Justin M Grant
5/22/2015 3:30 PM Office Visit Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **8574389** Provider: **Michael P. Cunningham, PA-C**

Encounter Status
Closed by Michael P. Cunningham, PA-C on 5/22/15 at 3:59 PM

Diagnoses
Left ankle sprain, initial encounter - Primary
ICD-10-CM:
S93.402A
ICD-9-CM:
845.00

Reason for Visit
Ankle Pain
Sprinting 2 weeks ago, came to a stop and felt pain in lt ankle.

Reason For Visit History Recorded

Reason for Visit Comments
Ankle Pain
Additional comments: Sprinting 2 weeks ago, came to a stop and felt pain in lt ankle.

Comments
Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

BP	Pulse	Ht	Wt	BMI
122/80	64	5' 9" (1.753 m) (74.59%*)	241 lb (109.317 kg) (99.83%*)	35.57 kg/m2 (99.32%*)

*Growth percentiles are based on CDC 2-20 Years data

Progress Notes
Michael P. Cunningham, PA-C at 5/21/2015 1:05 PM
Author Type: Physician Assistant Status: Signed

SUBJECTIVE:

CC: Left ankle pain x 2 weeks

HPI: Patient is a 15 y.o. male who comes in today for evaluation of the left ankle. Patient has been seen previously in orthopedics and had a left knee arthroscopy in 2014.

He noted the sudden onset of ankle pain 2 weeks ago. Mechanism of injury: Doing suicide sprints in physical education class when he sustained what is described as an inversion mechanism to the left ankle. He initially was not able to weight-bear, but over the next few hours was able to walk on it

When asked where he hurts he points to the anterolateral ankle and rates the pain as 7 /10. In addition, Justin notes ability to bear weight, but with some pain and swelling.

Aggravating activities are running. Treatment thus far has consisted of elevation, ice and OTC ibuprofen. He reports previous left ankle mild sprains, but nothing as severe as this current incident.

He is supposed to start spring football for Tiger high school next week.

ROS: The following ten systems were reviewed and negative except as noted:
Constitutional:
Neurologic:

PMFH: The history section was last reviewed by Michael P. Cunningham, PA-C on May 22, 2015.

OBJECTIVE:
Physical Exam
Constitutional: Well-developed, well-nourished and obese male. Appears well and no distress.
- Oriented to person, place, and date.

VITALS: BP 122/80 | Pulse 64 | Ht 5' 9" (1.753 m) | Wt 241 lb (109.317 kg) | BMI 35.57 kg/m2
Gait/Station: Mild antalgia on left
Eyes: Normal conjunctiva and lids, no discharge, erythema or swelling. Pupils equal and round.

HENT:
Head: Normocephalic without obvious abnormality, atraumatic.
ENT: Ears with normal shape and symmetry. Nose with normal symmetry and without discharge.

Neck: Normal, painless ROM of neck. No asymmetry or masses.
Cardiovascular: Normal rate and intact distal pulses with good capillary refill.
Pulmonary/Chest: Speaks in full sentences without audible wheezing; No tachypnea, retractions or cyanosis.

Skin: Normal and without scars, lesions, erythema.
Lymph: No abnormally enlarged lymph nodes.
Neurological: Alert. Speech: Normal.
Psychiatric: Normal with appropriate affect.

Musculoskeletal:
ANKLE EXAM: Left

INSPECTION:

Right Ankle
SKIN: Intact without scars, lesions, erythema, or ecchymosis
SWELLING: none

Left Ankle:
SKIN: Intact without scars, lesions, erythema, or ecchymosis
SWELLING: Moderate soft tissue swelling along the lateral aspect of the ankle

ARCH: Not Assessed
GAIT: Mild antalgia on left

PALPATION:

Pain on palpation over:	**LEFT**
Lateral Malleolus	yes
Distal Syndesmosis	no
Proximal Fibula	no
ATFL	yes
CFL	no
PTFL	yes
Peroneals	no
Sinus Tarsi	no
Base 5th Metatarsal	no
Medial Malleolus	no
Deltoid	no
Sustenaculum Tali	no
Navicular	no
Post Tibialis	no
FDL	no
FHL	no
Calcaneal Dome	no
Achilles Tendon	no
Retrocalcaneal bursa	no

Anterior Tibialis	no
EHL	no
EDL	no
Extensor Retinaculum	no

ROM:

	RIGHT
DF	10
PF	50
INV	5
EV	5

Pain with ROM: No

	LEFT
DF	4
PF	40
INV	5
EV	5

Pain with ROM: Yes plantarflexion and end inversion

STRENGTH:

	LEFT
DF	5/5
PF	5/5
INV	5/5
EV	5/5

Pain with Strength testing: Yes

SPECIAL TESTS:

	LEFT
ANT DRAWER	Negative
ER STRESS	Negative
SQUEEZE	Negative

He is distally neurovascularly intact along the left foot and ankle.

Imaging: X-rays available for review consist of 3 views of the left ankle taken today.

Fracture or Dislocation: no abnormality other than some lateral soft tissue swelling.

Mortise Symmetrical: Yes

Osseous Lesions: No

Arthritis: No

ASSESSMENT: Left, lateral ankle sprain

PLAN: Discussed nature of ankle sprains and a handout was provided on the diagnosis. Ankle mortise is symmetrical. Stable injury although ankle sprains can take months before they stop hurting. He is able to weight-bear fairly well so I do not think I need to immobilize him in a ankle-stirrup brace. A physical therapy referral was provided to work on decreasing pain and inflammation, improving range

of motion and strength, and finally balance/proprioception.

He should continue to ice especially after activity and may use over-the-counter ibuprofen as needed. A letter was provided to his athletic trainer at the high school allowing him to participate in spring football with certain restrictions.

Follow-up in approximately 3-4 weeks with Dr. Sandmeier for recheck.

***Parts of this document was created using voice recognition software and may have inadvertent typographical and other errors. Please verify any discrepancies with the author.*

H&P Notes

No notes of this type exist for this encounter.

Level of Service

PR OFFICE OUTPATIENT VISIT 25 MINUTES [99214]

Follow-up and Disposition

Return in about 4 weeks (around 6/19/2015).

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

Letters

Letter Information

	Status
Michael P. Cunningham on 5/22/2015	Sent

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99214	PR OFFICE OUTPATIENT VISIT 25 MINUTES	5/22/2015	Michael P. Cunningham, PA-C		1

CODING QUERY

Create an InBasket Message

Routing History

Recipient	Method	User	Date	Routed To
Justin M Grant 7909 SW Cedarcrest St TIGARD OR 97223 Phone: 503-702-6551	Mail	Michael P. Cunningham, PA-C [516] Letter: created on 5/22/2015 by Michael P. Cunningham, PA-C	5/22/2015	(none on file)

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Justin M Grant

5/21/2015 10:50 AM Orders Only Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **8574840** Provider: **Michael P. Cunningham, PA-C**

Encounter Status

Closed by Elizabeth Size, ATC on 5/21/15 at 1:49 PM

Progress Notes

No notes of this type exist for this encounter.

H&P Notes

No notes of this type exist for this encounter.

Diagnoses

Pain in joint, ankle and foot, left - Primary

ICD-10-CM:
M25.572
ICD-9-CM:
719.47

Orders

Orders Placed This Encounter

Future Labs/Procedures	Expected by	Expires
XR Ankle Left, 3 View [IMG143 Custom]	5/21/2015	7/21/2015

Justin M Grant
9/29/2014 10:10 AM Office Visit Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **7209749** Provider: **Robert H. Sandmeier, MD**

Encounter Status
Closed by Robert H. Sandmeier, MD on 9/29/14 at 11:16 AM

Diagnoses
Strain of knee, left, initial encounter - Primary
ICD-10-CM:
S86.812A
ICD-9-CM:
844.8

Reason for Visit
Knee Pain

Reason for Visit Comments
Left knee injured during football practice on 09/24/14.
Meningococcal Vaccine(#1) due on 04/30/2011
Hpv Vaccines(#1) due on 04/30/2011
Influenza Vaccine due on 09/01/2014
Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

BP	Pulse	Ht	Wt	BMI
114/80	76	5' 9" (1.753 m) (86.58%*)	232 lb (105.235 kg) (99.84%*)	34.24 kg/m2 (99.18%*)

*Growth percentiles are based on CDC 2-20 Years data
Vitals History Recorded

Progress Notes
Robert H. Sandmeier, MD at 9/29/2014 11:14 AM
Author Type: Physician Status: Signed
Justin M Grant is a 14 y.o. male returns to follow up for
Encounter Diagnosis

Name	Primary?
• Strain of knee, left, initial encounter	Yes

He presents today with a primary complaint of discomfort in the lateral aspect of the left knee and says that he had been feeling fine and was back to participating in football without difficulties until he was being pushed back when he was on the line and had his left knee go into a valgus sort of position with subsequent discomfort.

