

Referral Queue ID: 480499054

Patient Referral

Patient Information:

Patient:	Cox, Imani N.	Home Phone:	(908) 251-1260
SSN:	143-92-9846	Work Phone:	
Address:	1308 Columbia Ave PLAINFIELD, NJ 07062	DOI:	10/27/2022
		DOB:	12/18/1991
			Cell Phone:(908) 251-1260

Employer Contact:

Employer Location:	Plainfield Board of Education	Contact:	Deborah Boyd
Address:	1200 Myrtle Ave Plainfield, NJ 070631139	Role:	Primary Contact
Auth. by:		Phone:	(908) 731-4243 Ext.:
		Fax:	

Program:

Billing Information:

Carrier:	D&H Alternative Risk Solutions	Billing:	D&H Alternative Risk Solutions
Address:	PO Box 68 Newton, NJ 078600068	Address:	PO Box 68 Newton, NJ 078600068
Phone:	(973) 940-1851	Claim #:	
Fax:	(908) 684-9911		
Notes:	Alt name, Dietz & Hammer		

Referral Contact:

Contact: Carolina Shell
Role: Adjuster
Phone: Ext.:
Fax:
Email:

****NOTE TO THE ABOVE FACILITY OR PHYSICIAN:**
Please send a copy of all reports on this patient to the payer and the center.

Referral Queue ID: 480499054

Patient Referral

Patient Information:

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SSN:	143-92-9846	Work Phone:	
Address:	1308 Columbia Ave PLAINFIELD, NJ 07062	DOI:	10/27/2022
		DOB:	12/18/1991
		Ext:	
		Cell Phone:	(908) 251-1260

Therapy Referral Information:

Referral Status: Opt-out

REFERRAL PRESCRIPTION

Provider Type: Physical Therapist

Requested

Total Treatments:	6	Request Comments:
Treatments per Week:	3	Auto Generated
Treatment Duration:	2 Weeks	

Diagnosis

ICD9 Code ICD10 Code Description

847 S13.9XXA SPRAIN OF JOINTS AND LIGAMENTS OF UNSP PARTS OF NECK, IN

Additional Notes

Emailed Adj Notes & Script - PT Scheduled Out...PB

Date: 11/03/2022

Referring Provider: Anthony Tarasenko, MD

*** *Provider Signature on File* ***

Number of Visits to Date: 0

Authorized

Total Treatments:	Auth Number:
Treatments per Week:	Effective Date:
Treatment Duration:	Expiration Date:
Authorization Comments:	Units Authorized:

****NOTE TO THE ABOVE FACILITY OR PHYSICIAN:**
Please send a copy of all reports on this patient to the payer and the center.

Claim Number:

Work Activity Status Report

Patient: Imani Cox

Last 4 Digits of SSN: xxx-xx-9846

Date of Birth: 12/18/1991

Address: 1308 Columbia Ave PLAINFIELD NJ 07062

Employer Location: Plainfield Board of Educa

Contact: Deborah Boyd

Home: (908) 251-1260 (H)

Address: 1200 Myrtle Ave Plainfield , NJ 07063-

Role: Primary Contact

Work:

Authorized by:

Phone: 908-731-4243

Fax: 0-0-0000

THIS VISIT

Visit Type: Recheck

Time In: 08:56:00 AM CST Time Out: 09:33:45 AM CST

Treating Clinician: Anthony Tarasenko, M.D.

Diagnoses:

Head contusion (S00.93XA)

Neck sprain (S13.9XXA)

Scalp laceration (S01.01XA)

Medications: Dispensed prescription medication Dispensed over-the-counter medication Medication(s) prescribed**PATIENT STATUS**

Employer Notice: The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Treatment Status:

Returning for follow-up: 11 10 2022

Continue Therapy/Rehabilitation as scheduled

MMI AnticipatedDate: 11 /30 /2022

Work Status:

Return to full work/activity today

Patient may work their entire shift

Activity Prescription:Key': **Occasionally** = up to 3 hrs/day; **Frequently** = up to 6 hrs/day; **Constantly** = up to 8 hours or greater per day

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Based on the Department of Labor definitions

NEXT VISIT(S)

Visit Date and Time:

11/10/2022 09:00 AM

Visit Type:

Medical	Therapy	Specialist
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clinician:

Anthony Tarasenko, MD

Transcription

Patient: Cox, Imani N. **Service ID #:** 486326719
Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 11/3/2022
Service Location: CMC - NNJ South Plainfield **Employer:** Plainfield Board of Education
Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Reason For Visit

Chief Complaint: The patient presents today with Rec; Pt it head while doing a pull up, no headaches just having pain in neck. Self reported.

Workers Compensation - Patient's Occupation: Teacher.

