

04/14/2021 - Video Visit in OCCUPATIONAL MEDICINE (continued)**Clinical Notes (continued)**

Body parts involved: Right foot/ankle

Radiating? no

Duration/timing: Constant with intermittent flares.

Character: Achy, Sharp

Pain worsened by: Certain activities (getting up from a seated position, standing/walking), palpation

Pain improved by: Rest, pain meds, soaking

Associated symptoms: None

Treatments tried in past & outcome:

Medication?

- not applicable

PT/OT? No

Acupuncture? No

Chiropractor? No

Injection? No

Surgery? No

Consult? No

Denies any significant history of injury to the affected body parts

REVIEW OF SYSTEMS:

The patient completed the Regional Review of Systems Questionnaire and I reviewed.

General: No fever, chills, or sweats

Eyes: No eye pain, blurry vision, double vision, or visual disturbances

Ears, Nose, Throat, and Mouth: No pain, hearing loss, or ear ringing

Cardiovascular: No chest pain or palpitations

Respiratory: No wheezing, cough, or shortness of breath

Gastrointestinal: No nausea, vomiting, or abdominal pain and No rectal bleeding or black stools

Genitourinary: No painful urination and No blood in urine

Skin: Mild swelling.

Neurologic: No numbness or tingling of extremities and No headache

Psychiatric: No anxiety or depression

Endocrine: No unexplained weight loss, excessive thirst or excessive urination

Hematology: No easy bruising or bleeding

Allergy: No known environmental allergies

ROS:

Extended Musculoskeletal:

I reviewed with the patient the following extended musculoskeletal systems.

Lower extremity: right foot and right ankle

Past Medical, Family, and Surgical History:

Reviewed Electronic Medical Records: Yes

Patient did not have a prior work related injury to the same body part(s).

04/14/2021 - Video Visit in OCCUPATIONAL MEDICINE (continued)**Clinical Notes (continued)**

Patient did not have a prior non-work related injury to the same body part(s).

Family History Reviewed: Reviewed but does not apply to this Workers' Compensation injury or illness.

SOCIAL HISTORY:

Work Status before this visit: Full Duty

Claim Information: pending.

OBJECTIVE FINDINGS:**Vital Signs:**

There were no vitals taken for this visit.

I confirm that I have performed the following examination(s):

Constitutional: Well developed and well nourished and Alert and conversant

Ears, Nose, Throat, and Mouth: No signs of trauma, or deformity

Eyes: Conjunctivae and EOMs are normal

Respiratory: No respiratory distress

Psychiatric: Pleasant, alert, no distress, mood and affect normal

PHYSICAL EXAMINATION:

Musculoskeletal:

Right ankle: No swelling or deformity. Decreased range of motion.

X-ray and laboratory ordered today:

no

DIAGNOSIS:

S93.401A RIGHT ANKLE SPRAIN, INIT

S93.601A RIGHT FOOT SPRAIN, INIT

There is no evidence of chemical or toxic compounds being involved.

Diagnosis:

(S93.401A) RIGHT ANKLE SPRAIN, INIT

(S93.601A) RIGHT FOOT SPRAIN, INIT

ARE YOUR FINDINGS AND DIAGNOSIS CONSISTENT WITH PATIENT'S ACCOUNT OF INJURY OR ONSET OF ILLNESS?

Yes

In the absence of any other injury, and based on the patient's clinical history, measurable objective findings, and medical records reviewed, it is my medical opinion that Carl Mayfield medical condition listed in the

04/14/2021 - Video Visit in OCCUPATIONAL MEDICINE (continued)**Clinical Notes (continued)**

diagnosis, is more likely than not, has a causal relationship to the traumatic injury (described above) while performing his/her duty during the course of employment. The clear inciting event is described in the mechanism of injury section of this documentation.

IS THERE ANY OTHER CURRENT CONDITON THAT WILL IMPEDE OR DELAY PATIENT'S RECOVERY?

No

TREATMENT RENDERED:

Carl Mayfield has been advised to continue the following previous medication(s):

The medication(s)/supplies/radiological studies ordered this visit:

Orders Placed This Encounter

BRACE, ANKLE, LACE UP

Order Specific Question: Result Release to patient?

Answer: Immediate

REFERRAL PHYSICAL THERAPY / OCCUPATIONAL THERAPY

Order Comments:

Reason: Initial Physical Therapy

The patient is being referred for physical therapy for foot - right.

Frequency: 2 times a week for 3 weeks - total of 6 treatments.

Physical Therapy is appropriate to help improve function, increase strength, range of motion, flexibility, and help minimize discomfort.

This is appropriate per MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine Treatment.

Referral Priority: Routine

Referral Type: Outpatient Service

Referral Reason: Specialty Services Required

Referral Location: *FONTANA

Acetaminophen (TYLENOL) 500 mg Oral Tab

Sig: Take 2 tablets by mouth every 6 hours as needed for pain . Do not exceed 6 tablets in 24 hours

Dispense: 100 tablet

Refill: 0

Order Specific Question: Is this medication for a workers' compensation condition?

Answer: Yes

Treatment and Supplies:

I discussed the patients diagnosis, prognosis, and treatment plan at length and all questions were answered.

I spent 20 minutes with face to face time with Carl Mayfield

1. Anti-inflammatories prescribed, take as directed. Risk and benefits discussed.

04/14/2021 - Video Visit in OCCUPATIONAL MEDICINE (continued)**Clinical Notes (continued)**

2. X-ray of right foot/ankle performed on date of injury showed no acute fracture or dislocation. Discussed with worker.
3. Apply ice to the affected area for 15 min duration, at 3 to 4 times a day
4. Requested authorization for 6 sessions of physical therapy, 2 times a week
5. Will continue full duty
6. Return to clinic as directed
7. Lace-up ankle brace administer

I anticipate treatment may last may last 6 to 12 weeks for this worker

Patient was informed to immediately go to emergency department before next appointment if symptoms worsen

FACTORS OF CARE:

Medical Work Up: Reviewed and summarized old records and Diagnostic imaging: ordered/reviewed

Medication: Medication prescribed/ordered with pertinent risks and benefits explained to the patient

Treatment Plans and Integration: Discussion with patient regarding return to work (full, modified or off work)

IF FURTHER TREATMENT REQUIRED, SPECIFY TREATMENT PLAN/ESTIMATED DURATION: More than likely the patient's condition is expected to improve or reach maximum medical improvement or full recovery in week(s).

IF HOSPITALIZED AS INPATIENT, GIVE HOSPITAL NAME, LOCATION, AND DATE ADMITTED:
no

WORK STATUS:

See Below

---End of FORM---