He and his mom said it was a little bit of swelling in the lateral aspect knee but this went down fairly quickly

He does not describe catching, locking or giving way

The event occurred approximately 4 days ago when he is already feeling considerably better

OBJECTIVE:

Filed Vitals:

	09/29/14 1016
BP:	114/80
Pulse:	76

Estimated body mass index is 34.24 kg/(m^2) as calculated from the following:
Height as of this encounter: 5' 9" (1.753 m).
Weight as of this encounter: 232 lb (105.235 kg).

Physical Exam

Constitutional: . well-developed and well-nourished. No distress.

HEENT: Head: Normocephalic and atraumatic.
Eyes: Conjunctivae are normal. No scleral icterus.
Neck: Grossly normal range of motion. Neck supple.
Cardiovascular: good capillary refill
Pulmonary/Chest: Breath sounds normal. No respiratory distress. speaks in full sentences
Neurological: alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: normal mood and affect.

Gait and station: normal

Today his left knee has range of motion from -5-135° of flexion. He has slight discomfort at maximal extension that is felt primarily anterolaterally

His knee is stable to varus, valgus as well as anterior and posterior drawer and Lachman exam

Meniscal signs are negative

He is maximal area of tenderness is in the lateral peripatellar retinaculum and somewhat over the lateral epicondyles as well

Plain films demonstrate no abnormality

ASSESSMENT:

Encounter Diagnosis

Name	Primary?
• Strain of knee, left, initial encounter	Yes

Possible patellar subluxation or irritation of his IT band without evident structural injury to the

PLAN:

I would have him continue with physical therapy and I think what is really happened is that he has never really had a good chance to get good shape this season as he first had his knee problem went to an arthroscopic procedure and then subsequently had a kidney stone Him out for a month and he is really trying to do things that can principle he should be able to do but is not quite shape needs to be and do them at a high level

He is going to work on physical therapy course follow up with me again on an as-needed basis

H&P Notes

No notes of this type exist for this encounter.

Patient Instructions

PHYSICAL THERAPY REFERRAL
Dr. Robert Sandmeier
9250 SW Hall Blvd.
Tigard, OR 97223
(503) 293-0161

PATIENT'S NAME: JUSTIN GRANT DATE: 09/29/14

DIAGNOSIS: **CHONDROMALACIA—717.46**

GOALS: 2 x week for 6 weeks to be adjusted based on progress
Decrease pain & swelling
Flexibility focusing on hamstrings, hip flexors and gastrocsoleus
Restore ROM with emphasis on full hip & knee extension
Strengthening with emphasis on quads & hip external rotators

Phase 1: Decrease pain & sensitivity while working on restoring normal motion.
Phase 2: Add strengthening exercises.
Phase 3: Gradual return to normal activity. Provide tools for patient to improve ability to deal with exacerbations, which are likely to occur.

RESTRICTIONS: NONE—avoid knee extension as they can aggravate anterior knee pain

Throughout the program the patient should be doing as much as possible and working on transitioning to their home exercise program. Modalities used to improve ability to do exercises but not as an isolated treatment.

What I tell the patient & would like you to reinforce:

Anterior knee pain is the final common pathway for many knee problems and the process can begin with any injury, even a minor one. After the knee has become painful you tend to limp and not use your knee in a normal way and this sets up the vicious cycle described below.

Pain and weakness results in limping, limping results in loss of muscle strength & flexibility and this results in decreased control of the knee. Decreased control of the knee results in increased pain starting the cycle again and may continue even if the initial problem has gotten better.

The pain you are experiencing is not a sign of damage occurring in you knee. It took a while for your knee to get as bad as it is and will also take a while for it to get better. Muscle development is a process that takes a long time so immediate results cannot be expected.

The therapists will help you find out which exercises you can do without aggravating the pain. This will involve trying out a number of exercises before you end up with a list that works well for you. Everyday you should do what you can to improve the strength & coordination of the muscle in your leg.

When your muscles are in good shape you will be able to do more things without pain. When you do something that does cause pain, it will be less severe and not last as long. It is not uncommon to have setbacks along the way so don't get discouraged. There is not a surgical solution for this problem—if you want to get better you must work diligently on the exercise program.

I will typically see the patient back after 6 weeks of therapy for re-evaluation.

_____**Robert Sandmeier, MD**

Level of Service

PR OFFICE OUTPATIENT VISIT 25 MINUTES [99214]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99214	PR OFFICE OUTPATIENT VISIT 25 MINUTES	9/29/2014	Robert H. Sandmeier, MD		1

CODING QUERY

Create an InBasket Message

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Justin M Grant

8/6/2014 2:30 PM Office Visit Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **6990815** Provider: **Robert H. Sandmeier, MD**

Encounter Status

Closed by Robert H. Sandmeier, MD on 8/6/14 at 2:55 PM

Diagnoses

S/P left knee arthroscopy - Primary
ICD-10-CM:
Z98.89
ICD-9-CM:
V45.89

Reason for Visit

Post-op Exam

Reason for Visit Comments

Post op left knee surgery on 5/23/14

Meningococcal Vaccine(#1) due on 04/30/2011
Hpv Vaccines(#1) due on 04/30/2011

Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

Pulse	Ht	Wt	BMI
84	5' 10" (1.778 m) (94.00%*)	↑ 234 lb 3.2 oz (106.232 kg) (99.87%*)	33.60 kg/m2 (99.09%*)

*Growth percentiles are based on CDC 2-20 Years data
Vitals History Recorded

Progress Notes

Robert H. Sandmeier, MD at 8/6/2014 2:52 PM

Author Type: Physician Status: Signed

Justin M Grant is a 14 y.o. male returns to follow up for

Encounter Diagnosis

Name	Primary?
• S/P left knee arthroscopy	Yes

He presents today reporting his knee still bothers him a little bit when he bends past 90° and he sometimes feels a little clicking sensation in the back of the knee.

We initially had him start with physical therapy after his knee arthroscopy as he did not seem to be taking off early on. It sounds as though this was stopped due to financial concerns and he has done very well with respect to range of motion and has done some of the exercises but is now trying to get ready for football and the transition seems to be difficult

He does not describe catching locking or giving way. The primary complaint is discomfort when he bears weight in deep flexion, for example doing squats.

OBJECTIVE:

Filed Vitals:

	08/06/14 1431
Pulse:	84

Estimated body mass index is 33.6 kg/(m^2) as calculated from the following:
Height as of this encounter: 5' 10" (1.778 m).
Weight as of this encounter: 234 lb 3.2 oz (106.232 kg).

Physical Exam

Constitutional: . well-developed and well-nourished. No distress.
HEENT: Head: Normocephalic and atraumatic.
Eyes: Conjunctivae are normal. No scleral icterus.
Neck: Grossly normal range of motion. Neck supple.
Cardiovascular: good capillary refill
Pulmonary/Chest: Breath sounds normal. No respiratory distress. speaks in full sentences
Neurological: alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: normal mood and affect.

Gait and station: normal

Today his left and right knees have a symmetrical appearance with the exception of well-healed arthroscopy portals. There is no effusion, range of motion is symmetrical, both knees are ligamentously stable, meniscal signs are negative.

Hip internal rotation is quite stiff on both sides stopping at as most about 10° of internal rotation. This maneuver does result in some discomfort felt in the lateral aspect of the left knee

ASSESSMENT:

Encounter Diagnosis

Name	Primary?
• S/P left knee arthroscopy	Yes

Stable postop but with incomplete rehabilitation and I believe some difficulties in understanding what he should be doing to get ready to return.

I do not believe he is causing any damage or harm by participating in all activities as he is able to do so but it sounds as though he is not able to do his body weight with the leg press so trying to do his body weight doing squats would seem to be a fruitless exercise

He has described that it hurts his knee a little bit to try and run and had impact but then within a few minutes he asks me if he can do Box jumps as part of his football training and again I would think this answer is fairly clear in that if he is not able to run without experiencing discomfort with impact it is unlikely that he would be able to jump from a height without experiencing discomfort.

PLAN:

My main advice for him is to begin a more progressive exercise program starting at a somewhat lower level than he is now. I have recommended the core performance exercise book as an excellent program to get him back into shape for football.

H&P Notes

No notes of this type exist for this encounter.

