | / Aunt/ Grandmother (maternal)/ Mother/ | -- |
| DM Type II | / Aunt/ Uncle/ | -- |
| Myocardial Infarction, Acute | / Father/70 | -- |

## Social History

| Finding | Status | Start/Stop | Quantity | Notes |
|---|---|---|---|---|
| Children | -- | --/-- | -- | 2 daughters |
| Divorced | -- | --/-- | -- | -- |
| Grandchildren | -- | --/-- | -- | 5 gkids- 3 girls, 2 boys; had gson oldest that lost 2008; 2 younger girls (Madison 12, Emily 7) with same mom (tammy); oldest 40 yo Sonya- with twin brother and son (17 yo) Marthew and Meghan), older brother died- Michael -was at 16 yo from MVA |
| Nondrinker | -- | --/-- | -- | -- |
| Smoker | -- | --/-- | 2 ppd | -- |
| Tobacco | Current every day | 18/-- | 2 PPD | -- |
| Truck Driver | -- | --/-- | -- | -- |

## Review of Systems

**Constitutional**
- **Denies** : weight loss, weight gain, loss of appetite

**HENT**
- **Denies** : headaches

**Cardiovascular**
- **Denies** : chest pain, dyspnea on exertion

**Respiratory**
- **Denies** : shortness of breath

**Gastrointestinal**
- **Denies** : nausea, vomiting, diarrhea, abdominal pain, jaundice

**Integument**
- **Denies** : rash, itching

**Neurologic**
- **Denies** : tingling or numbness

**Musculoskeletal**
- **Denies** : additional musculoskeletal symptoms except as noted in the HPI

**Endocrine**
- **Denies** : polyuria, polydipsia, cold intolerance, heat intolerance

**Psychiatric**
- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Vitals

| Date | Time | BP | Position | Site | L\R | Cuff Size | HR | RR | TEMP(°F) | WT | HT | BMI kg/m² | BSA m² | O2 Sat | HC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 04/07/2016 | 02:00 PM | 117/70 | Sitting | | | | 75 - R | | 97.8 | 102lbs 4oz | | | | | |

## Physical Examination

**Constitutional**
- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Eyes**
- **Conjunctivae** : conjunctiva normal
- **Sclerae** : sclera white
- **Pupils and Irises** : pupils equal, round, and reactive to light and accommodation bilaterally

**Respiratory**
- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**
- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
  - **Extremities** : no edema or cyanosis

**Gastrointestinal**
- **Abdominal Examination** : non-distended, bowel sounds positive, no appreciable masses, tenderness or organomegaly

**Skin and Subcutaneous Tissue**
- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**
- **Mental Status Examination** :
  - **Orientation** : oriented
  - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

**Psychiatric**
- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

## Assessment

- Depression Improving 311/F32.9

Suspect contributing to appetite issues / wt loss. agreeable to adding fluoxetine. feels unable to maintain current intensity of job due to lost endurance, strength with low weight.

- Insomnia Stable 307.40/F51.9
  wants to consider changing med to Lunesta- will reassess at FU.
- Anxiety Disorder Stable 300.00/F41.9
- Hypercholesterolemia 272.0/E78.0
  willing to resume statin.
- Tobacco Abuse 305.1/Z72.0
- Weight loss 783.21/R63.4
  routine cancer screening- mammo, chest CT. ct normal, mammo pending. some weight gain off week - pt confident she can continue to gain weight off work x 1 more week. will refer back to surgeon.

  DR Fowler
- Fatigue 780.79/R53.83

## Plan

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- Return Visit Request in/on 2 weeks +/- 2 days (87130).

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on April 7, 2016 03:32:09 PM

# Progress Note

| | | | |
|---|---|---|---|
| **Patient Name:** | Jennie Cox | **Visit Date:** | April 22, 2016 |
| **Patient ID:** | 55780 | **Provider:** | Jennifer T. Ellis, MD |
| **Sex:** | Female | **Location:** | Hillcrest Family Practice |
| **Birthdate:** | August 14, 1952 | **Location Address:** | 717 SE Main St<br>Simpsonville, SC 296813237 |
| | | **Location Phone:** | (864) 963-1548 |

## Chief Complaint

- F/U to discuss Depression and Anxiety.
- Pt would like to know if she should be taking both Restoril and Remeron.
- Pt declines to discuss smoking cessation.

## History Of Present Illness

The patient returns for follow up of Her depression Since the last visit She has been doing better She is currently taking the following prescription medications: fluoxetine 20 mg oral tablet She is not taking any over the counter medications for the symptoms. She has been compliant with the medication regiment. She feels like the following symptoms have improved: sadness. And she feels like the following symptoms have worsened: none have worsened. She is is currently experiencing fatigue. She denies difficulty concentrating, difficulty performing routine daily activities, insomnia, loss of interest in pleasurable activities, out of control feelings, and panic attacks. She has the following issues going on that are affecting the condition: job stress. She is not currently seeing a therapist. This patient feels that she is able to care for herself. She currently lives alone.

