Medical records provided for review came from the following sources:

Ann Doe, M.D. (Emergency Medicine)

Erick Brick, M.D. (Radiology)

Minnie Mouse, M.D.

Long Stoke, M.D. (Critical Care Surgery)

Daffy Cobbler, M.D. (Diagnostic Radiology)

Sharon Stone, M.D. (Radiology)

Jack Dawson, M.D. (Orthopedic Surgery)

Bella Stone, M.D. (Surgery)

Michael Hayden, M.D. (Emergency Medicine)

Rose Dawson, M.D. (Orthopedic Surgery)

Theodor Seuss, M.D. (Orthopedic Surgery)

Jack Sparrow, M.D. (Anesthesiology)

James Dre, M.D. (Clinical Radiology)

Monica Seles, M.D. (Internal Medicine)

Nutty Witty, M.D. (Orthopedic Surgery)

Hugh Jackman, M.D. (Radiology)

Jimmy Johns, L.O.T.R. (Occupational Therapy)

Gandalf Wizard, M.D. (Undersea and Hyperbaric Medicine)

Mary Jane, N.P.

Fred Flintstone, M.D. (Hyperbaric Medicine)

Arnold Schwarzenegger, M.D. (Orthopedic Surgery)

Sylvester Stallone, M.D. (Diagnostic Radiology)

Narrow Broad, M.D. (Orthopedic Surgery)

Ice Cool, M.D. (Orthopedic Surgery)

Emma Bird, R.T.

Diamond Coal, L.P.N.

Jane Fisherman, M.D. (Emergency Medicine)

Alla Din, M.D. (Orthopedic Surgery)

Orlando Orange, M.D. (Anesthesiology)

Jackie Chan, M.D. (Pathology)

Jet Li, M.D. (Family Medicine)

Page number references in the summary below refer to a scanned .PDF file made from the medical records sent for my review. The records were reviewed, summarized, and put into chronological order as below.

Medical records provided for review span a timeframe from **04/29/2013 to 01/21/2014.**

Date of Injury: 04/29/2013

Brief Summary/Flow of Events

04/29/2013 - Patient sustained a gunshot wound to the right shoulder after an attempted robbery.

Patient was evaluated at the Emergency Department of Interim LSU Public Hospital.

X-ray of the right shoulder revealed comminuted fracture of the distal acromion process, fracture at the base of the acromion process, fracture of the greater tuberosity and lateral head of the humerus, multiple surrounding ballistic fragments, soft tissue swelling, and soft tissue emphysema.

Also on this date, patient was discharged from the hospital since there was no acute indication for washout of joint.

05/07/2013 - Patient underwent incision and drainage of right shoulder, open reduction and internal fixation (ORIF) of right greater tuberosity with rotator cuff repair and bullet removal.

05/21/2013 - Patient presented to Interim LSU Public Hospital with drainage from wound, pain, and chills. Patient reported self discontinued the sutures around postoperative day #7-9, had hyperbaric wound treatment arranged by a friend, and had serous drainage since the removal of sutures.

Patient underwent a right shoulder single-shot injection under ultrasound guidance, performed by Jack Sparrow, M.D.

Patient underwent right shoulder wound irrigation and debridement, performed by Rose Dawson, M.D.

Also on this date, right shoulder Gram smear showed one colony of Staphylococcus, coagulase-negative light growth of Propionibacterium acnes.

05/22/2013 - Dr. Dawson continued IV Vancomycin, which was started on 05/21/2013.

Patient received 6 days of IV Vancomycin and then left the hospital against medical advice.

Patient was started on Bactrim and Rifampin, reported was allergic to Bactrim, and was only taking Rifampin.

05/29/2013 - Monica Seles, M.D. prescribed Minocycline 100 mg 2 times a day for at least 6 weeks with Rifampin 300 mg

Patient underwent occupational therapy from **06/14/2013 through 07/29/2013** for right shoulder.

Patient received wound care to right shoulder wound from **06/20/2013 through 07/11/2013.**

08/19/2013 - Ice Cool, M.D. tentatively scheduled for shoulder arthroscopy on 09/06/2014.

09/06/2014 - Surgery was canceled.

10/10/2013 - Patient underwent a right interscalene nerve block under ultrasound guidance, performed by Orlando Orange, M.D.

Also on this date, patient underwent right open rotator cuff repair (chronic), right arthroscopic limited debridement of labrum and synovium, and removal of deep right shoulder hardware, performed by Michael Hunter, M.D.

Patient History

Allergies: Bactrim (Sulfamethoxazole-Trimethoprim), Penicillin.

Family History: History of cancer.

Past Medical History: Kidney stones, shoulder arthroscopy.

Past Surgical History: Lithotomy

Social History: Patient worked in medical sales.

Detailed Chronology

Date	Provider	Occurrence/Treatment	Bates Reference
04/29/2013	Ann Doe, M.D. (Emergency Medicine) Mickey Mouse, M.D. (Emergency Physician) Interim LSU Public Hospital	**Emergency Department Note** **Chief Complaint:** Gunshot wound (GSW) to the right shoulder. **History of Present Illness:** Patient was HOII RM 4 activation. **Review of Systems:** GSW to the right shoulder. **Physical Examination:** Unable to range right shoulder, but 5/5 strength at elbow and wrist. Wound was no longer bleeding. **Medical Decision Making:** Patient sustained a single gunshot wound to the right upper shoulder region, had no difficulty breathing, was protecting airway without trouble, was hemodynamically stable, and was not actively bleeding. **Imaging:** Initial chest x-ray did not show evidence of pneumothorax. **Plan:** Patient was recommended observation and was ordered repeat chest x-ray in 4 hours and dedicated right shoulder x-ray series to evaluate for fracture. Patient with fracture at base of acromion, comminuted fracture of distal acromion, and fracture of lateral humeral head. Pain controlled with Dilaudid 2 mg. Per Ortho recommendation, Clindamycin 600 mg via IV administered due to anaphylactic penicillin allergy.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 8-11, 10
04/29/2013	Erick Brick, M.D. (Radiology) Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the Chest** **Clinical Indication:** Gunshot wound. **Impression:** Ballistic fragments projected over the right lateral shoulder. Fracture of the lateral right humerus head, fracture of the base and distal acromion process, surrounding soft tissue swelling and emphysema. No acute cardiopulmonary findings.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 39

04/29/2013	Minnie Mouse, M.D. Interim LSU Public Hospital	**Trauma Service Consultation/History and Physical** Dr. Mouse stated patient sustained a GSW to the right shoulder. **Physical Examination:** Swelling to the right shoulder, single GSW. **Plan:** Dr. Mouse ordered x-rays of the chest in 4 hours and recommended to discharge if within normal limits, x-rays of the shoulder 1 view, x-rays of the scapula, CBC and differential, CMP, APTT, Protime-INR, transfusion vital signs – to hold transfusion and notify physician if transfusion reaction suspected.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 16-23
04/29/2013	Long Stoke, M.D. (Critical Care Surgery) Interim LSU Public Hospital	**Trauma Note** Dr. Stoke stated patient arrived with GSW to right upper chest (infraclavicular) with palpable bullet to right shoulder. Vital signs: BP 145/91. PR 100. Temp 97.2. RR 16. Ht 5'6". Wt 150 lbs. Transfusion was stopped. **Plan:** Dr. Stoke ordered x-rays of the shoulder, repeat x-rays of the chest in 4 hours, and recommended Ortho consult. **Findings:** Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, and soft tissue emphysema.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 16
04/29/2013	Erick Brick, M.D. Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the Right Shoulder** **Clinical Indication:** Gunshot wound. **Impression:** Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 39
04/29/2013	Erick Brick, M.D. Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the Right Scapula** **Clinical Indication:** Gunshot wound. **Impression:** Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, and soft tissue emphysema.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 40

04/29/2013	Daffy Cobbler, M.D. (Diagnostic Radiology) Interim LSU Public Hospital	**Radiology/Diagnostics** **X-Ray of the Chest** **Clinical Indication:** Gunshot wound. **Impression:** 1. Right shoulder Chapman 2. Right acromion fracture. 3. No significant cardiopulmonary abnormality was identified.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 38
04/29/2013	Sharon Stone, M.D. (Radiology) Interim LSU Public Hospital	**Radiology/Diagnostics** **CT Angiogram of the Right Upper Extremity with Contrast** **Clinical Indication:** Gunshot wound. **Impression:** Comminuted fracture of the acromion process and greater tuberosity. The axillary and subclavian arteries were intact. No evidence of contrast extravasation.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 38
04/29/2013	Interim LSU Public Hospital	**Laboratory Report** WBC 11.9 (high), RDW 18.1 (high), absolute monocytes 1.2 (high). CO2 21 (low), glucose 108 (high), BUN 32 (high), AST 50 (high), GFR MDRD non Af Amer 57 (low).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 36, 37

04/29/2013	Jack Dawson, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Orthopedics Consultation Report** **Chief Complaint:** Gunshot wound. **History of Present Illness:** Dr. Dawson noted patient sustained a GSW to the right shoulder after an attempted robbery and presented as a room 4 activation with a Glasgow Coma Scale score (GCS) of 15. Dr. Dawson reported patient's pain was well controlled, localized to GSW site, and received intravenous (IV) clindamycin in ED and Tdap booster after a thorough bedside washout. **Physical Examination:** Vital signs: BP 116/74. PR 67. Temp 96.6. RR 18. Right upper extremity revealed GSW to right superior aspect of shoulder with steady, small volume oozing, and appropriate tenderness to palpation around wound. Patient received Clindamycin IV in the ED and TDAP booster. **Imaging:** Dr. Dawson reviewed serial x-rays of chest, shoulder x-rays which showed a severely comminuted acromial fracture and a gouge in the lateral greater tuberosity of the humerus, and a CT angiogram which characterized the damage as not involving the glenohumeral joint. **Assessment:** Patient with GSW to right shoulder with no vascular injury, comminuted fracture of acromion, fracture of the greater tuberosity without intraarticular extension. **Plan:** Dr. Dawson noted no acute indication for washout of joint status post GSW to shoulder without intraarticular bullet per on-call staff, indicated oozing from bullet wound in a hemodynamically stable patient with a clean CT angiogram was unlikely to represent serious vascular pathology, recommended pressure dressing application, outpatient oral antibiotics, and close follow up in clinic on Wednesday.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 13-16
04/29/2013	Bella Stone, M.D. (Surgery) Interim LSU Public Hospital	**Surgery Progress Note** Dr. Stone stated patient still had oozing from gunshot wound site, was hemodynamically stable, and neurovascularly intact. **Imaging:** Dr. Stone reviewed repeat chest x-rays which revealed no evidence of ptx/cardiopulmonary abnormalities, and a CTA of the right upper extremity. **Plan:** Dr. Stone noted Ortho was consulted for acromion fracture, humeral head fracture, and greater tuberosity fracture, indicated patient was cleared from General Surgery standpoint, and deferred recommendations to Ortho.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 23-24

04/29/2013	Michael Hayden, M.D. (Emergency Medicine) Interim LSU Public Hospital	**Emergency Department Note** **Chief Complaint:** Gunshot wound. **History of Present Illness:** Patient was seen by Ortho and Trauma Surgery. CT shoulder reviewed by Ortho. **Physical Examination:** Wound to the right shoulder anterior and posterior and decreased range of motion. **Plan:** Dr. Hayden discussed plan of care with Surgery and Ortho staff, and recommended wound care and ortho follow up.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 7
04/29/2013	Ann Doe, M.D. Interim LSU Public Hospital	**Emergency Department Note** Vital signs: BP 116/74. PR 67. Temp 96.6. RR 18. Ht 5'6". Wt 150 lbs. SpO2 98%. Dr. Doe noted Surgery and Ortho felt that the patient could go home and okayed with Dr. Dawson and Dr. Oz. Dr. Doe indicated would discharge the patient and advised to follow up on 05/01/2013. Final diagnoses: Other closed fractures of upper end of humerus. Closed fracture of acromial process of scapula. Open wound of shoulder region, without mention of complication. Need for prophylactic vaccination with combined diphtheria-tetanus-pertussis vaccine. Emergency Department Disposition: Patient was discharged to home.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 6, 10
05/20/2013	Interim LSU Public Hospital	**ECG** HR 107, PR Int 116 ms, QRS dur 92 ms, QT/QTc interval 324/387 ms. P/QRS/T 42/-43/37. RV5/SV1 amp 0.70/0.37 mV. **Impression:** Sinus tachycardia, short PR interval, nonspecific ST elevation, and abnormal left axis deviation. Abnormal ECG.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 105, 265
05/20/2013	Erick Brick, M.D. Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the chest** **Clinical Indication:** Preop. **Impression:** No acute cardiopulmonary or pleuroparenchymal finding. Chronic-appearing right shoulder and scapular fractures with surgical hardware placement.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 279
05/20/2013	Interim LSU Public Hospital	**Laboratory Report:** Red blood cell count 3.86 (low), hemoglobin 11.7 (low), hematocrit 36.3 (low), RDW 16.0 (high), and platelet count 504 (high). Glucose 101 (high).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 266, 267

05/21/2013	Rose Dawson, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Progress Note** Dr. Dawson noted patient was taken to the operating room on 05/07/2013 after improvement of swelling for incision and drainage of right shoulder, open reduction and internal fixation (ORIF) of right greater tuberosity with rotator cuff repair and bullet removal, presented to clinic the previous day with a draining wound and no sling, had removed own sutures about 5-7 days ago, and wound began draining after that, and had been doing exercises beyond strict pendulum only exercises that he was given. Patient reported pain was better and had been worsening over the last few days and had chills. **Physical Examination:** Patient had right upper extremity swelling much improved, incision was superficially boggy with expressible cloudy serous drainage, very small areas of dehiscence 1-2 mm along wound. **Imaging:** Dr. Dawson reviewed x-rays of the right shoulder, which revealed no evidence of hardware failure or complication and reduced greater tuberosity fragment remained in place. **Plan:** Dr. Dawson recommended irrigation and debridement of wound with drain placement, intraoperative cultures, to start empiric antibiotics after, to be kept on antibiotics until culture data speciated and sensitivities were obtained, and patient agreed to proceed with surgical management.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 204-205
05/21/2013	Theodor Seuss, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Ortho Progress Note** Patient reported had some shoulder pain. **Physical Examination:** Right upper extremity revealed proximal half of incision with minor dehiscence (approximately 1 mm gap) with fibrinous exudate bridging the incision edges plus seropurulent drainage, mild surrounding fluctuance, erythema, and warmth. **Assessment:** Patient was status post open reduction and internal fixation of the right shoulder greater tuberosity fracture with rotator cuff repair. **Plan:** Dr. Seuss recommended to remain nothing by mouth (NPO), operating room for shoulder irrigation and debridement, pain control, and to hold antibiotics until after intraoperative cultures were taken.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 206-207
05/21/2013	Jack Sparrow, M.D. (Anesthesiology) Interim LSU Public Hospital	**Anesthesia Block Note** Patient underwent a right shoulder single-shot injection under ultrasound guidance.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 122

05/21/2013	Rose Dawson, M.D.	**Operative Report** **Pre/Postop Diagnoses:** 1. Right shoulder wound infection. 2. Status post gunshot wound to right shoulder on 04/29/2013. 3. Status post open reduction and internal fixation of right greater tuberosity with rotator cuff repair and bullet excision. 4. Status post irrigation and debridement of bony fragments for acromion and scapular fractures. **Procedure Performed:** Right shoulder wound irrigation and debridement. **Specimen:** Right shoulder wound microbiology x2. **Recommendations:** Dr. Dawson noted patient would remain on IV Vancomycin, would likely require 6 weeks of antibiotic treatment given the close proximity of the presumed infection to implanted screws and suture anchors, strictly instructed to remain in sling except for pendulum exercises, and indicated would remove drains on postoperative day #2 when the drain output was diminished.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 212-216
05/21/2013	Theodor Seuss, M.D. Interim LSU Public Hospital	**Postoperative Note** Patient stated pain was controlled. **Physical Examination:** Hemovac (HV) in place. Neuro exam was altered because of block. **Plan:** Dr. Seuss recommended to admit the patient, IV Vancomycin, follow up cultures, pain control, nonweightbearing to the right upper extremity, and pendulums.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 204-205
05/21/2013	James Dre, M.D. (Clinical Radiology) Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the Right Shoulder** **Clinical Indication:** Postoperative. **Impression:** Shoulder appeared located. ORIF stabilizing greater trochanteric fracture without evidence of complication. Comminuted acromion fracture in adequate position.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 279
05/21/2013	Interim LSU Public Hospital	**Laboratory Report** **Specimen:** Right shoulder wound x2. **Pathology Report:** Right shoulder Gram smear showed one colony of Staphylococcus, coagulase-negative light growth of Propionibacterium acnes.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 272, 276, 278

05/22/2013	Rose Dawson, M.D. Interim LSU Public Hospital	**Ortho Progress Note** **Subjective:** Dr. Dawson noted patient felt well and nerve block had worn off. **Plan:** Dr. Dawson recommended dressing change the next day with drain removal, to continue Vancomycin, and indicated was awaiting culture results.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 201
05/22/2013	Theodor Seuss, M.D. Interim LSU Public Hospital	**Ortho Progress Note** Patient stated had shoulder pain and nerve block had worn off. **Physical Examination:** Right shoulder HV drain in place. **Assessment:** Status post I&D right shoulder wound postoperative day #1. **Plan:** Dr. Seuss recommended to follow up cultures and Vancomycin trough, pain control, deep venous thrombosis prophylaxis, physical therapy/occupational therapy, nonweightbearing to right upper extremity, pendulum exercises only, PICC line, and Infectious Disease consult once cultures returned.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 201
05/22/2013	Rose Dawson, M.D. Interim LSU Public Hospital	**Progress Note** Dr. Dawson noted patient felt well postop, pain controlled with block, and remained in sling. **Plan:** Dr. Dawson recommended to continue Vancomycin, follow up with cultures, sequential compression devices (SCDs), and nonweightbearing with pendulums only.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 201, 202, 204-205
05/22/2013	Interim LSU Public Hospital	**Laboratory Report** WBC 12.5 (high), red blood cell count 4.16 (low), hemoglobin 12.6 (low), hematocrit 39.5 (low), RDW 16.3 (high), and platelet count 472 (high), and absolute neutrophils 9.5 (high).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 268
05/23/2013	Interim LSU Public Hospital	**Laboratory Report** Red blood cell count 4.11 (low), hemoglobin 12.4 (low), hematocrit 38.7 (low), RDW 16.1 (high), platelet count 489 (high), and absolute neutrophils 8.3 (high).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 271
05/24/2013	Interim LSU Public Hospital	**Laboratory Report** Red blood cell count 4.14 (low), hemoglobin 12.6 (low), hematocrit 38.9 (low), RDW 16.4 (high), platelet count 528 (high), and absolute monocytes 1.2 (high). Glucose 126 (high). Urinalysis: Color: Pale yellow. Blood: 10.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 271