Level of Service

PR POST-OP FOLLOW-UP VISIT [99024]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99024	PR POST-OP FOLLOW-UP VISIT	8/6/2014	Robert H. Sandmeier, MD		1

CODING QUERY

Create an InBasket Message

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Justin M Grant

6/24/2014 3:20 PM Office Visit Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **6813965** Provider: **Robert H. Sandmeier, MD**

Encounter Status

Closed by Robert H. Sandmeier, MD on 6/24/14 at 4:19 PM

Diagnoses

S/P left knee arthroscopy - Primary
ICD-10-CM:
Z98.89
ICD-9-CM:
V45.89

Reason for Visit

Post-op Exam

Reason for Visit Comments

Post op left knee scope on 5/23/14

Hpv Vaccines(#1) due on 04/30/2011

Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

BP	Pulse	Wt
130/78	80	↑255 lb (115.667 kg) (99.95%*)

*Growth percentiles are based on CDC 2-20 Years data

Progress Notes

Robert H. Sandmeier, MD at 6/24/2014 3:19 PM

Author Type: Physician Status: Signed

SUBJECTIVE:

CC: Follow-up left knee.

HPI: Patient is a 14 y.o. male who is 1 month out of a left knee arthroscopic partial lateral menisectomy. Dr. Sandmeier and I are seeing this patient together.

Date of Surgery: 5/23

He reports that overall he has improved, but not 100% just yet. Post op problems: none.

Taking pain medication: no
OTC Meds: None.
Physical Therapy: Yes with Kim Mineo
Crutches/Brace: no

ROS: The following two systems were reviewed and negative except as noted:
Constitutional:
Neurologic:

PMFH: The history section was last reviewed by Michael P. Cunningham, PA-C on Jun 24, 2014.

OBJECTIVE:
Physical Exam
Constitutional: Well-developed, well-nourished and obese male. Appears well and no distress. Oriented to person, place, and date.
VITALS: BP 130/78 | Pulse 80 | Wt 255 lb (115.667 kg)
Gait/Station: normal gait and station
Eyes: Normal conjunctiva and lids, no discharge, erythema or swelling. Pupils equal and round.

HENT:
Head: Normocephalic without obvious abnormality, atraumatic.

ENT: Ears with normal shape and symmetry. No anterior cervical adenopathy. Sinuses nontender.

Neck: Normal, painless ROM of neck. No asymmetry or masses.
Cardiovascular: Normal rate and intact distal pulses with good capillary refill.
Pulmonary/Chest: Speaks in full sentences without audible wheezing; No tachypnea, retractions or cyanosis.

Skin: Normal and without scars, lesions, erythema.
Lymph: No abnormally enlarged lymph nodes.
Neurological: Alert. Speech: Normal.
Psychiatric: Normal with appropriate affect.

Musculoskeletal:
Portals are well-healed without erythema, ecchymosis, or drainage. There is a trace effusion. Mild tenderness to palpation along the anterior portion of the lateral joint line. Range of motion is from full extension to 135° of flexion without pain. Medial and lateral McMurray's is negative. Patient walks with a non-antalgic gait on the left.

Patient demonstrates a squat. He is not quite able to get down to wear his thighs are parallel with the ground as he reports pain in the left knee with this.

ASSESSMENT: Stable status post one-month left knee partial lateral meniscectomy. With a very good mid term result

PLAN: Progress activities as tolerated. Followup on an as needed basis if he has any problems or questions

***Parts of this document was created using voice recognition software and may have inadvertent typographical and other errors. Please verify any discrepancies with the author.*

Revision History

H&P Notes

No notes of this type exist for this encounter.

Level of Service

PR POST-OP FOLLOW-UP VISIT [99024]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99024	PR POST-OP FOLLOW-UP VISIT	6/24/2014	Robert H. Sandmeier, MD		1

CODING QUERY

Create an InBasket Message

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Justin M Grant
6/3/2014 10:10 AM Office Visit Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **6674240** Provider: **Robert H. Sandmeier, MD**

Encounter Status
Closed by Robert H. Sandmeier, MD on 6/3/14 at 10:33 AM

Diagnoses
Tear of lateral cartilage or meniscus of knee, current - Primary
ICD-10-CM:
S83.289A
ICD-9-CM:
836.1

Reason for Visit
Post-op Exam

Reason for Visit Comments
Left knee scope 05/23/14.
Hpv Vaccines(#1) due on 4/30/2011
Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

BP	Pulse	Temp(Src)	Wt
120/60	92	97.8 °F (36.6 °C) (Tympanic)	255 lb (115.667 kg) (99.96%*)

*Growth percentiles are based on CDC 2-20 Years data

Progress Notes
Robert H. Sandmeier, MD at 6/3/2014 10:31 AM
Author Type: Physician Status: Signed

Subjective:

Postop 10 days out after partial lateral meniscectomy for a radial tear in the mid body

No complaints, feels things are going as expected. He has noted some popping noises in the lateral aspect of the knee

Adequate pain control

progressively improving with a return to normal activities

Objective:

NAD
A + O x 3

Ambulates with a nearly normal gait

Effusion 1+

ROM bends well past 90 degrees and extends to 0 or better

Portals healing well without erythema or drainage

Assessment:

Stable Post op with the expected early results and no signs of infection or other problems

Plan:

Progress activities per post op protocol

Discussed a return to activity program.

PT referral was provided today

Follow up in 3 weeks to make sure things are continuing to progressively improve

H&P Notes

No notes of this type exist for this encounter.

Orders Placed This Encounter

Ambulatory referral to Physical Therapy [REF87 Custom]

Level of Service

PR POST-OP FOLLOW-UP VISIT [99024]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99024	PR POST-OP FOLLOW-UP VISIT	6/3/2014	Robert H. Sandmeier, MD		1

CODING QUERY

Create an InBasket Message

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Justin M Grant

5/5/2014 8:30 AM Consult Department: **Ortho Tmo** Description: **Male DOB: 4/30/2000**
MRN: **5965991** CSN: **6581103** Provider: **Robert H. Sandmeier, MD**

Encounter Status

Closed by Robert H. Sandmeier, MD on 5/5/14 at 9:27 AM

Diagnoses

Tear of lateral cartilage or meniscus of knee, current - Primary
ICD-10-CM:
S83.289A
ICD-9-CM:
836.1

Reason for Visit

Knee Pain

Reason for Visit Comments

Left knee pain, clicking and popping

Hpv Vaccines(#1) due on 4/30/2011

Overdue and upcoming health maintenance items were reviewed with the patient. Patient has been advised to follow up with their primary care provider regarding these items.

Vitals

BP	Pulse	Wt
118/70	76	↑230 lb (104.327 kg) (99.87%*)

*Growth percentiles are based on CDC 2-20 Years data
Vitals History Recorded

Progress Notes

Robert H. Sandmeier, MD at 5/5/2014 8:58 AM

Author Type: Physician Status: Signed

SUBJECTIVE:

CC: Left knee pain x 5 months

HPI: This is a 14 y.o. male who comes in today for evaluation of the left knee. Patient accompanied by his mom. Dr. Sandmeier and I are seeing this patient together. Patient has been sent for consultation by Dr. Crist.

He noted the insidious onset of left knee pain 5 months ago. Mechanism of injury: No trauma, but started after playing a football game in cold weather. When asked where he hurts he points to the lateral aspect of the knee and rates the pain as 8/10. Additional symptoms: Popping which does cause pain. He denies any knee giving out, locking, swelling.

Aggravating activities are running and standing after sitting. Treatment thus far has consisted of heat, ice, physical therapy at TMO with Angela and rest. Reports that the physical therapy did help, but pain returned about 1-2 weeks of baseball. He denies previous left knee problems.

ROS: The following ten systems were reviewed and negative except as noted:
Constitutional:
Cardiovascular:
Pulmonary:
Gastrointestinal:
Musculoskeletal:
Dermatologic:
Endocrine:
Hematologic:
Neurologic:
Psychiatric:
Immune:

PMFH:

Past Medical History

Diagnosis	Date
• Healthy infant or child	

Past Surgical History

Procedure	Laterality	Date
• Circumcision		

Current Outpatient Prescriptions on File Prior to Visit

Medication	Sig	Dispense	Refill
• ibuprofen (ADVIL,MOTRIN) 200 MG tablet	Take 400 mg by mouth every 6 (six) hours as needed.		
• Multiple Vitamin (MULTIVITAMIN) tablet	Take 1 tablet by mouth daily.		

Allergies

Allergen	Reactions
• Amoxicillin	Hives

Social History

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol Use:	No
• Drug Use:	No
• Sexually Active:	No

History

Social History Narrative

Lives with parents and older brother, younger sister.
Dad Eric, 8-7-78
Mom Leanna, 9-26-79.
Brother Jacob, 5-14-95
Sister Erica, 11-7-09

Exercise/Athletics: Football and baseball.

