RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

VKP MEDICAL

920 Main Street, Niagara Falls, NY 14301
5 Limestone Drive, Williamsville, NY14221
(P) 716.686.7816 (F) 978. 495.9911

NGAEN :

Initial Evaluation

DTC3B964E1-A66B-42EC-901C-A5559BAA77D8

RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

VKP MEDICAL

920 Main Street, Niagara Falls, NY 14301
5 Limestone Drive, Williamsville, NY14221
(P) 716.686.7816 (F) 978. 495.9911

HPI:

Accident and Treatment History: This is a 63-year-old right-handed man who has sustained a work-related injury on 11/9/1999. The patient was working as a laborer for Hora Building and Maintenance. He was taking care of plazas and stripping the inside of a store and was lifting an AC. He then developed sudden onset lower back pain. He did go to OLV Hospital the next day and he was not admitted. He did see Dr. Simmons and underwent a lumbar fusion in 2004. He reports that his gave him no relief. He did see a pain management provider in Las Vegas (Dr. Thomas) who recommended a morphine pump, but the patient refused this treatment option. He had physical therapy and chiropractic treatment more than 1 year ago. He is taking a BC powder (aspirin) which he states gives him significant relief. He has not tried neuropathic medications. He is not taking any opioid medications. He states that he is not interested in pursuing further lumbar surgery or undergoing any conservative treatment options such as physical therapy, chiropractic treatment or pursuing any therapeutic injections.

Prior Injuries (related to the chief complaints):

He reports having no prior lower back pain.

Vocational History at the time of initial consultation:

He currently is 75% disabled.

ADL functioning prior to the injury: Independent with all ADLs.

Interim History:

CC: Constant pain: Lower back.

RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

Current pain level: 7/10. Pain duration: 20+ years. Pain quality: Aching. Pain aggravated by: Standing and walking. Pain alleviated by: Rest. Pain radiation: Lower back pain radiates down both legs along the buttocks and posterior thighs. Denies new onset progressive weakness or bowel/bladder dysfunction.

Per I-STOP was prescribed no opioid medications. He does take a BC powder for pain relief which provides him significant relief of his lower back pain.

Review of diagnostic studies:
None on file to review.

UDS Results: None on file to review.

I-STOP reviewed: 11/18/2020: Consistent.

Opioid Pill Counts: N/A

Opioid Medication Questions:

1. Does patient show signs of tolerance to medications?	N/A
2. Does patient show signs of drug abuse?	N/A
3. Is patient taking medication as prescribed?	N/A

Functional Status Assessments:

Lawton IADL score (IADL functioning): {Scored from 0 (low function, dependent) to 8 (high function, independent}: 11/18/2020: 8

As limited by your pain condition (assessed 11/18/2020):

1. How long can you drive? 30 mins
2. How long can you sit? 15 mins
3. How long can you stand? 15 mins
4. How long can you walk? 5-10 mins
5. How many hours of sleep do you get? 2-4 hours

RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

Since Initial Consultation:

Medications decrease my pain by: N/A

Physical Therapy/chiropractic/massage treatments decrease my pain by: N/A

Therapeutic injections decrease my pain by: N/A

Durable medical equipment (Back/neck traction device) decrease my pain by: N/A

Opioid Risk and Depression Screening Assessment:

1. Opioid Risk Assessment:

   ORT score (0-3 low risk, 4-7 moderate risk, 8 or higher high risk): 11/18/2020: 4

2. Depression Screening Assessment:

   PHQ-9 score (less than 10 (minimal depression); 10-19 (moderate depression); 20 or higher (severe depression): 11/18/2020: 7

Past Medical History: No significant medical history.

Past Surgical History: Lumbar fusion.

Family History: Arthritis, diabetes, hypertension.

Social History: Employment Status: Disabled. Marital Status: Widowed. Tobacco use: He smokes less than 1-pack per day for the last 40 years. Alcohol Use: Drinks socially. Illicit drug use: Denies.

Current Medications: BC powder.

Allergies: No known drug allergies. He denies allergies to iodine, latex, tape and shellfish.

RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

ROS:
Const: Positive for weakness. Denies excessive sweating, insomnia, unexplained weight loss, fatigue.
Eyes: Denies vision changes.
ENMT: Denies difficulty swallowing, sore throat, ringing in the ears.
CV: Denies chest pain, edema, high blood pressure, irregular pulse and palpitations.
Resp: Denies chronic cough, shortness of breath.
GI: Denies abdominal pain, indigestion, stomach ulcers and bowel incontinence.
GU: Denies difficulty voiding.
Musculo: Denies joint pain.
Skin: Denies skin, hair and nail symptoms.
Neuro: Denies headache.
Psych: Denies depressed mood, suicidal thoughts.