Taking alprazolam 1-2 x/ week, when feeling worried about how going to get things done

Previously running team (had partner). Reports got more rest. Drive 10 hrs alternating.

Now drives - not supposed to drive over 11hours.

Dedicated run: Left greenville 11 am Monday, returned Wed. Leave again Thursday and return Saturday.

## Past Medical History

Abdominal Radiologic Abnormality; Anxiety Disorder; Bone Infection; Hypercholesterolemia; Insomnia; Irritable Bowel Syndrome; Joint Pain; Low Back Pain

## Past Surgical History

Adenoidectomy; Appendectomy; Colonoscopy; EGD; hystw/oooph; jaw surgery; Lysis of adhesions; Tonsillectomy

## Medication List

alprazolam 0.5 mg oral tablet; atorvastatin 40 mg oral tablet; fluoxetine 20 mg oral tablet; mirtazapine 7.5 mg oral tablet; Restoril 30 mg oral capsule

## Allergy List

Magnesium; Nickel; Simvastatin; Ultram

## Family Medical History

Alzheimer's Disease; DM Type II; Myocardial Infarction, Acute

## Social History

Children; Divorced; Grandchildren; Nondrinker; Smoker; Tobacco (Current every day); Truck Driver

## Review of Systems

**Constitutional**

- **Denies** : weight loss, weight gain, loss of appetite

**HENT**

- **Denies** : headaches

**Neurologic**

- **Denies** : tingling or numbness

**Psychiatric**

- **Denies** : additional psychiatric symptoms except as noted in the HPI

## Physical Examination

**Constitutional**

- **Appearance** : well nourished, well developed, alert, oriented, in no acute distress

**Respiratory**

- **Respiratory Effort** : breathing unlabored
- **Auscultation of Lungs** : normal breath sounds

**Cardiovascular**

- **Heart** :
  - **Auscultation of Heart** : regular rate and rhythm, no murmurs present
- **Peripheral Vascular System** :
  - **Extremities** : no edema or cyanosis

**Skin and Subcutaneous Tissue**

- **General Inspection** : no rashes present, no lesions present, no areas of discoloration present
- **General Palpation** : no abnormalities on palpation, no masses present on palpation, no tenderness to palpation

**Neurologic**

- **Mental Status Examination** :
  - **Orientation** : oriented
  - **Memory** : memory intact
- **Cranial Nerves** : cranial nerves intact bilaterally

**Psychiatric**

- **Judgement and Insight** : judgement and insight intact
- **Mood and Affect** : normal, appropriate

## Assessment

- Anxiety Disorder 300.00/F41.9
  long discussion about relationship between job/ injury/ mood/ weight. believe wt loss / fatigue multifactorial. will increase prozac further to address. encouraged pt to pursue less demanding driving position.
- Weight loss 783.21/R63.4

## Plan

**Medications**

- fluoxetine 40 mg oral capsule
  SIG: take 1 capsule (40 mg) by oral route once daily in the evening for 30 days
  DISP: (30) capsules with 11 refills
  **Adjusted on 04/22/2016**

**Instructions**

- Patient instructed to contact physician if mood disturbance intensifies
- Patient instructed to seek medical help immediately if suicidal or homicidal ideation occur, or if she is unable to care for herself and/or dependents

**Disposition**

- Return Visit Request in/on 2 weeks +/- 2 days (87836).

**Correspondence**

- Work/School Excuse (Pain v3.6)FHv1 (Jennie C. Cox) - 04/22/2016

**Electronically Signed by:** Jennifer T. Ellis, MD -Author on April 22, 2016 03:18:28 PM

GREENVILLE HEALTH SYSTEM

Hillcrest Family Medicine

Robert E. Croker, MD
Francis E. Holdt, MD
Katharine A. Dow, DNP, APRN, FNP-C
David C. Gilliland, MD
Jennifer Ellis, MD
Lindsey Collier, MSN, APRN, FNP-C
Katherine Trotter, MD
Glenna W. Lollis, DNP, APRN, FNP-C

717 S.E. Main St., P.O. Box 1177 • Simpsonville, SC 29681 • (864) 522-5400

DEA#:

Name: Jennie Cox DOB: 8/14/1952

Address: Date:

Tamper-resistant features include safety paper with uniform background color and VOID pantograph, along with refill indicator.

℞ Physical Therapy / Working Hardening.

Dx. ① Body Strengthening
② Fatigue
③ Weakness

☐ 1-24
☐ 25-49
☐ 50-74
☐ 75-100
☐ 100-150
☐ 151 and over
Units: ____

☐ LABEL

REFILL NR 1 2 3 4 5 6

DISPENSE AS WRITTEN — SUBSTITUTION PERMITTED

APA #9
DONALD L. RIDGELL, D.M.D
UPSTATE PROSTHODONTICS, LLC
10/04/12-10/28/15

Yo'r Fab

Date 10/4/12

# Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name Jonnie Cox  Date of Birth 8/14/52

