UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

July 15, 2022

Office seen at:
Liberty Rhea Ranada Ebarle PT PC
14 Bruckner Blvd
Bronx, NY 10454
Phone # (718) 402-5200

Re: Reyes, Sasha
DOB: 04/07/1989
DOA: 09/15/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, left knee, left hip, neck, mid back and low back pain.

HISTORY OF PRESENT ILLNESS: A 33-year-old right-hand dominant female involved in a motor vehicle accident on 09/15/2021. The patient was a driver and was wearing a seatbelt. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported to St. John's Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, left knee, left hip, neck, mid back and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 10 months with little relief.

PAST MEDICAL HISTORY: Hypertension.

PAST SURGICAL HISTORY: Left shoulder surgery done one year ago.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She can sit for 5 minutes before needing to change positions secondary to pain. 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 heavy

objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 7-8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, popping. The patient is unable to reach overhead or behind the back and unable to sleep at night due to pain. Worse with range of motion and improves with rest, medication, physical therapy, and ice.

Left knee: Left knee pain is 9/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking. Worse with range of motion and improves with rest.

REVIEW OF SYSTEMS: Temperature taken at the time of exam was 98.6 degrees Fahrenheit.
General: No fever, chills, night sweats, weight gain, or weight loss.
HEENT: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nosebleeds, sore throat or hoarseness.
Endocrine: No cold intolerance, appetite changes or hair changes.
Skin: Clear, no rashes or lesions.
Neuro: No headaches, dizziness, vertigo or tremor.
Respiratory: No wheezing, coughing, shortness of breath or difficulty breathing.
Cardiovascular: The patient has hypertension but no chest pain, murmurs, or irregular heart rate.
GI: No nausea, vomiting, diarrhea, constipation, jaundice or changes in bowel habits.
GU: No blood in urine, painful urination, loss of bladder control or urinary retention.
Hematology: No active bleeding, bruising, anemia or blood clotting disorders.
Psychiatric: No anxiety, change in sleep pattern, depression or suicidal thoughts.

PHYSICAL EXAMINATION: The patient's height is 5 feet 3 inches, weight is 240 pounds, and BMI is 42.5. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, proximal biceps tendon. There is no swelling, heat, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 160/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 degrees. The patient has no motor or sensory deficit of the right upper extremity.

The left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, inferior pole of the patella. There is no heat, erythema, or deformity appreciated. There is swelling and crepitus appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 120/130 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 12/29/2021, shows impingement and outlet syndrome. Axillary lymph nodes. Subacromial sub-fascial deltoid bursitis. Incomplete rotator cuff tear with acute component supraspinatus and infraspinatus portion of the cuff. MRI of the left knee, done on 12/14/2021, shows evidence for medial meniscus tear. Lateral meniscal myxoid reaction. Additional ACL injury suggested. Quadriceps and patellar tendinitis. No gross bony derangement.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.81 Shoulder tendinitis, right shoulder.
5. S43.431A Labral tear, right shoulder.
6. M75.41 Impingement, right shoulder.
7. M65.811 Tenosynovitis, right shoulder.
8. M75.51 Bursitis, right shoulder.
9. M75.21 Bicipital tendinitis, right shoulder.
10. M25.511 Pain, right shoulder.
11. S49.91XA Injury, right shoulder.
12. S46.101A Biceps tendon tear, right shoulder.
13. M67.211 Hypertrophy synovitis, right shoulder.
14. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
15. M25.411 Joint effusion, right shoulder.
16. S83.242A Medial meniscus tear, left knee.
17. S83.282A Lateral meniscus tear, left knee.
18. S83.512A Anterior cruciate ligament sprain, left knee.
19. S83.412A Medial collateral ligament sprain, left knee.
20. S83.32XA Tear of articular cartilage, left knee.
21. M22.2X2 Patellofemoral chondral injury, left knee.
22. M25.462 Joint effusion, left knee.
23. M12.569 Traumatic arthropathy, left knee.
24. S80.912A Injury, left knee.
25. M25.562 Pain, left knee.
26. M65.162 Synovitis, left knee.
27. M24.662 Adhesions, left knee.

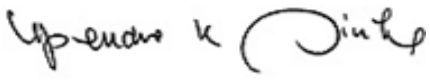
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left knee 3 days/week.
6. Discussed left knee arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient would like to think about surgery.

7. It is medically necessary to perform the suggested surgery to properly diagnose the patient's condition and to objectively verify presence and severity of internal derangement and other left knee pathology in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the left knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
10. All the questions in regard to the procedure were answered.
11. Follow up in 2 weeks.

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.

AFFIRMATION: Being duly licensed to practice medicine in the state of New York, pursuant to the applicable provisions of the Civil Practice Laws and Rules, I hereby affirm under penalty of perjury that the statements contained herein are true and accurate.



U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon

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