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July 25, 2022

Re: Viera, Tasha

DOB: 02/02/1986

DOA: 03/01/2022

Location: Woodside-Ortho

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: This is an initial orthopedic evaluation for a 36-year-old right-handed dominant female, involved in a work-related accident on 03/01/2022. Patient works for transit, was changing a heavy garbage bag where she immediately felt pain on her right shoulder and lower back. The patient was transported via ambulance to Mount Sinai. Imaging studies were negative. Pain medications were given in the hospital and was treated and released the same day. The patient has been treated with physical therapy for the last 3 months without adequate relief. The patient states that the pain is interfering with day-to-day activities.

Right shoulder pain is 8 out of 10, described as constant pain. The patient is unable to reach overhead or behind the back and is frequently woken up at night due to pain. Patient reports popping in the right shoulder with ROM.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: LATEX CAUSES HIVES OCCASIONALLY.

MEDICATIONS: The patient is taking Motrin prn. .

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally.

ADL CAPABILITIES: As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: driving, lifting heavy objects, carrying, reaching overhead, and exercising.

REVIEW OF SYSTEMS: General: No fever, chills, night sweats, weight gain, or weight loss.

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PHYSICAL EXAMINATION: The patient's height is 5 feet 6 inches, weight is 180 pounds, and BMI is 29.

Right Shoulder: Reveals no erythema, swelling, heat. Tenderness to palpation on the supraspinatus and AC joint. Positive cross-over test. Positive empty test. Positive O'Brien test. Positive impingement test. Range of motion, abduction is 140 degrees, normal is 180 degrees; flexion is 150 degrees, normal is 180 degrees; internal rotation is to L5 degrees, normal is 90 degrees; external rotation is 60 degrees, normal is 90 degrees. The patient has no motor or sensory deficit of the right upper extremity.

FINAL DIAGNOSES:

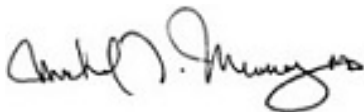
1. M24.811 Internal derangement, right shoulder.
2. M25.511 Pain, right shoulder.

PLAN:

1. All treatment options discussed with the patient.
2. Continue anti-inflammatory and muscle relaxant medications p.r.n.
3. Continue physical therapy for right shoulder 3 days/week.
4. Pending approval for right shoulder MRI.
5. Follow up in 4-6 weeks.

IMPAIRMENT RATING: Patient is currently and temporarily 100% disabled.

CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on 03/01/2022. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.



Nadezhda Bababekova, NP-BC
Michael Murray, MD

NB/AEI