



197 Ridgedale Avenue, Suite 300
Cedar Knolls, NJ 07927
Phone: 973-538-2334

Office Visit Summary

Exam Date: 11/8/22 Date of Injury: 11/02/2022 Physician: DAVID EPSTEIN, MD
Patient: KYLE ALLEYNE Carrier: D&H Clm#: IWC081849
Adjustor: ANGELA MONTGOMERY Phone: 973-940-1851 Ext: 241
Email: AMONTGOMERY@RISKSOLUTIONS.COM Fax: 973-940-1852
Case Mgr/Other: Phone: Ext:
Email: Fax:
Diagnosis: ① Foot/Ankle lateral sprain
ICD-10: Causality: (first visit only) Yes ☒ No ☐

Work Status

Unable to work effective: 11/8/22 Return to work full duty effective: _____
Return to work with modifications: _____
Restrictions include: ☐ No Climbing ☐ No Kneeling ☐ No Squatting ☐ No Overhead lifting
Maximum lift and push/pull of _____ lbs with affected extremity
NWB TTWB PWB FWB No use of: _____ Other: _____

Able to drive at work: Yes ☐ No ☐ Estimated MMI: _____
Able to drive outside of work: Y/N _____

Treatment Plan

Physical Therapy: 2-3 x/wk 4 wk ☐ MRI/MRI Arthrogram ☐ CT Scan
☐ Injection ☐ EMG/NCS ☐ Brace ☐ Splint ☐ CAM Walker
☐ HEP/Therabands ☐ Consults _____
☐ Other _____

Medications

Narcotic prescribed: _____ Start Date: _____
Pain Score prior to narcotic initiation: (0-10) _____ Pain Score after Narcotic initiation (0-10) _____
Referral to pain management: _____
Follow up appointment: _____ @ _____ AM/PM MMI: ☐ Yes ☐ No
TCO Case Manager: 2-kr Ext: _____

Orthopedic Surgeon

TRI-COUNTY ORTHOPEDICS

World-Class Team. Hometown Choice.

PO BOX 1446, Morristown, NJ 07962-1446 Main: 973-538-2334 Billing: 973-538-0329

☐ 197 Ridgedale Ave, 3rd floor
Cedar Knolls, NJ 07927
Fax: 973-267-6882 (Sport)
Fax 973-538-4081 (Joint)

☐ 1590 Route 206
Bedminster, NJ 07921
Fax: 908-234-2022

☐ 757 Route 15
Lake Hopatcong, NJ 07849

Durable Medical Equipment/Braces

Today's Date: 11-8-2022

Physician Name: David Epstein M.D.

Patient Name: Kyle Alleyne

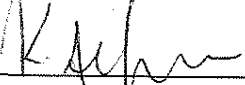
DOB: 04/19/1987

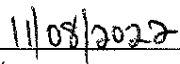
☒ Left ☐ Right Size (Circle One): XS SM MD **LG** XL XXL XXXL

Key Code	Product Description	Quantity
L4386	Walker Boot Short	1
L4386	Walker Boot Tall	
L3265	Cast Shoe	
L3923 / L3924	Actimove (CMC Splint)	
L1902	Ankle orthosis	
L1906	Ankle foot orthosis, multi-ligamentous ankle support	
L1971	Ankle foot orthosis, plastic or other material with ankle joint, prefabricated	
L3260	Surgical Boot	
L2820	Soft interface for molded plastic, below knee section	
L3000	Foot, insert, removable, molded to patient	
L4361	Walking boot, pneumatic and/or vacuum	
L4397	Ankle foot orthosis, including soft interface material, adjustable for fit	
E0110	Crutches	
E0100	Cane	

DME Label:  **ANKLE FIXED WALKER LG**
 6 30745 04738 2 SUGGESTED HCPCS **LARGE**
 LOT PO-5287 D CODE **L4386 OR L4387** U/M EA ITEM # **79-1062-000**
 AA000

- I understand that my physician has prescribed this medical supply as part to my treatment plan.
- I understand that I have a choice in where I receive my prescribed orthopedic supplies and services.
- I had the option of taking a prescription and obtaining the brace elsewhere, such as a medical supply store.
- I authorize Tri-County Orthopedics to furnish this service./product and provide my insurance carrier with any information requested for payment.
- I instruct my insurance provider to pay Tri-County Orthopedics directly for these services/products.
- I understand that my insurance provider may deny payment for this supply because it is a non-covered item or deemed not medically necessary.
- I understand that I am responsible for any deductible or coinsurance cost related to this service/supply.
- I understand any cost not covered by my insurance provider will be my financial responsibility.
- I have received the prescribed item and have been fully instructed on its use/application.
- I understand the brace is guaranteed for material defects for 3 months.
- I understand that once I leave the office, this brace is not returnable, unless there is a material defect.


