UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418

INITIAL INTAKE SHEET

WC (NF) LIEN

Patient Name: Daqelce Navoro M / F **DOA:** 2/6/2022.
DOB: 8/12/2000 **Age:** 21 **Height:** 5'7 **Weight:** 150 **Handed:** (R) / L
Chief Complaint: (R/ SH) (L/SH) (R /KN) L/ KN R/ Elb L/ Elb R/ Hip L/ Hip R/ Ank L/ Ank
(R/ Wri) (L/ Wri) Neck Mid-back Low-back

Type of Injury: MVA Work-Related **Working:** Y / (N) **Degree of Disability:** _____%
Asymptomatic prior to accident: Y / N **History of prior trauma:** Y / N
Pain in: _____
Other: _____

__Pedestrian __Bicyclist __Motorcyclist __Bus pass. (Driver) Front Pass. Rear Pass
Vehicle hit: Rear Front Driver-side front Driver side rear Passenger side front
Passenger side rear T-Boned Driver side T-Bone Passenger side
Airbags deployed: (Y) / N **EMS Arrived:** (Y) / N **Police at Scene:** (Y) / N
Went to Hospital: Y (N) **Hospital name:** _____ Amb. Car
PMH: None Diabetes HTN HLD (Asthma) Cardiac Thyroid CA _____
PSH: None _____
Meds: None /Pain meds PRN lidocain patches, (PCP) pain ointment
Drug Allergy: Y / (N) _____
Soc. His: Smoke Y / (N) _____**ppd** Alcohol Y / (N) Recreational Drugs Y / (N)
PT/Chiro: Y / N **Duration:** _____ Weeks /Months/Years **Relief:** Good Little None
Walk: Y / N _____blocks **Stand:** Y / N _____mins **Sit** Y / N _____mins
Unable to: Garden Play sports Drive Lift Childcare (Carry) Reach overhead
Laundry Shopping Errands Kneel Squat Stairs Jog (Exercise)

PRESENT COMPLAINTS:

R SH Pain 8 /10	**L SH** Pain 7 /10	**R KN** Pain 10 /10	**L KN** Pain ____/10
Constant Intermittent	Constant Intermittent	Constant Intermittent	Constant Intermittent
Stiff Weak Pop Click	Stiff Weak Pop Click	Stiff Weak	Stiff Weak
Reach overhead Y / (N)	Reach overhead Y / N	Diff rising from chair (Y) / N	Diff rising from chair Y / N
Reach back Y / N	Reach back Y / N	Diff w/ stairs (Y) / N	Diff w/ stairs Y / N
Unable to sleep at night	Unable to sleep at night	Click Pop Buckl Lock	Click Pop Buckl Lock
Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice

R HIP Pain ____/10	**L HIP** Pain ____/10	**R ANK** Pain ____/10	**L ANK** Pain ____/10
Constant Intermit Lock	Constant Intermit Lock	Constant Intermittent	Constant Intermittent
Pain w/ stand walk climb	Pain w/ stand walk climb	Pain w/ stand walk climb	Pain w/ stand walk climb
Standing from sitting	Standing from sitting	Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice
Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice		

R WRI Pain ____/10	**L WRI** Pain ____/10	**R ELB** Pain ____/10	**L ELB** Pain ____/10
Constant Intermittent	Constant Intermittent	Constant Intermittent	Constant Intermittent
Weak Numb Tingle	Weak Numb Tingle	Weak Numb Tingle	Weak Numb Tingle
Pain w/ lift carry drive	Pain w/ lift carry drive	Pain w/ lift carry drive	Pain w/ lift carry drive
Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice	Imp w/ Rest Med PT Ice

Other Complaints: Patient cant sleep on right side.

