May 01, 2025  
Office seen at:  
Ilya Kopach, FNP  
Multi Specialty Medical Center  
1894 Eastchester Road Suite 201  
Bronx, 10461 NY  
  
RE:  Thomas, Emma  
DOB:  01/01/1995   
DOA:  02/11/2025   
WCB#:  
  
 INITIAL ORTHOPEDIC CONSULT EXAMINATION  
CHIEF COMPLAINT: Right shoulder, left shoulder, right knee and left knee pain.  
  
HISTORY OF PRESENT ILLNESS: A 30-year-old left-hand dominant female involved in a work-related motor-vehicle accident on 02/11/2025. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the front end. The airbags did not deploy. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder, left shoulder, right knee and left knee pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for the last 10 weeks with little relief.   
  
WORK HISTORY: The patient is currently not working  
PAST MEDICAL HISTORY: Diabetes. There is no previous history of trauma. The patient was asymptomatic prior to accident.   
PAST SURGICAL HISTORY: C-section.   
DRUG ALLERGIES: ASPIRIN.  
MEDICATIONS: The patient is not taking any medication at this time.   
SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. The patient does not use recreational drugs.  
PRESENT COMPLAINTS:   
Right shoulder: Right shoulder pain is 7/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has pain with lifting and carrying. The patient is able to reach overhead, but is 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, physical therapy, and ice.  
  
Left shoulder: Left shoulder pain is 7/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has pain with lifting and carrying. The patient is able to reach overhead, but is 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, physical therapy, and ice.  
  
Right knee: Right knee pain is 7/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. There is swelling noted. The patient has difficulty bending, kneeling and squatting. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking and buckling. Worse with range of motion and improves with rest, medication, physical therapy, and ice.  
  
Left knee: Left knee pain is 7/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. There is swelling noted. The patient has difficulty bending, kneeling and squatting. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking and buckling. Worse with range of motion and improves with rest, medication, physical therapy, and ice.  
  
PHYSICAL EXAMINATION:  The patient’s height is 5 feet 2 inches, weight is 145 pounds, and BMI is 28.5.  
  
Right Shoulder: Inspection: There is - swelling, - ecchymosis, - deformity, - masses.   
  
Palpation: There is tenderness over: 

|  |  |
| --- | --- |
| AC Joint | Mild |
| Scapula spine | No |
| Anterior deltoid | No |
| Proximal biceps tendon | No |
| Supraspinatus tendon |  |
| Trapezius |  |

Crepitus: No.

|  |  |  |
| --- | --- | --- |
|  | ROM (degrees) | Muscle strength |
| Forward elevation | 155/180 | 4/5 |
| Abduction | 160/180 | 4/5 |
| Internal rotation | 55//70 | 4/5 |
| External rotation | 60/90 | 4/5 |
| Posterior extension | 50/60 | 4/5 |
| Adduction | 30/30 | 5/5 |

|  |  |
| --- | --- |
| PROVOCATIVE TEST |  |
| Hawkins | Positive |
| Neer’s | Positive |
| Yergason | Negative |
| Speed | Negative |
| O’Brien | Negative |
| Lift-off | Negative |
| Belly press | Negative |
| Cross Arm | Positive |
| Drop Arm | Negative |

Left Shoulder: Inspection: There is - swelling, - ecchymosis, - deformity, - masses.   
  
Palpation: There is tenderness over: 

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| Lift-off | Negative |
| Belly press | Negative |
| Cross Arm | Positive |
| Drop Arm | Negative |

Right Knee:  Inspection: There is mild swelling, - ecchymosis, - deformity, - masses.  
  
Palpation: There is tenderness over: 

|  |  |
| --- | --- |
| Medial joint line | Mild |
| Lateral joint line | Mild |
| Quad tendon | Mild |
| Patellar tendon | No |
| Popliteal fossa |  |

Crepitus: Mild.

|  |  |  |
| --- | --- | --- |
|  | ROM (degrees) | Muscle strength |
| Flexion | 130/140 | 4/5 |
| Extension | 0/0 | 5/5 |

|  |  |
| --- | --- |
| PROVOCATIVE TEST |  |
| McMurray’s | Positive |
| Apley’s | Positive |
| Anterior drawer | Negative |
| Lachman | Positive |
| Pivot shift | Negative |
| Posterior drawer | Negative |
| Valgus stress | Negative |
| Varus stress | Negative |
| Patellar compression | Positive |
| Patellar apprehension | Negative |

Left Knee:  Inspection:  There is mild swelling, - ecchymosis, - deformity, - masses.  
  
