

**HUDSON PRO ORTHOPAEDICS & SPORTS MEDICINE
HAND SURGERY & REHABILITATION
OF NORTH JERSEY, P.C.**

**Roman Isaac, M.D.
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Board Certified Orthopedic Surgery

American Society for Surgery of the Hand

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Suite B-107
Union, NJ 07083

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D&H

Attn: Carolina Shell
Fax: 973-940-1852

RE: ERNIE MARTINEZ
CLAIM: PVS074253

DATE: 10/17/2022

Dear Ms. Shell:

HISTORY OF PRESENT ILLNESS: Mr. Martinez is 35 days postop right total wrist fusion. He is doing well, here with new x-rays.

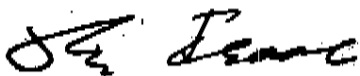
PHYSICAL EXAMINATION:

Right Wrist Exam: Cast is in good position. Neurovascularly intact.

DIAGNOSTIC STUDIES AND IMAGING: X-rays of the right wrist, AP, lateral and oblique, showed a well-aligned fusion site.

ASSESSMENT: Status post right wrist total fusion.

PLAN: The patient will continue with casting and follow up in two weeks for cast removal and new x-rays. He will continue with restrictions and no use of the right wrist. Follow up 10/31 at 9am.



Roman Isaac, M.D.

RI:mcr

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Date: 10/17/22

Ernie Martinez had an appointment in our office today.

Please allow the patient to return to: Full duty ☒ Light duty, if available
☒ Immediately or on date / /

 Left Extremity ☒ Right Extremity Both Extremities

Please allow the patient to return to light duty, if available with the following restrictions:

☒ No Use of the Hand/wrist /extremity

 No lifting, gripping, or carrying greater than pounds

Other restrictions: Do not get wet
 No driving
 No Typing
 No vibration tools
 Brace at all Times
 NO Restrictions

Next appointment: 2 weeks. MMI

Comments:

Sincerely,



Roman Isaac M.D.

☐ Call STAT Report ☐ Phone Report

Please Provide Patient With: ☒ CD ☐ Film

Today's Date: 10/17/22

Date of Order: 10/17/22

Patient: Mahary, Enie

DOB: _____

Diagnosis ICD10 Code: _____

History: _____

Special Instructions: _____

GENERAL DIAGNOSTIC X-RAY

- | | | | | |
|--|--|---------------------------------------|--|---|
| <input type="checkbox"/> Shoulder AP, Axillary, and Scapular Y | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Hips | Weight Bearing AP, Lateral and False Profile | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Humerus AP and Lateral | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Femur | AP and Lateral | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Elbow AP, Lateral, Internal & External Rotation | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Knee | Weight Bearing AP and Lateral, Sunrise | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Forearm AP and Lateral | <input type="checkbox"/> L <input type="checkbox"/> R | | Tunnel View | |
| <input checked="" type="checkbox"/> Wrist AP, Lateral and Oblique | <input type="checkbox"/> L <input checked="" type="checkbox"/> R | <input type="checkbox"/> Tibia/Fibula | AP and Lateral | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Hand AP, Lateral and Oblique | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Ankle | AP, Lateral and Mortise | <input type="checkbox"/> L <input type="checkbox"/> R |
| | | <input type="checkbox"/> Foot | AP, Lateral and Oblique | <input type="checkbox"/> L <input type="checkbox"/> R |

Spine & Pelvis

- ☐ Cervical ☐ 5 views ☐ 2 views ☐ Scoliosis Study
- ☐ Sacrum & Coccyx ☐ Lumbar ☐ 4 views ☐ 2 views
- ☐ Thoracic/Dorsal ☐ 2 views ☐ Pelvis

Other:

- ☐ Extremity (specify): ☐ L ☐ R

CT 64 SLICE

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Thoracic Spine | |
| <input type="checkbox"/> Extremity (specify): _____ | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Knee <input type="checkbox"/> W/MAKOplasty | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Hip <input type="checkbox"/> W/MAKOplasty | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Foot | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Lumbosacral Spine | | <input type="checkbox"/> Ankle | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Cervical Spine | | <input type="checkbox"/> Other (Specify) _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
- ☐ W/O Contrast ☐ W/ & W/O Contrast

CT ARTHROGRAM

- ☐ CT Arthrogram of: _____ ☐ L ☐ R

MAGNETIC RESONANCE IMAGING (HIGH FIELD OPEN LIKE)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Other (Specify) _____ |
- ☐ W/O Contrast ☐ W/ & W/O Contrast

MR ARTHROGRAM

- ☐ MR Arthrogram of: _____ ☐ L ☐ R

VASCULAR ULTRASOUND (VENOUS)

- ☐ Venous Duplex ☐ Upper ☐ Lower ☐ Bilateral ☐ Unilateral ☐ Left ☐ Right

- ☐ Imran Ashraf, MD ☒ Roman Isaac, MD ☐ Aleksey Lazarev, MD ☐ Thomas Azzolini, DPM ☐ Shital Sharma, DPM

Referring Physician Signature

, MD