Work Status History: patient has been working regular duty.

Chaperone was offered: Patient declined the presence of a chaperone

Vitals

Vital Signs

Recorded: 03Nov2022 09:15AM

Systolic: 140

Diastolic: 90

BP Cuff Size: Large - Adult

Heart Rate: 90

Respiration: 16

Height: 5 ft 6 in

Weight: 270 lb

BMI Calculated: 43.58 kg/m²

BSA Calculated: 2.27

Medical History

No significant past medical history.

FAMILY HISTORY:

The patients family history has been obtained and carefully reviewed. It has been determined that the patients family history is noncontributory to the current injury.

Surgical History

History of No pertinent past surgical history (Z78.9)

Allergies

No Known Drug Allergies

History of Present Illness

Musculoskeletal:

Imani Cox is returning for a recheck of injury(s): here for metal sytiple removal of 11 and rx for neck sprain for pt on regularr duty.

Neck Pain: Head traum with 11 metal staples of the scalp.

Work Status History: patient has been working regular duty.

Review of Systems

Genitourinary: no missed menstrual period.

Musculoskeletal: neck pain.

Documented By: Anthony Tarasenko, MD
Documented On: 11/3/2022 9:32 AM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486326719
Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 11/3/2022
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Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Integumentary: laceration.

Neurological: Reviewed and found to be negative.

Physical Exam

Constitutional: well appearing and well nourished.

Head/Face: external swelling of the head. there is evidence of trauma.

Eyes: conjunctiva and lids with no swelling, erythema or discharge. Pupils are equal, round, and reactive to light and cornea clear. Normal optic discs and normal retina. Extraocular movements intact.

ENT: No erythema or edema of the external ears or nose. Tympanic membranes translucent with normal light reflex. Canals patent without erythema. Hearing is grossly normal. nasal mucosa and turbinates are normal without edema or erythema. No nasal discharge. Lips, teeth and gums are normal. Oropharynx with no erythema, edema, exudate or lesions.

Neck: The neck is supple and symmetric with midline trachea and no masses.

Breasts: breast exam was declined.

Pulmonary: no increased work of breathing or signs of respiratory distress. all lung fields clear to auscultation bilaterally. Normal to percussion. Normal to palpation.

Cardiovascular: normal rate and rhythm, normal S1 and S2, without gallops or rubs.

Normal PMI, no thrills. Carotid pulses 2+ bilaterally with no bruits. Extremities are warm with no edema.

Abdomen: soft, non-distended, and no tenderness.

Genitourinary: pelvic exam was declined.

Lymphatic: no lymphadenopathy.

Musculoskeletal: Normal gait. No tenderness or swelling of extremities. Range of motion is within normal limits. Normal muscle strength and tone.

Shoulder: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal. No signs of impingement.

Upper Arm: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Elbow: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Forearm: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Wrist: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Hand/Fingers: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Hip: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Documented By: Anthony Tarasenko, MD
Documented On: 11/3/2022 9:32 AM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486326719
Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 11/3/2022
Service Location: CMC - NNJ South Plainfield **Employer:** Plainfield Board of Education
Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Thigh: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Knee: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Lower Leg: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Ankle: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Foot/Toes: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.

Chest: Chest is normal in appearance.

Cervical Spine: Cervical Spine: Palpation reveals bilateral muscle spasms, left-sided muscle spasms and right-sided muscle spasms.

Thoracic Spine: without kyphosis, no tenderness, full range of motion.

Lumbosacral Spine: with normal lordosis, no tenderness and full ROM. Straight leg raises negative bilaterally.

Skin: sp 11 metal stapler in place

Neurologic: No interosseous weakness present. cranial nerves grossly intact. normal mental status. upper and lower extremity reflexes symmetric bilaterally. sensation intact to light touch. normal finger to nose and negative Romberg. Gait evaluation demonstrated a normal gait, full weight bearing, no ataxia, no shuffling.

Psychiatric: . Judgment and insight are normal. oriented to person, place, and time. speech is appropriate in content and delivery. Recent and remote memory is intact. mood and affect are appropriate.

Procedure

Suture Removal

Procedure Suture Removal:

The wound was located on the saclp. The wound was 20 cm in length.

Wound Exam: well healed with no sign of infection. There was no dehiscence of the wound. There was no drainage from the wound. Suture removal tray used 11 sutures/staples are present. 11 sutures/staples were removed.

Dressing: an antibiotic ointment was applied.

Post-Procedure: Patient Status: the patient tolerated the procedure well.

Functional Restoration and Status of Healing

Imani Cox is at functional goal, not at end of healing.