ROS:
General: Fevers chills night sweats weight gain weight loss
HEENT: Double vision eye pain eye red. hearing loss earache ear ringing nose bleeds sore throat hoarseness
Endocrine: Cold intolerance appetite changes hair changes
Skin: Clear no rashes or lesions
Neuro: Headaches dizziness vertigo tremors
Respiratory: Wheezing coughing shortness of breath difficulty breathing
Cardiovascular: Chest pain murmurs irregular heart rate hypertension
GI: Nausea vomiting diarrhea constipation jaundice change in bowel habits
GU: Blood in urine painful urination loss of bladder control urinary retention
Hematology: Active bleeding bruising anemia blood clotting disorders
Psychiatric: Anxiety change in sleep pattern depression suicidal thoughts

PHYSICAL EXAMINATION:

C SPINE: Pain Sharp Shoot Burn Constant Intermit Numb Tingling Radiates to R L
Pain w/ neck bend lift carry Impoves w/ Rest Med PT Ice
ROM: Flex. ____/45 Ext. ____/45 R Lat Flex. ____/45 L Lat Ext. ____/45 Rot ____/60

L SPINE: Pain Sharp Shoot Burn Constant Intermit Numb Tingling Radiates to R L
Pain w/ stand walk sit bend Impoves w/ Rest Med PT Ice
ROM: Flex. ____/80 Ext. ____/25 R Lat Flex. ____/35 L Lat Ext. ____/45 Sac Hip Flex ____/45

R /SH: Swelling /Tender to palp → Supraspinatus AC joint Trap. Prox biceps Coracoid Deltoid Scapula
Heat Erythema Crepitus Deformity
Drop Arm Cross-Over Empty Can Yergason Deltoid Atrophy
O'Brien's Impingement Lift off test Hawkins
ROM: Abd. 95 /180 Add. 30 /45 For Flex. 110 /180 Ext. 30 /60 IR ____/90 ER 60 /90
IR: sacrum mid back _____no motor or sensory deficit

L /SH: Swelling/Tender to palp→ Supraspinatus AC joint Trap. Prox biceps Coracoid Deltoid Scapula
Heat Erythema Crepitus Deformity
Drop Arm Cross-Over Empty Can Yergason Deltoid Atrophy
O'Brien's Impingement Lift off test Hawkins
ROM: Abd. 100 /180 Add. ____/45 For Flex. 100 /180 Ext. 35 /60 IR 45 /90 ER 70 /90
IR: sacrum mid back _____no motor or sensory deficit

R /KN: Swelling / Tender along → Med joint line Lat joint line Sup. patella Inf. Patella Pop. fossa
Heat Swelling Erythema Crepitus Deformity
McMurray Lachmans Pat. fem. grind Ant. draw Post. draw
ROM: Flexion 120 /130 Extension 0 /5 __Stable varus/valgus ____no motor or sensory deficit

L/ KN: Swelling / Tender along → Med joint line Lat joint line Sup. patella Inf. Patella Pop. fossa
Heat Swelling Erythema Crepitus Deformity
McMurray Lachmans Pat. fem. grind Ant. draw Post. draw
ROM: Flexion ____/130 Extension_____/5 __Stable varus/valgus _____no motor or sensory deficit

R /HIP: Swelling /Hematoma / Effusion / bruise _____ Trendelenburg +ve - ve
Tenderness to palpation → Great Troch Groin Medial thigh. ROM: Full Limited and painful.
ROM: Abd. ____/45 Add. ____/35 Flex. ____/120 Ext. ____/30 IR ____/45 ER ____/45

L /HIP: Swelling /Hematoma / Effusion / bruise _____ Trendelenburg +ve - ve
Tenderness to palpation → Great Troch Groin Medial thigh. ROM: Full Limited and painful.