Patient/Guarantor Signature


Date

For product or billing questions please call 973-538-2334, then select option 3.

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David Epstein M.D.

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Lake Hopatcong, NJ 07849

FOOT & ANKLE PHYSICAL THERAPY PRESCRIPTION:

Patient Name: **Kyle Alleyne**

Date: **11-8-2022**

Diagnosis: ☐ Right ☒ Left ☐ Bilateral Frequency: ☒ 2-3x/week Duration: ☒ 4 wks ☐ 6 wks

M25.572 Pain in left ankle and joints of left foot **Lateral hindfoot sprain**

☐ Continue as per initial protocol

MODALITIES:

- ☒ Modalities as needed
- | | |
|--|---|
| <input type="checkbox"/> Cryo-therapy | <input type="checkbox"/> Moist Heat |
| <input type="checkbox"/> Aqua-therapy | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> NMES |
| <input type="checkbox"/> Whirlpool | <input type="checkbox"/> TENS |
| <input type="checkbox"/> Sensory Re-education
& Desensitization | <input type="checkbox"/> Soft Tissue Manipulation |
| | <input type="checkbox"/> Scar Management |
| | Local Wound Care |

WEIGHT BEARING: ☐ NWB ☐ PWB ☐ WBAT

EDEMA CONTROL:

- ☐ Edema Control Techniques ☐ Coban
- ☐ Compression Stocking ☐ Elastic Wrap
- Jobst Stocking

PRECAUTIONS:

- ☐ No Pivoting
- ☐ No Cutting
- ☐ No Twisting
- ☐ No Jumping
- ☐ No Heavy Squatting
- ☐ Minimize Impact Loading

BRACING/EQUIPMENT/SUPPLIES:

- ☐ CAM Walking Boot ☐ Low - ☐ High
- ☐ Air-Cast Ankle Splint ☐ Lace-Up Ankle Brace ☐ Heel Lift (Wedge/Gel Cup)
- ☐ Orthotic Shoe Insert ☐ Hard Sole ☐ Medial Arch Support ☐ Lateral Post ☐ Metatarsal Pad
- ☐ Custom Orthotic: _____

Physician's Signature: _____

(I have medically prescribed the above treatment)

David M. Epstein, MD

Sports Medicine & Orthopedic Surgery
Shoulder, Knee, Foot & Ankle Surgery

ANKLE/FOOT EXERCISE:

- ☒ AROM (Limits: _____)
- ☒ AAROM (Limits: _____)
- ☒ PROM (Limits: _____)
- ☒ Gait Training ☒ ADL's
- ☒ Babst Board Exercises (Platform Roller Ball)
- ☒ Plantar Fascia Stretching (Can Rolling- Under Foot)
- ☒ Proprioceptive Training
- ☐ Foam Cushion (Standing Single Leg Balance)
- ☐ "Toe Grabs" (Pick up/Move Objects)
- ☐ Single Leg Toe & Heel Raises
- ☒ Core LE Strengthening & Endurance Program
- ☐ Closed Chain ☐ Open Chain
- ☐ (Patient Education / Home Exercises)
- ☐ Return to Sport Specific Exercise/Training Activity

SPECIAL REHABILITATION PROGRAMS:

- ☐ Agility & Plyometric Exercises
- ☐ Peroneal Strengthening
- ☐ Achilles Stretching/Strengthening
- ☐ Eccentric Exercises
- ☐ Patient Education/Home Program
- ☐ Kinetic Chain/ Core Strengthening
- ☐ Theraband Resistance Exercises
- ☐ Corrective Exercises - LE Mechanical Alignment

Please send progress notes

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(973) 538-2334

Nov 8, 2022

Patient Name: Kyle Alleyne

The above named patient has been under my care for an orthopedic problem.

☒ Had an appointment today

☒ Work guidelines: _____

☒ No Work: **As of 11/08/2022** _____

If there are any questions, please feel free to contact our office.

Sincerely,



Physician Name: David Epstein M.D.