Exam: Vitals: BP: 138/75. HR: 62. Pulse oximetry: 98% on room air.
Const: Appears healthy and well developed. No signs of acute distress present. Patient is cooperative.
Head/Face: Atraumatic and Normocephalic on inspection
Eyes: Conjunctivae clear. Eyelids normal and palpebral fissures equal. Pupils round and equal in size. Sclerae clear and anicteric. EOMI
ENMT: External ears WNL on inspection. External nose: WNL on inspection. Lips: Appear normal and healthy on inspection. Oral mucosa moist with no thrush and no mucositis.
Musculo: Walks with a normal gait.

Spine:

Lumbar Spine:
Inspection: IC heights are equal.

Palpation: Positive lumbar paraspinal trigger points on the right and left. Positive lumbar spine tenderness. Positive right and left lumbar facet tenderness. Negative right SI joint tenderness. Negative left SI joint tenderness. Special Tests: Positive right Slump test. Positive left Slump test.

Lumbar Active Range of Motion (AROM): Flexion: 46/90 degrees. Extension: 13/30 degrees. Positive pain with active range of motion.

All AROM were measured objectively using a hand-held digital goniometer.

RE: **Dennis Bradley**
Date of Birth: **August 30, 1957**
Date of Injury: **November 9, 1999**
Date of Visit: **November 18, 2020**

Neuro:
Sensation: Intact to light touch in both lower extremities.
Strength:
L2 - hip flexors 5/5 on the left and 5/5 on the right.
L3 - knee extensors 5/5 on the left and 5/5 on the right.
L4 - ankle dorsiflexors 5/5 on the left and 5/5 on the right.
L5 - long toe extensors 5/5 on the left and 5/5 on the right.
S1 - ankle plantar flexors 5/5 on the left and 5/5 on the right.

Reflexes: Lower extremity DTR's are 2+ bilaterally. Babinski's reflex is downgoing bilaterally.

Skin: Moist and warm with no edema, lesions, or rash. There is a well-healed surgical scar over the lumbar spine.
Resp: Respiration rate is normal. Chest expansion is symmetrical. Breathing Unlabored.
CV: Extremities: Pedal pulses are 2+ bilaterally.
Abdomen: The abdomen is nondistended. No visible herniations. Abdomen is soft and nontender.
Psych: Mood/Affect: Mood is normal. Affect is normal. Cognition: Alert and oriented x3.

15 minutes was spent with the patient going over the results of the depression screening tool and it was explained to the patient how the results can affect treatment outcomes.

Assessment (Diagnoses):

1. Post-laminectomy syndrome of the lumbar spine with a bilateral lumbar radiculopathy.
2. Long-term use of drug therapy.

Plan/Discussion:
This is a 63-year-old right-handed man who has sustained a work-related injury on 11/9/1999 which led to the development of new onset lower back pain. He underwent a lumbar spinal fusion and is still having persistent lower back pain with radiation down both legs.

I explained to him about several treatment options including physical therapy, chiropractic treatment and therapeutic injections. The patient does not want to pursue any conservative treatment options. He does not want to pursue further lumbar surgery. He is not interested in

being prescribed medications other than what he is already taking. At this point, I have no further treatment recommendations. I did obtain a urine drug screen to assess for opioid compliance and the presence of illicit drugs.

Followup: None.

Worker's Compensation Questions:
Is the patient working? No
In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? Yes
Are the patient's complaints consistent with his history of the injury/illness? Yes
Is the patient's history of the inj/illness consistent with your obj findings? Yes
What is the percentage (0-100%) of temporary impairment? 75%

Causality:

If the above history is correct, then there is a causal relationship between the patient's accident and his/her above complaints, injuries, impairments and disabilities.

I had explained to the patient about the pain conditions which have developed as a result of the work related injury. The patient was educated on avoiding or minimizing any aggravating factors which can worsen the pain related to these conditions.

This document serves as a letter of medical necessity for the above stated diagnostic testing, physical therapy, referrals for specialist consultation, medications and therapeutic injections.

I, Vikas Pilly, M.D., being a physician duly licensed to practice in the state of New York, under the penalties of perjury, pursuant to CPLR 2106, do hereby affirm the contents of the foregoing.

Vikas K. Pilly, MD
Board Certified, Physical Medicine & Rehabilitation
Board Certified, Pain Management
mg