ROM: Abd. ____/45 Add. ____/35 Flex. ____/120 Ext. ____/30 IR ____/45 ER ____/45

R /ANK: Swell /Hemato/ bruise → Ant. Post. Lat. Malleo Ant Draw +ve - ve Inv Stress +ve - ve
Tenderness to palpation → Med. aspect Lat. aspect. ROM: Full Limited and painful.
ROM: Dorsi flexion ____/20 Plantar flex. ____/50 Inversion ____/15 Eversion ____/15

L /ANK: Swell /Hemato/ bruise → Ant. Post. Lat. Malleo Ant Draw +ve - ve Inv Stress +ve - ve
Tenderness to palpation → Med. aspect Lat. aspect. ROM: Full Limited and painful.
ROM: Dorsi flexion ____/20 Plantar flex. ____/50 Inversion ____/15 Eversion ____/15

R /WRI: Pain to palp. → Ulnar styl. Distal rad. Scaphoid ____/5 grip strength Swell Erythema Bruise
Tinel +ve - ve Phalen +ve - ve
ROM: Flexion ____/80 Extension ____/70 Radial dev. ____/20 Ulnar dev. ____/30

L /WRI: Pain to palp. → Ulnar styl. Distal rad. Scaphoid ____/5 grip strength Swell Erythema Bruise
Tinel +ve - ve Phalen +ve - ve
ROM: Flexion ____/80 Extension ____/70 Radial dev. ____/20 Ulnar dev. ____/30

R /ELB: Swell Erythema Bruise Deltoid atrophy ____/5 musc stren Tender → Med Epi Lat Epi Ole Pro
Varus +ve - ve Valgus +ve - ve Tinel +ve - ve
ROM: Flexion ____/150 Extension ____/150 Supin. ____/90 Pron. ____/90

L /ELB: Swell Erythema Bruise Deltoid atrophy ____/5 musc stren Tender → Med Epi Lat Epi Ole Pro
Varus +ve - ve Valgus +ve - ve Tinel +ve - ve
ROM: Flexion ____/150 Extension ____/150 Supin. ____/90 Pron. ____/90

Dx:

Right Shoulder	**Left Shoulder**	**Right Knee**	**Left Knee**
S46.011A Partial rot cuff tear	S46.012A Partial rot cuff tear	S83.241A Med. Men. tear	S83.242A Med. Men. tear
M75.121 Complete rot cuff tear	M75.122 Complete rot cuff tear	S83.281A Lat. Men. tear	S83.282A Lat. Men. tear
M24.811 Internal derangement	M24.812 Internal derangement	M23.91 Internal derangement	M23.92 Internal derangement
M75.01 Adhesive Capsulitis	M75.02 Adhesive Capsulitis	S83.519A ACL tear	S83.519A ACL tear
M75.81 Shoulder tendinitis	M75.82 Shoulder tendinitis	S83.511A ACL sprain	S83.512A ACL sprain
S43.431A Labral tear	S43.432A Labral tear	S83.411 MCL sprain	S83.412A MCL sprain
S43.431A SLAP tear	S43.432A SLAP tear	M94.261 Chondromalacia	M94.262 Chondromalacia
M75.41 Impingement	M75.42 Impingement	S83.31XA Tear artic. cartilage	S83.32XA Tear artic. cartilage
M65.811 Tenosynovitis	M 65.812 Tenosynovitis	M22.2X1 PF chondral injury	M22.2X2 PF chondral injury
M75.51 Bursitis	M75.52 Bursitis	M25.461 Joint effusion	M25.462 Joint effusion
M75.21 Bicipital tendinitis	M 75.22 Bicipital Tendinitis	M12.569 Trauma. arthropathy	M12.569 Trauma. arthropathy y
M25.511 Pain	M25.512 Pain	S80.911A Injury	S80.912A Injury
S49.91XA Injury	S49.92XA Injury	M25.561 Pain	M25.562 Pain
S46.101A Biceps tendon tear	S46.102A Biceps tendon tear	M65.161 Synovitis	M65.162 Synovitis
M24.10 Glenoid chondr defect	M24.10 Glenoid chondr defect	M23.40 Loose body in knee	M23.40 Loose body in knee
M94.211 Chondromal, glen/HH	M94.212 Chondromal, glen/HH	M24.10 Chondral lesion	M24.10 Chondral lesion
M67.211 Hypertroph. synovitis	M67.212 Hypertroph. synovitis	M93.261 Osteochondral lesion	M93.262 Osteochondral lesion
M89.311 AC joint hypertrophy	M89.312 AC joint hypertrophy	M17.11 Osteoarthritis	M17.12 Osteoarthritis
M24.011 Loose Bodies	M24.012 Loose Bodies	M24.661 Adhesions	M24.662 Adhesions
M25.311 Shoulder instability	M25.312 Shoulder instability	M67.51 Medial plica	M67.52 Medial plica
M19.011 Primary osteoarthritis	M19.012 Primary osteoarthritis	M25.761 Osteophyte	M25.762 Osteophyte
M25.411 Joint Effusion	M25.412 Joint Effusion	M70.41 Prepatellar bursitis	M70.42 Prepatellar bursitis