Name wish to be called Jonnie  Marital Status D

Address 222 W. Chapman Rd  Home Phone 864-243-2032

City Belton  State SC  Zip Code 29627

Social Security # 250-94-3648  E-Mail Address NA

Student NA  School NA  Cell 864-304-2723

Employer Palmetto State Transportation  Address 1050 Park West, Greenville SC

Occupation Truck driver  Work Phone 1-800-2690275  Cell

Name of Spouse NA  Employer NA

Person Responsible for Payment Workers Comp Cherokee Insurance

Address Warren MI

Family Physician Dr. Jennifer Ellis  Date of Last Medical Exam 12/11

Previous Dentist Dr. Fowler-Plastic Surg - Greenville SC  Date of Last Dental Exam

Who Referred You to This Office Dr. Cobb

What dental problem caused you to seek treatment at this office? Explain

Accident - May 31, 2012 Broke jaw (L) Side no toothach

Preferred Day of Appointments  Time  AM/PM

## Confidential Medical History

Are you now or have you recently been under a physician's care? Reason accident on job broke jaw

Have you ever been a patient in a hospital or had any serious illness? Explain

Circle any of the following which you have had or suspected: No Health Problems

| | | | | |
|---|---|---|---|---|
| Cancer or Tumors | Tuberculosis | Prolonged Bleeding | Rheumatic Fever | Severe Infections |
| Diabetes | Severe Infections | Heart Trouble | Frequent Thirst | Severe Headaches |
| Heart Murmur | Kidney/Bladder Trouble | Epilepsy | High/Low Blood Pressure | Anemia |
| Thyroid Disease | Chest Pain | Lung Disease | Glaucoma | Venereal Disease |
| Stroke | Pneumonia | Radiation Treatment | Shortness of Breath | Fainting Tendency |
| Asthma or Hay Fever | Blood Diseases | (Tonsils Removed) | Sinus Trouble | Liver Disease |
| Mental Disorders | Hepatitis or Jaundice | Slow Healing | AIDS/HIV Positive | Other |

Are you taking any medications? (list) Restril - Sleep

Medication: Dosage (mg and # per day): 30  Action:

Are you allergic to or suffer ill effects from: (circle) NKDA Lortab - nausea

Penicillin Codeine Nitrous Oxide Aspirin Sedatives Other

Women Only: Are you pregnant? Yes (No) How many months?

DR 10/4/12

Jennie Cox 10-4-12

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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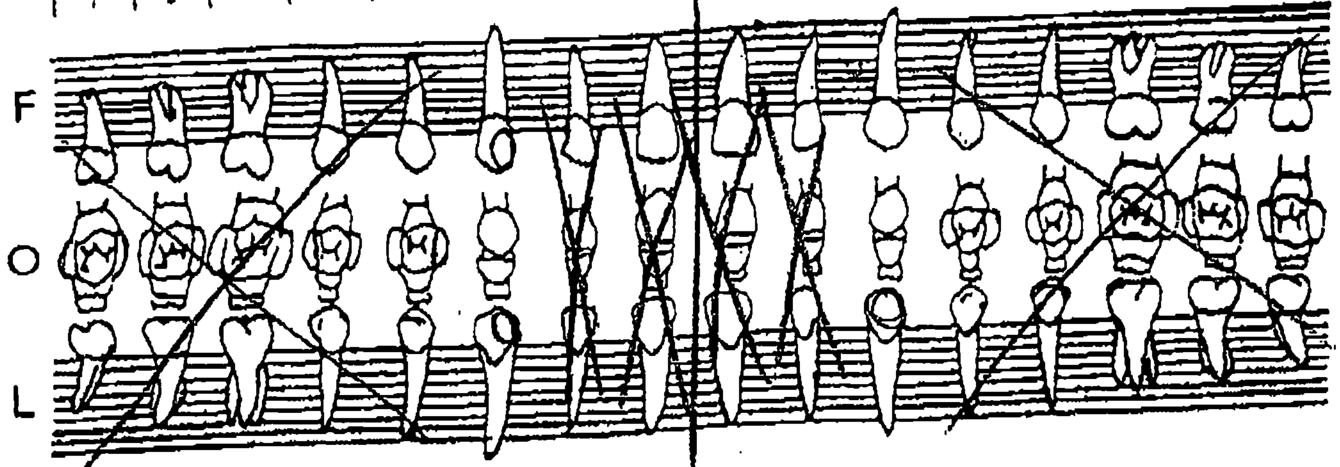