OBJECTIVE:

Physical Exam

Constitutional: Age-appropriate development, well-nourished and overweight male. Appears well and no distress. Oriented to person, place, and date.
VITALS: BP 118/70 | Pulse 76 | Wt 230 lb (104.327 kg)
Gait/Station: normal gait and station
Eyes: Normal conjunctiva and lids, no discharge, erythema or swelling. Pupils equal and round.

HENT:
Head: Normocephalic without obvious abnormality, atraumatic.
ENT: Ears with normal shape and symmetry. No anterior cervical adenopathy. Sinuses nontender.

Neck: Normal, painless ROM of neck. No asymmetry or masses.
Cardiovascular: Normal rate and intact distal pulses with good capillary refill.
Pulmonary/Chest: Speaks in full sentences without audible wheezing; No tachypnea, retractions or cyanosis.

Skin: Normal and without scars, lesions, erythema.
Lymph: No abnormally enlarged lymph nodes.
Neurological: Alert. Speech: Normal.
Psychiatric: Normal with appropriate affect.

Musculoskeletal:
KNEE EXAM: Bilateral

INSPECTION:

Right Knee :

SKIN: Intact without scars, lesions, erythema, or ecchymosis
EFFUSION: no
SWELLING: none
ALIGNMENT: mild valgus
QUAD ATROPHY: No

Left Knee:

SKIN: Intact without scars, lesions, erythema, or ecchymosis
EFFUSION: no
SWELLING: none
ALIGNMENT: mild valgus
QUAD ATROPHY: No

PALPATION:

Pain on palpation over:	**LEFT**
Lateral joint line	Yes: Anterior > posterior
Lateral femoral condyle	no
Lateral collateral ligament	no
IT Band	yes
Proximal Fibula:	no
Lateral patellar retinaculum	no
Medial joint line	no
Medial femoral condyle	no
Medial collateral ligament	no
Medial patella retinaculum	no
Pes Bursa:	no
Quad tendon	no
Patella:	no
Patellar tendon	no
Tibial tubercle	no
Popliteal fossa	no

ROM:	**RIGHT**
EXT:	5
FLEX:	140

LEFT

EXT: 5
FLEX: 140

STABILITY: **RIGHT**
VARUS stable
VALGUS stable
POST DRAW stable

LACHMAN'S: stable
Endpoint: firm

LEFT
VARUS stable
VALGUS stable
POST DRAW stable

LACHMAN'S: stable
Endpoint: firm

MENISCAL SIGNS: **RIGHT**
McMurray
Medial: Negative
Lateral: Negative
Bounce Home Negative

LEFT
McMurray
Medial: Positive for lateral joint line pain
Lateral: Negative
Bounce Home Negative

PATELLAR GLIDE:	**RIGHT**	**LEFT**
Medial	2	2
Lateral	2	2
Pain	No	No
Appreh	No	No

HIP ROM: No pain with passive range of motion of the bilateral hips. Internal/external rotation is smooth.

Imaging: MRI of the left knee reviewed from 4/21.

Effusion: no
Bone Edema: no

Medial Meniscus:
Tear: no
Intrasubstance Degen: no
Extruded: no

Lateral Meniscus:
Tear: Yes anterior horn with discoid appearance
Intrasubstance Degen: no
Extruded: no

Ligaments:
ACL: Normal

PCL: Normal
MCL: Normal
LCL: Normal

OCD: no

OA: no

ASSESSMENT: Left knee lateral meniscus tear with a radial tear in the somewhat anterior aspect of the mid body of the lateral meniscus. He has had symptoms now for about 5 months despite a course of physical therapy.

Generally, none degenerative meniscus tears do have a lower chance of resolving without surgical intervention but he has given us a very good try nonsurgically already.

PLAN: After discussing the available options, including operative and non operative management, the patient has elected to proceed with surgery.

The proposed procedure is a diagnostic arthroscopy and anticipated meniscectomy.

Risks that were discussed today include the risk of infection at about .5%, DVT at about 1-2%, and the possibility that the symptoms may not be improved.

All of the patients questions were answered.

***Parts of this document was created using voice recognition software and may have inadvertent typographical and other errors. Please verify any discrepancies with the author.*

Revision History

H&P Notes

No notes of this type exist for this encounter.

Orders Placed This Encounter

Case Request [SURG01 Custom]

Level of Service

PR OFFICE OUTPATIENT NEW 45 MINUTES [99204]

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet

Referring Provider

Jonathan C. Crist, MD

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99214	PR OFFICE OUTPATIENT VISIT 25 MINUTES	5/5/2014	Robert H. Sandmeier, MD		1

CODING QUERY

Create an InBasket Message

Other Encounter Related Information

Allergies & Medications

Problem List

History

Patient-Entered Questionnaires

Surgical Log

5/23/2014 Hospital Visit — **Justin M Grant** | MRN: **5965991**

Log ID

Log 15463

General Information

Date: **5/23/2014** | Time: **10:00 AM** | Status: **Posted**
Location: **ALBERTY SURGICAL CENTER** | Room: **OR 04** | Service: **Orthopedics**
Patient class: **Outpatient** | Case classification: **Elective**

Case Information

Surgeons & Procedures

Panel 1

Surgeon	Role	Service	Start Time	End Time
Robert H. Sandmeier, MD	Primary	Orthopedics	9:59 AM	10:29 AM

Procedure	Laterality	Anesthesia
KNEE ARTHROSCOPY and partial med menisc	Left	General

Patient Diagnosis

Pre-op diagnosis: Tear of lateral cartilage or meniscus of knee, current [836.1]
Post-op diagnosis: Tear of lateral cartilage or meniscus of knee, current [836.1]

Complications

None

Adverse Events

None

Verification History

Staff Name	Date	Time	Type
Geoffrey Jutzy, RN	5/23/2014	9:48 AM	Pre-Op
Ryan Grimm, RN	5/23/2014	10:29 AM	Intra-Op
Jerri Glanders, RN	5/23/2014	11:48 AM	Post-op (Phase I and II)

Procedure Documentation

OP Notes

Op Note by Robert H. Sandmeier, MD at 5/23/2014 10:23 AM

Author:	Robert H. Sandmeier, MD	Author Type:	Physician	Filed:	5/23/2014 10:24 AM
Note Status:	Signed	Cosign:	Cosign Not Required	Note Time:	5/23/2014 10:23 AM
Editor:	Robert H. Sandmeier, MD (Physician)				

SURGICAL CENTER OPERATIVE RECORD

Patient: Justin M Grant, d.o.b: 4/30/2000, MRN: 5965991
Date of Procedure: 5/23/2014

Pre-op Diagnosis: Tear of lateral cartilage or meniscus of knee, current [836.1]

Post-op Diagnosis: Tear of lateral cartilage or meniscus of knee, current [836.1]

Procedure(s) (LRB):
KNEE ARTHROSCOPY and partial med menisc (Left)

Surgeon(s) and Role:
*** Robert H. Sandmeier, MD - Primary**

Anesthesia : General

Indications for surgery:
knee pain that has failed to respond to conservative management that is thought to be due to a tear of the meniscus

Narrative description:

The patient was placed on the operating table in the supine position.

A sequential venous compression device was placed on the nonoperative leg.

Preoperative antibiotics were given.

The left knee was examined under anesthesia.

ROM -5 to 140

The was stable to varus, valgus, posterior drawer and Lachman exam.

There was a Small effusion.

The limb was sterilely prepped and draped in the usual fashion, exsanguinated with an Esmarch bandage and the tourniquet inflated to 270 mm hg.

Anterior medial, anterior lateral and superior medial portals were created. The knee was then sequentially inspected.

There was no pathology identified in the medial gutter, the lateral gutter or the suprapatellar pouch.

Chondromalacia of the articular surfaces:
Patella: none
Trochlea none
Medial femoral condyle none
Medial tibial plateau none
Lateral femoral condyle none
Lateral tibial plateau none

The lateral meniscus had a radial tear of the mid body that was debrided to a stable rim using basket forceps and the arthroscopic shaver to preform an estimated 25 % meniscectomy.

There was no pathology identified in the posterior medial corner.

The intracondylar notch had intact anterior and posterior cruciate ligaments.

The medial meniscus was intact.

All arthroscopic instrumentation was removed. The skin edges of the portals were reapproximated with steri strips. The knee was injected with ropivacaine for post operative

anesthesia. A sterile compressive dressing was applied.

The patient tolerated the procedure well without complications and was transferred to the recovery room in stable condition.

Blood loss was minimal, no blood or blood products were used.