05/25/2013	Interim LSU Public Hospital	**Laboratory Report** Red blood cell count 4.00 (low), hemoglobin 12.1 (low), hematocrit 37.3 (low), RDW 16.2 (high), platelet count 461 (high).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 274
05/26/2013	Interim LSU Public Hospital	**Laboratory Report** Red blood cell count 4.00 (low), hemoglobin 12.1 (low), hematocrit 37.8 (low), RDW 16.0 (high), platelet count 442 (high). Right shoulder wound Gram smear culture revealed light growth of Diphtheroids.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 275
05/29/2013	Monica Seles, M.D. (Internal Medicine) Interim LSU Public Hospital	**Progress Note** **Subjective:** Patient presented status post gunshot wound on 04/29/2013 after an armed robbery, underwent procedures on 05/07/13, self discontinued the sutures around postoperative day #7-9, had hyperbaric wound treatment arranged by a friend, had serous drainage since sutures were removed, was re-admitted on 05/20/2013, had I&D of right shoulder on 05/21/2013, culture grew 1 colony of CoNS and light Propionibacterium, was started on IV Vancomycin, received 6 days of that, then left against medical advice, was prescribed Bactrim 800-160 mg and Rifampin 300 mg, but referred was allergic to Bactrim, was only taking Rifampin at that point. **Physical Examination:** Temp 98.7. PR 89. RR 18 BP 131/66. Ht 5’5”. Wt 138 lbs. Right shoulder with an approximately 10 cm surgical wound with staples, healing well, 1 small area with minimal serous discharge. **Assessment:** Right shoulder coagulase-negative Staphylococcus (CoNS) osteomyelitis. **Plan:** Dr. Seles recommended starting IV antibiotics for at least 2 weeks and then continuing oral, but patient refused, prescribed Minocycline 100 mg 2 times a day for at least 6 weeks with Rifampin 300 mg, ordered a CT of the right shoulder in 1 month and labs, advised follow up with Orthopedics in 6 weeks, and to return on 07/17/2013.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 125-127, 128-130, 123

05/29/2013	Rose Dawson, M.D. Interim LSU Public Hospital	**Progress Note** **Subjective:** Patient had a postoperative follow up visit 1 week status post I&D for wound infection and scar/necrotic tissue excision. Dr. Dawson reported at the most recent surgery patient was found to have some necrosis of the deltoid, and deserted the hospital the past weekend. Dr. Dawson noted on that day, patient again admitted to doing more than just pendulum exercise. **Examination:** BP 124/79. PR 87. Temp 99.2. RR 20. Ht 5'5". Wt 139 lbs. Limited right shoulder range of motion in abduction and forward flexion and external rotation was to neutral. **Assessment:** Displaced fracture of greater tuberosity of right humerus. **Plan:** Continue oral antibiotics, pendulum exercises, start further range of motion at next visit if wound looked okay. Dr. Dawson instructed patient again to refrain from weightlifting, biking, and working out until wound healed and advised follow up in 1 week for wound check and likely suture removal.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 134-135, 137-138
05/29/2013	Nutty Witty, M.D. Orthopedic Surgery Interim LSU Public Hospital	**Progress Note** **Subjective:** Patient presented for a follow up of a GSW to right shoulder with a comminuted acromion and greater tuberosity fracture. **Examination:** Sutures in place and small spotting of serous drainage, but wound intact and resolved erythema. **Assessment:** Comminuted acromion and greater tuberosity status post GSW with postoperative wound infection. **Plan:** Dr. Witty advised to follow up with Infectious Disease as scheduled, discussed about the importance of keeping with antibiotics regimen, advised to continue to work on pendulum exercises and follow up on 06/05/2013 for suture removal.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 135-136, 138
05/29/2013	James Dre, M.D. Diagnostic Radiology Interim LSU Public Hospital	**Radiology/Diagnostics** **X-rays of the Right Shoulder.** **Clinical Indication:** Pain. **Impression:** Healing fracture of the greater tuberosity of the right humeral head fixed with 2 cortical screws. Ballistic injury with multiple fragments identified. Bone defect was noted along the superolateral portion of the humeral head extending up to the articular surface.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 136-137

06/05/2013	Jack Dawson, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Progress Note** Patient presented for a follow up and was approximately 4 weeks status post open reduction internal fixation of right greater tuberosity fracture and approximately 2 weeks status post I&D of superficial infection of surgical incision and initiation of Rifampin and Minocycline. Had some hypertrophic granuloma at incision. Patient had been going to hyperbaric oxygen treatments, had been doing pendulum exercises, and stated that Percocet made the stomach hurt. **Physical Examination:** BP 116/68, PR 80, Temp 97.7. RR 19. Right upper extremity revealed sutures in place in surgical incision, which was healing well, one less than 0.5 cm area of small granulomatous exudates on lateral aspect of incision. Minimal external rotation past neutral. About 30 degrees of passive abduction and forward flexion. **Plan:** Sutures were removed. Dr. Dawson noted would allow granulomatous area to declare a little more, if necessary would apply Silver Nitrate at next appointment, recommended to continue pendulum exercises, begin gentle range of motion exercises, continue antibiotics per ID, referred to Occupational Therapy, and advised follow up in 3 weeks.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 141, 144-145, 148-149
06/05/2013	Rose Dawson, M.D. Interim LSU Public Hospital	**Progress Note** **Subjective:** Patient presented for a follow up visit. Dr. Dawson noted patient had some hypertrophic granuloma at incision, rest of incision looked quite good, and sutures were removed without incident. **Examination:** External rotation to neutral, internal rotation to hip, and abduction to 30 degrees. **Plan:** Dr. Dawson believed patient would have significant loss of range of motion and function of this shoulder given the amount of trauma and debris, noted concern at that point was to have the greater tuberosity heal and eradicate or control any infection, indicated in the future patient might benefit from further procedures to help with range of motion. Dr. Dawson recommended to start some gentle range of motion beyond pendulums, referred to Occupational Therapy, and advised patient to continue antibiotics and to follow up in 3 weeks.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 143-144, 147-148

06/05/2013	Hugh Jackman, M.D. Radiology Interim LSU Public Hospital	**Radiology/Diagnostics** **X-rays of the Right Scapula** **Clinical Indications:** Post operative. Right scapular and proximal humeral fractures secondary to gunshot wound. **Impression:** Two screws with washers were again noted in the proximal humerus, apparently stabilizing a fracture of the proximal humerus involving predominantly the greater tuberosity. Fractures of the scapular spine and acromion process were again noted. Position and alignment did not appear to have changed significantly since previous postoperative images of 05/29/2013. Metallic opacities consistent with bullet fragments were again noted about the shoulder.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 147
06/14/2013	Jimmy Johns, L.O.T.R. (Occupational Therapy) Interim LSU Public Hospital	**Occupational Therapy Upper Extremity Initial Assessment** Patient underwent an Occupational Therapy evaluation and was provided a treatment plan, which included therapy 1 time per week for 12 weeks with short term goals of being independent with home exercise program and all upgrades, demonstrate increase in right shoulder active range of motion by 30 degrees in all planes for improved dressing and bathing, and use right upper extremity to reach hanging shirt in closet independently and long term goals to demonstrate shoulder strength 4/5 for improved performance carrying activities of daily living (ADL) objects and reaching items overhead and report pain 2/10 during ADL.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 152-153
06/20/2013	Gandalf Wizard, M.D. (Undersea and Hyperbaric Medicine) Interim LSU Public Hospital	**Wound Ostomy Progress Note** Patient presented for wound care. Dr. Wizard noted patient came to Family Physicians Center and saw Dr. Scholls, started HBOT, wound reopened 2 weeks ago, suture was expressed, had been draining since then, slightly yellow, clear discharge, and patient was still on antibiotics. **Physical Examination:** Right shoulder scar with 5 x 10 mm protruding fatty/granular bubble of tissue, slightly tender, epithelium growing on tissue protuberance from medial aspect of wound, cleft on lateral aspect, and very limited range of motion. **Assessment:** Status post right shoulder gunshot wound with foreign body (FB) reaction versus sinus tract. **Plan:** Dr. Wizard recommended local wound care and physical therapy.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 166-167

06/26/2013	Mary Jane, N.P. Interim LSU Public Hospital	**Progress Note** Patient presented for a follow up and was still complaining of pain in the right shoulder, currently taking Percocet 10/325 mg for pain, reported changing the bandage 3 times per day, and with drainage on each bandage, and currently on Minocycline 100 mg and Rifampin daily. **Physical Examination:** BP 115/71. PR 74. Temp 99.1. RR 19. Ht 5'5". Wt 140 lbs. The incision remained with a central area measuring approximately 1 cm with tissue protruding and slight drainage. **Plan:** Ms. Jane recommended that the patient continue antibiotic until course was complete, refilled pain medication stepping down Percocet 5/325 mg, and advised follow up on 07/24/2013.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 184-186, 188-189
06/26/2013	Hugh Jackman, M.D. Interim LSU Public Hospital	**Radiology/Diagnostics** **X-rays of the Right Shoulder** **Clinical Indications:** Pain. Gunshot wound right shoulder and open reduction internal fixation proximal humerus. **Impression:** Posttraumatic and postoperative findings, similar to those demonstrated on previous study of 06/05/2013.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 187
06/27/2013	Gandalf Wizard, M.D. Interim LSU Public Hospital	**Progress Note** Patient presented for a recheck. Patient reported no complaints of pain, had a small amount of discharge, and was scheduled for ID appointment next week, and with Ortho weeks from now. **Physical Examination:** A 5 x 9 mm fleshy protruding open wound right anterior shoulder and slight turbid yellow discharge. **Assessment:** Probably foreign body reaction. **Plan:** Dr. Wizard recommended to continue local treatment, Silver Nitrate again, and advised follow up in 2 weeks or sooner if patient developed infection again.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 191, 195
07/11/2013	Fred Flintstone, M.D. Hyperbaric Medicine Interim LSU Public Hospital	**Progress Note** Patient presented for regularly scheduled follow up for left shoulder wound, no new complaints, stated he was healed, and symptoms were resolved. **Assessment:** Stable condition (left anterior shoulder healed). **Plan:** The patient was discharged to home in good condition.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 563-564

07/11/2013	Interim LSU Public Hospital	**Wound Care** Patient received wound care to right shoulder wound from 06/20/2013 to 07/11/2013.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 168-169, 193-194, 564-565
07/19/2013	Jimmy Johns, L.O.T.R. Interim LSU Public Hospital	**Occupational Therapy Re-assessment Report** Patient underwent an occupational therapy re-evaluation and was provided a treatment plan, to continue therapy 2 times a week for 12 weeks, with short term goals of patient would be independent with home exercise program and all upgrades, would demonstrate an increase in right shoulder active range of motion by 30 degrees in all planes for improved dressing and bathing and use right upper extremity to reach hanging shirt in closet independently and long term goals of patient would demonstrate shoulder strength 4/5 for improved performance carrying ADL objects and reaching items overhead, and would report pain 2/10 during activities of daily living.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page s 574-575
07/24/2013	Arnold Schwarzenegger, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Progress Note** **Subjective:** Patient had a follow up visit for right humerus fracture approximately 10 weeks status post open reduction and internal fixation of right greater tuberosity fracture, approximately 9 weeks status post incision and debridement of superficial infection of surgical incision and initiation of Rifampin and Minocycline, finished course. Dr. Schwarzenegger noted patient completed approximately 12 Hyperbaric oxygen sessions, had been seeing physical therapy once a week, and continued to ask if he can return to the gym and restart weightlifting exercises, had also been seeing wound care, and wound had now fully granulated in. Patient reported was frustrated, believed never had an infection, reported pain with exercises, and had been actively ranging the shoulder. **Examination:** Right upper extremity revealed lateral incision was well healed. **Plan:** Dr. Schwarzenegger encouraged range of motion exercises and advised postponing strengthening exercises at this time, noted could provide an Ultram script but the patient declined, indicated would discuss with Dr. Hunter for possible ATS, scar debridement and possible hardware removal (HWR), recommended continued occupational therapy, to schedule outpatient CT for evaluation of bone resorption, and advised follow up on 08/21/2013 after CT.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page s 588-590, 592-593

07/24/2013	Sylvester Stallone, M.D. (Diagnostic Radiology) Interim LSU Public Hospital	**Radiology/Diagnostics** **X-rays of the Right Shoulder** **Clinical Indication:** Postoperative. **Impression:** Right proximal humerus fracture with intact hardware and no evidence of loosening, defect, or complication. Right acromionectomy. Healing right scapular spine. Osteopenia.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 591-592
07/29/2013	Interim LSU Public Hospital	**Occupational Therapy Sessions** Patient participated in occupational therapy sessions until 07/29/2013 for right shoulder.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 160, 549, 595, 602
08/19/2013	Narrow Broad, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Office Visit** **Chief Complaint:** Right shoulder pain. **History of Present Illness:** Patient complained of right shoulder pain that limited range of motion, was approximately 14 weeks status post ORIF right greater tuberosity fracture, had been working with physical therapy until 2 weeks ago, and stated pain increased during one session and had not been able to move his arm well since. Patient reported attempted to follow up over the past 2-3 weeks, but had not reached LSU Ortho and was very frustrated with the clinic and ease of care. **Physical Examination:** Palpable hardware at lateral shoulder and sulcus seen at lateral shoulder and patient refused range of motion (ROM) and strength due to pain. **Assessment:** Status post ORIF right greater tuberosity fracture. **Plan:** Dr. Broad recommended an MRI of the right shoulder and indicated would consider treating as rotator cuff tear (RCT) pending results, and advised to follow up in 2 weeks or after MRI was obtained.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 625
08/19/2013	Ice Cool, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**Progress Note** Dr. Cool noted MRI was scheduled and patient was tentatively scheduled for shoulder arthroscopy on 09/06/2013.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 624
08/19/2013	James Dre, M.D. Interim LSU Public Hospital	**Radiology/Diagnostics** **X-ray of the Right Shoulder** **Clinical Indication:** Pain. **Impression:** Healing fracture of the right femur greater tuberosity. Continue follow up.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 627

08/27/2013	Emma Bird, R.T. Interim LSU Public Hospital	**Progress Note** An MRI of the right shoulder was attempted and it was aborted due to gross distortion of anatomical structures secondary to presence of metal in joint.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 629
09/06/2013	Diamond Coal, L.P.N. Interim LSU Public Hospital	**Nursing Note** Patient requested not wanting a catheter during surgery and also requested that no resident physician be involved in the surgery and wanted only Dr. Hunter to do the surgery.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 653
09/10/2013	Jane Fisherman, M.D. (Emergency Medicine) Interim LSU Public Hospital	**Urgent Care Clinic Note** Patient presented to the Urgent Care Clinic requesting a refill of pain medications. Patient was complaining of continuing pain in right shoulder with an intensity of 4/10, and described pain as sharp during complete rest, that prevented patient from moving shoulder completely. Patient was supposed to receive a third surgery this past Friday, but due to disagreement with surgeons would be seeing a new doctor next Tuesday. Patient came for a refill of Percocet until that time and also requested something for sleep. **Review of Systems:** Positive for joint swelling. **Physical Examination:** Right shoulder revealed healed surgical scars seen with decreased range of motion. **Assessment:** Encounter for medication refill and right shoulder pain. **Plan:** Dr. Fisherman informed patient of the UCC Policy of not refilling narcotic pain meds and that he needed to follow up with a Primary Care Physician for continuing treatment, noted patient became very upset refusing to take an alternative, prescribed Oxycodone-Acetaminophen 10/325 mg (standing) and Tramadol 50 mg, recommended to follow up with Ortho as scheduled, and advised to follow up if symptoms worsened or failed to improve.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 674

09/17/2013	Michael Hunter, M.D. LSU Healthcare Network/St. Charles Multi-Specialty Clinic	**Initial Evaluation Report** **Reason for Visit:** Right shoulder pain. **History of Present Illness:** Patient reported pain and weakness to right shoulder, pain was superior and lateral, worse with attempted elevation of the shoulder and rolling onto side, some occasional numbness and paresthesias in the volar aspect of the extremity. **Physical Examination:** Right shoulder exam revealed evidence of deltoid muscle loss and atrophy, multiple areas including the screw heads/washers, the edge of the remaining acromion, and the edge of the scapula spine were prominent and sensitive to palpation, decreased range of motion, diminished rotator strength, positive Neer impingement sign, and Hawkins impingement sign. **Assessment:** Right shoulder pain and weakness status post gunshot wound, ORIF of greater tuberosity, open repair of rotator cuff, open treatment of acromion and scapula spine fractures, and irrigation and debridement, and anger. **Plan:** Dr. Hunter prescribed Oxycodone-Acetaminophen 5/325 mg, Diazepam 5 mg, recommended surgical approach of right shoulder arthroscopy with possible removal of any retained metallic fragments, possible debridement of any prominent bony regions, hardware removal, and possible repair of the rotator cuff and planned to proceed with surgery at ILH the next time, and also placed a Psychiatric consult for anger issues.	Potter Harry LSU client provided medicals.pdf_Pages 4-6, 7
10/01/2013	Interim LSU Public Hospital	**Laboratory Report** RDW 19.0 (high) and CO2 23 (low).	Records of Harry Potter from Interim LSU Public Hospital.pdf_Page 698
10/10/2013	Alla Din, M.D. (Orthopedic Surgery) Interim LSU Public Hospital	**History and Physical Report** Patient reported continued mechanical pain and irritation from implanted hardware. **Physical Examination:** Incision well healed with no fluctuance, erythema, or warmth. **Imaging:** Dr. Din reviewed imaging, which revealed evidence of hardware loosening. **Assessment:** Status post ORIF right shoulder greater tuberosity fracture with rotator cuff repair. **Plan:** Dr. Din recommended patient to be taken to the Operating Room (OR) for shoulder arthroscopy, I&D with possible hardware removal and rotator cuff repair.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 719-720