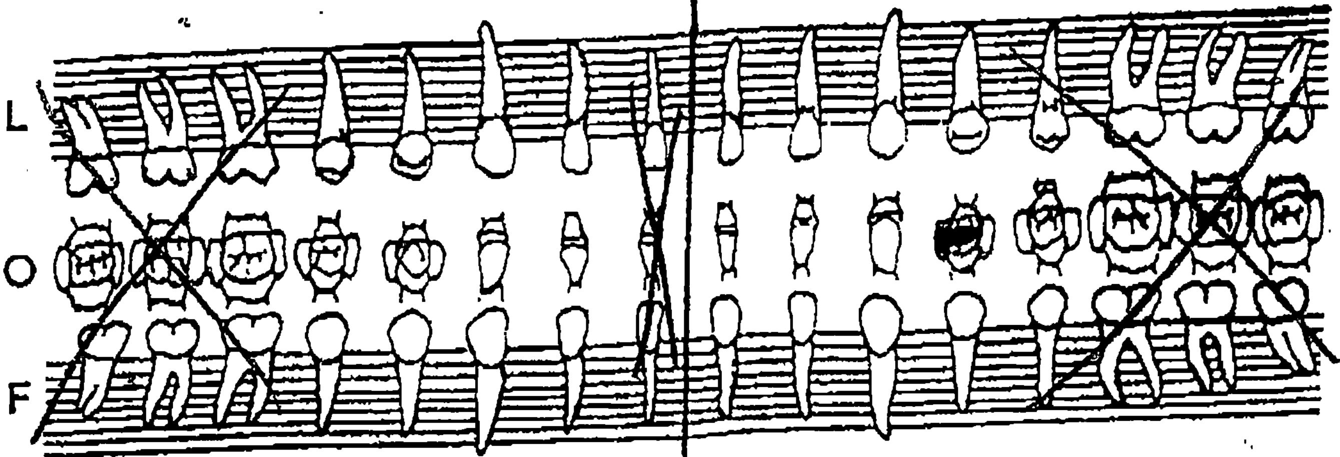


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Comments or notes:

No partial's etc

# Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name: Jennie Cox  Referred by: [illegible]

Gen. Oral Health: Pt 2° Elect. / Post trauma  Personal:

Medical Alert:  BP  P

2012

| Date | Tooth | |
|---|---|---|
| 12/4 | | Med hx w/ noncardiac, totally intelligent. Hx of accident in Atl, GA on 5/31/12. In back of truck on dock - massive [illegible] fell out of truck - hit her on head - broke face (L Cond) (L Jaw, Bruised lung - "lucky to be alive) - on/under clin for time - was seen in Atl, ~~[illegible]~~ ambulance ride to Greenville, Dr Fowler did initial surgery to repair bones - to also took teeth out to allow healing - wired shut - now has teeth. Dr Cobb - he is thinking implants / complete arch restoration of maxill. & mandibular arches. Workman's Comp will be 1° provider. |
| | | D: Multiple missing teeth and 'horrible' occlusal relationship due to fractured jaw and no teeth to interdigitate, some decay but won't be a concern because I agree w/ Dr Cobb, full mouth extract & implant replacement is best solution - teeth probably not in ~~[illegible]~~ best condition prior to accident |
| | | P: see tx plan. will pre-determine to get started |
| 12/12 | | Sent Treatment Est. SL |
| 12/19 | | Emailed copy's of Pre Authorization to Pt's daughter tneely3@ghs.org and to adjustor @ Cherokee Insurance Co. (mdecarolis@cherokeeinsurance.com SL |
| 2013 | | |
| 1/8 | | Received Pre treat. 25% reduction in fee - but will do to help Dr Cobb get case for tx planning services = |
| 1/9 | | Prelims for TX C/TX C, face bow, Shade: 2A |
| | | W: Bite registration |
| 1/10 | | Surgery w/ Cobb scheduled 1/24 @ 8:00 |
| 1/16 | | Bite registration |
| 1/31 | | Cue soft of C/C - immediate post surgery - sinus graft & 2 plate of ML removed. all teeth extracted. Pt seems to be tolerating well. |
| | | NV: 2-3 wks for possible Cue soft |
| 2/11 | | Recheck, smoothed some rough spots, pt doing very well - W: 3 to 4 wks recheck |

| Date | Tooth | |
|---|---|---|
| 1-7 | Tx | C/C adj, C/ under rdge |
| | | /C LL facial |
| | | removed upper sutures - first fixodent use |
| | | NA: 4 WKS |
| 4/4 | | Emailed Cherokee Ins. / Mike DeCarolis to expedite payment for claims SL |
| 1-8 | C/C | pt reports w/ no actual sore spots just has to reapply fixodent to lowers frequently. adj 22 + 27 area. |
| | | pt wants to wait on surg. if possible so she can gain weight - 96 lbs |
| | | Dr R said she can't wait real long or grafting will start disappear. |
| | | we will see her if sore spots, Coe soft needed & she sees Dr [illegible] & they are ready for implants (lower) |
| 1-18 | | prelim appt for impressions to make implant guides for Dr [illegible] |
| | | pt to have implant surg. 4-29-13 |
| | | we will see mid June |
| 6-20 | | pt reports to office after visiting Dr [illegible]'s office. She is now ready to have 6 implants placed on top & uncover 5 implants that were placed on lower. |
| | | Prelims made |
| | | Surg w/ Dr [illegible] 7-17-13 then here at 1:30 |
| | | Coe Soft /C - NA: 7-17-13 |
| 6/20 | | Sent email for /ci treatment to Mike DeCarolis SL |
| 7-17 | | pt reports to office after uncovering by Dr [illegible] - 6 upper 5 lower |
| | | Coe Soft placed on upper + lower |
| | | NA: Start lowers in 10 days |
| | | (FI) |
| 7-29 | /C | FI (5 implants on ↓) w/ Fast Set Aquasil abutments, floss tied to abutments, Triad set |
| | C/ | upper prelim done |
| | | NA: 1) verification jig 2) Wax [illegible] |
| | | 3) JJ 4) D??? /Ci |

# Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name: Jennie Cox  Referred by: 

Gen. Oral Health:  Personal: 

Medical Alert:  BP  P 

2013

| Date | Tooth | |
|---|---|---|
| 8-15 | 1C | verification jig tried in - fit great - replaced healing caps |
| | C/ | wax rim Bite + Shade |
| | | NA: TI |
| 8/21 | | LM for Cherokee Ins Company to call back regarding Claim status for 1C - filed 6/20/13. |
| 8-26 | C/C | removed healing caps + tried verification jig in again - fits great - removed + did try in of teeth - upper teeth protruded out too far - Dr Ridgell reset them - looked better - plugs look great out of mouth but when placed in mouth they are too tall + "cresent moon" (◠) look - Dr Ridgell marked them + said another try in - |
| | | NA: TI 1C (just teeth after removing 30 min (healing caps not verif. jig) |
| 8/27 | | Called Cherokee Ins. Company and spoke to Mike DeCarolis asked about claim status of 6/20/13. He said a check # 416822 was mailed on 6/28/13 in the amount of $6735.00. He will put a tracer on it and call back in 2 days. (800) 201-0450 - Workers Comp / Mike DeCarolis Also emailed final portion of Tx. Plan DOS 8/26/13 to Mr. DeCarolis. SL |
| 8/29 | | Tried to call Mr. DeCarolis to ~~double check~~ follow up on check that was supposedly issued. LM for him to call back (Erin) SL |
| 9-5 | C/C | removed healing caps for try in - (LL post. healing cap had to be replaced after difficulty in removing). try in - midline off + LL was sloping so Dr Ridgell reset them - replaced healing caps w/ topical - |
| | | NA: TI ~~[illegible]~~ [illegible] |

2013 cont.

| Date | Tooth | |
|---|---|---|
| 9-16 | /C | removed healing caps + did another try In. Dr Tidwell moved upper teeth 6 + 8 + now everything looks good + bite is right - (we will start upper about the time lowers are done) NA: 1) Frame Try In 2) Del L Ci |
| 10-14 | | Lower fixed tried in - fit + looks great - upper already informed Pt we will start upper after delivery of lower - Prelim C/ NA: 1) Del L fixed 2) FI C/ |
| 10-24 | /Ci | delivered lower fixed detachable torqued screws - Fermit placed, pink acrylic + A2 herculite. adj. Bite on Tx C/ to fit new lower. NA: FI C/ (w/ bar) |
| 11-7 | | FI C/ w/ 3i Certain Analogs + Fast Set Aquasil - replaced healing caps NA: WR C/ + verif. jig try In / TI / 3WKS / Bar TI / 2WKS / FTI 3.3.14 / TI / Del / WPD |
| 12/2 | C/i | Wax Rim and verification jig for bars - W: Tryin - |
| 12/9 | C/i | Tryin of C/i, W: Bar tryin |
| 2014 3-3 | C/i | Bar Try In - (very sore tissue due to not removing for awhile + tissue grew up around healing caps) - topical + used - NA: Del C/ - Dr Tidwell said no more try ins - straight to delivery - |

# Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Name: Jennie Cox Referred by: ____________

Gen. Oral Health: ____________ Personal: ____________

Medical Alert: ____________ BP ______ P ______

2014 cont.

| Date | Tooth | |
|---|---|---|
| 3-17 | C/ | Del. denture after removing healing caps & placing Bars in - Torqued screws & fermit placed - adj. made to dentures to snap in - fit great - homecare kit given - NA: WPP |
| 3-24 | C/ | adj. made to UR ling where metal at end of denture was rubbing tongue raw - pt said teeth were a little loose - replaced 2 (posterior both sides) lock clips - |
| 6-2 | C/C | pt reports for 3 month recheck on c/ - all implants doing good on top - cleaned/polished denture & [illegible] on upper - prophy'd lower fixed due to [illegible] - pt reports food getting trapped under lower teeth - normal occurrence - Pt. advised that replacement of teeth usually takes place every 7-10 yrs and cleanings are due every 6 months - NA: 6 months 1 hr appt to remove lower fixed appliance + polish/clean bar + abutments - |
| 10-23 | | Walk In - pt stopped by for us to check/feel LL jaw - It feels like plate/screws sticking out from original [illegible]. Panorex made - Referred to Dr. [illegible] to eval/treat - appt Mon. 10-27-14<br>Amox 500mg X4D CVS 299-0231 |
| 12-8 | | 6 month recall for cleaning - removed lower fixed & cleaned denture in ultrasonic - lower had mild to moderate plaque & upper bar had light calculus - cleaned [illegible] [illegible] replaced lower [illegible] |