  
Palpation: There is tenderness over: 

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| Varus stress | Negative |
| Patellar compression | Positive |
| Patellar apprehension | Negative |

DIAGNOSTIC TESTING:   
04-01-2025 - MRI of the right shoulder: Small degenerative tear in the anterior glenoid labrum. Mild thickening of the labroligamentous complex. Diffuse tendinosis of the muscles of the rotator cuff. Subtle tendinosis in the insertional fibres of the supraspinatus and infraspinatus. Mild tendinosis with subtle tendinitis of the insertional fibres of the subscapularis with subtle concealed interstitial delamination towards the superior insertional fibres. Early changes of adhesive capsulitis. Type II acromion. Degenerative change in the acromioclavicular joint. Mild thickening of ligament of the coracoacromial arch. Effusion of the subacromial bursa. .  
04-01-2025 - MRI of the left shoulder: Diffuse tendinosis of the muscles of the rotator cuff. Subtle tendinosis in the insertional fibres of the supraspinatus and infraspinatus. Mild tendinosis with subtle tendinitis of the insertional fibres of the subscapularis with subtle concealed interstitial delamination towards the superior insertional fibres. Early changes of adhesive capsulitis. Type II acromion. Degenerative change in the acromioclavicular joint. Mild thickening of ligament of the coracoacromial arch. Effusion of the subacromial bursa. .  
04-12-2025 - MRI of the right knee: A tear of the lateral meniscus is seen from the anterior horn to the mid body as noted. An interstitial tear of the ACL is noted. There is no laxity. A large joint effusion is seen without evidence of a loose body. There is a contusion over the patellar tendon.  
04-12-2025 - MRI of the left knee: A prominent contusion overlies the patella and patellar tendon extending laterally. A horizontal tear is seen peripherally at the anterior horn of the lateral meniscus. An interstitial tear of the ACL is noted. There is no laxity.  
  
  
ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M75.81 Shoulder tendinitis, right shoulder.
3. M25.511 Pain, right shoulder.
4. S49.91XA Injury, right shoulder.
5. M75.122 Complete rotator cuff tear, left shoulder.
6. M75.42 Impingement, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. S83.241A Medial meniscus tear, right knee.
10. M25.461 Joint effusion, right knee.
11. S80.911A Injury, right knee.
12. M25.561 Pain, right knee
13. S83.282A Lateral meniscus tear, left knee.
14. M12.569 Traumatic arthropathy, left knee.
15. S80.912A Injury, left knee.
16. M25.562 Pain, left knee.

PLAN:  