Right Hip	Left Hip	Right Ankle	Left Ankle

Right Wrist	Left Wrist	Right Elbow	Left Elbow

C Spine	L Spine

Plan:

____Recommend steroid inj. for pain mgmt. **R /SH L /SH R /KN L /KN R /HIP L /HIP R /ANK L /ANK R /WRI L /WRI R /ELB L /ELB C Spine L Spine**

Patient ____Accepts ____Refuses.

____Brace ordered **R /SH L /SH R /KN L /KN R /HIP L /HIP R /ANK L /ANK R /WRI L /WRI R /ELB L /ELB**

____MRI ordered **R /SH L /SH R /KN L /KN R /HIP L /HIP R /ANK L /ANK R /WRI L /WRI R /ELB L /ELB C Spine L Spine**

____Follow up in _____Weeks / Months / PRN.

____Discussed **R /SH L /SH R /KN L /KN R /HIP L /HIP R /ANK L /ANK R /WRI L /WRI R /ELB L /ELB C Spine L Spine**

____Proceed w/ Sx ____Wants to think about it ____Proceed with_____ Sx after rehab on_____

____Med Clearance needed prior to Sx. _____ W/C authorization needed prior to Sx

____Patient consents to _____ Sx.

____Patient scheduled for **R /SH L /SH R/ KN L /KN Surgery** on _____

COMPLETE YOUR FORMS | MEDICAL INFORMATION

Return all documents to Sedgwick in one of three ways:
upload: mySedgwick® | email: WalmartForms@sedgwicksir.com | fax: 859-264-4372 or 859-280-3270

Certification of healthcare provider for associate's serious health condition

Associate name: DÃ¢Â¿Â¿Angeleze Navarro **Associate WIN:** 228604738
Case number: C202080204800283TC

Instructions to the associate:
Please give this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

It is your responsibility to ensure that the certification is provided in a timely manner. Return the completed form by email, fax or upload to mySedgwick® (as shown above), or send through the mail to: **Walmart Disability and Leave Service Center at Sedgwick, PO Box 14028, Lexington, KY, 40512.** (Please keep a copy for your records.)

Instructions to the healthcare provider:
Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of the condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the associate is seeking leave. Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name: _____

Business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____

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TC202080204800283TC-2048

5/27/2022 C202080204800283TC 562022052725207

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Associate name: DÃ¢Â¿Â¿Angeleze Navarro **Associate WIN:** 228604738
Case number: C202080204800283TC

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ___No ___Yes If so, dates of admission: Date admitted:_____ Date released:_____

   Date(s) you treated or are scheduled to treat the patient for condition (including telemedicine visits conducted by video conference):

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes

   Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

   Was the patient referred to any other healthcare provider(s) for evaluation or treatment (e.g., physical therapist)? ____No ____Yes

   If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ___No ___Yes If so, expected delivery date: _____

3. For the following question, use the job information provided by the employer. If the employer fails to provide a list of the associate's essential functions or a job description, answer these questions based upon the associate's own description of his/her job functions.

   Is the associate unable to perform any of his/her job functions due to the condition: ____ No ____ Yes

   If so, identify the job functions the associate is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the associate seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

NOTE: In California, Connecticut and Wisconsin, do not disclose the underlying diagnosis unless you have received consent from the patient.