10/10/2013	Orlando Orange, M.D. (Anesthesiology) Interim LSU Public Hospital	**Procedure Note** Patient underwent a right interscalene nerve block under ultrasound guidance without complications.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 716
10/10/2013	Michael Hunter, M.D. Interim LSU Public Hospital	**Operative Report** **Preoperative Diagnoses:** Gunshot wound right shoulder status post prior ORIF greater tuberosity fracture and rotator cuff repair. Retained metallic foreign bodies right shoulder. **Postoperative Diagnosis:** Right complete rotator cuff tear (chronic). **Procedure performed:** Right open rotator cuff repair (chronic). Right arthroscopic limited debridement of labrum and synovium. Removal of deep right shoulder hardware.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 723-724
10/10/2013	Jackie Chan, M.D. (Pathology) Interim LSU Public Hospital	**Surgical Pathology Consultation Report** **Specimen:** Surgical hardware, removal, gross ID only **Final Diagnoses:** Gross and microscopic: Gross diagnosis only. Hardware, right shoulder, removal: Two metallic screws and washers (medical devices) identified.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 745-746
10/10/2013	Michael Hunter, M.D. Interim LSU Public Hospital	**Physician Discharge Summary Report** Patient was discharged home in a good condition with discharge diagnoses of right shoulder gunshot wound, and right shoulder posttraumatic stiffness, rotator cuff tear (RCT). Dr. Hunter recommended to continue Clindamycin 150 mg, Oxycodone-Acetaminophen 10/325 mg, pendulum exercises to right shoulder, active range of motion (AROM) to elbow, wrist, and hand, regular diet, dressing change after 3 days, keep clean/dry, okay to shower once dry, and advised to follow up within 2 weeks.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 718-719

10/17/2013	Jet Li, M.D. (Family Medicine) Interim LSU Public Hospital	**History and Physical Report** Patient presented requesting extracorporeal shock wave lithotripsy (ESWL) for treatment of a large right renal calculus, which was noted on CT from 09/28/2013. Patient reported having had approximately 16-18 stone episodes, less recently as he had been following the Paleo diet for the past year. Patient endorsed left greater than right pain, described as severe. Dr. Li noted patient was recently shot in the right shoulder while being mugged in the French quarter, had open surgery for that, and patient became agitated during the encounter, threatening to leave several times, left prior to PAT appointment being scheduled. **Imaging:** Dr. Li reviewed a CT with Dr. Potter, which revealed a right lower pole calculus of approximately 12 mm in greatest dimension, some punctate hyperdensities in left calyces, no hydro or evidence of obstruction bilaterally. **Review of Systems:** Right arm in sling and surgical dressings on right shoulder. **Assessment:** Right renal calculus and recurrent kidney stones. **Plan:** Dr. Li prescribed Flomax, Toradol 10 mg, recommended scheduling patient for ureteroscopy/holmium laser lithotripsy (HLL), of right renal calculus on 12/12/2013, ordered labs, preoperative visit, and indicated obtained urine culture and urinalysis.	Records of Harry Potter from Interim LSU Public Hospital.pdf_Pages 785-790
10/22/2013	Michael Hunter, M.D. LSU Healthcare Network/St. Charles Multi-Specialty Clinic	**Follow up Evaluation** **Reason for Visit:** Patient was seen in follow up for surgical aftercare status post right shoulder arthroscopy with hardware removal and mini open rotator cuff repair. **Subjective:** Patient returned for suture removal and reported doing fairly well and rated pain at a 3/10. **Physical Examination:** Surgical incision clean, dry, and intact with sutures in place. **Impression:** Two weeks status post right shoulder arthroscopy with open rotator cuff repair and hardware removal. **Plan:** Dr. Hunter prescribed Oxycodone-Acetaminophen 7.5/325 mg for pain, recommended pendulum supine passive forward elevation to 90 degrees and supine passive external rotation to 20 degrees, and advised follow up in 1 month.	Potter Harry LSU client provided medicals.pdf_Page 3

11/12/2013	Michael Hunter, M.D. LSU Healthcare Network/St. Charles Multi-Specialty Clinic	**Follow up Evaluation** Patient was seen in follow up for evaluation of the right shoulder pain rated at 4/10, and had been performing pendulum exercises up to that point. **Physical Examination:** Right shoulder could be passively elevated to 100 degrees and externally rotated to 20 degrees. **Assessment:** Status post right shoulder ATS with hardware removal, and mini open rotator cuff tear (RCT) repair. **Plan:** Dr. Hunter recommended patient to continue Oxycodone-Acetaminophen 7.5/325 mg, renewed Diazepam 5 mg, to continue passive supine forward elevation and passive supine external rotation exercises, and to perform some active assisted wall climbs, and to follow up in 4-6 weeks.	Potter Harry LSU client provided medicals.pdf_Page 2
01/21/2014	Michael Hunter, M.D. LSU Healthcare Network/St. Charles Multi-Specialty Clinic	**Follow up Evaluation** Patient had a follow up visit and reported a sharp pain rated 4/10 towards the distal end of incision, and had been performing pendulum and passive range of motion exercises. **Physical Examination:** Right shoulder could be passively elevated to 110 degrees and externally rotated to 20 degrees, and had weakness in elevation and external rotation. **Assessment:** Three months status post right shoulder ATS with hardware removal, and mini open RCT repair. **Plan:** Dr. Hunter advised patient to start gentle rotator cuff and deltoid strengthening exercises, to continue Diazepam 5 mg, and to follow up in 3 months.	Potter Harry LSU client provided medicals.pdf_Page 1

<< Back to Review

History

Chief Complaint

Patient presents with

- Gun Shot Wound

HPI Comments: HOII Rm 4 activation: 42M with single GSW seen at 4:58 with staff present.

A- phonating, protecting airway
B- breath sounds present and equal
C- RRR no murmur
D- GCS 15, single GSW to the right shoulder

A- penicillin
M- none
P- none
L- greater than 5 hours
E- no past surgeries

History reviewed. No pertinent past medical history.

No past surgical history on file.

No family history on file.

History

Substance Use Topics

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol Use: Not on file

Review of Systems
Constitutional: Negative for diaphoresis and fatigue.
HENT: Negative for neck pain.
Eyes: Negative for visual disturbance.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain and palpitations.
Gastrointestinal: Negative for abdominal pain and abdominal distention.
Skin: Positive for wound.
GSW to the right shoulder

Physical Exam

BP 116/74 | Pulse 67 | Temp(Src) 96.6 °F (35.9 °C) (Oral) | Resp 18 | Ht 1.676 m (5' 6") | Wt 68.04 kg (150 lb) |

24.21 kg/m2 | SpO2 98%

Physical Exam
Nursing note and vitals reviewed.
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He exhibits no tenderness.
Abdominal: Soft. Bowel sounds are normal. He exhibits no distension. There is no tenderness. There is no guarding.
Musculoskeletal: Normal range of motion. He exhibits no edema and no tenderness.
Neurological: He is alert and oriented to person, place, and time. Coordination normal.
Skin: Skin is warm and dry. He is not diaphoretic.
Psychiatric: He has a normal mood and affect.

ED Course
Procedures
Findings:
Estimated Blood Loss:
Specimens Removed:
Postoperative Diagnosis:

MDM
Number of Diagnoses or Management Options
Fracture of acromion of scapula:
GSW (gunshot wound):
Humeral head fracture:
Diagnosis management comments: HOII: Pt sustained a single GSW to the right upper shoulder region. He has no difficulty breathing and is protecting his airway without trouble. He is hemodynamically stable and is not actively bleeding. Initial CXR does not show evidence of pneumothorax. We will observe him and obtain a repeat CXR in 4 hours. We will also obtain a dedicated right shoulder XRAY series to evaluate for fracture.

HO I: Trauma intern not available to place R4 orders due to other cases going on in OR, so basic trauma labs and imaging order placed by ED team, okayed by surgery resident on call.

ED Provider Notes - Encounter Notes (continued)

Update:
Pain control with dilaudid 2mg. Tetanus updated and antibiosed with clinda 600mg IV per ortho recs due to anaphylactic penicillin allergy. Pt has fracture at base of acromion, comminuted fracture of distal acromion, and fracture of lateral humeral head. Discussed case with from ortho and he will review films and give formal recs after conference. Dispo currently pending these recs and 4 hour CXR at 9:30. If this is negative for hemo/pneumothorax, will likely wash out wound and discharge home with sling and outpatient ortho appointment unless they call back with other instructions for caring for pt's fracture.

AOC HO III Note: Patient has good distal pulses on the right ext. Unable to range the right shoulder, but 5/5 at elbow and wrist. Wound is no longer bleeding. Ortho called back would like him to have a CT of his right arm. Will do CT, clean around the wound, and give pain control.

Pt had ct-angio as well as ct of shoulder, ortho has been to bedside. Spoke with trauma surg intern to see if there is anything they would like and to talk about the CT. They are waiting to talk with their upper level. We are in a holding pattern on the patient's dispo. He continues to be neurovascularly intact, the dressing is soaked, but no symptoms of acute blood loss. Will continue to monitor.

Surgery has seen the patient, they feel comfortable with him being discharged, however ortho is still unsure if he needs to be washed out at bedside or if he needs OR. They have call back expressing the confusion. We are awaiting their final recs before discharging the patient. Ortho is aware that surgery is ready for discharge as well as the ER.

Ortho feels that the patient can go home and does not need a wash out at this time. Ok'd this with . Will be seen in clinic on at 8am. Will discharge.

Visit Diagnoses:

Diagnoses that have been ruled out:
None
Diagnoses that are still under consideration:

Fracture of acromion of scapula
Humeral head fracture

Final diagnoses:

Humeral head fracture
Fracture of acromion of scapula
GSW (gunshot wound)

Re-Evaluation

Vitals Reviewed?
Pain status post procedure?
Pain status post medication?

Attending Provider: No att. providers found

ED Staff:
I have seen and evaluated the patient in conjunction with the resident house staff. I have personally examined the patient and reviewed the plan of care. I agree with the history, physical, and plan as documented.

at bedside giving discharge instructions to friend. Med student at bedside re-applying dressing. Sling/swath applied. Pt verbalized understanding of instructions.

Pt is awaiting results of CT angio. Pt has strong pulses, cap refill <3 seconds, and movement in bilateral upper and lower extremities, movement is limited in upper right extremity pt states due to pain. Pt resting comfortably in bed SR up x2 HOB elevated. Awaiting further dispo.

notified of three dark red bloody dressing changes, bright red drainage and ecchymosis noted at

ED Provider Notes - Encounter Notes (continued)

Update:
Pain control with dilaudid 2mg. Tetanus updated and antibiosed with clinda 600mg IV per ortho recs due to anaphylactic penicillin allergy. Pt has fracture at base of acromion, comminuted fracture of distal acromion, and fracture of lateral humeral head. Discussed case with from ortho and he will review films and give formal recs after conference. Dispo currently pending these recs and 4 hour CXR at 9:30. If this is negative for hemo/pneumothorax, will likely wash out wound and discharge home with sling and outpatient ortho appointment unless they call back with other instructions for caring for pt's fracture.

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Ortho feels that the patient can go home and does not need a wash out at this time. Ok'd this with . Will be seen in clinic on at 8am. Will discharge.

Visit Diagnoses:

Diagnoses that have been ruled out:
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Diagnoses that are still under consideration:

Fracture of acromion of scapula
Humeral head fracture

Final diagnoses:

Humeral head fracture
Fracture of acromion of scapula
GSW (gunshot wound)

Re-Evaluation

Vitals Reviewed?
Pain status post procedure?
Pain status post medication?

Attending Provider: No att. providers found

(continued)

TYPE AND CROSSMATCH] **(continued)** Resulted: 1453, Result Status: Final result

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	
16 - HCSDLAB	HCSD SUNQUEST	Unknown	Unknown	

Radiology Results

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: , Result Status: In process

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: , Result Status: In process

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: , Result Status: Final result

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection
Narrative:

Clinical History
GUN SHOT WOUND

Findings
Ballistic fragments project over the right lateral shoulder. Fracture of the lateral right humerus head, fracture of the BASE and distal acromion process. Surrounding soft tissue swelling and emphysema. No acute cardiopulmonary findings.

Impression
As above.

Xray Shoulder 1 View (specify) or per radiology protocol [28149596] Resulted: Status: In process

Ordering Provider:
Resulting Lab: GE RIS
by:
Specimen Collection

Xray Scapula AP & Lat or complete per radiology protocol [28149597] Resulted: Result Status: In process

Ordering Provider: T
Resulting Lab: GE RIS
Resulted by:
Specimen Collection

Xray Shoulder 1 View (specify) or per radiology protocol [28149596] Resulted , Result Status: In process

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection

Xray Scapula AP & Lat or complete per radiology protocol [28149597] Resulted: Result Status: In process

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection

Xray Shoulder 1 View (specify) or per radiology protocol [28149596] Resulted: Status: Final result

Ordering Provider:
Resulting Lab: GE RIS
Resulted by:
Specimen Collection
Narrative: Laterality->Right Ordering:
Clinical History
GUN SHOT WOUND

Findings
Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.

DOB:

Consults - Encounter Notes (continued)

Component	Value	Range
Phosphorus	3.3	2.5 - 4.7 MG/DL

Imaging:
Shoulder XRs show comminuted fracture of the acromion with greater tuberosity lateral fracture. No extension into glenohumeral articulation.

CT angiogram of shoulder reveals intact vasculature. The bullet is not in the joint.

Assessment:
44 y.o. male c GSW to R shoulder c no vascular injury, comminuted fracture of acromion, fracture of the greater tuberosity without intraarticular extension

Plan:
1. No acute indication for washout of joint status post GSW to shoulder without intraarticular bullet, per on-call staff
2. Oozing from bullet wound in hemodynamically stable patient with a clean CT angiogram unlikely to represent serious vascular pathology. Recommend pressure dressing application.
3. IV abx received in ED, recommend outpatient PO antibiotics
4. Close follow up in clinic on Wednesday.

Pt seen and examined in Room 4 with trauma surgery team. Arrives with GSW right upper chest (infraclavicular) with palpable bullet right shoulder. AAOx4, GCS 15, no distress, lungs clear equal. Abdomen soft, non-tender. Distal neurovascular intact in RUE. CXR shows no PTX/HTX but proximal humerus fx. Will obtain further dedicated shoulder images, repeat CXR in 4 hrs, and consult ortho.

The patient was examined with the residents, lab and radiology data reviewed. I have reviewed the notes, assessments, and/or procedures performed by concur with her documentation of

Trauma/Critical Care/ Acute Care Surgery

Consults - Encounter Notes (continued)

Trauma Service Consult/History & Physical
Admitting Service Black Surgery

Epsilon Epsilon Twenty-Seven is a 113 y.o. males/p GSW to R shoulder, AVSS, GCS15

Airway- protecting airway, speaking in full sentences
Breathing- CTAB
Circulation- 2+ peripheral pulses
Disability- GSW to R. shoulder
Exposure/enviornment- Full exposure, no other injuries

Allergies- is allergic to penicillins.
Medications-
Prior to Admission medications
Not on File

Past medical/surgical history- has no past medical history on file. has no past surgical history on file.
Last meal- 5hr
Events- Last tetanus unknown

Family/Social History:family history is not on file. does not have a smoking history on file. He does not have any smokeless tobacco history on file.

ROS: Unable to perform

BP 145/91 | Pulse 100 | Temp 97.2 °F (36.2 °C) | Resp 16 | Ht 1.676 m (5' 6") | Wt 68.04 kg (150 lb) | BMI 24.21 kg/m2 | SpO2 96%

General appearance - alert, well appearing, and in no distress

Mental Status - GCS 15

Eyes - pupils equal and reactive, extraocular eye movements intact

Ears - not examined

Neck - supple, no significant adenopathy

Chest - clear to auscultation, no wheezes, rales or rhonchi, symmetric air entry

Heart - normal rate, regular rhythm, normal S1, S2, no murmurs, rubs, clicks or gallops

Abdomen - soft, nontender, nondistended, no masses or organomegaly

GU Male - deferred

Rectal - deferred

Back exam - full range of motion, no tenderness, palpable spasm or pain on motion

Neurological - alert, oriented, normal speech, no focal findings or movement disorder noted

Musculoskeletal - Swelling to R. Shoulder, no expanding hematoma, single GSW

Extremities - peripheral pulses normal, no pedal edema, no clubbing or cyanosis

Skin - normal coloration and turgor, no rashes, no suspicious skin lesions noted

Medications

hYDROmorphone (DILAUDID) 2 mg/mL injection (not administered)
clindamycin (CLEOCIN) 600 mg in dextrose 50 ml IVPB (not administered)
Tdap (BOOSTRIX/ADACEL) injection 0.5 mL (not administered)
hYDROmorphone (DILAUDID) 2 mg/mL injection 1 mg (1 mg Intravenous Given 0615)
hYDROmorphone (DILAUDID) 2 mg/mL injection 1 mg (1 mg Intravenous Given 0620)

Labs Reviewed

PREPARE EMERGENCY RBC UNITS
TYPE AND CROSSMATCH
RAPID HIV FOR ER
CBC AND DIFFERENTIAL
COMPREHENSIVE METABOLIC PANEL
APTT
PROTIME-INR

ED Imaging Orders

Start		Status	
	Xray Chest PA & Lat or 2 views per radiology protocol 1 TIME IMAGING	Acknowledged	
	Xray Shoulder 1 View (specify) or per radiology protocol 1 TIME IMAGING	Final result	
	Xray Scapula AP & Lat or complete per radiology protocol 1 TIME IMAGING	Final result	
	XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE 1 TIME IMAGING	Final result	

Imaging Results

Xray Shoulder 1 View (specify) or per radiology protocol (Final result)
Final result by External
Narrative:
Laterality->Right Ordering:
Clinical History
GUN SHOT WOUND

Findings
Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.

Impression
As above.

Xray Scapula AP & Lat or complete per radiology protocol (Final result)
Final result by External Ris In Edi ( )
Narrative:
Laterality->Right Ordering:
Clinical History
GUN SHOT WOUND

Findings
Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.

Impression
As above.

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE (Final result)
Final result by External Ris In Edi (
Narrative:

Clinical History
GUN SHOT WOUND

Findings
Ballistic fragments project over the right lateral shoulder. Fracture of the lateral right humerus head, fracture of the BASE and distal acromion process. Surrounding soft tissue swelling and emphysema. No acute cardiopulmonary findings.

Impression
As above.

