PATIENT NAME **PN: 00000**
00/00/2010

SUBJECTIVE: The patient returns today with regard to his left shoulder. He was last seen on January 28, 2010, at which time he was diagnosed with left shoulder impingement with rotator cuff tendinopathy as well as downsloping of the acromion and AC joint arthritis. In the past, the patient has undergone injections as well as therapy. The injections he has had in the past have given him a couple of hours of improvement, but once the numbness had worn off, the symptoms recurred. At the time of his last appointment, he was given an injection in the subacromial space at which time he had excellent relief of his pain for approximately two hours. However, the symptoms subsequently recurred and he has continued to have pain since. He had been in therapy for over a month previously, and this actually caused the pain to get worse.

OBJECTIVE: HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light with accommodation. Extraocular muscles intact. Neck: Supple, nontender. Heart: Regular rate and rhythm. Lungs: Clear. Abdomen: Soft. Musculoskeletal: On review of the left shoulder, the patient has tenderness over the anterior acromion as well as the lateral acromion. He has positive impingement signs and tenderness over the AC joint.

IMAGING STUDIES: The patient brought in his MRI today for review. On review of his MRI, the patient does have some lateral downsloping of the acromion, he has a type II acromion with an anterior spur and AC joint arthritis, and chronic tendinopathy of the distal supraspinatus tendon.

ASSESSMENT AND PLAN: Left shoulder impingement with rotator cuff tendinopathy and acromioclavicular joint arthritis. Options were discussed with the patient. The patient has failed conservative measures including therapy, time, and injections, so I discussed with him surgical options. I feel this would most likely consist of a left shoulder arthroscopy and debridement with subacromial decompression and distal clavicle resection and bursectomy. The patient had his MRI in October, and from his symptomatology, I would doubt that he has developed a rotator cuff tear by now. However, I will schedule him for a possible rotator cuff repair, just in case he has developed a tear in the rotator cuff since the time of his MRI, so that we can fix it at the time of surgery if necessary. However, at this time, that is not expected. After discussing the procedure, risks, benefits, and expected postoperative course with the patient, the patient wishes to proceed. He will be off work for approximately five to six weeks and then will be able to return to work with some lifting restrictions unless, of course, there is a rotator cuff tear, which would elongate the recovery process. We will plan to schedule the patient on March 9, 2010, and then plan to see him back on the usual postoperative basis.

<Dictating Physician>
XX/mt
D: 00/00/2010
T: 00/00/2010

SAMPLE

January 8, 2010

<Physician>
<Clinic>
<Address>
<City, State, Zip>

RE: <Patient Name>
DOB: 00/00/0000
PN: 00000.0
DOV: 00/00/2010

Dear Dr. <Name>:

Thank you for consulting me on <Patient Name>. As you know, she is a very pleasant 48-year-old female who injured her right shoulder while she was riding a bike when a car hit her right shoulder. This occurred on November 2, 2008. She is right-hand dominant. She states the pain is mostly in her shoulder with some numbness, tingling and weakness in her arm.

PAST MEDICAL HISTORY: Significant for pneumonia and cervical cancer for which she had a LEEP. Her teeth need repair or extraction.

PAST SURGICAL HISTORY: LEEP surgery.

HOSPITALIZATIONS: No other hospitalizations.

MEDICATIONS: She is on Mobic, Vicodin and Fioricet.

ALLERGIES: Prednisone.

SOCIAL HISTORY: She does not drink. She smokes a quarter of a pack a day. She is not working at the present time.

REVIEW OF SYSTEMS: Noncontributory. Please refer to the patient questionnaire form.

OBJECTIVE: On physical examination of her right shoulder, forward flexion is to 160 degrees limited secondary to pain and abduction is to 140 degrees limited secondary to pain. She has positive cross-chest adduction, positive apprehension, positive relocation test and negative liftoff sign. Elbow has full extension, flexion to 150 degrees, supination to 90 degrees and pronation to 90 degrees. Left elbow has full extension, flexion to 150 degrees, supination to 90 degrees and pronation to 90 degrees. Forward flexion is to 120 degrees and abduction is to 150 degrees.

ASSESSMENT: Right shoulder instability and AC joint arthritis.

PLAN: I recommend therapy to see how the patient does. If she continues to have symptoms, then I would get an MR arthrogram. Therapy will be scapular stabilization and Jobe exercises.

Thank you so much for consulting me on this patient.

Sincerely,

<Dictating Physician>
XX/mt
D: 00/00/2010
T: 00/00/2010

SAMPLE

PATIENT NAME **PN: 00000**
00/00/2010

SUBJECTIVE: The patient presents today with a chief complaint of increased redness, swelling and pain at the tip of the right fifth finger. He sustained a traumatic amputation of his right fifth finger about six months ago. He underwent a series of wound checks and dressing changes in our office. His wound had healed adequately. He was subsequently discharged from care and has not had any problems with his finger for the last six months. He notes that about three weeks ago he started to notice some increased redness around the tip of his right finger and the development of a white spot at the tip of his right finger. He then went away on vacation when he noticed an increase in pain, redness and swelling. Also, the size of the white dot on the tip of his finger increased in size as well. While he was on vacation, the white dot turned into a wound that looked like a blister. He notes increased pain at this time as well. While on vacation the blister popped and started draining pus. Since then he has noted a decrease in pain, swelling and redness. He notes that the wound at the tip of his right fifth finger has now almost completely subsided, but he still felt that he should keep his appointment today for a wound check, regardless.

OBJECTIVE: Weight 185 pounds. Pulse 70. Blood pressure 124/86. Physical examination: General appearance: No acute distress. Alert, awake, and oriented. HEENT: No scleral icterus present. Extraocular muscle function is intact. Musculoskeletal: Examination of the right hand reveals a scab on the tip of the right fifth finger. The wound is clean, dry, and intact. There is no erythema or drainage noted. The patient can flex and extend the right finger with minimal pain and stiffness. Palpation does elicit moderate tenderness around the tip of the right fifth finger and around the area of the wound. Overall, the wound looks very good.

ASSESSMENT: Cellulitis, right fifth finger.

PLAN: I think that Brett had an abscess on the tip of the right fifth finger, which was the finger that he had amputated about six months ago. While on vacation, the wound ruptured and leaked pus. Since then the wound has gotten significantly better. Today the wound looks very good. I am going to give him a prescription for antibiotics for 5 days. I gave him a prescription for Keflex 500 mg. I also gave him a prescription for some pain medicine today as he said the pain is keeping him from sleeping at night. I gave him a prescription for Norco 10/325 mg, #60, with 1 refill. We will fill this for him one time since he had the infection. He is to come back to see us again if his symptoms persist or if the infection returns, and if it does, we will get an x-ray of his finger to see if he has a foreign body left in his finger from the amputation that is causing the infection.

<Dictating Physician>
XX/mt
D: 00/00/2010
T: 00/00/2010

SAMPLE