ASSESSMENT

Documented By: Anthony Tarasenko, MD
Documented On: 11/3/2022 9:32 AM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486326719
Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 11/3/2022
Service Location: CMC - NNJ South Plainfield **Employer:** Plainfield Board of Education
Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

1. Head contusion (S00.93XA)
2. Neck sprain (S13.9XXA)
3. Scalp laceration (S01.01XA)

Plan

1. Physical Therapy Referral Physical Therapy See Referral Comment! Done: 03Nov2022
09:30AM

Ordered:

For: Neck sprain; Ordered By: Tarasenko, Anthony Performed: Due: 17Nov2022

Laterality 1 : Bilateral

Body Part 1 : Neck - Soft Tissue

PT Necessary : PT is medically necessary to address objective impairment/functional loss and to expedite return to full activity

Frequency : 3 x week

Duration : 2 weeks

Therapy Order : Evaluate and Treat
otc analgesics

NO MEDICATIONS WERE PRESCRIBED OR DISPENSED FOR THIS ENCOUNTER.

Discussion/Summary

regular duty

pt to the neck with script given

Chaperone was declined

A comprehensive discussion was held with the patient to review the diagnosis and overall treatment plan and objectives. The patient verbally acknowledged their understanding of all items discussed, and was afforded an opportunity to get clarification and/or ask additional questions regarding the proposed treatment(s). Patient was instructed to keep their scheduled appointments for follow-up and/or return to Concentra.

Documented By: Anthony Tarasenko, MD
Documented On: 11/3/2022 9:32 AM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486326719
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Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Activity Status and Restrictions

Treatment Status:

Returning for follow-up: 11 10 2022

Continue Therapy/Rehabilitation as scheduled.

Anticipated date of MMI: 11. 30. 2022.

Activity Status

Return to full work/activity today.

Work Duration

Patient may work their entire shift.

Signatures

Electronically signed by : Anthony Tarasenko, M.D.; Nov 3 2022 9:32AM EST -

Author

Electronically signed by : Anthony Tarasenko, M.D.; Nov 3 2022 9:32AM EST - Author

Documented By: Anthony Tarasenko, MD
Documented On: 11/3/2022 9:32 AM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486323097
Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 10/31/2022
Service Location: CMC - NNJ South Plainfield **Employer:** Plainfield Board of Education
Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Reason For Visit

Chief Complaint: The patient presents today with NI; Pt hit head while doing pull up, having pain in neck and head is sore. Self reported.

Workers Compensation - Patients Occupation: teacher aide.

Chaperone was offered: Patient declined the presence of a chaperone

Vitals

Vital Signs

Recorded: 31Oct2022 01:47PM

Systolic: 136

Diastolic: 80

BP Cuff Size: Large - Adult

Heart Rate: 100

Respiration: 16

Height: 5 ft 6 in

Weight: 270 lb

BMI Calculated: 43.58 kg/m²

BSA Calculated: 2.27

Medical History

No significant past medical history.

FAMILY HISTORY:

The patients family history has been obtained and carefully reviewed. It has been determined that the patients family history is noncontributory to the current injury.

Surgical History

History of No pertinent past surgical history (Z78.9)

Allergies

No Known Drug Allergies

Occupational History

Occupational History

Occupational history was provided by the patient.

Type of job / Job title: Teacher Assistant

Major job functions: Office Work, Working with students

Length of time at this job: 4 year(s).

Average daily work hours: 6.5. Average weekly work hours: 30.

Recent overtime: No

History of Present Illness

Acute Musculoskeletal:

Documented By: Anthony Tarasenko, MD

Documented On: 10/31/2022 2:15 PM

Transcription

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Soc. Sec. #: XXX-XX-9846 **Referral Q ID:**
Date of Birth: 12/18/1991 **Age:** 30 **Injury Date:** 10/27/2022 **Service Date:** 10/31/2022
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Claim Number: **Dictated By:** Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Acute Musculoskeletal Injury History: injured on 10 27 2022

This is the result of a direct blow.

Occurred while at work, while doing pull up banged her head and had a laceration of the scalp, was seen at the hospital for head and neck injury with scalp laceration of 10 metal sutures her for staple removal too soon for removal, ct scan neg and neck scan neg sp 10 metal staples.

Additional History:

head trauma with neck sprain with 10 metal staples.

Review of Systems

Constitutional: Reviewed and found to be negative.

Eyes: Reviewed and found to be negative.

Cardiovascular: Reviewed and found to be negative.

Respiratory: Reviewed and found to be negative.

Gastrointestinal: Reviewed and found to be negative.

Genitourinary: no missed menstrual period.

Musculoskeletal: neck pain and joint stiffness.

Integumentary: Reviewed and found to be negative.

Neurological: headache.

Psychiatric: Reviewed and found to be negative.

Hematologic and Lymphatic: Reviewed and found to be negative.