Implants: * No implants in log *

Specimens: * No specimens in log *

Tourniquet:
Total Tourniquet Time Documented:
Thigh (Left) - 7 minutes

Implant Details

MAR History by Date Range

All administrations
05/23/14 - 05/23/14

All Flowsheet Templates (all recorded)

Pre-op Phone Call Flowsheet
Call in Progress Flowsheet
Call Complete Flowsheet
PONV Risk Assessment Flowsheet
Surgery Escort & Contact Flowsheet
Screenings Flowsheet
OR Checklist Flowsheet
Assessment Flowsheet
Vital Signs Flowsheet
Custom Formula Data Flowsheet
Anthropometrics Flowsheet
OR Lines/Drains/Airways/Wounds Flowsheet
PACU Flowsheet
Encounter Vitals Flowsheet

Staff and Times

Pre-op Nurses

Pre-op nurse: **Geoffrey Jutzy, RN** Pre-op bed:

Anesthesia Staff Information

Type	Staff	Start	End
Anesthesiologist	**Samuel Metz, MD**	9:59 AM	10:29 AM

Intra-op Staff Information

Staff Type	Staff Member	Start	End
Circulator	**Ryan Grimm, RN**	9:59 AM	10:29 AM
Surgical Technologist	**Virginia Reid, ST**	9:59 AM	10:29 AM
Circulator	**Masayo Yamamoto, RN**	9:59 AM	10:02 AM

Phase I Nurses

Post-op nurse: **Jerri Glanders, RN** Post-op bed:

Phase II Nurses

Phase II nurse: **Jerri Glanders, RN** Phase II bed:

Case Tracking Events

Event	Time In
In Facility	8:42 AM
In Pre-Op	8:55 AM
Patient Ready	9:48 AM
Room Ready	9:56 AM
Anesthesia Start	9:59 AM
In Room	9:59 AM
Conscious Sedation Start	
Procedure/Incision Start	10:13 AM
At Cecum	
Procedure End	10:22 AM
Out of Room	10:29 AM
Anesthesia End	10:35 AM
In Phase I	10:29 AM
Out of Phase I	11:26 AM
In Phase II	11:26 AM
Out of Phase II	11:48 AM
Discharge	11:48 AM

Perioperative Notes

Perioperative Nursing Notes

Nursing Notes

Surgeon Documentation

Op Notes | H&P Notes | Surgeon Notes

Miscellaneous Perioperative Notes

Misc Notes

Pre-Incision Documentation

Timeouts

Geoffrey Jutzy, RN at Fri May 23, 2014 9:03 AM

Timeout Details

Timeout type: Admit / Block

Procedures

Panel 1: Left KNEE ARTHROSCOPY and partial med menisc with Robert H. Sandmeier, MD

Timeout Questions

Correct patient? Yes
Correct site? Yes
Correct side? Yes
Correct procedure? Yes
Site marked? No

Staff

Staff: Geoffrey Jutzy, RN

History

Staff	Performed	Verified
Geoffrey Jutzy, RN	Fri May 23, 2014 9:03 AM	Fri May 23, 2014 9:03 AM

Masayo Yamamoto, RN at Fri May 23, 2014 9:59 AM

Timeout Details

Timeout type: In Room

Procedures

Panel 1: Left KNEE ARTHROSCOPY and partial med menisc with Robert H. Sandmeier, MD

Timeout Questions

Correct patient? **Yes**
Correct site? **Yes**
Correct side? **Yes**
Correct position? **Yes**
Correct procedure? **Yes**
Site marked? **Yes**

Staff

Surgeons	Robert H. Sandmeier, MD
Anesthesia Staff	Samuel Metz, MD
Staff	Ryan Grimm, RN, Virginia Reid, ST, Masayo Yamamoto, RN

History

Staff	Performed	Verified
Masayo Yamamoto, RN	Fri May 23, 2014 9:59 AM	Fri May 23, 2014 10:02 AM

Ryan Grimm, RN at Fri May 23, 2014 10:05 AM

Timeout Details

Timeout type	Pre-procedure

Procedures

Panel 1: Left KNEE ARTHROSCOPY and partial med menisc with Robert H. Sandmeier, MD

Timeout Questions

Correct patient? **Yes**
Correct site? **Yes**
Correct side? **Yes**
Correct position? **Yes**
Correct procedure? **Yes**
Site marked? **Yes**
Antibiotics ordered and given? **Yes**
Consents verified? **Yes**
Radiology studies available? **Yes**
Relevant lab results available? **N/A**
Safety precautions reviewed? **Yes**
Allergies reviewed? **Yes**
Are all required blood products & devices for the procedure available? **Yes**
Is documentation verified? **Yes**
Are adequate antibiotics and irrigation fluids available? **Yes**

Staff

Surgeons	Robert H. Sandmeier, MD
Anesthesia Staff	Samuel Metz, MD
Staff	Ryan Grimm, RN, Virginia Reid, ST

History

Staff	Performed	Verified
Ryan Grimm, RN	Fri May 23, 2014 10:05 AM	Fri May 23, 2014 10:05 AM

Ryan Grimm, RN at Fri May 23, 2014 10:19 AM

Timeout Details

Timeout type	Post-Procedure

Procedures

Panel 1: Left KNEE ARTHROSCOPY and partial med menisc with Robert H. Sandmeier, MD

Timeout Questions

Are counts correct? **Yes**
Have specimens been labeled? **N/A**
Have all new equipment problems been addressed? **N/A**
Have all recovery issues been reviewed? **N/A**

Staff

Surgeons	Robert H. Sandmeier, MD
Anesthesia Staff	Samuel Metz, MD
Staff	Ryan Grimm, RN, Virginia Reid, ST

History

Staff	Performed	Verified
Ryan Grimm, RN	Fri May 23, 2014 10:19 AM	Fri May 23, 2014 10:19 AM

Patient Preparation

Area	Laterality	Scrub	Paint	Hair Removal
Leg - Circumferential ankle to tourniquet	Left	Chlorohexidine	ChloraPrep	
Knee	Left			Clipped

Skin Condition

Skin Site	Condition
Operative	**Warm, Dry, Intact**
Tourniquet	**Warm, Dry, Intact**

Positioning Information

Panel-1 Information

KNEE ARTHROSCOPY and partial med menisc (Left) - Position 1

Body:	**Supine** Sheet Draw, Strap Safety, Table O/R	Left Arm:	**Extended** Armboard, Strap Safety	Right Arm:	**Extended** Armboard, Strap Safety
Head:	**Aligned** Pillow	Left Leg:	**Prepped in Field** Leg Holder Lateral Post	Right Leg:	**Straight**
Positioned by:	**Ryan Grimm, RN** **Robert H. Sandmeier, MD** **Samuel Metz, MD**			Comments:	

Counts

Type	Which?	Correct?	X-Ray?	MD Notif?	Counted By	Verified By
Sponge	Initial	Yes	No	Yes	Virginia Reid, ST	Ryan Grimm, RN
Sponge	Final	Yes	No	Yes	Virginia Reid, ST	Ryan Grimm, RN
Needles/Sharps	Initial	Yes	No	Yes	Virginia Reid, ST	Ryan Grimm, RN
Needles/Sharps	Final	Yes	No	Yes	Virginia Reid, ST	Ryan Grimm, RN

Closing and Post-Op Documentation

Post-op Skin Information

Skin Site	Condition
Operative	**Warm, Dry, Intact**
Tourniquet	**Warm, Dry, Intact**

Case Completion Information

Incision Site	Laterality	Dressings
Leg - Circumferential	Left	DRESSING STERI-STRIP 1/2" (), DRESSING KERLIX 4" (), DRESSING ACE 6" ()

PNDS Information

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of chemical injury. (O3)
Yes	The patient is free from signs and symptoms of electrical injury. (O4)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)

Yes	The patient is free from signs and symptoms of injury related to transfer/transport. (O8)
Yes	The patient receives appropriate medication(s), safely administered during the perioperative period. (O9)
Yes	The patient is free from signs and symptoms of infection. (O10)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	The patient's care is consistent with the individualized perioperative plan of care. (O24)
Yes	The patient's right to privacy is maintained. (O25)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Diagnoses

Present?	Description (Code)

No diagnosis documented

Discharge Instructions

Discharge Instructions

Order Information

Orders Report

MAR History by Medication

Equipment / Instruments / Supplies

Sequential Compression Devices

SCD Type	SCD	Area	Laterality	Pressure	Left Pulse	Right Pulse	Applied By
Sequential Compression Device	**AIRCAST VENAFLOW - E00089**	Lower Leg	Right				Ryan Grimm, RN

Tourniquets

Tourniquet Type	Unit No.	Area	Laterality	Pressure	Inf. Date/Time	Def. Date/Time	Applied By
Tourniquet	**STRYKER TOURNIQUET - 277436**	Thigh	Left	270	5/23/14 10:13 AM	5/23/14 10:20 AM	Robert H. Sandmeier, MD

Warming Devices

Device Type	Device	Setting	Area	Laterality	Temp	Applied By
Bair Hugger	**BAIR HUGGER - 43988**	Medium	Full body	N/A		Samuel Metz, MD