| Date | Tooth | |
|---|---|---|
| 12-8 | Cont | w/ white tape, flexi #18 area mlg, A2 + pink acrylic - upper replaced #3 area flexi. CA screening neg, joints clear - pt still has "knot" LL jaw area + Dr told said he could remove but pt not sure if she wants it done. |
| 2015 | | |
| 2/9 | | Faxed all records to The Mims Law Firm SC |
| 4/9 | | Sent WC Form 14B to the Mims Law Firm SC |
| 4/14 | | Faxed all records to McKay, Cauthen, Settana + Stubley, PA. Also mailed copies. SC |
| 6-8 | | 6 months recall on lower fixed detachable - removed (5 screws) + cleaned C/C in ultrasonic - polished upper bar in mouth (pt has never brushed upper bar - went over hygiene w/ her) replaced screws, white tape - flexi #18 area - pink, Trial + A2 Recalibrate |
| 6-22 | / C | pt reports for us to remove lower fixed detachable - she will have surgery in the A.M. by Dr. Fowler - He hopes to go through LL area + hopefully release any tissue + possibly debride any infection if there is any. pt will stay overnight - holding appliance - we will see as needed. |
| 6/23 | | Phone conv. w/ Dr Cobb. Dr Fowler is asking her to remove Lt post implant but he is not sure why - Jennie is in hospital for scar revision surgery for hypertrophic scar under Lt mand [illegible] |
| 7-29 | / C | pt reports to let Dr Lidgell look at lower to see if pt is ready to have fixed detachable replaced. Dr. Fowler wants Dr Lidgell to make the decision - we replaced lower w/ pink acrylic, A2 tape + flexi. NA: Dec for cleaning |
| 11/28 | | Faxed ledger + copy of notes to McKay, Cauthen, Settanna + Stubley, PA - Copy in chart. SC |

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

# Physician's Statement

Claimant's Name: Jennie Cox

Employer's Name: Palmetto State Transportation

Physician's Name: Donald L. Ridgell, D.M.D.

Insurance Carrier: Cherokee Insurance Company

Practice/Clinic: Upstate Prosthodontics

SCWCC File No: 1206236

Preparer's Name: Donald Ridgell

Phone: 864 2323882

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

**Date of Injury or Illness:** May 31, 2012

Date of first office visit: 10/4/12 Date of last visit: 12/8/14

Diagnosis or nature of injury or illness: Missing teeth/bone of jaws from trauma

Body part(s) injured: maxilla/mandibular jaws Body part(s) affected: Teeth/maxillae/mandible

Date of **Maximum Medical Improvement**: 6/12/14

Based on the **AMA Guidelines**, the claimant has sustained a ______ **% medical impairment** to ______ injured body part(s) and a ______ **% medical impairment** to ______ other affected body part(s). Surgeon to rate

✓ The claimant is **able to return to work** without restriction.

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

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

_____ Claimant **possesses retained hardware** casually related to this injury.

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

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

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

Maintenance procedure annually - more expensive than natural teeth
Replace or refurbish appliances every 6-8 yrs.
Oral Surgeon visit 5 yrs for radiograph / CT scan

[signature]
**Treating Physician**

4/9/15
**Date**

APA #10
LARRY W. COBB, D.M.D
PIEDMONT ORAL SURGERY
10/30/12-10/27/16

October 30, 2012

RE: Jennie Cox

Workers Compensation #: WC34192

To Whom It May Concern:

Mrs. Jennie Cox has had a full work up including a physical examination and CBCT evaluation to determine the treatment necessary to restore her teeth for maximum function. She has a very complicated case secondary to her normal petite size and small jaws. This has been further compromised by the very significant jaw injuries including multiple bone fractures and loss of teeth. Her remaining teeth are terminal due to the lack of bone support. These will all have to be removed. She has very minimal maxillary bone and will lose more when her teeth are removed. She will require extensive bone grafting before any definitive treatment can be achieved. Either one or both bone plates will need to be removed from the mandible before any treatment can be implemented there as well.

The following treatment will be necessary to enable restoration to as near normal function as possible.

Stage I:

| | |
|---|---|
| Anesthesia: **D9220** | $ 355.00 |
| Surgical removal of teeth #s 4,6, and 11: **D7210** | $ 645.00 |
| Bilateral sinus lift @ $3200.00 each side:**D7940** | $6400.00 |
| Stage I Total Charges: | $7400.00 |

Stage II:

| | |
|---|---|
| Anesthesia **D9220** | $ 355.00 |
| Surgical removal #s 21,22,26,27,28,&29 **D7210** | $1290.00 |
| Removal of superior bone plate **D7997** | $ 600.00 |
| Possible removal inferior bone plate **D7997** | $ 600.00 |
| Stage II Total Charges: | $2845.00 |

Stage III:

| | |
|---|---|
| Re-evaluate with CBCT:**D0363** | $250.00 |
| Plan implant placement with CAD/CAM surgical guide fabrication @ $400.00 each **D5982** | $800.00 |
| Stage III Total Charges: | $ 1050.00 |

Stage IV:

| | |
|---|---|
| Placement of 6 maxillary implants: **D6010** | $12,435.00 |
| Placement of 5 mandibular implants **D6010**: | $10,485.00 |
| Stage IV Total Charges: | $22,920.00 |

Stage V:

Uncover implants and release patient for definitive prosthetic rehabilitation

Total Charges for Restoration/Implant Process: $34,215.00
Fees for prosthetic work will need to be obtained from Dr. Donald Ridgell

Please feel free to call our office at 864-271-9990 with any questions that you may have.