EKG Results
None

Trauma Primary Assessment - Airway

Date and Time	Obstructed?	Obstructed By	Spine Precautions Maintained
	--	--	**No**
	Patent	--	--

Trauma Primary Assessment - Breathing

Date and Time	Breathing Effort	Trachea	Chest Wall	Breath Sounds Right	Breath Sounds Left
	--	--	--	**Diminished**	**Clear**
	Spontaneous	**Midline**	**WDL**	**Diminished**	**Clear**

Trauma Primary Assessment - Circulation

Date and Time	Skin	Pulses	Color	Uncontrolled Bleeding	Uncrossmatched Blood Ordered
	WDL	**Present**	**WDL**	**No**	**Yes**

Trauma Primary Assessment - Disability

Date and Time	Responsiveness	Length of LOC (Seconds)	R Pupil Size (mm)	L Pupil Size (mm)	R Pupil Reaction	L Pupil Reaction

Alert	--	--	--	--	--

Trauma Mechanism of Injury

Date and Time	Blunt: Motor Vehicle	Type of Collision	Fall/ Jump	Approximate Height (feet)	Assault	Weapon/ Type Of Assault	Penetrating	Injury Type	Thermal	Thermal Injury Type	Who
	--	--	--	--	--	--	**Yes**	**Gunshot Wound**	--	--	

Trauma Secondary Assessment - Glasgow Coma Scale

Date and Time	Eye Opening	Best Verbal Response	Best Motor Response	Glasgow Coma Scale Score
	4	**5**	**6**	**15**

Trauma Secondary Assessment - Revised Trauma Score

Date and Time	Respirations	SBP	Convert GCS	Revised Trauma Score Total
	4	**4**	**4**	**12**

Trauma Secondary Assessment - Circulation

Date and Time	R Carotid Pulse	L Carotid Pulse	R Radial Pulse	L Radial Pulse	R Pedal Pulse	L Pedal Pulse	R Posterior Tibial Pulse	L Posterior Tibial Pulse	Cap Refill
	+2	**+2**	**+2**	**+2**	**+2**	**+2**	**+2**	**+2**	**<3**
	--	--	--	--	--	--	--	--	

Consults - Encounter Notes (continued)

Sec J

Trauma Secondary Assessment - GI/GU

Date and Time	GIABS	Bowel Sounds	Rectal Exam-Tone	Hemoccult	Blood At Meatus	Estimated Date of Conception	Fetal Heart Tones	Focused Assessment with Sonography for Trauma	
	--	**Normal Bowel Sounds**	--	--	--	--	--	--	

Trauma Secondary Assessment - Skin/Musculoskeletal

Date and Time	Skin/Musculoskeletal	
	Image	

Trauma Secondary Assessment - Neurological

Date and Time	TM Right	TM Left	Spine Precautions Maintained	C-Spine Clear By	
	Clear	**Clear**	**No**	--	

Trauma Secondary Assessment - Respiratory

Date and Time	Breath Sounds Right	Breath Sounds Left	
	Diminished	**Clear**	
	Diminished	**Clear**	

Assessment: There were no encounter diagnoses.
Plan:

Orders Placed This Encounter

Procedures

Consults - Encounter Notes (continued)

- XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE
- Xray Shoulder 1 View (specify) or per radiology protocol
- Xray Scapula AP & Lat or complete per radiology protocol
- Xray Chest PA & Lat or 2 views per radiology protocol
- CBC and differential
- Comprehensive metabolic panel
- APTT
- Protime-INR
- Transfusion vital signs
- Hold Transfusion and Notify Physician if:
- Give Patient/Family Transfusion Information Brochure
- If transfusion reaction suspected
- Verify informed consent
- Prepare Emergency RBC Units
- TYPE AND CROSSMATCH

Repeat CXR in 4 hrs, discharge if WNL

Electronically

Pt discussed with resident team. I have reviewed the notes, assessments, and/or procedures performed by
I concur with her documentation of except as noted below:

44yo M s/p Gsw to RUE

Repeat CXR reveals no evidence of ptx/ cardiopulmonary abnormalities
Pt still oozing for gsw site, hemodynamically stable, neurovascularly intact

Consults - Encounter Notes (continued)

Component	Value	Range
Phosphorus	3.3	2.5 - 4.7 MG/DL

Imaging:
Shoulder XRs show comminuted fracture of the acromion with greater tuberosity lateral fracture. No extension into glenohumeral articulation.

CT angiogram of shoulder reveals intact vasculature. The bullet is not in the joint.

Assessment:
44 y.o. male c GSW to R shoulder c no vascular injury, comminuted fracture of acromion, fracture of the greater tuberosity without intraarticular extension

Plan:
1. No acute indication for washout of joint status post GSW to shoulder without intraarticular bullet, per on-call staff
2. Oozing from bullet wound in hemodynamically stable patient with a clean CT angiogram unlikely to represent serious vascular pathology. Recommend pressure dressing application.
3. IV abx received in ED, recommend outpatient PO antibiotics
4. Close follow up in clinic on Wednesday.

Pt seen and examined in Room 4 with trauma surgery team. Arrives with GSW right upper chest (infraclavicular) with palpable bullet right shoulder. AAOx4, GCS 15, no distress, lungs clear equal. Abdomen soft, non-tender. Distal neurovascular intact in RUE. CXR shows no PTX/HTX but proximal humerus fx. Will obtain further dedicated shoulder images, repeat CXR in 4 hrs, and consult ortho.

The patient was examined with the residents, lab and radiology data reviewed. I have reviewed the notes, assessments, and/or procedures performed by I concur with her documentation of

All Results (continued)

TYPE AND CROSSMATCH] **(continued)**

Testing Performed By

Lab - Abbreviation	Name	Director	Address
13 - GE	GE RIS	Unknown	Unknown
16 - HCSDLAB	HCSD SUNQUEST	Unknown	Unknown

Radiology Results

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: Result Status: In process

Provider: , Resulted by: ,
Resulting Lab: GE RIS Specimen Collection

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: , Result Status: In process

Provider: Resulted by:
Resulting Lab: GE RIS Specimen Collection

XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE [28149588] Resulted: , Result Status: Final result

Provider: Resulted by:
Resulting Lab: GE RIS Specimen Collection
Narrative:

GUN SHOT WOUND

Findings
Ballistic fragments project over the right lateral shoulder. Fracture of the lateral right humerus head, fracture of the BASE and distal acromion process. Surrounding soft tissue swelling and emphysema. No acute cardiopulmonary findings.

Impression
As above.

Narrative: Laterality->Right
Clinical History
GUN SHOT WOUND

Findings
Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.

<< Back to Review

Findings
Comminuted fracture of the distal acromion process. Fracture at the base of the acromion process. Fracture of the greater tuberosity and lateral head of the humerus. Multiple surrounding ballistic fragments, soft tissue swelling, soft tissue emphysema.

Impression

Findings

Right shoulder gunshot wound with underlying acromion fracture.
Midline bronchovascular crowding and accentuation of heart size on the expiration images.
Lungs clear on the inspiratory images.
Normal heart size. Pulmonary vascularity is normal.

Impression

1. Right shoulder Chapman.
2. Right acromion fracture.
3. No significant cardiopulmonary abnormality is identified

Technique
2.5 mm axial slices of the lumbar spine were obtained with coronal and sagittal reconstructions

Contrast
Contrast Agent Ultravist Soln 77% (Iopromide) 100 ml intravenous

Findings
Comminute fracture of the acromion process and great tuberosity.
There are multiple bullet fragments within the soft tissue.
The clavicle is intact. The glenohumeral joint space is maintained.
The axillary and subclavia arteries are intact. No evidence of contrast extravasation.
Soft tissue emphysema.

Impression
Comminute fracture of the acromion process and great tuberosity. The axillary and subclavia arteries are intact. No evidence of contrast extravasation.

Findings

Right shoulder gunshot wound with underlying acromion fracture.
Midline bronchovascular crowding and accentuation of heart size on the expiration images.
Lungs clear on the inspiratory images.
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The axillary and subclavia arteries are intact. No evidence of contrast extravasation.
Soft tissue emphysema.

Impression
Comminute fracture of the acromion process and great tuberosity. The axillary and subclavia arteries are intact. No evidence of contrast extravasation.

<< Back to Review

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	11.9	4.5 - 11.0 10^3/UL	H	-	HCSDLAB
Red Blood Cell Count	4.82	4.5 - 5.9 10^6/UL		-	HCSDLAB
Hemoglobin	14.5	13.5 - 17.5 GM/DL		-	HCSDLAB
Hematocrit	44.6	40 - 51 %		-	HCSDLAB
MCV	92.5	80 - 100 FL		-	HCSDLAB
MCH	30.1	26 - 34 PG		-	HCSDLAB
MCHC	32.5	31 - 37 G/DL		-	HCSDLAB
RDW	18.1	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	294	130 - 400 10^3/UL		-	HCSDLAB
MPV	8.9	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	7.6	1.8 - 8.0 10^3/UL		-	HCSDLAB
Lymphocytes Absolute	2.8	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	1.2	0.2 - 1.1 10^3/UL	H	-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	63	%		-	HCSDLAB
Lymphocytes Relative	24	%		-	HCSDLAB
Monocytes Relative	10	%		-	HCSDLAB
Eosinophils Relative	3	%		-	HCSDLAB
Basophils Relative	0	%		-	HCSDLAB

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	138	135 - 146 MMOL/L		-	HCSDLAB
Potassium	3.6	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	103	96 - 110 MMOL/L		-	HCSDLAB
CO2	21	24 - 32 MMOL/L	L	-	HCSDLAB
Glucose	108	65 - 99 MG/DL	H	-	HCSDLAB
BUN	32	7 - 25 MG/DL	H	-	HCSDLAB
Creatinine	1.35	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.0	8.4 - 10.3 MG/DL		-	HCSDLAB
Total Protein	7.1	6.0 - 8.0 GM/DL		-	HCSDLAB
ALBUMIN	4.1	3.4 - 5.0 GM/DL		-	HCSDLAB
Total Bilirubin	0.6	<1.3 MG/DL		-	HCSDLAB
AST	50	<45 U/L	H	-	HCSDLAB
Alkaline Phosphatase	54	20 - 120 U/L		-	HCSDLAB
ALT	33	<46 U/L		-	HCSDLAB
GFR MDRD Non Af Amer	57	>59 mL/MIN	L	-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

Component	Value	Ref Range	Flag	Comment	Lab
aPTT	25.2	24.0 - 37.0 SEC		-	HCSDLAB

Component	Value	Ref Range	Flag	Comment	Lab
Protime	9.7	9.0 - 12.7 SEC		-	HCSDLAB
INR	0.9	0.9 - 1.2		-	HCSDLAB
INR THER RANGES	SEE NOTES				HCSDLAB
Comment:	2.0 - 3.0 - ROUTINE ORAL ANTICOAGULATION 2.5 - 3.5 - ORAL ANTICOAGULATION IN RECURRENT THROMBOEMBOLUS &/OR MECHANICAL HEART VALVES				

Phosphorus [28149616]

Resulting Lab: HCSD SUNQUEST Specimen: 0607

Component	Value	Ref Range	Flag	Comment	Lab
Phosphorus	3.3	2.5 - 4.7 MG/DL		-	HCSDLAB

Component	Value	Ref Range	Flag	Comment	Lab
HIV AG/AB COMBO	NON REACTIVE	NON REACTIVE		-	HCSDLAB

<< Back to Review

I agree with the resident note.

Chief Complaint

Patient presents with

- Gun Shot Wound

.

HPI:
44 y.o. male c single GSW to R shoulder after attempted robbery. Presented as a room 4 activation with GCS 15, no hemodynamic instability. Serial CXRs showed no evidence of pneumothorax. Shoulder XRs showed a severely comminuted acromial fracture and a gouge in the lateral greater tuberosity of the humerus. CT angiogram this morning further characterized the damage as not involving the glenohumeral joint. Patient pleasant, conversive, pain well controlled, localized to GSW site. Received IV clindamycin in ED and tdap booster after a thorough bedside washout. Vitals have been stable in ED.

PMH:
History reviewed. No pertinent past medical history.

PSH:
No past surgical history on file.

Allergies:
Allergies as of - never reviewed

Allergen	Reaction	Noted
• Penicillins	Anaphylaxis	

Social history:
does not have a smoking history on file. He does not have any smokeless tobacco history on file.

Vitals:
Filed Vitals:

BP:	116/74
Pulse:	67
Temp:	96.6 °F (35.9 °C)
Resp:	18

PE:
Gen: AOx3, NAD

CV: RRR by RP
Pulm: No increased WOB
Extremities:
RUE:
GSW evident to R superior aspect of shoulder c steady small volume oozing
No other obvious trauma or injury
No pulsatile mass under clavicle or in axilla
Appropriately TTP around wound
SILT deltoid distribution
Distal limb shows SILT M/R/U
EPL/FPL/DIO intact
Grip strength maintained
2+ RP at wrist, BCR < 2s in all fingers

Recent Results (from the past 24 hour(s))

PREPARE EMERGENCY RBC UNITS

Collection Time

Component		Range
SAMPLE EXPIRATION		
UNIT NUMBER	W067113040594	
COMPONENT TYPE	RED BLOOD CELLS	
STATUS OF UNIT	REL FROM ALLOC	
TRANSFUSION STATUS	OK TO TRANSFUSE	
UNIT NUMBER	W067113023828	
COMPONENT TYPE	RED BLOOD CELLS	
STATUS OF UNIT	REL FROM ALLOC	
TRANSFUSION STATUS	OK TO TRANSFUSE	

RAPID HIV FOR ER

Collection Time

Component	Value	Range
HIV AG/AB COMBO	NON REACTIVE	NON REACTIVE

TYPE AND CROSSMATCH

Collection Time

Component	Value	Range
ABO/Rh Type	O NEGATIVE	
Antibody Screen	NEGATIVE	
SAMPLE EXPIRATION		

CBC AND DIFFERENTIAL

Collection Time

Component	Value	Range
CBC PROFILE	RESULTS:	
WBC	11.9 (*)	4.5 - 11.0 10^3/UL
Red Blood Cell Count	4.82	4.5 - 5.9 10^6/UL
Hemoglobin	14.5	13.5 - 17.5 GM/DL
Hematocrit	44.6	40 - 51 %
MCV	92.5	80 - 100 FL

MCH	30.1	26 - 34 PG
MCHC	32.5	31 - 37 G/DL
RDW	18.1 (*)	11.5 - 14.5 %
Platelet Cnt	294	130 - 400 10^3/UL
MPV	8.9	7.4 - 10.4 FL
DIFFERENTAL	RESULTS:	
Differential Type	AUTO	
Neutrophils Absolute	7.6	1.8 - 8.0 10^3/UL
Lymphocytes Absolute	2.8	1.1 - 5.0 10^3/UL
Monocytes Absolute	1.2 (*)	0.2 - 1.1 10^3/UL
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL
Neutrophils Relatives	63	
Lymphocytes Relative	24	
Monocytes Relative	10	
Eosinophils Relative	3	
Basophils Relative	0	

COMPREHENSIVE METABOLIC PANEL

Collection Time

Component	Value	Range
Sodium	138	135 - 146 MMOL/L
Potassium	3.6	3.6 - 5.2 MMOL/L
Chloride	103	96 - 110 MMOL/L
CO2	21 (*)	24 - 32 MMOL/L
Glucose	108 (*)	65 - 99 MG/DL
BUN	32 (*)	7 - 25 MG/DL
Creatinine	1.35	0.70 - 1.40 MG/DL
Calcium	9.0	8.4 - 10.3 MG/DL
Total Protein	7.1	6.0 - 8.0 GM/DL
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Alkaline Phosphatase	54	20 - 120 U/L
ALT	33	<46 U/L
GFR MDRD Non Af Amer	57 (*)	>59 mL/MIN
GFR MDRD Af Amer	>60	>59 mL/MIN

APTT

Collection Time

Component	Value	Range
aPTT	25.2	24.0 - 37.0 SEC

PROTIME-INR

Collection Time

Component	Value	Range
Protime	9.7	9.0 - 12.7 SEC
INR	0.9	0.9 - 1.2
INR THER RANGES	SEE NOTES	

PHOSPHORUS

Component	Value	Range
Phosphorus	3.3	2.5 - 4.7 MG/DL

Imaging:
Shoulder XRs show comminuted fracture of the acromion with greater tuberosity lateral fracture. No extension into glenohumeral articulation.

CT angiogram of shoulder reveals intact vasculature. The bullet is not in the joint.

Assessment:
44 y.o. male c GSW to R shoulder c no vascular injury, comminuted fracture of acromion, fracture of the greater tuberosity without intraarticular extension

Plan:
1. No acute indication for washout of joint status post GSW to shoulder without intraarticular bullet, per on-call staff
2. Oozing from bullet wound in hemodynamically stable patient with a clean CT angiogram unlikely to represent serious vascular pathology. Recommend pressure dressing application.
3. IV abx received in ED, recommend outpatient PO antibiotics
4. Close follow up in clinic on Wednesday.

Notes:

Pt seen and examined in Room 4 with trauma surgery team. Arrives with GSW right upper chest (infraclavicular) with palpable bullet right shoulder. AAOx4, GCS 15, no distress, lungs clear equal. Abdomen soft, non-tender. Distal neurovascular intact in RUE. CXR shows no PTX/HTX but proximal humerus fx. Will obtain further dedicated shoulder images, repeat CXR in 4 hrs, and consult ortho.

The patient was examined with the residents, lab and radiology data reviewed. I have reviewed the notes, assessments, and/or procedures performed by I concur with her documentation of

Consults - Encounter Notes (continued)

- XRY CHEST 1 VIEW FRONTAL AP PA PORTABLE
- Xray Shoulder 1 View (specify) or per radiology protocol
- Xray Scapula AP & Lat or complete per radiology protocol
- Xray Chest PA & Lat or 2 views per radiology protocol
- CBC and differential
- Comprehensive metabolic panel
- APTT
- Protime-INR
- Transfusion vital signs
- Hold Transfusion and Notify Physician if:
- Give Patient/Family Transfusion Information Brochure
- If transfusion reaction suspected
- Verify informed consent
- Prepare Emergency RBC Units
- TYPE AND CROSSMATCH

Repeat CXR in 4 hrs, discharge if WNL

Pt discussed with resident team. I have reviewed the notes, assessments, and/or procedures performed by e, I concur with her documentation of ' except as noted below:

Surgery HO I

44yo M s/p Gsw to RUE

Repeat CXR reveals no evidence of ptx/ cardiopulmonary abnormalities
Pt still oozing for gsw site, hemodynamically stable, neurovascularly intact

CTA or RUE revealed no vascular injury
Ortho consulted for acromion fx and humeral head fx, greater tuberosity fx

Plan:
Cleared from gen surg standpoint
Will defer recs to ortho

at bedside giving discharge instructions to friend. Med student at bedside re-applying dressing. Sling/swath applied. Pt verbalized understanding of instructions.

As above. See my primary note.

1542

EM FACULTY CONTINUATION NOTE

presents with

Chief Complaint

Patient presents with

- Gun Shot Wound

Pt with GSW shoulder. Seen by ortho and trauma surgery.
A&O RRR CTA Soft +wound rt shoulder ant and posterior. No bruit. No active bleeding. Decreased ROM.
CT shoulder reviewed by ortho.
D/W plan of care with both surgery and ortho staff.