Other Equipment

Type	Equipment	Setting	Setting Low	Setting High	Applied By
Lateral Post					
Suction					
Video Tower					
Pneumatic IV Pole					

Instruments

Instrument Type	Instrument	Start	End
Arthroscopy Adds Tray			
Arthroscopy Tray			
Arthroscope 4mm 30-degree			
Camera Head - Autoclavable			
Basin - Large			

Supplies (CASE COMBINED)

Supplies	Tmp?	Type	Used	Wstd	Rsn Wasted	Chrg?	Inv Location	Latex?
PACK KNEE ARTHROSCOPY CUSTOM	No	Pack	1	0				

DRESSING STERI-STRIP 1/2"	No	Dressing	1	0
SHAVER AGGRESSIVE PLUS 4.0MM	No	Shaver	1	0
DRESSING KERLIX 4"	No	Dressing	1	0
DRAPE 1050	No	Drape	1	0
DRESSING ACE 6"	No	Dressing	1	0
GLOVE BIOGEL BLUE 8	No	Glove	1	0
GLOVE BIOGEL YELLOW 8	No	Glove	1	0
ARTHROSCOPY TUBING	No	Tubing	1	0
STERILE WATER IRRIGATION BOTTLE, 1000ML	No	Other	1	0
LACTATED RINGERS, 3000ML	No	Other	1	0
HIBICLENS SCRUB BRUSH	No	Other	1	0

Scanned Documentation

Encounter-Level Documents:

Surgery Documentation - Scan on 5/27/2014 1:01 PM

Order-Level Documents:

There are no order-level documents.

Patient-Level Documents:

Photo ID - Scan on 4/16/2012 2:26 PM : mom odl

Insurance Card - Scan on 4/16/2012 2:25 PM : TERMED 10/31/14

HIPAA Notice of Privacy - Scan on 4/17/2012 7:30 AM

Face Sheet - Scan on 4/17/2012 7:30 AM

Surgical Center Disclosure - Scan on 5/29/2014 7:26 AM

Face Sheet - Scan on 10/27/2014 9:25 AM : expired

Insurance Card - Scan on 5/22/2015 2:57 PM : Anthem - blue card

OFFICE VISIT REPORT 08/12/2014

JUSTIN GRANT

MRN: **76512**
DOB: **04/30/2000, 14 year old Male**
SSN:

PRIMARY CARE:
REFERRING: **LAURA BLEDSOE MD**
PROVIDER: **Daniel A. Hirselj, M.D.**
LOCATION: **NUC - Northwest Urological Clinic**
2230 NW Pettygrove
Suite 210
Portland, OR 97210-2659
(503) 223-6223
(503) 223-3665

ALLERGIES: Amoxicillin

MEDICATIONS: None
Notes: **FLOMAX, OXYCODONE**

GU PMH: None

NON-GU PMH: None

PROCEDURES:

Urinalysis Auto w/Scope - 81001

Dipstick	Dipstick Cont'd	Micro
Specimen: Voided	Blood: Neg	**WBC/hpf: 3-5**
Appearance: Clear	Protein: Neg	**RBC/hpf: 15-20**
Color: Yellow	Urobilinogen: Neg	Epithelial Cells: Neg
Glucose: Neg	Nitrites: Neg	Bacteria: Neg
Bilirubin: Neg	Leukocyte Esterase: Neg	Fine Grain Casts/lpf: Neg
Ketones: Neg		Coarse Grain Casts/lpf: Neg
		Hyaline Casts/lpf: Neg
		Mucous: Neg
		Yeast: Neg
		Trichomonas: Neg

****** Signed by Daniel A. Hirselj, M.D. on 08/12/14 at 11:10 AM (PDT)******

LEGACY HEALTH SYSTEM
Legacy Emanuel Medical Center
2801 N Gantenbein
Portland OR 97227

OPERATIVE/PROCEDURE REPORT

GRANT, JUSTIN
9501288000
RCDS
PT TYPE: A
DOB: 04/30/2000
ADM. DATE: 08/14/2014

SURGERY DATE: 08/14/2014

ATTENDING PHYSICIAN: DANIEL A HIRSELJ

PERFORMED BY: Daniel A. Hirselj, MD

PREPROCEDURE DIAGNOSES:
1. Right renal stone.
2. Right ureteral stone.

POSTPROCEDURE DIAGNOSES:
1. Right renal stone.
2. Right ureteral stone.
3. Partial duplication anomaly on the right.

PROCEDURE PERFORMED:
1. Cystoscopy.
2. Right retrograde pyelogram.
3. Right ureteral stent placement (6-French x 28-cm double-J ureteral stent).

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

FLUIDS: Crystalloid and irrigation.

SPECIMENS AND FINDINGS: On retrograde pyelography, the child had a common sheath ureter with a partial duplication anomaly. The confluence was noted at approximately the distal third of the ureter. The child had a markedly dilated right lower pole ureteral segment. There was a question as to whether there was a kink at the right lower pole UPJ. The right upper pole segment appeared grossly normal. After inspection of the bladder after ureteral catheterization, the efflux from the right lower pole segment was markedly cloudy and purulent. The decision was then made to proceed with decompression and relief of his obstruction with stenting. More definitive management of his stones will take place at a later date.

Dictation ID: 1784479
DRAFT COPY FOR DANIEL A. HIRSELJ, MD

LEGACY HEALTH SYSTEM
Legacy Emanuel Medical Center
2801 N Gantenbein
Portland OR 97227

OPERATIVE/PROCEDURE REPORT

GRANT, JUSTIN
9501288000

COMPLICATIONS: None.

DRAINS: A 6-French x 28-cm double-J ureteral stent to the right lower pole segment.

INDICATIONS FOR PROCEDURE: Please see H&P.

DETAILS OF PROCEDURE: After appropriate consents were obtained, patient was brought to the operating suite and placed supine on the operating table. After the induction of general anesthesia, the patient was prepped and draped in a sterile fashion and placed in a modified lithotomy position. Careful attention was paid to pad his lower extremities and to avoid hyperflexion and hyperextension. Under direct visualization and irrigation using a 23-French cystoscope and a 30-degree lens, diagnostic cystourethroscopy was performed. The urethral mucosa appeared grossly normal. Upon entrance into the bladder, the bladder mucosa appeared grossly normal. Both ureteral orifices were seen in their native position and appeared nonrefluxing in nature.

A 5-French open-ended ureteral catheter was inserted through the working channel of the cystoscope. The ureteral catheter was able to intubate the ureteral orifice without difficulty. Using approximately 20 mL of water soluble contrast and C-arm fluoroscopy, a right retrograde pyelogram was performed. The child was noted to have a partial duplication anomaly to his right. The child had a common distal ureter for approximately the distal most one-third. The child then had a bifurcation of his ureter. The lower pole ureteral segment was markedly dilated, in particular compared to the upper pole segment. Following the contrast to the kidney, the child had what appeared to be a kink near his lower pole UPJ. The upper pole caliceal anatomy was difficult to discern.

Under fluoroscopic guidance, the ureteral catheter was preferentially able to traverse into the lower pole ureteral segment. Very carefully, the ureteral catheter was advanced to near the UPJ. Continued fluoroscopic images were taken in an attempt to better delineate the anatomy near the UPJ. Unfortunately, the caliceal anatomy was so dilated, clear depiction of the UPJ was unable to be obtained.

With the ureteral catheter clearly in the more dilated segment, a 0.035 Glidewire was inserted through the lumen of the ureteral catheter. A good coil was seen in the kidney under fluoroscopic guidance. The cystoscope was subsequently disarticulated, and the ureteral catheter was removed. The wire was then secured to the patient's drapes.

LEGACY HEALTH SYSTEM
Legacy Emanuel Medical Center
2801 N Gantenbein
Portland OR 97227

OPERATIVE/PROCEDURE REPORT

GRANT, JUSTIN
9501288000

The cystoscope was then reintroduced through the urethra and into the bladder under direct visualization and irrigation. Interestingly, upon entrance into the bladder, the efflux from the right ureter was grossly cloudy and purulent. Given the efflux from the ureter, the decision was made to proceed with stenting, with more definitive management of the stone burden at a later date. The child was then given 2.5 mg/kg IV of gentamicin. The cystoscope was withdrawn. The 0.035 Glidewire was then backloaded through the working channel of the cystoscope, and the cystoscope was then reintroduced into the patient's bladder. A 6-French x 28-cm double-J ureteral stent was then passed over the wire through the working channel of the cystoscope. A metal tip pusher was used to then advance the stent in the appropriate position. The metal tip pusher and wire were then removed. A good coil was seen in the bladder cystoscopically good. A good proximal coil to the stent was seen in the lower pole kidney under fluoroscopy.

