**Patient Name:** NORIEGA, CECELIA

**Date of Birth:** 05/28/1973

**Date of Service:** 05/17/2022

**History of Present Illness:**  
This is a 49 year-old right\_left hand dominant female who was involved in a motor vehicle /work related accident on . Accident description. Patient injured Right Shoulder, Left Ankle/Foot in the accident. The patient is here today for orthopedic evaluation. Patient has tried \_\_\_\_\_ months of PT.

The patient complains of right shoulder pain that is rated at 8/10, with 10 being the worst. Shoulder pain radiates into fingers\_\_\_\_. Pain increases with lifting objects, reaching behind activities and improves with rest.

The patient complains of left ankle pain that is rated at 8/10, with 10 being the worst. Pain improves with rest.

**Past Medical History:**  
Noncontributory

**Past Surgical History:**  
C-section x3, right knee surgery

**Past Accident/Injuries:**

**Daily Medications:**  
None

**Allergies:**  
Amoxicillin.

**Social History:**  
Noncontributory.

**Physical Examination:**  
**Vitals:** On physical examination, the patient is 5 feet 4 inches tall weighs 170 pounds   
**General Appearance:** Patient is a well-developed, well-nourished female in no acute distress. Awake, alert,   
and oriented x 3. Mood and affect are normal.  
**Gait and Station:** Gait is normal

**Left Ankle/Foot:**  
Examination reveals there is no heat, swelling, effusion, erythema, crepitus, instability, or atrophy appreciated.

**Right Shoulder:**  
Examination of the shoulder revealed no tenderness to palpation. There was no effusion. No crepitus was present. No atrophy was present. Drop arm test is (+/-) with pain. Hawkins, Neers, O'briens test is positive, Apprehension tests were negative. Range of motion Abduction 120 degrees (180 degrees normal ) Forward flexion 130 degrees (180 degrees normal ) Internal rotation 20 degrees (80 degrees normal ) External rotation 45 degrees (90 degrees normal )   
Strength 4/5 with \_\_\_\_ internal rotation and external rotation.

**Diagnostic Imaging:**  
06/15/2021 - MRI of the right shoulder reveals moderate rotator cuff tendinosis/strain and subacromial subdeltoid bursitis. High grade partial thickness tear distal supraspinatus measuring 16 x 14 mm. Appearance consistent with SLAP tear with extension to the proximal aspect of long head biceps tendon. Mild changes of acromioclavicular osteoarthritis with spurring. Subacromial spur. Type II as acromiale.  
  
06/15/2021 - MRI of the left ankle reveals mild to moderate low ankle sprain, including grade 2 sprains of the anterior and posterior talofibular ligaments and grade 1 sprain of deltoid ligament. Mild to moderate changes of peroneal tenosynovitis without tear. Plantar fasciitis with intermediate grade partial-thickness tear. No evidence of fracture or malalignment at the mortise.

**Assessment and Plan:**  
Diagnosis: 1. Rotator cuff tear.  
 2. SLAP tear.  
 3. Impingement.  
Recommend right shoulder arthroscopy.

The patient has failed conservative management which has included physical therapy, oral medications, and injections. The MRI was reviewed with the patient as well as the clinical examination findings. I have gone over all treatment options with the patient. At this time, I have discussed the benefits and risks of Right shoulder arthroscopy, acromioplasty, subacromial decompression, debridement of rotator cuff versus possible rotator cuff repair, biceps tenotomy versus tenodesis and all other related procedures with the patient. I answered all their questions in regards to the procedure. The patient verbally consents to the procedure and will be scheduled.

The patient’s Right Shoulder, Left Ankle were examined   
MRI of the Right Shoulder, Left Ankle were reviewed.

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 the specified date. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient. Patient is considered 100% temporarily disabled.  
  
In response to the required COVID-19 mandates the following precautions have been taken. Doctors and Medical Assistants wore masks and gloves; examination rooms are completely disinfected after each use. Patient was required to wear a mask. Temperature scan was administered prior to examination. No more than 10 people were permitted in the waiting room at any time as this is the max that can be achieved while still maintaining six (6) feet social distancing guidelines. Only the patient was permitted in the examination room.



**L Sean Thompson, M.D.**