

UK Sinha Physician, P.C.

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July 08, 2022

Re: Belfon, Kari
DOB: 07/18/1979
DOA: 02/08/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, right knee, left knee, left wrist, left elbow pain, neck, and low-back.

HISTORY OF PRESENT ILLNESS: A 42-year-old right-hand dominant female involved in a work related accident on 02/08/2021. The patient was climbing stairs to deliver mail and tripped on block of ice. The EMS arrived on the scene. The police were not called to the scene of the accident. The patient was transported via ambulance to Brookdale Hospital Medical Center and was treated and released the same day. The patient presents today complaining of left shoulder, right knee, left knee, left wrist, left elbow, neck, and low-back pain sustained in the work related accident. The patient was attending physical therapy for the last 2 weeks with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: C-section.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n. and acid reflux medications.

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

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: Left shoulder: Left shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has popping and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with rest, medication, and physical therapy.

Right knee: Right knee pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, and buckling. Worse with range of motion and improves with rest, medication, and physical therapy.

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

Left wrist: Left wrist pain is 5/10, described as intermittent, dull, achy pain. Denies weakness, numbness, tingling. The patient has pain with lifting, carrying, and driving. Worse with range of motion and improves with rest, medication, and physical therapy.

Left elbow: Left elbow pain is 8/10, described as constant, dull, achy pain. The patient has pain with lifting and carrying. Worse with range of motion and improves with rest, medication, and physical therapy.

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: No chest pain, murmurs, irregular heart rate or hypertension.

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 6 feet 2 inches, weight is 280 pounds, and BMI is 35.9. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, and deltoid. There is crepitus appreciated. There is no heat, swelling, erythema 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 110/180 degrees, adduction 35/45 degrees, forward flexion 110/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and

external rotation 60/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The right knee reveals tenderness along the medial joint line and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 105/130 degrees and extension 0/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

The left knee reveals tenderness along the medial joint line and superior pole of patella. there is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 105/130 degrees and extension 0/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

The left wrist reveals pain to palpation over the ulnar styloid. Grip strength is 4/5. Negative Tinel sign. Negative Phalen test. Range of motion reveals flexion 60/80 degrees, extension 50/70 degrees, radial deviation 15/20 degrees, ulnar deviation 25/30 degrees.

The right elbow reveals swelling, erythema, bruise, and deltoid atrophy. Muscle strength is 4/5. There is tenderness to palpation over the lateral epicondyle. Negative Varus test. Negative Valgus test. Negative Tinel sign. Range of motion reveals flexion 130/150 degrees, extension 140/150 degrees, supination 80/90 degrees, pronation 80/90 degrees.

DIAGNOSTIC TESTING: MRI of the right knee, done on 08/25/2022, shows no meniscal tear, ligamentous or osteochondral injury. Patella alta with high-grade cartilage thinning of the lateral patellar facet and milder cartilage thinning of the lateral femoral trochlea. Mild edema of the superior lateral infrapatellar fat pad likely related to friction with patellar maltracking. Minimal effusion.

ASSESSMENT:

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M75.02 Adhesive capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. S43.432A Labral tear, left shoulder.
5. M75.42 Impingement, left shoulder.
6. M75.52 Bursitis, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. M25.412 Joint effusion, left shoulder.
10. S83.241A Medial meniscus tear, right knee.
11. S83.511A Anterior cruciate ligament sprain, right knee.
12. S83.411 Medial collateral ligament sprain, right knee.

13. M94.261 Chondromalacia, right knee.
14. M25.461 Joint effusion, right knee.
15. S80.911A Injury, right knee.
16. M25.561 Pain, right knee.
17. M65.161 Synovitis, right knee.
18. S83.242A Medial meniscus tear, left knee.
19. S83.512A Anterior cruciate ligament sprain, left knee.
20. S83.412A Medial collateral ligament sprain, left knee.
21. M94.262 Chondromalacia, left knee.
22. M25.462 Joint effusion, left knee.
23. S80.912A Injury, left knee.
24. M25.562 Pain, left knee.
25. M65.162 Synovitis, left knee.
26. Partial tear of the palmar radial scaphoid ligament, left wrist.
27. Posttraumatic lateral epicondylitis, left elbow.

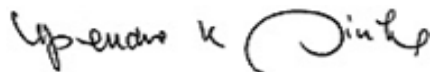
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left shoulder, right knee, left knee, left wrist, and left elbow.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, right knee, left knee, left wrist, and left elbow 3 days/week.
6. Discussed right 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 proceed with surgery.
7. Workers' Compensation Board authorization needed prior to surgery.
8. 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 right 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.
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the right 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.
11. All the questions in regard to the procedure were answered.
12. The patient verbally consents for the arthroscopy of right knee and the patient will be scheduled for right knee surgery. On the day of the surgery, before the procedure, the surgeon will explain all related questions of the procedure. The patient will sign a written consent and be witnessed by the surgeon.
13. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

IMPAIRMENT RATING: 100%.

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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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

UKS/AEI