Physical Exam

Constitutional: well appearing and well nourished.

Head/Face: external swelling of the head. there is evidence of trauma. sp 10 metal staples.

Eyes: conjunctiva and lids with no swelling, erythema or discharge. Pupils are equal, round, and reactive to light and cornea clear. Normal optic discs and normal retina. Extraocular movements intact.

ENT: No erythema or edema of the external ears or nose. Tympanic membranes translucent with normal light reflex. Canals patent without erythema. Hearing is grossly normal. nasal mucosa and turbinates are normal without edema or erythema. No nasal discharge. Lips, teeth and gums are normal. Oropharynx with no erythema, edema, exudate or lesions.

Neck: The neck is supple and symmetric with midline trachea and no masses.

Breasts: breast exam was declined.

Pulmonary: no increased work of breathing or signs of respiratory distress. all lung fields clear to auscultation bilaterally. Normal to percussion. Normal to palpation.

Cardiovascular: normal rate and rhythm, normal S1 and S2, without gallops or rubs. Normal PMI, no thrills. Carotid pulses 2+ bilaterally with no bruits. Extremities

Documented By: Anthony Tarasenko, MD

Documented On: 10/31/2022 2:15 PM

Transcription

Patient: Cox, Imani N. Service ID #: 486323097
Soc. Sec. #: XXX-XX-9846 Referral Q ID:
Date of Birth: 12/18/1991 Age: 30 Injury Date: 10/27/2022 Service Date: 10/31/2022
Service Location: CMC - NNJ South Plainfield Employer: Plainfield Board of Education
Claim Number: Dictated By: Anthony Tarasenko, MD
Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

are warm with no edema.
Abdomen: soft, non-distended, and no tenderness.
Genitourinary: pelvic exam was declined.
Lymphatic: no lymphadenopathy. no cervical lymphadenopathy. no axillary lymphadenopathy. no inguinal lymphadenopathy.
Musculoskeletal: Normal gait. No tenderness or swelling of extremities. Range of motion is within normal limits. Normal muscle strength and tone.
Shoulder: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal. No signs of impingement.
Upper Arm: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Elbow: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Forearm: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Wrist: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Hand/Fingers: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Hip: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Thigh: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Knee: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Lower Leg: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Ankle: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Foot/Toes: Appearance normal. No deformity. No tenderness. Full range of motion. Strength normal.
Chest: Chest is normal in appearance.
Cervical Spine: with normal lordosis, no tenderness and full range of motion.
Thoracic Spine: without kyphosis, no tenderness, full range of motion.
Lumbosacral Spine: with normal lordosis, no tenderness and full ROM. Straight leg raises negative bilaterally.
Skin: sp 10 metal staples in place
Neurologic: No interosseous weakness present. cranial nerves grossly intact. normal mental status. upper and lower extremity reflexes symmetric bilaterally. sensation intact to light touch. normal finger to nose and negative Romberg. Gait evaluation

Documented By: Anthony Tarasenko, MD
Documented On: 10/31/2022 2:15 PM

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Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

demonstrated a normal gait, full weight bearing, no ataxia, no shuffling.
Psychiatric: . Judgment and insight are normal. oriented to person, place, and time.
speech is appropriate in content and delivery. Recent and remote memory is intact.
mood and affect are appropriate.

ASSESSMENT

1. Head contusion (S00.93XA)
2. Scalp laceration (S01.01XA)
3. Neck sprain (S13.9XXA)

Plan

otc analgesics

NO MEDICATIONS WERE PRESCRIBED OR DISPENSED FOR THIS ENCOUNTER.

Discussion/Summary

Chaperone was declined

A comprehensive discussion was held with the patient to review the diagnosis and overall treatment plan and objectives. The patient verbally acknowledged their understanding of all items discussed, and was afforded an opportunity to get clarification and/or ask additional questions regarding the proposed treatment(s). Patient was instructed to keep their scheduled appointments for follow-up and/or return to Concentra.

Activity Status and Restrictions

Treatment Status:

Returning for follow-up: 11 3 2022

Documented By: Anthony Tarasenko, MD
Documented On: 10/31/2022 2:15 PM

Transcription

Patient: Cox, Imani N. **Service ID #:** 486323097
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Diagnosis: S00.93XA CONTUSION OF UNSPECIFIED PART OF HEAD, INITIAL ENCOUNTER-S00.93XA

Notes:

Anticipated date of MMI: 11. 30. 2022.

Activity Status

Return to full work/activity today.

Work Duration

Patient may work their entire shift.

Signatures

Electronically signed by : Anthony Tarasenko, M.D.; Oct 31 2022 2:15PM EST - Author

Documented By: Anthony Tarasenko, MD
Documented On: 10/31/2022 2:15 PM