Plan: wound care, ortho fup.

ED Disposition

Discharge		discharge to home/self care.

Condition at discharge: Stable

ED Provider Notes - Encounter Notes (continued)

Update:
Pain control with dilaudid 2mg. Tetanus updated and antibiosed with clinda 600mg IV per ortho recs due to anaphylactic penicillin allergy. Pt has fracture at base of acromion, comminuted fracture of distal acromion, and fracture of lateral humeral head. Discussed case with from ortho and he will review films and give formal recs after conference. Dispo currently pending these recs and 4 hour CXR at 9:30. If this is negative for hemo/pneumothorax, will likely wash out wound and discharge home with sling and outpatient ortho appointment unless they call back with other instructions for caring for pt's fracture.

AOC HO III Note: Patient has good distal pulses on the right ext. Unable to range the right shoulder, but 5/5 at elbow and wrist. Wound is no longer bleeding. Ortho called back would like him to have a CT of his right arm. Will do CT, clean around the wound, and give pain control.

Pt had ct-angio as well as ct of shoulder, ortho has been to bedside. Spoke with trauma surg intern to see if there is anything they would like and to talk about the CT. They are waiting to talk with their upper level. We are in a holding pattern on the patient's dispo. He continues to be neurovascularly intact, the dressing is soaked, but no symptoms of acute blood loss. Will continue to monitor.

Surgery has seen the patient, they feel comfortable with him being discharged, however ortho is still unsure if he needs to be washed out at bedside or if he needs OR. They have call back expressing the confusion. We are awaiting their final recs before discharging the patient. Ortho is aware that surgery is ready for discharge as well as the ER.

Ortho feels that the patient can go home and does not need a wash out at this time. Ok'd this with and Will be seen in clinic on at 8am. Will discharge.

Visit Diagnoses:

Diagnoses that have been ruled out:
None
Diagnoses that are still under consideration:

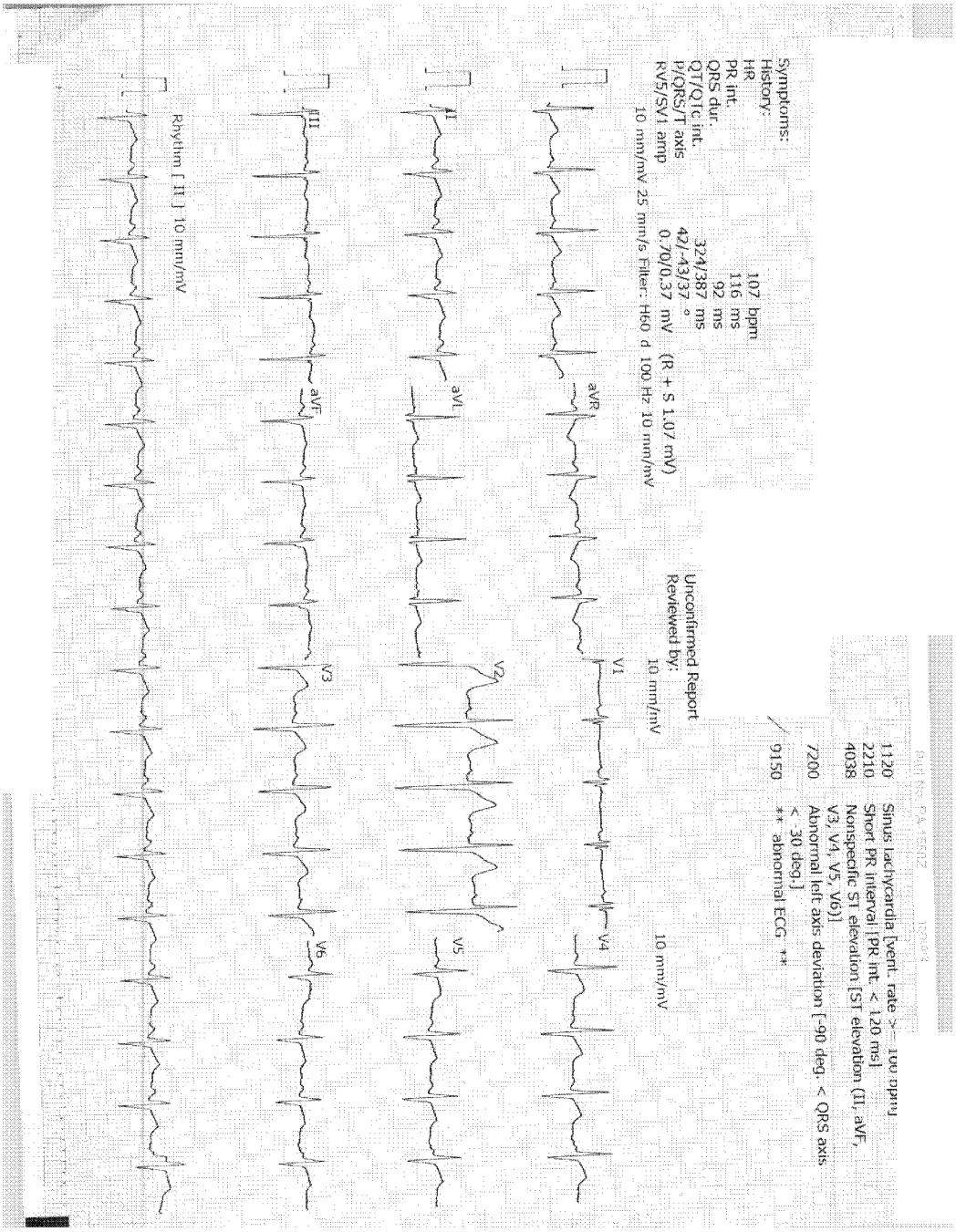
Fracture of acromion of scapula
Humeral head fracture

Final diagnoses:

Humeral head fracture
Fracture of acromion of scapula
GSW (gunshot wound)

Re-Evaluation

Vitals Reviewed?
Pain status post procedure?
Pain status post medication?



Order-Level Documents:

There are no order-level documents.

EKG 12 LEAD (*EKG*) ECG, Electrocardiogram [29483302]

Result:

```
Sinus tachycardia
Short PR interval
Left axis deviation
Abnormal
NO PREVIOUS TRACING
```

EKG 12 LEAD (*EKG*) ECG, Electrocardiogram [29483302]

Ordering Provider:
Resulting Lab:

Resulted by:
Specimen:

Component		Ref Range	Flag	Comment
Interpretation	-			Reason for Exam-> : pre op

Result:

```
**  abnormal ECG  **
Sinus tachycardia
Short PR interval
Nonspecific ST elevation
Abnormal left axis deviation
NO PREVIOUS TRACING
```

<< Back to Review

Xray Chest PA & Lat or 2 views per radiology protocol [29484553] (continued)

Ordering Provider:
Resulting Lab: GE RIS
Narrative:

Resulted by:
Specimen Collection

Clinical History
pre op

Technique
Frontal and lateral views of the chest

Comparison
None.

Findings
Femoral screws transfix the right humeral head. There are multiple radiopaque ballistic fragments in the left shoulder. There are age indeterminate, chronic appearing, right scapular and humeral head fractures. The bone screws appear intact.
The lungs are clear. There is no pleural effusion.
The cardiomediastinal contours are normal in size and configuration.

Impression
No acute cardiopulmonary or pleuroparenchymal finding.
Chronic appearing right shoulder and scapular fractures with surgical

Xray Ext/Int Rotation or Min 2 views per radiology protocol

Ordering Provider:
Resulting Lab: GE RIS
Narrative: To be done in PACULaterality->Right Ordering:
Examination
Frontal, transcapular Y views of the right shoulder

Resulted by:
Specimen Collection

Clinical History
Postoperative

Comparison
None

Findings
Findings of ORIF with 2 fully threaded screws stabilizing a greater trochanteric fracture is visualized. Additional, minimally displaced comminuted fracture of the acromion is present. Grossly, the acromioclavicular joint appears congruent. Metallic projectile debris is noted over the soft tissues of the proximal extremity
The humeral head is properly located in the glenohumeral joint.
Bone mineralization is within normal limits.
The visualized lung is clear.

Impression
Shoulder appears located. ORIF stabilizing greater trochanteric fracture without evidence of complication. Comminuted acromion fracture in adequate position.

Xray Chest PA & Lat or 2 views per radiology protocol [29484553] (continued)

Narrative:

Clinical History
pre op

Technique
Frontal and lateral views of the chest

Comparison
None.

Findings
Femoral screws transfix the right humeral head. There are multiple radiopaque ballistic fragments in the left shoulder. There are age indeterminate, chronic appearing, right scapular and humeral head fractures. The bone screws appear intact.
The lungs are clear. There is no pleural effusion.
The cardiomediastinal contours are normal in size and configuration.

Impression
No acute cardiopulmonary or pleuroparenchymal finding.
Chronic appearing right shoulder and scapular fractures with surgical hardware placement, as above.

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	7.9	4.5 - 11.0 10^3/UL		-	HCSDLAB
Red Blood Cell Count	3.86	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	11.7	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	36.3	40 - 51 %	L	-	HCSDLAB
MCV	93.9	80 - 100 FL		-	HCSDLAB
MCH	30.3	26 - 34 PG		-	HCSDLAB
MCHC	32.3	31 - 37 G/DL		-	HCSDLAB
RDW	16.0	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	504	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.5	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	5.3	1.8 - 8.0 10^3/UL		-	HCSDLAB
Lymphocytes Absolute	1.6	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	0.7	0.2 - 1.1 10^3/UL		-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	68	%		-	HCSDLAB
Lymphocytes Relative	20	%		-	HCSDLAB

All Results (continued)

CBC and differential | (Abnormal) (continued)

Monocytes Relative	9	%	-	HCSDLAB
Eosinophils Relative	3	%	-	HCSDLAB
Basophils Relative	0	%	-	HCSDLAB

Protime-INR [29483295]

Ordering Provider:
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
Protime	11.3	9.0 - 12.7 SEC		-	HCSDLAB
INR	1.1	0.9 - 1.2		-	HCSDLAB
INR THER RANGES	SEE NOTES				HCSDLAB
Comment:	2.0 - 3.0 - ROUTINE ORAL ANTICOAGULATION 2.5 - 3.5 - ORAL ANTICOAGULATION IN RECURRENT THROMBOEMBOLUS &/OR MECHANICAL HEART VALVES				

APTT

Ordering Provider:
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
aPTT	33.9	24.0 - 37.0 SEC		-	HCSDLAB

Basic metabolic panel (Abnormal) , Result Status: Final result

Ordering Provider:
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	141	135 - 146 MMOL/L		-	HCSDLAB
Potassium	3.9	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	103	96 - 110 MMOL/L		-	HCSDLAB
CO2	29	24 - 32 MMOL/L		-	HCSDLAB
Glucose	101	65 - 99 MG/DL	H	-	HCSDLAB
BUN	18	7 - 25 MG/DL		-	HCSDLAB
Creatinine	1.24	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.3	8.4 - 10.3 MG/DL		-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN		-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

- Wound dehiscence

S/p I&D R Shoulder Wound POD #1

Plan:
-- F/u cultures
-- Vanc, f/u trough
-- Pain Control, DVT PPX
-- PT/OT; NWB RUE; pendulum exercises only
-- ID consult once cultures return.
-- PICC line

Post-op Note

Seen/examined in Rm. Pain controlled

BP 150/73 | Pulse 77 | Temp(Src) 98.1 °F (36.7 °C) (Oral) | Resp 18 | Ht 1.651 m (5' 5") | Wt 58.968 kg (130 lb) | BMI 21.63 kg/m2 | SpO2 99%

PE
NAD, Alert
Dressing C/D/I
HV in place

Neuro exam altered because of block

A/P
-- Admit
-- IV Vanc
-- F/u cultures
-- Pain Control
-- NWB RUE, pendulums

with their documentation of

Please see their full H&P/clinic notes for details. Also please note that this patient is registered under 2 separate MRNs and has documentation in both charts.

37yM RHD sp GSW to R shoulder on during armed robbery. He was taken to the OR on after improvement of swelling for I&D R shoulder, ORIF R greater tuberosity with rotator cuff repair and bullet removal. He presented to clinic yesterday with a draining wound and no sling. Pt states he removed his own sutures about 5-7 days ago and wound began draining after that. He also states he has been doing exercises beyond the strict pendulum only exercises he had been given. He states his pain was better and has been worsening over the last few days. He has not had fevers however he has had chills.

PMH: kidney stones PSH: As above Meds: percocet 10/325 All: PCN
SH: works in medical sales. No tob.
PE: AFVSS
43yM, WDWN
NAD, A&Ox3
Breathing symmetric, nonlabored
RRR

RUE:
Swelling much improved
Incision is superficially boggy with expressible cloudy serous drainage
Very small areas of dehiscence 1-2 mm along wound
SILT m/r/u/ax
5/5 epl/fdp/dio/thumb abd
Shoulder ROM pain much improved since preop
WWP, brisk CR, 2+ RP

Imaging: Xrays R shoulder show no evidence of hardware failure/complication. Reduced greater tuberosity fragment remains in place.

Patient understands the plan for irrigation and debridement of his wound with drain placement. We will obtain intraop cultures and start empiric antibiotics after. We will keep him on antibiotics until his culture data speciates and we obtain sensitivities. He is reluctant to stay in the hospital and we had a long discussion re: his compliance with our instructions. I have re-emphasized to him the importance of following our recommendations.

Patient understands the risks of this injury & surgery include bleeding, infection, need for further surgery, damage to nerves/vessels, stiffness, scarring, loss of function, loss of limb, need for prolonged antibiotics.

After the risks and benefits of operative & non-operative intervention, complications, alternatives and time for recovery were discussed with the decision was made to proceed with surgical management and informed consent was obtained.

Subjective:
(-) AEON, reports some shoulder pain, otherwise denies new complaints.

NPO

Objective:
Last 24 Hour Vital Signs:
BP Min: 100/58 Max: 137/82
Temp Avg: 98.6 °F (37 °C) Min: 96.4 °F (35.8 °C) Max: 100.7 °F (38.2 °C)
Pulse Avg: 86.3 Min: 66 Max: 110
Resp Avg: 17.3 Min: 16 Max: 18

No intake or output data in the 24 hours ending 0614

Physical Examination:
NAD, Alert

RUE:
Proximal half of incision with minor dehiscence (~ 1mm gap) with fibrinous exudate bridging the incision edges.
+ seropurulent drainage
Mild surrounding fluctuance/erythema/warmth
Skin otherwise intact
+ Ax/EPL/FPL/OP/EDC/FDP/IO
LTSI Ax/R/M/U
2+ RP

Laboratory:

Cultures: @MICROBIOLOGY@

Trended Lab Data:

Lab	2252
WBC	7.9
HGB	11.7*
HCT	36.3*

PLT	504*
MCV	93.9
RDW	16.0*
NA	141
K	3.9
CL	103
CO2	29
BUN	18
CREATININE	--
SER	--
GLU	101*
PROT	--
ALBUMIN	--
BILITOT	--
AST	--
ALKPHOS	--
ALT	--

No results found for this basename: TROPONINI:3,CKTOTAL:3,CKMB:3 in the last 168 hours

Radiology:
Current Medications:
Infusions:

- dextrose 5 % and 0.45 % NaCl with KCl 20 mEq 1,000 mL (0101)

Scheduled:

- sodium chloride

PRN:
acetaminophen, diphenhydrAMINE, docusate sodium, morphine IV/IM, ondansetron hcl (PF), oxyCODONE-acetaminophen, oxyCODONE-acetaminophen

Assessment:
43 y/o M 2 weeks s/p ORIF Right Shoulder Greater Tuberosity fx w/ RTC repair

Plan:
-- NPO, OR today for shoulder I&D
-- Pain Control
-- Hold abx until after intra-op cultures are taken

<< Back to Review

g

This order was created via procedure documentation

Block - Other

Laterality: Right

Prep: ChloraPrepPatient Location is pre-op.
Needles
Injection technique: Single-shot
Needle:
Needle type: Pencil-tip 5 cm 22 G
Preanesthetic Checklist
Completed: patient identified, site marked, surgical consent, pre-op evaluation, timeout performed, IV checked, risks and benefits discussed, monitors and equipment checked, at surgeon's request, post-op pain management and anesthesia consent given
Procedures
Procedures: ultrasound guided
Monitoring with continuous pulse oximetry, cardiac monitor and heart rate.
Narrative
Injection made incrementally with aspirations every 5 mL.
Performed by: Personally

Additional Notes
Sterile prep/drape, U/S guided, NO complications, 30ml 0.5% ropivicaine in divided doses. VSS.

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Problem: Infection
Goal: Signs and symptoms of infections are decreased or avoided
Outcome: Progressing
Target Date:

Problem: Infection
Goal: Signs and symptoms of infections are decreased or avoided
Target Date:

Will monitor and assess wound to right shoulder. Monitor dressing for s/s of drainage.

OPERATIVE REPORT

ATTENDING PHYSICIAN:

AGE: 43

PREOPERATIVE DIAGNOSES:

1. Right shoulder wound infection.
2. Status post gunshot wound to right shoulder on
3. Status post open reduction and internal fixation of right greater tuberosity with rotator cuff repair and bullet excision.
4. Status post irrigation and debridement of bony fragments for acromion and scapular fractures.

POSTOPERATIVE DIAGNOSES:
1. Right shoulder wound infection.
2. Status post gunshot wound to right shoulder on
3. Status post open reduction and internal fixation of right greater tuberosity with rotator cuff repair and bullet excision.
4. Status post irrigation and debridement of bony fragments for acromion and scapular fractures.

PROCEDURE:
Right shoulder wound irrigation and debridement.

SURGEON:

ASSISTANTS:

ANESTHESIA:
Regional plus MAC.

ESTIMATED BLOOD LOSS:
50 mL.

INTRAVENOUS FLUIDS:
500 mL.

URINE OUTPUT:
Due to void.

SPECIMENS:
Right shoulder wound microbiology x2.

IMPLANTS:
None.

None.