1. Imaging studies and clinical examinations were reviewed with the patient.
2. (Minimal findings MRI paragraph) The patient understands that the MRI of the right shoulder shows minimal pathology (slap tear). However, because of the persistence of symptoms despite 10 weeks of physical therapy and mechanical findings on physical exam, the patient wants to proceed with surgery. Because the MRI shows minimal pathology the patient understands that symptoms may not improve and that symptoms may actually get worse. The patient understands and wants to proceed with diagnostic right shoulder arthroscopy.
3. All treatment options discussed with the patient.
4. Cold compresses for left shoulder.
5. Continue anti-inflammatory and muscle relaxant medications p.r.n.
6. Continue physical therapy for left shoulder 3 days/week.
7. Continue physical therapy for 3-6 months. The patient is encouraged to continue PT for an additional six weeks but refuses due to limited progress.
8. Recommend steroid injections with pain management for left shoulder. The patient accepts.
9. Left shoulder brace ordered to decrease strain on injured tissue and decrease pain.
10. MRI ordered of left shoulder to rule out ligament tear and/or synovial injury.
11. Follow up in 4 months.
12. Discussed left shoulder 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
13. / to think about surgery
14. The patient needs medical clearance prior to surgery. Workers' Compensation Board authorization needed prior to surgery.
15. The patient is educated that surgery is mainly for diagnostic purposes due to lack of response to conservative treatments.
16. 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 shoulder 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.
17. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
18. All the benefits and risks of the left shoulder 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.
19. All the questions in regard to the procedure were answered.
20. The patient verbally consents for the arthroscopy of left shoulder and the patient will be scheduled for left shoulder 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.
21. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.
22. Medical necessity for right shoulder arthroscopy: The pathology of partial-thickness rotator cuff tear was discussed with the shoulder diagram. We discussed the anticipation for further improvement with arthroscopic surgery. Further observation and conservative treatment is not recommended since the patient has demonstrated no improvement and this condition limits the patient’s ADLs and ability to return to work due to persistent loss in range of motion and weakness. Anti-inflammatory medication and physical therapy was recommended initially but failed to significantly relieve pain and function. Shoulder subacromial steroidal injection is contraindicated in the setting of high-grade rotator cuff tear/was refused by the patient due to its potential side effects. Shoulder arthroscopy with rotator cuff debridement, possible repair, possible SLAP/labral repair and partial acromioplasty is at this stage medically necessary, will improve patient’s daily activity and function, and will bring the level of disability lower.
23. Medical necessity for left shoulder arthroscopy: The pathology of partial-thickness rotator cuff tear was discussed with the shoulder diagram. We discussed the anticipation for further improvement with arthroscopic surgery. Further observation and conservative treatment is not recommended since the patient has demonstrated no improvement and this condition limits the patient’s ADLs and ability to return to work due to persistent loss in range of motion and weakness. Anti-inflammatory medication and physical therapy was recommended initially but failed to significantly relieve pain and function. Shoulder subacromial steroidal injection is contraindicated in the setting of high-grade rotator cuff tear/was refused by the patient due to its potential side effects. Shoulder arthroscopy with rotator cuff debridement, possible repair, possible SLAP/labral repair and partial acromioplasty is at this stage medically necessary, will improve patient’s daily activity and function, and will bring the level of disability lower.
24. Medical necessity for right knee arthroscopy: The pathology of meniscus tear in the setting of pre-existing degenerative changes was discussed with the knee diagram. We discussed the anticipation for further improvement with arthroscopic surgery since she demonstrates mechanical symptoms concordant with her pathology. Further observation and conservative treatment is not recommended since the patient has demonstrated no improvement and this condition limits her ADLs and ability to return to work. Anti-inflammatory medication and physical therapy was recommended initially but failed to significantly relieve pain. Knee arthroscopy with partial meniscectomy, synovectomy and chondroplasty is at this stage medically necessary, will improve patient’s daily activity and function, and will bring the level of disability lower.
25. Medical necessity for left knee arthroscopy: The pathology of meniscus tear in the setting of pre-existing degenerative changes was discussed with the knee diagram. We discussed the anticipation for further improvement with arthroscopic surgery since she demonstrates mechanical symptoms concordant with her pathology. Further observation and conservative treatment is not recommended since the patient has demonstrated no improvement and this condition limits her ADLs and ability to return to work. Anti-inflammatory medication and physical therapy was recommended initially but failed to significantly relieve pain. Knee arthroscopy with partial meniscectomy, synovectomy and chondroplasty is at this stage medically necessary, will improve patient’s daily activity and function, and will bring the level of disability lower.
26. The patient understands that there is a high-grade rotator cuff tear, and that continued PT will not solve the problem and may even propagate the tear size. The patient is advised to proceed with surgery and repair to prevent increase in tear size and resume PT after repair. The patient understands and wants to proceed with diagnostic shoulder arthroscopy with rotator cuff repair.
27. The patient understands that there is a large complex meniscal and that continued PT will not solve the problem and may even propagate the tear size. The patient is advised to proceed with surgery and repair/reconstruction to prevent increase in tear size and resume PT after repair. The patient understands and wants to proceed with knee arthroscopy with repair/reconstruction.

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: I am a physician duly licensed to practice in the State of New York and affirm the truth of the foregoing under penalty of perjuries pursuing to CPRL2106. This report was prepared by me and is based upon my observation and treatment of the patient and contains my opinions, which are made within reasonable degree of medical certainty.  
  
  
   
Anjani Sinha, M.D.  
RICHARD AMINOV, PA-C  
Transcribed but not proofread