agile OCCUPATIONAL MEDICINE

15401 S Main St.
Gardena, CA 90248 - 2214
PH: 424 292-3260
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TELEMEDICINE FOLLOW UP VISIT PROGRESS NOTE

Patient First Name:	Patient Last Name:	Date of Birth:	Sex:
Fidel	Martinez Trujillo	04-19-1969	Male
Attending Provider:	**Referring Provider:**	**Visit Date:**	**Chart No.:**
Minh Nguyen, DO, MPH, FACOEM		09-19-2023	SCL57276
Insurance:	**Employer:**	**Claim Number:**	**Date of Injury:**
Zenith	Wish Farms Ca	991734	09-05-2023
Appointment Location:		**Appointment Location Address:**	
Agile Occupational Medicine, Gardena		15401 S Main St., Gardena CA 90248 - 2214	

Telehealth Statement: I advised the patient that this visit will be performed using a HIPAA compliant telehealth tool, including a live video connection between the patient's location and my location. I answered all the patient's questions, and the patient gave his/her consent for telehealth visit. Subsequently, I performed consultation using telehealth and live video conference. I performed a virtual musculoskeletal or neurological examination based on specific set of guidelines to enhance the information obtained when evaluating the musculoskeletal and neurological systems. Most of these tests are based on validated physical exam maneuvers under my observation. REFERENCE: Mayo Clinic: The Telemedicine Musculoskeletal Examination https:\\www.mayoclinicproceedings.org/article/S0025-6196(20)30542-5/fulltext. Neurology: Primer on the In-home Teleneurologic Examination. Clinical Practice April 2021 vol. 11 no. 2 https:\\cp.neurology.org/content/11/2/e157.full.

History of Present Illness
Patient is a 54 year old male.
Patient following up on laceration of LIF. Patient having trouble moving his LIF because of stiffness. Patient has not been working. Patient works in the strawberry fields and cutting the weeds. No fever and completed antibiotics.

Past Medical History
No Known Past Medical History

Surgical History
No Known Surgical History

Allergy
No Known Drug Allergies.

Current Medication
acetaminophen 500 mg tablet 1 Tablet Four Times A Day
Bacitracin
Bacitracin
Bactrim
Tylenol 500 mg
Tylenol 500mg
Tylenol 500mg

Social History
Work History: He is employed - full time. He has been in the current profession for 9 months.
Use of Drugs/Alcohol/Tobacco: Never drinks any alcohol. Smoking Status (MU) never smoker. He has never used any illicit drugs. He denies using street drugs with a needle.

Review of Systems
Constitutional Symptoms: Normal Appearance. Denies Any kind of disability, for any reason, fever, weight loss or fatigue.
Eyes: Denies blurred vision, double vision, glaucoma, discharge, itching, lacrimation, pain or redness of eyes.
Ears/Nose/Throat/Mouth: Denies poor hearing, dry mouth or sore throat.
Cardiovascular: Denies chest pain, chest tightness, tightness/pressure/squeezing, palpitations, prior heart attack, heart murmur or fainting.
Respiratory: Denies shortness of breath with exertion, shortness of breath with lying flat, chest tightness, asthma, COPD or Pneumonia.
Gastrointestinal: Denies blood in stool, ulcers, diarrhea or constipation.
Genitourinary: Denies kidney stones, frequent urination or bladder infection.
Skin: Denies cancer, bruising, rash, infection/ulcer or discoloration in legs.
Musculoskeletal: Denies arthritis, gout or sore muscles.
Hematologic/Lymphatic: Denies anemia, swelling or leukemia.
Endocrine: Denies diabetes, thyroid disease or Cushing disease.
Neurologic: Denies dizziness, strokes, headaches or difficulty walking.
Psychiatric: Denies anxiety or depression.
Allergic / Immunologic: Denies hay fever, sinusitis or immune deficiency.

Vitals
Pain scale was 4 out of 10.
Weight: 148.00 lbs.
Height: 62.00 inches.
Temperature: 98.30 F.
Pulse: 83 per min.
Pulse rhythm regular: Yes
Respiration: 12 breaths per min.
BMI: 27.
BP Systolic: 119 mm Hg.
BP Diastolic: 76 mmHg.
Pulse Oximetry: 99

Physical Examination

No evidence of infection.

Swelling reduced from previous appointment, sutures intact and steri strips x2 intact no erythema or discharge. Patient able to move his LIF at DIP, PIP, and MCP joint but slowly.

Previous procedure note:
3.5 centimeter u shaped laceration on dorsum of left index finger proximal phalanx full thickness with dry edges, no tendon involvement, neurovascular status intact, capillary refill under 2 seconds, flap in the direction of the MP joint closed with sutures intact swelling resolving, area clean and dry no signs of infection. Adequate blood flow to flap from all directions.

Suture Removal / Wound **Suture removal/wound:** The procedure performed was suture removal. No antibiotics were given. No pain medications were given. A total of 6 sutures were removed by suture removal scissors and forceps. Sterile dressings were applied.

Assessment and Plan
ICD: Laceration of left index finger without foreign body without damage to nail, initial encounter (S61.211A)
Assessment: Patient with 3.5 cm U shaped wound with 6 sutures placed and steri-strip x 2 intact. No evidence of infection and patient able to move his LIF at MCP and DIP and PIP joints.
Plan: Sutures removed x 6 without complications. Steri-strips applied. OTC Tylenol for pain if needed. Wound care instructions given and may return to work with keeping wound clean and dry. Follow up in 1 week for possible discharge.

CPT Codes:
Office O/p Est Low 20-29 Min (99213)
WC002 (WC002)

Follow up: -

Minh Nguyen DO, MPH, FACOEM

This has been electronically signed by Minh Nguyen DO, MPH, FACOEM for visit dated 09-19-2023.
Clinic Address: 15401 S Main St., Gardena CA 90248 - 2214

Minh Nguyen DO, MPH, FACOEM
Rendering Provider

This has been electronically signed by Minh Nguyen DO, MPH, FACOEM for visit dated 09-19-2023.