INDICATIONS FOR PROCEDURE:
The patient is a 43-year-old right-hand dominant gentleman who sustained a right shoulder gunshot wound on during an armed robbery. He was subsequently taken to the operating room on after improvement of swelling. He underwent irrigation and debridement of the right shoulder with removal of copious bony debris. He underwent open reduction and internal fixation of his right greater tuberosity fracture with rotator cuff repair and bullet removal. At that time, he was noted to
have some muscle loss of the deltoid in the distal acromion. He presented to clinic on with a draining wound and no sling. He states he removed his own sutures some time around postop day #7 and then the wound began draining immediately after that. He also states he has been doing exercises beyond the strict pendulum-only exercises instructions he had been given. He states the pain had been better after surgery; however,
has worsened over the last few days concurrent with his drainage. He has not had any fevers; however, he has had chills at home. He was admitted for planned operative irrigation and debridement.
Antibiotics were held in order to facilitate culture data in the operating room. His x-ray showed no evidence of hardware failure or complication, and he does understand the plan for irrigation and debridement of his wound
with likely drain placement. We will plan on obtaining intraoperative cultures and start empiric antibiotics after this. We will keep him on antibiotics until his culture data speciates and we obtain sensitivities. Given the proximity of the screws and suture anchors to the area of wound drainage, he will likely need PICC line and prolonged antibiotics. He is reluctant to stay in the hospital and admits to having difficulty complying
with our instructions. We have re-emphasized to him over and over the importance of following our recommendations. He does understand the risks of this injury and surgery include bleeding, infection, need for further surgery, damaged nerves and vessels, stiffness, scarring, loss of function,
loss of limb, and need for prolonged antibiotics.

After the risks and benefits of operative and nonoperative intervention, complications, alternatives, and time for recovery were discussed with the patient, the decision was made to proceed with surgical management and informed consent was obtained.

DESCRIPTION OF PROCEDURE:
The patient had regional anesthesia initiated in the preoperative area. He was brought into the operating room. He was placed supine on the operating room table on a beanbag. MAC anesthesia was then initiated. Preoperative antibiotics were held given our desire to obtain culture data. The patient was then placed in a sloppy lateral position on a beanbag. The right upper extremity was prepped and draped in the usual sterile fashion. The correct patient, operative side, operative site, and site marked were confirmed, and a timeout was performed. The previous incision was incised with the 15-blade. Cloudy serous fluid was able to be expressed easily from this as well as what appeared to be necrotic fatty tissue. The first set of cultures was taken. Dissection was carried further down and noted that the anterosuperior deltoid did appear very scarred. The tissue at the previous distal acromion fracture appeared necrotic. This was debrided. The nonviable areas of scar and deltoid were debrided. Subsequently, the shoulder was irrigated thoroughly with 9 L of normal saline. Second set of cultures was then taken from the right shoulder wound. Vancomycin was then initiated.

The shoulder was taken through a range of motion and the greater tuberosity fragment was found to be intact and stable. Subsequently, a Hemovac drain was placed deep into the wound and the deltoid there was closed loosely with 2-0 PDS. The second Hemovac limb was placed in the superficial layer above the deltoid and the subcutaneous skin was closed with 2-0 PDS. Skin was closed with 3-0 Prolene. The skin was washed and dried and the incision was dressed with the dry sterile dressing. He was placed into a sling. He awoke from anesthesia without complications and brought to PACU in stable condition.

PLAN:
The patient will remain on IV vancomycin until his culture data returns. He does have a PENICILLIN ALLERGY. Depending on his culture data and ID input, we will then cater our antibiotic plan to this data. It is likely he will require 6 weeks of antibiotic treatment given the close proximity of the presumed infection to his implanted screws and suture anchors. He

has strict instructions to remain in his sling except for pendulum exercises. He has strict instructions to remain in the hospital. We will plan on removing the drains on likely postop day #2 when the drain output is diminished.

attending orthopedic surgeon, was present for and performed all critical portions of the procedure.

AUTHENTICATION

I have verified and signed this report to authenticate the documentation. I am returning this report to the Medical Records Department for placement in the patient's chart. This will meet the requirement for chart completion.

Progress Notes - Encounter Notes (continued)

- Wound dehiscence

S/p I&D R Shoulder Wound POD #1

Plan:
-- F/u cultures
-- Vanc, f/u trough
-- Pain Control, DVT PPX
-- PT/OT; NWB RUE; pendulum exercises only
-- ID consult once cultures return.
-- PICC line

Post-op Note

Seen/examined in Rm. Pain controlled

BP 150/73 | Pulse 77 | Temp(Src) 98.1 °F (36.7 °C) (Oral) | Resp 18 | Ht 1.651 m (5' 5") | Wt 58.968 kg (130 lb) | BMI 21.63 kg/m2 | SpO2 99%

PE
NAD, Alert
Dressing C/D/I
HV in place

Neuro exam altered because of block

A/P
-- Admit
-- IV Vanc
-- F/u cultures
-- Pain Control
-- NWB RUE, pendulums

with their documentation of

Please see their full H&P/clinic notes for details. Also please note that this patient is registered under 2 separate MRNs and has documentation in both charts.

37yM RHD sp GSW to R shoulder on during armed robbery. He was taken to the OR on after improvement of swelling for I&D R shoulder, ORIF R greater tuberosity with rotator cuff repair and bullet removal. He presented to clinic yesterday with a draining wound and no sling. Pt states he removed his own sutures about 5-7 days ago and wound began draining after that. He also states he has been doing exercises beyond the strict pendulum only exercises he had been given. He states his pain was better and has been worsening over the last few days. He has not had fevers however he has had chills.

PMH: kidney stones PSH: As above Meds: percocet 10/325 All: PCN
SH: works in medical sales. No tob.
PE: AFVSS
43yM, WDWN
NAD, A&Ox3
Breathing symmetric, nonlabored
RRR

RUE:
Swelling much improved
Incision is superficially boggy with expressible cloudy serous drainage
Very small areas of dehiscence 1-2 mm along wound
SILT m/r/u/ax
5/5 epl/fdp/dio/thumb abd
Shoulder ROM pain much improved since preop
WWP, brisk CR, 2+ RP

Imaging: Xrays R shoulder show no evidence of hardware failure/complication. Reduced greater tuberosity fragment remains in place.

Patient understands the plan for irrigation and debridement of his wound with drain placement. We will obtain intraop cultures and start empiric antibiotics after. We will keep him on antibiotics until his culture data speciates and we obtain sensitivities. He is reluctant to stay in the hospital and we had a long discussion re: his compliance with our instructions. I have re-emphasized to him the importance of following our recommendations.

Patient understands the risks of this injury & surgery include bleeding, infection, need for further surgery, damage to nerves/vessels, stiffness, scarring, loss of function, loss of limb, need for prolonged antibiotics.

After the risks and benefits of operative & non-operative intervention, complications, alternatives and time for recovery were discussed with the decision was made to proceed with surgical management and informed consent was obtained.

<< Back to Review

Xray Chest PA & Lat or 2 views per radiology protocol [29484553] (continued)

Ordering Provider:
Resulting Lab: GE RIS
Narrative:

Resulted by:
Specimen Collection

Clinical History
pre op

Technique
Frontal and lateral views of the chest

Comparison
None.

Findings
Femoral screws transfix the right humeral head. There are multiple radiopaque ballistic fragments in the left shoulder. There are age indeterminate, chronic appearing, right scapular and humeral head fractures. The bone screws appear intact.
The lungs are clear. There is no pleural effusion.
The cardiomediastinal contours are normal in size and configuration.

Impression
No acute cardiopulmonary or pleuroparenchymal finding.
Chronic appearing right shoulder and scapular fractures with surgical

Xray Ext/Int Rotation or Min 2 views per radiology protocol

Ordering Provider:
Resulting Lab: GE RIS
Narrative: To be done in PACULaterality->Right Ordering:

Resulted by:
Specimen Collection

Examination
Frontal, transcapular Y views of the right shoulder

Clinical History
Postoperative

Comparison
None

Findings
Findings of ORIF with 2 fully threaded screws stabilizing a greater trochanteric fracture is visualized. Additional, minimally displaced comminuted fracture of the acromion is present. Grossly, the acromioclavicular joint appears congruent. Metallic projectile debris is noted over the soft tissues of the proximal extremity
The humeral head is properly located in the glenohumeral joint.
Bone mineralization is within normal limits.
The visualized lung is clear.

Impression
Shoulder appears located. ORIF stabilizing greater trochanteric fracture without evidence of complication. Comminuted acromion fracture in adequate position.

CBC with differential (Abnormal) (continued)

Hemoglobin	12.6	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	38.9	40 - 51 %	L	-	HCSDLAB
MCV	94.0	80 - 100 FL		-	HCSDLAB
MCH	30.5	26 - 34 PG		-	HCSDLAB
MCHC	32.4	31 - 37 G/DL		-	HCSDLAB
RDW	16.4	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	528	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.4	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	6.9	1.8 - 8.0 10^3/UL		-	HCSDLAB
Lymphocytes Absolute	1.5	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	1.2	0.2 - 1.1 10^3/UL	H	-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	69	%		-	HCSDLAB
Lymphocytes Relative	15	%		-	HCSDLAB
Monocytes Relative	12	%		-	HCSDLAB
Eosinophils Relative	3	%		-	HCSDLAB
Basophils Relative	1	%		-	HCSDLAB

Basic metabolic panel [29580445] (Abnormal)

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	138	135 - 146 MMOL/L		-	HCSDLAB
Potassium	4.1	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	103	96 - 110 MMOL/L		-	HCSDLAB
CO2	26	24 - 32 MMOL/L		-	HCSDLAB
Glucose	126	65 - 99 MG/DL	H	-	HCSDLAB
BUN	13	7 - 25 MG/DL		-	HCSDLAB
Creatinine	1.12	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.3	8.4 - 10.3 MG/DL		-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN		-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUNC

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	ONE COLONY STAPHYLOCOCCUS, COAGULASE NEGATIVE			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Urinalysis [29580452] Resulted:

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Urine; URINE 1245

Urinalysis [29580452] (Abnormal) Resulted: , Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Urine; URINE

Component	Value	Ref Range	Flag	Comment	Lab
Color, UA	PALE YELLOW	YELLOW	A	-	HCSDLAB
APPEARANCE, UA	CLEAR	CLEAR		-	HCSDLAB
Specific Gravity, UA	1.017	1.005 - 1.030		-	HCSDLAB
PH, UA	7.0	4.5 - 8.0		-	HCSDLAB
Protein, UA	NEGATIVE	NEGATIVE MG/DL		-	HCSDLAB
Glucose, UA	NORMAL	NORMAL MG/DL		-	HCSDLAB
Ketones, UA	NEGATIVE	NEGATIVE MG/DL		-	HCSDLAB
Bilirubin, UA	NEGATIVE	NEGATIVE MG/DL		-	HCSDLAB
Blood, UA	10	NEGATIVE /uL	A	-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530451] (continued)

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 1			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	LIGHT GROWTH DIPHTHEROIDS			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	-			-	HCSDLAB
Result:	ONE COLONY STAPHYLOCOCCUS, COAGULASE NEGATIVE LIGHT GROWTH DIPHTHEROIDS				
REPORT STATUS	PENDING			-	HCSDLAB
Result:					

Anaerobic and Aerobic Culture w/gram stain [29530451]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 1			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	LIGHT GROWTH PROPIONIBACTERIUM ACNES			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457] Resulted , Result Status: Preliminary result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND 1352

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	-			-	HCSDLAB
Result:	ONE COLONY STAPHYLOCOCCUS, COAGULASE NEGATIVE LIGHT GROWTH PROPIONIBACTERIUM ACNES				
REPORT STATUS	PENDING			-	HCSDLAB
Result:					

Anaerobic and Aerobic Culture w/gram stain [29530457] Resulted:

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	-			-	HCSDLAB

All Results (continued)

FUNGUS CULTURE(REFLEX)] (continued)

Comment: No yeast or mold isolated after 4 weeks.
PERFORMED AT: LABCORP BIRMINGHAM, 1801 1ST AVE SOUTH, BIRMINGHAM, AL 35233 PHONE: DIRECTOR:

Resulting Lab: HCSD SUNQUEST Specimen:

FUNGUS CULTURE(REFLEX) [30349122] Resulted Result Status: Final result

Resulting Lab: HCSD SUNQUEST Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
FUNGUS RESULT1	Comment				HCSDLAB

Comment: No yeast or mold isolated after 4 weeks.
PERFORMED AT: LABCORP BIRMINGHAM, 1801 1ST AVE SOUTH, BIRMINGHAM, AL 35233 PHONE: DIRECTOR:

Afb Culture and Stain [29530452]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 1			-	HCSDLAB
AFB Smear	SMEAR NEGATIVE FOR AFB			-	HCSDLAB
CULTURE RESULTS	ACID FAST CULTURE NEGATIVE			-	HCSDLAB
REPORT STATUS	FINAL			-	HCSDLAB

Afb Culture and Stain [29530459]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
AFB Smear	SMEAR NEGATIVE FOR AFB			-	HCSDLAB
CULTURE RESULTS	ACID FAST CULTURE NEGATIVE			-	HCSDLAB
REPORT STATUS	FINAL			-	HCSDLAB

Testing Performed By

Lab - Abbreviation	Name	Director	Address
13 - GE	GE RIS	Unknown	Unknown
16 - HCSDLAB	HCSD SUNQUEST	Unknown	Unknown
201 - ILHPYRAMIS	ILHPYRAMIS	Unknown	Unknown

<< Back to Review

I have reviewed the notes, assessments, and/or procedures performed by ', I concur with her/his documentation of

Pt feels well. Nerve block resolved.
NVI.

- Dressing change tomorrow with drain removal.
- Awaiting culture data.
- Cont Vanco.

I have reviewed the notes, assessments, and/or procedures performed by ', I concur with her/his documentation of

Pt feels well postop. Pain controlled with block. Remains in sling.

- Cont vanco.
- F/u cxs.
- SCDs.
- NWB/pendulums only.

<< Back to Review

I agree with the student clinician's note

I have reviewed the notes, assessments, and/or procedures performed by I concur with her/his documentation of

Pt feels well. Nerve block resolved.
NVI.

- Dressing change tomorrow with drain removal.
- Awaiting culture data.
- Cont Vanco.

I have reviewed the notes, assessments, and/or procedures performed by ', I concur with her/his documentation of

Pt feels well postop. Pain controlled with block. Remains in sling.

- Cont vanco.
- F/u cxs.
- SCDs.
- NWB/pendulums only.

Ortho HOII Progress Note

<< Back to Review

I agree with the student clinician's note

I have reviewed the notes, assessments, and/or procedures performed by with her/his documentation of

Pt feels well. Nerve block resolved.
NVI.

- Dressing change tomorrow with drain removal.
- Awaiting culture data.
- Cont Vanco.

I have reviewed the notes, assessments, and/or procedures performed by y, I concur with her/his documentation of

Pt feels well postop. Pain controlled with block. Remains in sling.

- Cont vanco.
- F/u cxs.
- SCDs.
- NWB/pendulums only.

Subjective:
(-) AEON, c/o shoulder pain. Nerve block has worn off

Objective:
Last 24 Hour Vital Signs:
BP Min: 111/65 Max: 150/73
Temp Avg: 98.1 °F (36.7 °C) Min: 97.1 °F (36.2 °C) Max: 99.5 °F (37.5 °C)
Pulse Avg: 77.3 Min: 70 Max: 84
Resp Avg: 18.3 Min: 16 Max: 20

Intake/Output Summary (Last 24 hours) at 0601
Last data filed at 2144

	Gross per 24 hour
Intake	1000 ml
Output	851 ml
Net	149 ml

HV drain output not recorded

Physical Examination:
NAD, Alert

R Shoulder Dressing C/D/I
HV in place
+ Delt/Bi/Tri/WF/WE/HI
LTSI Ax/Rad/Med/Ulna
2+ RP

Laboratory:
Cultures:
Intra-op Cultures:
Gram Stain: No Organisms Seen
Cx: NGTD

Trended Lab Data:

Lab	**2252**
WBC	7.9
HGB	11.7*
HCT	36.3*
PLT	504*
MCV	93.9
RDW	16.0*
NA	141
K	3.9

- Wound dehiscence

S/p I&D R Shoulder Wound POD #1

Plan:
-- F/u cultures
-- Vanc, f/u trough
-- Pain Control, DVT PPX
-- PT/OT; NWB RUE; pendulum exercises only
-- ID consult once cultures return.
-- PICC line

Post-op Note

Seen/examined in Rm. Pain controlled

BP 150/73 | Pulse 77 | Temp(Src) 98.1 °F (36.7 °C) (Oral) | Resp 18 | Ht 1.651 m (5' 5") | Wt 58.968 kg (130 lb) | BMI 21.63 kg/m2 | SpO2 99%

PE
NAD, Alert
Dressing C/D/I
HV in place

Neuro exam altered because of block

A/P
-- Admit
-- IV Vanc
-- F/u cultures
-- Pain Control
-- NWB RUE, pendulums

I have reviewed the notes, assessments, and/or procedures performed by and , I concur

with their documentation of

Please see their full H&P/clinic notes for details. Also please note that this patient is registered under 2 separate MRNs and has documentation in both charts.

37yM RHD sp GSW to R shoulder on during armed robbery. He was taken to the OR on after improvement of swelling for I&D R shoulder, ORIF R greater tuberosity with rotator cuff repair and bullet removal. He presented to clinic yesterday with a draining wound and no sling. Pt states he removed his own sutures about 5-7 days ago and wound began draining after that. He also states he has been doing exercises beyond the strict pendulum only exercises he had been given. He states his pain was better and has been worsening over the last few days. He has not had fevers however he has had chills.

PMH: kidney stones PSH: As above Meds: percocet 10/325 All: PCN
SH: works in medical sales. No tob.
PE: AFVSS
43yM, WDWN
NAD, A&Ox3
Breathing symmetric, nonlabored
RRR

RUE:
Swelling much improved
Incision is superficially boggy with expressible cloudy serous drainage
Very small areas of dehiscence 1-2 mm along wound
SILT m/r/u/ax
5/5 epl/fdp/dio/thumb abd
Shoulder ROM pain much improved since preop
WWP, brisk CR, 2+ RP

Imaging: Xrays R shoulder show no evidence of hardware failure/complication. Reduced greater tuberosity fragment remains in place.

Patient understands the plan for irrigation and debridement of his wound with drain placement. We will obtain intraop cultures and start empiric antibiotics after. We will keep him on antibiotics until his culture data speciates and we obtain sensitivities. He is reluctant to stay in the hospital and we had a long discussion re: his compliance with our instructions. I have re-emphasized to him the importance of following our recommendations.

Patient understands the risks of this injury & surgery include bleeding, infection, need for further surgery, damage to nerves/vessels, stiffness, scarring, loss of function, loss of limb, need for prolonged antibiotics.

After the risks and benefits of operative & non-operative intervention, complications, alternatives and time for recovery were discussed with the decision was made to proceed with surgical management and informed consent was obtained.