The bladder was filled and then emptied on a number of occasions in an attempt to establish more clear efflux. The stent was examined. There was clearly cloudy efflux coming through the side ports on the ureteral stent throughout for the next several minutes. The cystoscope was then withdrawn in an antegrade fashion under direct visualization and irrigation. The patient was then awakened and transferred to recovery in stable condition.

PLAN: Patient will continue on perioperative antibiotics. An intraoperative urine culture was also obtained prior to starting him on gentamicin. The stent will be left in place for approximately 1 to 2 weeks. The child will then undergo more definitive management of his ureteral and renal calculi.

DANIEL A HIRSELJ MD

PT Name: GRANT, JUSTIN
DAH/ **Dictation ID: 1784479**
D: 08/14/2014 17:43:49
T: 08/16/2014 11:03:45

CC:
DANIEL A HIRSELJ MD
DANIEL A HIRSELJ

epic IMAGING
HALL/NIMBUS FACILITY | 8959 SW Nimbus Ave., Beaverton, OR 97008 | 800.330.6259
503.253.1105 | fax. 503.535.8398 | epicimaging.com

PATIENT NAME	ACCOUNT NO	ACCESSION NO	OUTSIDE NO	STATUS
GRANT, JUSTIN MICHAEL. (H) (503) 840-2771	2320296	11002011744629		Final

AT THE REQUEST OF	DATE OF BIRTH	AGE / SEX	DATE OF SERVICE	SEND
DANIEL A HIRSELJ MD 2230 NW PETTYGROVE ST, SUITE 210 PORTLAND, OR 97210	04/30/2000	14 Years / Male	08/21/14	FPC

X-RAY ABDOMEN/KUB, ONE VIEW

History: Abdominal pain. Rule out kidney stone.

Comparison: No priors.

Findings: A right trans-ureteral stent courses from the right renal hilar region to the bladder. No calculi are identified along the course of the stent. However, there is a focal calcific density projecting over the lower pole of the right kidney which could be a calculus or possibly bowel content. If there are old studies, comparison may be helpful. The bowel gas pattern is appropriate. Solid visceral shadows are unremarkable, as shown. Psoas margins appear sharp. Bones appear intact.

IMPRESSION

Right trans-ureteral stent appears appropriately positioned.

Focal calcification projecting over lower pole of the right kidney, possibly calyceal calculus or bowel content.

Interpreted by Daniel Kocarnik MD
Dictated: 08/21/2014 17:08
Signed: 08/21/2014 17:52 DK/
CC: LAURA BLEDSOE MD, 15950 SW MILLIKAN WAY, BEAVERTON, OR, 97006 / SEND – F

LEGACY HEALTH SYSTEM
Legacy Emanuel Medical Center
2801 N Gantenbein
Portland OR 97227

OPERATIVE/PROCEDURE REPORT

GRANT, JUSTIN
9501288000
RC 8A
PT TYPE: A
DOB: 04/30/2000
ADM. DATE: 08/27/2014

SURGERY DATE: 08/27/2014

ATTENDING PHYSICIAN: DANIEL A HIRSELJ

PERFORMED BY: Daniel A. Hirselj, MD

PREPROCEDURE DIAGNOSES:
1. Right ureteral calculus.
2. Right lower pole renal calculus.

POSTPROCEDURE DIAGNOSES:
1. Right ureteral calculus.
2. Right lower pole renal calculus.

PROCEDURE PERFORMED:
1. For right renal calculus: Cystoscopy with flexible ureteroscopy, holmium laser lithotripsy, stone basketing, and ureteral stent placement.
2. For distal ureteral calculus: Flexible ureteroscopy with stone manipulation and laser lithotripsy.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

FLUIDS: Crystalloid and irrigation.

SPECIMENS AND FINDINGS:
1. Right lower pole renal calculi.
2. Right distal ureteral calculus in an area of distal ureteral stenosis.
3. Relative stenosis at the right lower pole ureteropelvic junction.
4. Despite laser lithotripsy and stone basketing, the small stone fragments were unable to be passed distal to this distal ureteral stenosis. Given the trauma to the area, the decision was made to leave the stones just proximal to the stenosis (near the area of the confluence of upper pole and lower pole ureters) and place a temporizing stent.

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COMPLICATIONS: None.

DRAINS: 6-French x 28 cm double-J ureteral stent to the right lower pole moiety.

INDICATIONS FOR PROCEDURE: Please see history and physical.

PROCEDURE IN DETAIL: After appropriate consents were obtained, the patient was brought to the operating suite and placed supine on the operating table. After the induction of general anesthesia, the patient was prepped and draped in a sterile fashion and placed in a modified lithotomy position. Careful attention was paid to pad his lower extremities and to avoid hyperflexion and hyperextension. Under direct visualization and irrigation using an adult cystoscope and a 30-degree lens, diagnostic cystourethroscopy was performed. The urethral mucosa and bladder mucosa were normal. Upon entrance into the bladder, the stent was seen emanating from the ureteral orifice. A flexible grasping device was inserted through the working channel of the cystoscope. The stent, grasper, and scope were then removed to the level of the urethral meatus. The stent was secured. A 0.035 Glidewire was then inserted through the lumen of the stent. Under C-arm fluoroscopy, the wire was seen coiled in the lower pole pelvis.

The ureteral stent was subsequently removed. The cystoscope was subsequently re-articulated. Again, under direct visualization and irrigation, cystoscopy was performed. A 5-French open-ended ureteral catheter was inserted through the working channel of the cystoscope. A second 0.035 Glidewire was then able to intubate the right ureteral orifice without difficulty. The C-arm fluoroscopy confirmed its position also in the right lower pole renal pelvis. The ureteral catheter and the cystoscope were then removed. A safety wire was secured to the patient's drapes.

A flexible ureteroscope was then passed over the working wire. There was some hangup in the distal ureteral segment. A 12-French/14-French ureteral access sheath was also attempted to be passed. It also hung up near this junction of the ureters. However, the tapered end of the ureteral access sheath was able to be passed more proximally, then the scope itself. With this as a passive dilation, the scope was then passed over the wire. The scope was able to traverse this area of stenosis and then was placed in the kidney.

Approximately 20 mL of water-soluble contrast was then connected to the irrigation port of the ureteroscope. Under gentle injection of the contrast and C-arm fluoroscopy, a pyelogram was performed. The young man's lower pole anatomy was easily appreciated. There were filling defects located in the lower-most pole calices. Surveillance ureteroscopy was then performed in a stepwise fashion, moving from the mid pole calices to the lower pole calices. The stones were

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identified in the lower-most pole calix. There was significant kinking on the scope in this area. The decision was made to proceed by first grasping the stones and then moving them toward the renal pelvis for more definitive treatment.

A 0-tip nitinol basket was inserted through the working channel of the ureteroscope. The stones were very difficult to grasp, given the angulation on the ureteroscope. However, both were able to be grasped in their entirety and then placed in the renal pelvis.

Next, the basket was removed and a 200-micron holmium laser fiber was inserted through the working channel of the ureteroscope. Using a power of 0.7 joules and a frequency of 6 Hz, holmium laser lithotripsy was performed on each of these lower pole stones. They were fragmented into very small fragments (less than 2 to 3 mm). Next, the decision was made to basket these stones and bring them down the ureter.

Again, the basket was inserted through the working channel of the ureteroscope. The larger of the 2 stones was easily able to be grasped. However, upon antegrade passage of the device, there was a significant stenosis appreciated at the lower pole UPJ. Rather than risk UPJ injury or further trauma, the basket was then advanced in a retrograde fashion and the stones were re-placed in the pelvis. The basket was removed. The laser fiber was re-placed through the ureteroscope, and further laser lithotripsy was performed to further fragment these stones.

After the stones were very small, the basket was then introduced through the working channel of the ureteroscope. The basket was actually able to grasp both stones in a perfect linear fashion. The basket, ureteroscope, and stones were able to traverse the UPJ, though it was somewhat traumatic. Passage down the lower pole ureteral segment was easy. However, just distal to the confluence of the upper pole and lower pole ureters, there was a significant stenosis. Ureteroscopic evaluation revealed a larger, heretofore unknown distal ureteral calculus. Now, the basket (with the smaller stones), along with this very large ureteral calculus, were lodged in this stenotic segment just distal to the confluence. Very carefully, the basket and ureteroscope were advanced in a retrograde fashion to go proximal to the stenosis. It was clear there was no way the stones could be forced through this stenotic segment. With the larger stone positioned just at the confluence of the ureters, the basket was able to disengage the stones. The basket was then removed.