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Associate name: DÃ¢Â¿Â¿Angeleze Navarro **Associate WIN:** 228604738
Case number: C202080204800283TC

PART B: AMOUNT OF LEAVE NEEDED

5. Will the associate be required to be away from work for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

   If so, provide an estimate of the continuous dates the associate will be away from work:
   Start date:_____ End date:_____

6. Will the associate need to attend follow-up treatment appointments because of the associate's medical condition? ___No ___Yes

   If so, are the treatments medically necessary? ___No ___Yes

   Estimate the treatment schedule, if any. Include the dates of any scheduled appointments and the time required for each appointment, including any travel time and any recovery period. **Please provide a numerical response** – For example: 1 appointment every 3 months, and requires 1 day of recovery per appointment:

   Frequency: _____ appointment(s) every _____ week(s) *or* _____ month(s)

   Duration: _____ hour(s) *or* ___ day(s) per appointment

7. Will the condition cause episodic flare-ups periodically preventing the associate from performing his/her job functions? ____No ____Yes

   Is it medically necessary for the associate to be absent from work during the flare-ups? ____No ____ Yes

   If so, explain:_____

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of time the patient may need to be away over the next 6 months. **Please provide a numerical response** – For example: 1 episode every 3 months lasting 1-2 days:

   Frequency: _____ time(s) per _____ week(s) *or* _____ month(s)

   Duration: _____ hour(s) *or* ___ day(s) per episode

8. Will the associate need to work part-time or on a reduced schedule because of the associate's medical condition? ___No ___Yes

   If so, is the reduced number of hours of work medically necessary? ___No ___Yes

   Estimate the part-time or reduced work schedule the associate needs, if any:

   _____ hour(s) per day; _____ day(s) per week from _____ through _____

ADDITIONAL INFORMATION: Please reference the question number for any related information you provide

_____

_____

_____

Signature of healthcare provider **Date**

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TC202080204800283TC-2048

6/6/2022

(08334)-Navarro DAngeleze J

Date of Birth - 12/27/2000 Sex - Female Marital Status - Single

Address: 88-21 75th street,Woodhaven,NY,11421
Phone #: (347) 768-6413

Social Security# - 053-46-7087

Employer or Company Name:
Address: 40-06 ITHACA ST QUEENS 11373 (PICK UP)
Emergency Name:
Work Phone #: 718-708-9899

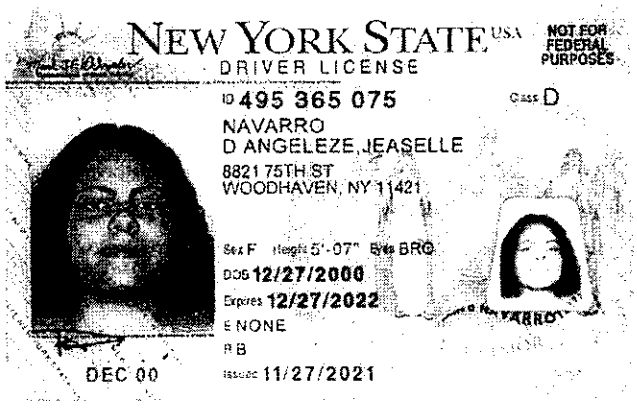
Date of Accident - 2/6/2022
Time/Place Accident - 78-02 Atlantic Avenue
Policy Report - Yes
Date of Visit - 2/10/2022
Condition Related to : Auto Accident

Insurance Company : GEICO
Address: PO Box 9507
Fredericksburg,VA, 22403
Phone: Fax: 518-560-3913

Claim# - 0324926190101141
Claim Address - GEICO NY PIP
PO Box 9507
Fredericksburg, VA 22403-9526
NF-2 - No
Policy Adjuster - Romel Mejia
Policy Effective Date - 10/29/2021
Policy# - 4506864844
Policy holder - Navarro, Jhon
WCB# -
Carrier case # -

Attorney - Scott L Wiss Firm Name - Law Offices of Scott L Wiss, P.C
Attorney Address - 510 Hempstead Turnpike #206, West Hempstead, NY 11552
Attorney Phone - (516) 747-3222 Fax - Contact Person -

Other Insurance -
Medicare -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