<< Back to Review

Fungus culture [29530453]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Other; OTHER 1348

Anaerobic and Aerobic Culture w/gram stain [29530451]

Resulted: , Result Status: Preliminary result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 1			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	PENDING			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457]

Resulted Result Status: Preliminary result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	PENDING			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Basic metabolic panel [29530475]

Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

CBC with differential [29530476]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

CBC with differential [29530476] (Abnormal)

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	12.5	4.5 - 11.0 10^3/UL	H	-	HCSDLAB
Red Blood Cell Count	4.16	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	12.6	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	39.5	40 - 51 %	L	-	HCSDLAB
MCV	95.0	80 - 100 FL		-	HCSDLAB
MCH	30.4	26 - 34 PG		-	HCSDLAB
MCHC	32.0	31 - 37 G/DL		-	HCSDLAB
RDW	16.3	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	472	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.9	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	9.5	1.8 - 8.0 10^3/UL	H	-	HCSDLAB

CBC with differential] **(Abnormal) (continued)** Result Status: Final result

Red Blood Cell Count	4.11	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	12.4	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	38.7	40 - 51 %	L	-	HCSDLAB
MCV	94.0	80 - 100 FL		-	HCSDLAB
MCH	30.2	26 - 34 PG		-	HCSDLAB
MCHC	32.1	31 - 37 G/DL		-	HCSDLAB
RDW	16.1	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	489	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.8	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	8.3	1.8 - 8.0 10^3/UL	H	-	HCSDLAB
Lymphocytes Absolute	1.2	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	1.1	0.2 - 1.1 10^3/UL		-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	76	%		-	HCSDLAB
Lymphocytes Relative	11	%		-	HCSDLAB
Monocytes Relative	11	%		-	HCSDLAB
Eosinophils Relative	2	%		-	HCSDLAB
Basophils Relative	0	%		-	HCSDLAB

Basic metabolic panel [29580442]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	139	135 - 146 MMOL/L		-	HCSDLAB
Potassium	3.9	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	100	96 - 110 MMOL/L		-	HCSDLAB
CO2	30	24 - 32 MMOL/L		-	HCSDLAB
Glucose	84	65 - 99 MG/DL		-	HCSDLAB
BUN	12	7 - 25 MG/DL		-	HCSDLAB
Creatinine	1.13	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.3	8.4 - 10.3 MG/DL		-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN		-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457]

Ordering Provider: Resulting Lab:
Specimen: WOUND

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	NO GROWTH TO DATE			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Basic metabolic panel [29580445] Resulted: , Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

CBC with differential [29580446] Resulted: Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

CBC with differential [29580446] (Abnormal) Resulted Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	9.9	4.5 - 11.0 10^3/UL		-	HCSDLAB
Red Blood Cell Count	4.14	4.5 - 5.9 10^6/UL	L	-	HCSDLAB

CBC with differential] **(Abnormal) (continued)** Result Status: Final result

Red Blood Cell Count	4.11	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	12.4	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	38.7	40 - 51 %	L	-	HCSDLAB
MCV	94.0	80 - 100 FL		-	HCSDLAB
MCH	30.2	26 - 34 PG		-	HCSDLAB
MCHC	32.1	31 - 37 G/DL		-	HCSDLAB
RDW	16.1	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	489	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.8	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	8.3	1.8 - 8.0 10^3/UL	H	-	HCSDLAB
Lymphocytes Absolute	1.2	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	1.1	0.2 - 1.1 10^3/UL		-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	76	%		-	HCSDLAB
Lymphocytes Relative	11	%		-	HCSDLAB
Monocytes Relative	11	%		-	HCSDLAB
Eosinophils Relative	2	%		-	HCSDLAB
Basophils Relative	0	%		-	HCSDLAB

Basic metabolic panel [29580442]

Ordering Provider: , Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	139	135 - 146 MMOL/L		-	HCSDLAB
Potassium	3.9	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	100	96 - 110 MMOL/L		-	HCSDLAB
CO2	30	24 - 32 MMOL/L		-	HCSDLAB
Glucose	84	65 - 99 MG/DL		-	HCSDLAB
BUN	12	7 - 25 MG/DL		-	HCSDLAB
Creatinine	1.13	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.3	8.4 - 10.3 MG/DL		-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN		-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530457]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Component	Value	Ref Range	Flag	Comment	Lab
SPECIMEN DESCRIPTION	WOUND			-	HCSDLAB
SPECIAL REQUESTS	SHOULDER, RIGHT NUMBER 2			-	HCSDLAB
GRAM SMEAR	NO ORGANISMS SEEN			-	HCSDLAB
CULTURE RESULTS	NO GROWTH TO DATE			-	HCSDLAB
REPORT STATUS	PENDING			-	HCSDLAB

Basic metabolic panel [29580445]

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

CBC with differential [29580446] Resulted: , Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

CBC with differential [29580446] (Abnormal) Resulted: Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	9.9	4.5 - 11.0 10^3/UL		-	HCSDLAB
Red Blood Cell Count	4.14	4.5 - 5.9 10^6/UL	L	-	HCSDLAB

KOH [29580458]

Resulting Lab: HCSD SUNQUEST Specimen: 1352

Vancomycin, trough [29580462] Resulted: Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

Vancomycin, trough [29580462] (Abnormal) Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
Vancomycin Tr	7.5	10.0 - 20.0 MCG/ML	L		HCSDLAB
Comment:	20-25 mcg/mL MAY BE INDICATED FOR PNEUMONIA AND OTHER SERIOUS MRSA INFECTIONS NOTE - NEW REFERENCE RANGE				
VANCOMYCIN TIME OF DOSE	UNKNOWN	HRS		-	HCSDLAB
VANCOMYCIN DOSE	UNKNOWN	MG		-	HCSDLAB
VANCOMYCIN FREQUENCY	UNKNOWN	HRS		-	HCSDLAB

Basic metabolic panel [29580463] Resulted: 16, Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen:

CBC with differential [29580464] Resulted: , Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

CBC with differential [29580464] (Abnormal) Resulted Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	10.1	4.5 - 11.0 10^3/UL		-	HCSDLAB
Red Blood Cell Count	4.00	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	12.1	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	37.3	40 - 51 %	L	-	HCSDLAB
MCV	93.3	80 - 100 FL		-	HCSDLAB
MCH	30.3	26 - 34 PG		-	HCSDLAB
MCHC	32.5	31 - 37 G/DL		-	HCSDLAB
RDW	16.2	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	461	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.4	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	7.0	1.8 - 8.0 10^3/UL		-	HCSDLAB
Lymphocytes Absolute	1.7	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	1.1	0.2 - 1.1 10^3/UL		-	HCSDLAB
Eosinophils Absolute	0.4	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	69	%		-	HCSDLAB
Lymphocytes Relative	17	%		-	HCSDLAB
Monocytes Relative	10	%		-	HCSDLAB
Eosinophils Relative	4	%		-	HCSDLAB
Basophils Relative	0	%		-	HCSDLAB

Basic metabolic panel [29580463] Resulted: Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	139	135 - 146 MMOL/L		-	HCSDLAB

All Results (continued)

Basic metabolic panel [29580463] (continued) Resulted: , Result Status: Final result

Potassium	4.3	3.6 - 5.2 MMOL/L	-	HCSDLAB
Chloride	104	96 - 110 MMOL/L	-	HCSDLAB
CO2	29	24 - 32 MMOL/L	-	HCSDLAB
Glucose	95	65 - 99 MG/DL	-	HCSDLAB
BUN	18	7 - 25 MG/DL	-	HCSDLAB
Creatinine	1.04	0.70 - 1.40 MG/DL	-	HCSDLAB
Calcium	9.1	8.4 - 10.3 MG/DL	-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN	-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN	-	HCSDLAB

Basic metabolic panel [29580467] Resulted: , Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

CBC with differential [29580468] Resulted: Result Status: In process

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

CBC with differential [29580468] (Abnormal) Resulted: , Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD

Component	Value	Ref Range	Flag	Comment	Lab
CBC PROFILE	RESULTS:			-	HCSDLAB
WBC	6.0	4.5 - 11.0 10^3/UL		-	HCSDLAB
Red Blood Cell Count	4.00	4.5 - 5.9 10^6/UL	L	-	HCSDLAB
Hemoglobin	12.1	13.5 - 17.5 GM/DL	L	-	HCSDLAB
Hematocrit	37.8	40 - 51 %	L	-	HCSDLAB
MCV	94.6	80 - 100 FL		-	HCSDLAB
MCH	30.3	26 - 34 PG		-	HCSDLAB
MCHC	32.1	31 - 37 G/DL		-	HCSDLAB
RDW	16.0	11.5 - 14.5 %	H	-	HCSDLAB
Platelet Cnt	442	130 - 400 10^3/UL	H	-	HCSDLAB
MPV	8.8	7.4 - 10.4 FL		-	HCSDLAB
DIFFERENTAL	RESULTS:			-	HCSDLAB
Differential Type	AUTO			-	HCSDLAB
Neutrophils Absolute	3.6	1.8 - 8.0 10^3/UL		-	HCSDLAB
Lymphocytes Absolute	1.4	1.1 - 5.0 10^3/UL		-	HCSDLAB
Monocytes Absolute	0.7	0.2 - 1.1 10^3/UL		-	HCSDLAB
Eosinophils Absolute	0.3	0.0 - 0.6 10^3/UL		-	HCSDLAB
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-	HCSDLAB
Neutrophils Relatives	59	%		-	HCSDLAB
Lymphocytes Relative	23	%		-	HCSDLAB
Monocytes Relative	12	%		-	HCSDLAB
Eosinophils Relative	5	%		-	HCSDLAB
Basophils Relative	1	%		-	HCSDLAB

Basic metabolic panel [29580467] Resulted Result Status: Final result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: Blood; BLOOD 0530

Component	Value	Ref Range	Flag	Comment	Lab
Sodium	141	135 - 146 MMOL/L		-	HCSDLAB
Potassium	3.9	3.6 - 5.2 MMOL/L		-	HCSDLAB
Chloride	104	96 - 110 MMOL/L		-	HCSDLAB
CO2	31	24 - 32 MMOL/L		-	HCSDLAB
Glucose	98	65 - 99 MG/DL		-	HCSDLAB
BUN	19	7 - 25 MG/DL		-	HCSDLAB
Creatinine	1.14	0.70 - 1.40 MG/DL		-	HCSDLAB
Calcium	9.1	8.4 - 10.3 MG/DL		-	HCSDLAB
GFR MDRD Non Af Amer	>60	>59 mL/MIN		-	HCSDLAB
GFR MDRD Af Amer	>60	>59 mL/MIN		-	HCSDLAB

Anaerobic and Aerobic Culture w/gram stain [29530451] Resulted: Result Status: Preliminary result

Ordering Provider: Resulting Lab: HCSD SUNQUEST
Specimen: WOUND

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Medications (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
10-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed. - Oral Class: Historical Med				
oxyCODONE-acetaminophen (PERCOCET) 5-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed for Pain. - Oral Class: Print	30 tablet	0		
sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet (Taking) Sig - Route: Take 1 tablet by mouth 2 (two) times daily. - Oral Class: Print	28 tablet	0		

Telephone Encounter

Call Information

Date & Time	Provider	Department	Center
		Ilh Id - Lsu	ILH CID

Reason for Call

Follow-up

Call Documentation

Subjective:

Patient ID: is a 43 y.o. male.

HPI

43 y.o. male with s/p gunshot wound on after he underwent an armed robbery. On the patient underwent the following procedures

1. Open reduction and internal fixation of right greater tuberosity fracture.
2. Open rotator cuff repair.
3. Open treatment of scapular and acromion fractures.
4. Right shoulder irrigation and debridement.
5. Right shoulder removal of subcutaneous foreign body/bullet.

Reports self d/c'ing the sutures around POD # 7-9 and having hyperbaric wound care treatments which was arranged by one of his friend which performs hyperbaric wound care. Reports serous drainage since his sutures were removed. He was re-admitted on and had I+D of right shoulder on Culture was drawn at that time and grew 1 colony of CoNS and light propionibacterium. He was started on IV vancomycin and received it for about 6 days and then he left against AMA, he was prescribed bactrim and rifampin but he refers he is allergic to bactrim so he is only taking rifampin at this point. He comes today for follow up. No chills, no fever, no pain.

Telephone Encounter (continued)

Call Documentation (continued)

Review of Systems
Negative

Objective:

Physical Exam
98.7 89 18 131/66 5'5" 138lbs
General: AAOx3
Heart: RRR, no murmurs
Lungs: CTAx2
Abdomen: BS+, soft, NT, ND
Extremities: right shoulder with ~10cm surgical wound, with staples, healing well, 1 small area with minimal serous discharge.

Assessment:

43 y.o. male with:
1. Right shoulder CoNS staph osteomyelitis. We recommended to start IV antibiotics for at least 2 weeks and then continue PO, but patient refuses. I discussed with him That we can try PO for at least 6 weeks and see how he does but *Explained that there is a risk that he may need another surgery in the future and IV antibiotics if this does not resolve, specially since he has hardware in place.*
He verbalized understanding but still wants to try PO only so we prescribed Minocycline 100mg BID and rifampin 300mg BID to complete at least 6 weeks and we will re-evaluate then. We also order a CT scan to be done in 1 month.

1. **Shoulder osteomyelitis, right** — CT Shoulder With and Without IV contrast, Sedimentation rate, manual, C-reactive protein, CBC Manual Differential, Comprehensive metabolic panel

Plan:

Right shoulder osteomyelitis:
1. Minocycline 100mg BID for at least 6 weeks + Rifampin 300mg BID
2. Right shoulder CT scan in 1 month
3. Follow up with us (with any available fellow) in 6 weeks.
4. Follow up with orthopedics.

Return in about 7 weeks (around

seen today for no specified reason.

Diagnoses and associated orders for this visit:

Shoulder osteomyelitis, right
- CT Shoulder With and Without IV contrast; Future
- Sedimentation rate, manual; Future
- C-reactive protein; Future

Telephone Encounter (continued)

Call Documentation (continued)

- CBC Manual Differential; Future
- Comprehensive metabolic panel; Future

Care Advice Given

No Care Advice given for this encounter.

Future

Frequency:
Electronically signed by: 1432
Diagnoses: Shoulder osteomyelitis, right [730.21]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: right shoulder osteomyelitis

Future

signed by:
Diagnoses: Shoulder osteomyelitis, right [730.21]

Future

Diagnoses: Shoulder osteomyelitis, right [730.21]

Future

All Orders (continued)

CBC Manual Differential [29580483] (continued) Future

signed by:
Diagnoses: Shoulder osteomyelitis, right [730.21]

Diagnoses: Shoulder osteomyelitis, right [730.21]

Other Orders

No orders found

Result Summary

All Results

No results found

HPI

43 y.o. male with s/p gunshot wound on after he underwent an armed robbery. On the patient underwent the following procedures

1. Open reduction and internal fixation of right greater tuberosity fracture.
2. Open rotator cuff repair.
3. Open treatment of scapular and acromion fractures.
4. Right shoulder irrigation and debridement.
5. Right shoulder removal of subcutaneous foreign body/bullet.

Reports self d/c'ing the sutures around POD # 7-9 and having hyperbaric wound care treatments which was arranged by one of his friend which performs hyperbaric wound care. Reports serous drainage since his sutures were removed. He was re-admitted on and had I+D of right shoulder on Culture was drawn at that time and grew 1 colony of CoNS and light propionibacterium. He was started on IV vancomycin and received it for about 6 days and then he left against AMA, he was prescribed bactrim and rifampin but he refers he is allergic to bactrim so he is only taking rifampin at this point. He comes today for follow up. No chills, no fever, no pain.

Review of Systems

Progress Notes (continued)

Negative

Objective:

Physical Exam

98.7 89 18 131/66 5'5" 138lbs

General: AAOx3

Heart: RRR, no murmurs

Lungs: CTAx2

Abdomen: BS+, soft, NT, ND

Extremities: right shoulder with ~10cm surgical wound, with staples, healing well, 1 small area with minimal serous discharge.

Assessment:

43 y.o. male with:

1. Right shoulder CoNS staph osteomyelitis. We recommended to start IV antibiotics for at least 2 weeks and then continue PO, but patient refuses. I discussed with him That we can try PO for at least 6 weeks and see how he does but *Explained that there is a risk that he may need another surgery in the future and IV antibiotics if this does not resolve, specially since he has hardware in place.*

He verbalized understanding but still wants to try PO only so we prescribed Minocycline 100mg BID and rifampin 300mg BID to complete at least 6 weeks and we will re-evaluate then. We also order a CT scan to be done in 1 month.

1. Shoulder osteomyelitis, right	CT Shoulder With and Without IV contrast, Sedimentation rate, manual, C-reactive protein, CBC Manual Differential, Comprehensive metabolic panel

Plan:

Right shoulder osteomyelitis:

1. Minocycline 100mg BID for at least 6 weeks + Rifampin 300mg BID
2. Right shoulder CT scan in 1 month
3. Follow up with us (with any available fellow) in 6 weeks.
4. Follow up with orthopedics.

Return in about 7 weeks (around

seen today for no specified reason.