Again, the 200-micron fiber was inserted through the working channel of the ureteroscope. The large ureteral calculus then underwent holmium laser lithotripsy. The edges were shaved off. The stone did fragment somewhat. Further laser lithotripsy was performed. There was,

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curiously, some difficulty manipulating the ureteroscope to center the laser fiber upon the stone. As such, there was some difficulty in completing laser lithotripsy.

The laser was removed and the basket was again inserted through the ureteroscope. The large ureteral stone was basketed easily. However, again upon antegrade passage, this stone fragment was not able to traverse this stenotic segment. I am curious whether this stenotic segment represents where the obstructed ureteral stone has been burrowed for the past several weeks, or if there is some other congenital issue in this area. Regardless, the stone was passed in a retrograde fashion, again near the confluence. The basket was opened and the stone was disengaged. The basket was then removed. The decision was made to proceed with stent placement.

The 0.035 safety Glidewire was backloaded through the cystoscope. The cystoscope was then introduced into the bladder. A 6-French x 28 cm double-J ureteral stent was then passed over the wire through the ureteral orifice. A metal-tip pusher was used to place the stent in the appropriate position. The wire was removed. A good coil was seen distally in the bladder cystoscopically. A proximal coil was appreciated in the kidney fluoroscopically. The cystoscope was disarticulated, and the bladder volume was drained. The cystoscope was then removed. The patient was awakened and transferred to recovery in stable condition.

PLAN: The patient will continue with antibiotics, pain medications, and maximal medical expulsive therapy. I will see him again in approximately 2 weeks for hopeful definitive treatment of his stones. The child may very well need balloon dilatation of his distal ureteral stenosis as well as his ureteropelvic junction stenosis. The mother is very understanding of the child's condition.

DANIEL A HIRSELJ MD

PT Name: GRANT, JUSTIN
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D: 08/27/2014 18:20:26
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OPERATIVE/PROCEDURE REPORT

GRANT, JUSTIN M
9501288000
RCDS
PT TYPE: A
DOB: 04/30/2000
ADM. DATE: 09/17/2014

SURGERY DATE: 09/17/2014

ATTENDING PHYSICIAN: DANIEL A HIRSELJ

PERFORMED BY: Daniel A. Hirselj, MD

PREPROCEDURE DIAGNOSES:
1. Right ureteral calculus.
2. Right renal calculus.

POSTPROCEDURE DIAGNOSIS: Right renal calculus.

PROCEDURE PERFORMED:
1. Cystoscopy.
2. Right ureteral stent removal.
3. Right retrograde pyelogram.
4. Balloon dilation of right proximal ureteral stricture and right distal ureteral stricture.
5. Flexible ureteroscopy.
6. Stone basketing/manipulation.
7. Right ureteral stent placement.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

FLUIDS: Crystalloid and irrigation.

SPECIMENS AND FINDINGS:
1. On retrograde pyelogram, relative stenosis distally just distal to the confluence of the incomplete ureteral duplication.
2. More proximally near the right lower pole ureteropelvic junction, corresponding stenosis. Both stenoses were amenable to balloon dilation.
3. Small residual lower pole stone fragment, basketed and removed.

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COMPLICATIONS: None.

DRAINS: 6-French x 28 cm double-J ureteral stent to the right lower pole kidney.

INDICATIONS FOR PROCEDURE: Please see H&P.

PROCEDURE IN DETAIL: After appropriate consents were obtained, patient was brought to the operating suite and placed supine on the operating table. After the induction of general anesthesia, the patient was prepped and draped in sterile fashion and placed in a modified lithotomy position. Sequential compression devices were placed on his lower extremities. All bony prominences were padded. Careful attention was paid so as to not hyperextend or hyperflex his lower extremities.

An adult cystoscope was inserted through the urethral meatus and into the bladder under direct visualization and irrigation. The right ureteral stent was seen emanating from the right ureteral orifice. A flexible grasping device was inserted through the working channel of the cystoscope. The distal end of the stent was grasped with a grasper. The stent, grasper, and cystoscope were then removed in an antegrade fashion. The stent was quite encrusted. As such, a Glidewire was then able to be inserted through the lumen of the stent. The stent was subsequently withdrawn.

Next, the cystoscope was rearticulated. Under direct visualization and irrigation, the cystoscope was passed back into the bladder. A 5-French open-ended ureteral catheter was inserted through the working channel of the cystoscope. The ureteral catheter was able to intubate the ureteral orifice without difficulty. Using approximately 25 mL of water-soluble contrast and C-arm fluoroscopy, a right retrograde pyelogram was performed. Again, the distal-most segment of his ureter was appreciated. There was an incomplete duplication appreciated as well. Just distal to this confluence, there was a relative stenosis in the ureter. Following the ureteral course more proximally, the upper pole segment appeared delicate and nondilated. There was another relative stenosis near the UPJ of the lower pole moiety. The ureteral catheter was able to pass beyond each of the stenoses. A 0.035 Glidewire was inserted through the lumen of the ureteral catheter. The wire was then appreciated proximally in the kidney under fluoroscopy. The ureteral catheter was subsequently withdrawn.

A 6-French, 4 cm ureteral dilating balloon was then inserted over the wire through the working channel of the cystoscope. Under fluoroscopy, the location of the more distal stenosis was appreciated. Using water-soluble contrast within the chamber of the dilating reservoir, the balloon dilation device was inflated to a pressure of approximately 16 atmospheres. It was held in place for 2-3 minutes. The ureteral balloon dilating device was then taken down. The balloon

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dilating device was then advanced more proximally to near the lower pole UPJ. Again under fluoroscopy, its location was confirmed. The dilating chamber was inflated to approximately 16 atmospheres. The balloon dilator was left in place for approximately 2-3 minutes. The balloon dilating device was then taken down. A syringe was used to make sure that all the irrigation fluid was removed from the balloon. The balloon dilating device was then subsequently withdrawn through the cystoscope.

With the cystoscope in the bladder, a second 0.035 Glidewire was inserted through the working channel of the cystoscope. The wire was able to intubate the ureteral orifice without difficulty. The wire was advanced to the level of the lower pole kidney. Its position in the kidney was confirmed fluoroscopically. The cystoscope was subsequently disarticulated. One of the wires was secured to the patient's drapes for safety.

A 12-French/14-French x 45 cm ureteral access sheath was then irrigated and lubricated. Under fluoroscopy, the ureteral access sheath was able to traverse both areas of stenosis. The working wire was removed, as well as the inner lumen of the access sheath.

Next, flexible ureteroscope was articulated. Using gravity irrigation, the ureteroscope was passed through the lumen of the access sheath. Meticulous ureteroscopy was performed through all of the mid pole and lower pole calices. There were no large stones appreciated in any calix. Indeed, under fluoroscopy, there were no shadows or silhouettes appreciated either. There was a small stone fragment with associated debris appreciated in the mid pole pelvis. A 0-tip nitinol basket was inserted through the working channel of the ureteroscope. The basket was opened. The mass was able to grasp this small fragment of stone and other material. The stone, basket, and ureteroscope were then withdrawn through the ureteral access sheath. The stone was sent off for specimen.

The ureteroscope was then passed again up the access sheath and into the renal pelvis. As repeat ureteroscopy confirmed there were no stones left in the kidney, the ureteroscope as well as the access sheath were then withdrawn in an anterograde fashion, leaving the tip of the ureteroscope open to evaluate the ureter in an antegrade fashion down its course. The confluence of the ureters was also appreciated. The ureteroscope was able to intubate the upper pole ureter, and it was advanced a small distance in a retrograde fashion. There were no stones identified within the upper pole ureter in this area. The ureter, as well as the access sheath, were then withdrawn distally distal to the confluence. There were no stone burdens in the common sheath. The ureteroscope and access sheath were then placed in the bladder. The access sheath and ureteroscope were then removed.

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After confirming no residual stone burden, given the fact the child had balloon dilatation x2, the decision was made to proceed with stent placement. The safety wire was unsecured from the patient's drapes. It was backloaded through the working channel of the cystoscope using a ureteral catheter. The cystoscope was then passed into the bladder under direct visualization and irrigation. A 6-French x 28 cm double-J ureteral stent was then passed over the wire through the cystoscope. A metal tip pusher was used to advance this into the appropriate position. The wire was withdrawn. A good distal coil was seen on the stent cystoscopically. A good proximal coil was seen on the stent fluoroscopically. The cystoscope was subsequently disarticulated. The sheath to the cystoscope was withdrawn after the bladder volume was drained. The patient was cleaned and dried. The string to the ureteral stent was then secured to the patient's penis using benzoin and Tegaderm, being mindful so as to not ensnare pubic hair. The patient was subsequently awakened and transferred to recovery in stable condition.

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PT Name: GRANT, JUSTIN M
DAH/ **Dictation ID: 1794847**
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