Sincerely,
Larry W. Cobb, DMD

COX, JENNIE H. 34513
222 W. CHAPMAN ROAD

BELTON, SC 29627
Home: (864)243-0032 Work: (800)269-0174
Age : 59 DOB: 08/14/1952
Ref : COFER, DR. W. A. (864)877-1891

REF OG2030
LOT CMSM13K1 2015-08
Manufacturer: Collagen Matrix, Inc.

OssegGuard Flex™
REF OGF1520
LOT 2014-11
Manufacturer: Collagen Matrix, Inc.

222 W. CHAPMAN ROAD

BELTON, SC 29627
Home: (864)243-8832 Work: (800)269-8174
Age : 60 DOB: 08/14/1950
Ref : ~~COOPER, DR. W. H.~~ (864)877-1891
Dr. [illegible]

ID: [illegible]
[illegible]
2.0 cc
[illegible]

OsseoGuard® [illegible]
REF OG2030
LOT [illegible] 2015-08
Manufacturer: Collagen Matrix, Inc.

OsseoGuard Flex™ [illegible]
REF OGF1520
LOT BCMU12M2 2014-11
Manufacturer: Collagen Matrix, Inc.

COX, JENNIE M. 24513
222 N. CHAPMAN ROAD (630-5004)

BELTON, SC 29627
Home: (864)243-0232 Work: (800)269-0174
Age : 60 DOB: 08/14/1952
Ref : RIDDELL, DONALD L. (864)222-3888

COX, JENNIE M. 34513
222 W. CHAPMAN ROAD

BELTON, SC 29627
Home: (864)243-0032 Work: (800)269-0174
Age : 60 DOB: 08/14/1952
Ref : RIDGELL, DONALD L. (864)232-3882

ALLERGIC TO Magnesium Metal

FEE ESTIMATE ____________ DEPOSIT ____________

COMPLAINT ____________

PURPOSE OF EXAM ____________
have 3 D scan

LOCAL ☐ GENERAL ☐

| DATE | |
|---|---|
| 7-17-13 | NPO p MN |
| | 96/60 |
| | Diazepam 5 mg |
| | Meperidine 50mg / Phenergan 12.5mg — PO @ 10am |
| | Meperidine 50 mg |
| | Methohexital 110 mg |
| | Decadron 8 |
| | Ketamine 8 |
| | 8 carp .5% Marcaine 1:200,000 epi |
| | 4 (10) Chromic |
| | Uncovered lower implants + placed — 4X11.5 4X11.5 4X11.5 4X11.5 4X11.5 4X11.5 |
| | H/A 4/4/4 on all |
| | Implants placed c anatomage guide |
| | Encode healing abutments placed - sizes noted on stickers |
| | XIFNT411 #3 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | XIFNT411 #11 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | #3 ENCODE® IBHA444 1124619-ON |
| | ENCODE® #5 IBHA443 1101843-ON |
| | #13 ENCODE® IBHA444 1124619-C |
| | XIFNT411 #5 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | XIFNT411 #12 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | ENCODE® #6 IBHA443 1124555-ON |
| | #12 ENCODE® IBHA444 1124619- |
| | XIFNT411 #6 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | XIFNT411 #14 2013030065 BIOMET 3I™ 2018-03 OSSEOTITE® Tapered Certain® Implant 4 X 11.5mm |
| | #14 ENCODE® IBHA446 1080437-ON |
| | 7-29 appt |
| 7.29.13 | Pt did not come in for appt today LM message on Tommy's cell phone # |
| 7-31-13 | Healing well, return in 4 months |
| | go back to work 8-12 Pt will call back for appt |
| | Will need 3-D scan + coordinate uncovering @ next visit |
| | 11-13-13 @ 2 |

Phenergan 25 mg x 2
Lortab 7.5 X 30
Amoxil 500 mg x 21
Peridex Extra
Benadryl 25 mg

OX, JENNIE M. 34513
22 W. CHAPMAN ROAD

ELTON, SC 29627
ome: (864)243-0032 Work: (800)269-0174
ge : 60 DOB: 08/14/1952
ef : RIDGELL, DONALD L. (864)232-3882

ALLERGIC TO Magnesium Metal

FEE ESTIMATE ______ DEPOSIT ______

COMPLAINT ______

PURPOSE OF EXAM ______

LOCAL ☐ GENERAL ☐

| DATE | |
|---|---|
| 11-13-13 | 3-D Scan – Healed well, all uncovered – may complete restorative |
| 10-27-14 | 3-D- Scan – Pt has sore bump at left inf. lat. border – firm non mobil – appears to be end of plate – Pt has pain + swelling – tx'd with [illegible] over the weekend – Scan shows small lip of bone over the end of the plate. If she cont to have pain we may try to remove the terminal screw + eval for small area of bone reduction. |

1-31-13 D

## ALLOGRAFT TRACKING FORM

FDA Regulations and Joint Commission Standards require tissue tracking systems in all hospitals, clinics and doctor's offices using allograft for transplantation. In order to comply with these requirements, please complete ALL fields on this form and fax to (937) 222-2538.

Patient's Last Name: Cox First: Jennie MI: M

Date of Birth: 8/14/1952 Sex: F Patient ID: 34513

Hospital/ Clinic/ Doctor's Office: Piedmont Oral Surgery

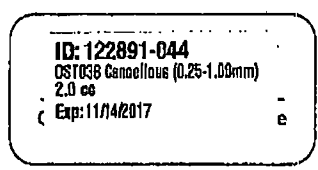
Physician: Dr. Larry Cobb Surgery Date: 1/31/13

Surgical Procedure: Bilateral Sinus graft

Completed by: C Johnson RN Date: 1/31/13

Comments:

*Place peel off label or write tissue ID# in the space provided. One patient, one procedure per tracking form.*


ID: 122891-044
OST038 Cancellous (0.25-1.00mm)
2.0 cc
Exp: 11/14/2017

*Retain this completed document with the patient's file.*

FAXED 1-31-13

## ALLOGRAFT TRACKING FORM

FDA Regulations and Joint Commission Standards require tissue tracking systems in all hospitals, clinics and doctor's offices using allograft for transplantation. In order to comply with these requirements, please complete ALL fields on this form and fax to (937) 222-2538.

Patient's Last Name: Jennie Cox First: ______ MI: M

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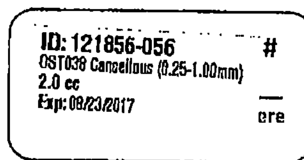
Physician: Dr. Larry Cobb Surgery Date: 1/31/13

Surgical Procedure: Bilateral sinus graft

Completed by: [illegible] Date: 1/31/13

Comments: ______

*Place peel off label or write tissue ID# in the space provided. One patient, one procedure per tracking form.*


ID: 121856-056 #
OST038 Cancellous (0.25-1.00mm)
2.0 cc
Exp: 09/23/2017
cre

***Retain this completed document with the patient's file.***

# Certificate to return to work or school

Mr.
Mrs.
Miss Jennie Cox

has been under my care from Thurs 1/31/13 to 2/12/2013

and is able to return to work/school on Wed 2/13/2013

Remarks Oral Surgery

Dr. Larry W Cobb Date 1/31/13

LARRY W. COBB, D.M.D. Dr Cobb
2-C Cleveland Court
Greenville, S.C. 29607
864-271-9990

FAXED 4-29-13

***PIEDMONT ORAL SURGERY***

*W. Keith Walker, DDS*
*Larry W. Cobb, DMD*
*2C Cleveland Court*
*Greenville, South Carolina 29607*
*Tel: 864-271-9990 Fax: 864-235-7959*

*RE:* Jennie Cox

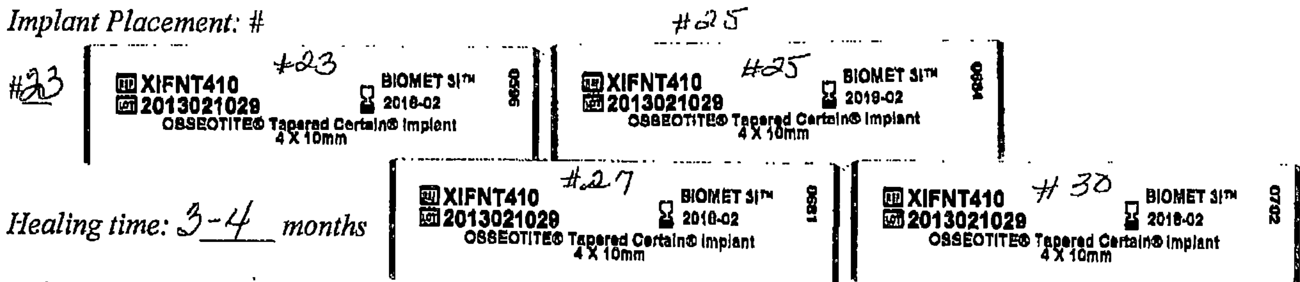
*Dear Dr.* Don Ridgell

*I would like to take this opportunity to update you on the care of* Jennie Cox.
*These are the procedures that were performed:* 4/29/13

*Extractions: #*

*Implant Placement: #* #25

#23




*Healing time:* 3-4 *months*

*Follow up Appointment:* May 9th, 2013

*Thank you for referring your patient to our office. The confidence of your referral is greatly appreciated.*

#30
XIFNT410
2013021029
BIOMET 3I™
2018-02
OSSEOTITE® Tapered Certain® Implant
4 X 10mm

*Sincerely,*

Larry W. Cobb D.M.D.

*Larry W. Cobb, DMD*

✓ *Flowers have been sent to patient from Dr. Cobb and Dr.* Ridgell