Diagnoses and associated orders for this visit:

Shoulder osteomyelitis, right

- CT Shoulder With and Without IV contrast; Future
- Sedimentation rate, manual; Future
- C-reactive protein; Future
- CBC Manual Differential; Future
- Comprehensive metabolic panel; Future

Notes (continued)

Progress Notes (continued)

Follow-up and Disposition History

	User	Date & Time
		2:34 PM

Disposition:

Return in about 7 weeks (around

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

		Date & Time
		2:33 PM

Disposition:

N/A

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

	User	Date & Time
		2:32 PM

Disposition:

Return in about 6 weeks (around

Follow-up:

Visit Summary

Reason for Visit

Follow-up

Diagnoses

Shoulder osteomyelitis, right - Primary

Problem List as of

	Codes	Priority	Class
GSW (gunshot wound)	879.8		
Fracture of acromion of scapula	811.01		
Humeral head fracture	812.09		
Wound infection	958.3		
Wound dehiscence	998.32		

Review Complete On: By:

	Type	Reactions
DELETED: Penicillins	Allergy	Anaphylaxis
Penicillins	Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)	Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid

Given By:

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
111/77	87	97.5 °F (36.4 °C) (Oral)	18	1.651 m (5' 5")	62.869 kg (138 lb 9.6 oz)

BMI
23.06 kg/m2

Patient History

	Date	Comments	Source
GSW (gunshot wound) [303343]		right shoulder	Provider
Gunshot wound [207566]		2 weeks ago	Provider

Surgical

Past Surgical History	Date	Comments	Source
KIDNEY STONE SURGERY [SHX686]			Provider

Family

Problem	Relation	Name	Age of Onset	Comments	Source
Cancer	Father			colon	Provider

Family Status

Relation	Name	Status	Death Age	Comments	Source
Father		Deceased			Provider

Tobacco Use

Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date
	Provider		1.0	10.0				Never Used	

as of

<< Back to Review

Medications (continued)

Medications at Start of Encounter (continued)

	Disp	Refills	Start	End
Class: Historical Med Reason for Discontinue: **Reorder**				
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet (Discontinued) Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed. - Oral Class: Historical Med Reason for Discontinue: **Reorder**				
sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet Sig - Route: Take 1 tablet by mouth 2 (two) times daily. - Oral Class: Print	28 tablet	0		

Discontinued Medications

	Reason for Discontinue
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Reorder
oxyCODONE-acetaminophen (PERCOCET) 5-325 mg per tablet	Reorder
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Reorder

Ordered Medications

	Disp	Refills	Start	End
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet (Discontinued) Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed. - Oral Class: Print	42 tablet	0		

Telephone Encounter

Call Information

Date & Time	Provider	Department	Center
9:00 AM		Ilh Ortho Cln - Lsu	ILH POY

Reason for Call

Post-Operative Exam	S/P SURGERY RIGHT UPPER EXTREMITY X 1 WEEK

Call Documentation

5:53 PM Pended

I have reviewed the notes, assessments, and/or procedures performed by I concur with her/his documentation of

43yM 3 wks sp R shoulder I&D, bullet removal, greater tuberosity ORIF and debridement of bone fragments from acromial fracture/greater tuberosity fracture. He is 1 week sp I&D for wound infection and scar/necrotic tissue excision after patient dc'd his own sutures around POD 7 and had wound dehiscence. He was also doing R shoulder exercises when he had been instructed to only perform pendulum exercises. At most recent surgery, he was found to have some necrosis of the deltoid from

Telephone Encounter (continued)

Call Documentation (continued)

Pt deserted the hospital (refused to sign AMA paperwork) this past weekend. Prior and after his I&D we had specifically discussed the importance of compliance with our instructions and recommendations. Patient expressed understanding about the plan for IV antibiotics/PICC placement. Today he again admits to doing more than just pendulum exercises. He went to his ID appointment today. Again ID recommended a 2 week course of IV abx. He again refused. He was prescribed rifampin & minocycline.

I had another discussion with him re: risk of continued/repeat infection and risk of hardware failure should he continue to dictate his own care. Although he expresses understanding, he admits that he will not agree to IV antibiotics and is unlikely to comply with our activity restrictions.

Today wound is c/d/i.
Shoulder ROM limited to ~30 deg abduction, 30 deg FF, ER to neutral.
Able to fire anterior and lateral deltoid.

Pt will cont on his PO abx.
F/u 1 week for repeat wound check and likely suture removal.
Pendulums. Will start further ROM at next visit if wound looks ok.
I have asked patient again to refrain from weight lifting, biking, working out until wound heals.

Mr. is a 43 y/o M who is here for follow up of a GSW to his right shoulder with a comminuted acromion and greater tuberosity fracture. He followed up in clinic with signs of a postoperative wound infection which prompted an admission and I&D in the OR. He grew out Coag Neg Staph and Propionibacterium acnes. He left AMA after only getting 6 days of IV abx and has only been taking the rifampin PO up to this point. He saw ID today who has recommended Minocycline and Rifampin PO for a total of 6 weeks of abx. They are drawing routine labs for monitoring during his abx course.

BP:	124/79
Pulse:	87
Temp:	99.2 °F (37.3 °C)
Resp:	20

EXAM:
Sutures in place.
Small spotting of serous drainage, but wound intact and resolving erythema noted.

ASSESSMENT/PLAN:
Comminuted acromion and greater tuberosity s/p GSW with postoperative wound infection.
Follow up with us in one week for suture removal. Follow up with ID as scheduled. Discussed with patient important of keeping with abx regimen and he is in agreement.
He will continue to work on pendulum excercises.

All Results (continued)

Xray Ext/Int Rotation or Min 2 views per radiology protocol [29580479] (continued) Resulted: , Result Status: Final result

3 views of the right shoulder.

Findings
2 cancellous screws are noted traversing through the greater tuberosity of the right humeral head. The ballistic injury with multiple fragments identified. Bone defect is noted along the superolateral portion of the humeral head extending up to the articular surface. Lateral margin of the acromion demonstrates a defect.

Impression
Healing fracture of the greater tuberosity of the right humeral head fixed with 2 cortical screws.
Ballistic injury with a cutaneous and bone defects identified as described above.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	

Notes

Progress Notes

5:53 PM Pended

I have reviewed the notes, assessments, and/or procedures performed by ', I concur with her/his documentation of '

43yM 3 wks sp R shoulder I&D, bullet removal, greater tuberosity ORIF and debridement of bone fragments from acromial fracture/greater tuberosity fracture. He is 1 week sp I&D for wound infection and scar/necrotic tissue excision after patient dc'd his own sutures around POD 7 and had wound dehiscence. He was also doing R shoulder exercises when he had been instructed to only perform pendulum exercises. At most recent surgery, he was found to have some necrosis of the deltoid from

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Shoulder ROM limited to ~30 deg abduction, 30 deg FF, ER to neutral.
Able to fire anterior and lateral deltoid.

Notes (continued)

Progress Notes (continued)

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F/u 1 week for repeat wound check and likely suture removal.
Pendulums. Will start further ROM at next visit if wound looks ok.
I have asked patient again to refrain from weight lifting, biking, working out until wound heals.

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Filed Vitals:

	05/
BP:	124/79
Pulse:	87
Temp:	99.2 °F (37.3 °C)
Resp:	20

EXAM:
Sutures in place.
Small spotting of serous drainage, but wound intact and resolving erythema noted.

ASSESSMENT/PLAN:
Comminuted acromion and greater tuberosity s/p GSW with postoperative wound infection.
Follow up with us in one week for suture removal. Follow up with ID as scheduled. Discussed with patient important of keeping with abx regimen and he is in agreement.
He will continue to work on pendulum excercises.

Electronically signed by

Follow-up and Disposition History

		Date & Time

Disposition:

Return in about 1 week (around

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Telephone Encounter (continued)

Call Documentation (continued)

Pt deserted the hospital (refused to sign AMA paperwork) this past weekend. Prior and after his I&D we had specifically discussed the importance of compliance with our instructions and recommendations. Patient expressed understanding about the plan for IV antibiotics/PICC placement. Today he again admits to doing more than just pendulum exercises. He went to his ID appointment today. Again ID recommended a 2 week course of IV abx. He again refused. He was prescribed rifampin & minocycline.

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BP:	124/79
Pulse:	87
Temp:	99.2 °F (37.3 °C)
Resp:	20

EXAM:
Sutures in place.
Small spotting of serous drainage, but wound intact and resolving erythema noted.

ASSESSMENT/PLAN:
Comminuted acromion and greater tuberosity s/p GSW with postoperative wound infection.
Follow up with us in one week for suture removal. Follow up with ID as scheduled. Discussed with patient important of keeping with abx regimen and he is in agreement.
He will continue to work on pendulum excercises.

Telephone Encounter (continued)

Call Documentation (continued)

Care Advice Given

No Care Advice given for this encounter.

All Orders

Xray Ext/Int Rotation or Min 2 views per radiology protocol [29580479] — Final result

Ordering User: — Authorized by:

Frequency: -
Electronically signed by:
Diagnoses: Displaced fracture of greater tuberosity of right humerus [812.03]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: pain
Comments:
3-View Right Shoulder

oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet [29580485] — Active

Ordering User: — Authorized by:
Frequency: Q4H PRN
Electronically signed by:
Discontinued by:
Diagnoses: Displaced fracture of greater tuberosity of right humerus [812.03]

Other Orders

No orders found

All Results

Xray Ext/Int Rotation or Min 2 views per radiology protocol [29580479]

Resulted by: — Resulting Lab: GE RIS
Specimen:
Narrative: 3-View Right ShoulderLaterality->Right Ordering:
Clinical History

pain

Comparison
None.

Technique

Notes (continued)

Progress Notes (continued)

Pt will cont on his PO abx.
F/u 1 week for repeat wound check and likely suture removal.
Pendulums. Will start further ROM at next visit if wound looks ok.
I have asked patient again to refrain from weight lifting, biking, working out until wound heals.

Physician 4:59 PM Signed

Mr. is a 43 y/o M who is here for follow up of a GSW to his right shoulder with a comminuted acromion and greater tuberosity fracture. He followed up in clinic with signs of a postoperative wound infection which prompted an admission and I&D in the OR. He grew out Coag Neg Staph and Propionibacterium acnes. He left AMA after only getting 6 days of IV abx and has only been taking the rifampin PO up to this point. He saw ID today who has recommended Minocycline and Rifampin PO for a total of 6 weeks of abx. They are drawing routine labs for monitoring during his abx course.

Filed Vitals:

	1235
BP:	124/79
Pulse:	87
Temp:	99.2 °F (37.3 °C)
Resp:	20

EXAM:
Sutures in place.
Small spotting of serous drainage, but wound intact and resolving erythema noted.

ASSESSMENT/PLAN:
Comminuted acromion and greater tuberosity s/p GSW with postoperative wound infection.
Follow up with us in one week for suture removal. Follow up with ID as scheduled. Discussed with patient important of keeping with abx regimen and he is in agreement.
He will continue to work on pendulum excercises.

Electronically signed by or 4:59 PM

Follow-up and Disposition History

	User	Date & Time
		4:57 PM

Disposition:

Return in about 1 week (around .

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

<< Back to Review

Telephone Encounter (continued)

Call Documentation (continued)

Scan on

Care Advice Given

No Care Advice given for this encounter.

Diagnoses: Displaced fracture of greater tuberosity of right humerus [812.03]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: pain
Comments:
3 View Right Shoulder

Diagnoses: Displaced fracture of greater tuberosity of right humerus [812.03]

Other Orders

No orders found

All Results

Xray Ext/Int Rotation or Min 2 views per radiology protocol [29580479] , Result Status: Final result

Resulted by: Resulting Lab: GE RIS
Specimen:
Narrative: 3-View Right ShoulderLaterality->Right Ordering: DLAND1: LANDRY, DALE
Clinical History

pain

Comparison
None.

Technique

All Results (continued)

Xray Ext/Int Rotation or Min 2 views per radiology protocol [29580479] (continued) Resulted Result Status: Final result

3 views of the right shoulder.

Findings
2 cancellous screws are noted traversing through the greater tuberosity of the right humeral head. The ballistic injury with multiple fragments identified. Bone defect is noted along the superolateral portion of the humeral head extending up to the articular surface. Lateral margin of the acromion demonstrates a defect.

Impression
Healing fracture of the greater tuberosity of the right humeral head fixed with 2 cortical screws.
Ballistic injury with a cutaneous and bone defects identified as described above.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	- Present

Notes

Progress Notes

Physician Pended

I have reviewed the notes, assessments, and/or procedures performed by ', I concur with her/his documentation of '

43yM 3 wks sp R shoulder I&D, bullet removal, greater tuberosity ORIF and debridement of bone fragments from acromial fracture/greater tuberosity fracture. He is 1 week sp I&D for wound infection and scar/necrotic tissue excision after patient dc'd his own sutures around POD 7 and had wound dehiscence. He was also doing R shoulder exercises when he had been instructed to only perform pendulum exercises. At most recent surgery, he was found to have some necrosis of the deltoid from

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I had another discussion with him re: risk of continued/repeat infection and risk of hardware failure should he continue to dictate his own care. Although he expresses understanding, he admits that he will not agree to IV antibiotics and is unlikely to comply with our activity restrictions.

Today wound is c/d/i.
Shoulder ROM limited to ~30 deg abduction, 30 deg FF, ER to neutral.
Able to fire anterior and lateral deltoid.

<< Back to Review

Visit Summary

Reason for Visit

Shoulder Injury Pt. states he is here for f/u visit, last surgery to his R Shoulder done

Diagnoses

Post-operative state - Primary

Displaced fracture of greater tuberosity of right humerus

	Codes	Priority	Class
GSW (gunshot wound)	879.8		
Fracture of acromion of scapula	811.01		
Humeral head fracture	812.09		
Wound infection	958.3		
Wound dehiscence	998.32		

Allergies as of **Review Complete** On

	Type	Reactions
DELETED: Penicillins	Allergy	Anaphylaxis
Penicillins	Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)	Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid

Given By:

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
116/68	80	97.7 °F (36.5 °C) (Oral)	19	1.651 m (5' 5")	63.504 kg (140 lb)

BMI
23.30 kg/m2

Telephone Encounter (continued)

Call Documentation (continued)

stay. At this point, attempting to be compliant with PO abx and our instructions. Continues hyperbaric O2 treatments that he initiated. Asking again to get back to working out, running, lifting, etc.

Today has some hypertrophic granuloma at incision. Rest of incision looks quite good. Sutures removed without incident.

ROM: ER neutral, IR to hip, abd to 30 deg.

Imaging shows GT & hardware in place.

We had another long discussion re: the severity of his injury. I believe he will have significant loss of ROM and function of this shoulder given the amount of trauma and debris. Our concern at this point is to have the GT heal and eradicate/control any infection. In the future, pt may benefit from further procedures to help with ROM however that is something that will have to be addressed down the road.

Encouraged pt to make wise decisions re: his activities.
May start some gentle ROM beyond pendulums.
F/u 3 wks.
Referral to OT.Cont abx per ID.

43 y.o. male now approximately 4 weeks s/p ORIF R greater tuberosity fx, approximately 2 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline. Seen about 1 week ago in clinic; no acute events since that time, has not self-d/c'd sutures, no increase in pain, no fevers/chills, decreasing amount of serous drainage. He has been going to hyperbaric O2 treatments. He has been doing pendulum exercises only. States percocet makes his stomach hurt. No other complaints.

Filed Vitals:

BP:	116/
Pulse:	
Temp:	°F (36.5 °C)
Resp:	19

Physical exam:
Gen: AOx3, NAD
RUE:
Sutures in place in surgical incision, which is healing well. One < 0.5cm area of small granulomatous exudate on lateral aspect of incision. No purulent drainage.
Minimal external rotation past neutral
About 30 degrees of passive abduction and FF.
SILT to deltoid
NVI distally

Imaging: XRs obtained in clinic today show no change in position of fragments or hardware fixation since prior study.

Telephone Encounter (continued)

Call Documentation (continued)

1. Sutures out today
2. Will allow granulomatous area to declare a little more; if necessary will apply silver nitrate at next appointment
3. Continue pendulum exercises; begin gentle external rotation exercises
4. RTC 3 weeks to assess and advance motion
5. Refer to OT to begin gentle passive ROM of R shoulder

Care Advice Given

No Care Advice given for this encounter.

Diagnoses: Post-operative state [V45.89]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: post op
Comments:
Axillary, scap Y, and grashey view

Signed by:
Diagnoses: Post-operative state [V45.89]
Questions: Clinical History Relevant to this Referral GSW to R shoulder s/p repair of greater tuberosity 4 weeks ago c limitation of passive ER, FF, ABD
Indicate Reason for Referral Fracture, unspecified

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Active

Notes (continued)

Progress Notes (continued)

stay. At this point, attempting to be compliant with PO abx and our instructions. Continues hyperbaric O2 treatments that he initiated. Asking again to get back to working out, running, lifting, etc.

Today has some hypertrophic granuloma at incision. Rest of incision looks quite good. Sutures removed without incident.

ROM: ER neutral, IR to hip, abd to 30 deg.

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We had another long discussion re: the severity of his injury. I believe he will have significant loss of ROM and function of this shoulder given the amount of trauma and debris. Our concern at this point is to have the GT heal and eradicate/control any infection. In the future, pt may benefit from further procedures to help with ROM however that is something that will have to be addressed down the road.

Encouraged pt to make wise decisions re: his activities.
May start some gentle ROM beyond pendulums.
F/u 3 wks.
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43 y.o. male now approximately 4 weeks s/p ORIF R greater tuberosity fx, approximately 2 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline. Seen about 1 week ago in clinic; no acute events since that time, has not self-d/c'd sutures, no increase in pain, no fevers/chills, decreasing amount of serous drainage. He has been going to hyperbaric O2 treatments. He has been doing pendulum exercises only. States percocet makes his stomach hurt. No other complaints.

Filed Vitals:

BP:	116/68
Pulse:	80
Temp:	97.7 °F (36.5 °C)
Resp:	19

Physical exam:
Gen: AOx3, NAD
RUE:
Sutures in place in surgical incision, which is healing well. One < 0.5cm area of small granulomatous exudate on lateral aspect of incision. No purulent drainage.
Minimal external rotation past neutral
About 30 degrees of passive abduction and FF.
SILT to deltoid
NVI distally

Imaging: XRs obtained in clinic today show no change in position of fragments or hardware fixation since prior study

Notes (continued)

Progress Notes (continued)

1. Sutures out today
2. Will allow granulomatous area to declare a little more; if necessary will apply silver nitrate at next appointment
3. Continue pendulum exercises; begin gentle external rotation exercises
4. RTC 3 weeks to assess and advance motion
5. Refer to OT to begin gentle passive ROM of R shoulder

Electronically signed by on 1:17 PM

Disposition:

Return in about 3 weeks (around

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents -

Scan on by (below)

Medications (continued)

Medications the Patient Reported Taking (continued)

	Disp	Refills
Reason for Discontinue: **Discontinued by another clinician**		

Medications at Start of Encounter

	Disp	Refills
rifampin (RIFADIN) 300 MG capsule (Taking) Sig - Route: Take 1 capsule by mouth daily. - Oral Class: Print	14 capsule	0
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet (Taking/Discontinued) Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed. - Oral Class: Print	42 tablet	0
sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet (Taking/Discontinued) Sig - Route: Take 1 tablet by mouth 2 (two) times daily. - Oral Class: Print Reason for Discontinue: **Discontinued by another clinician**	28 tablet	0

Discontinued Medications

	Reason for Discontinue
sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet	Discontinued by another clinician
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	

Ordered Medications

	Disp	Refills
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet (Discontinued) Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed. - Oral Class: Print	35 tablet	0

Shoulder Injury	Pt. states he is here for f/u visit, last surgery to his R Shoulder done

Call Documentation

Signed

I have reviewed the notes, assessments, and/or procedures performed by , I concur with her/his documentation of

43yM now 4 wks sp ORIF R GT fx and 2 wks sp I&D. Refused IV abx treatment and abandoned hospital at last

Telephone Encounter (continued)

Call Documentation (continued)

stay. At this point, attempting to be compliant with PO abx and our instructions. Continues hyperbaric O2 treatments that he initiated. Asking again to get back to working out, running, lifting, etc.

Today has some hypertrophic granuloma at incision. Rest of incision looks quite good. Sutures removed without incident.

ROM: ER neutral, IR to hip, abd to 30 deg.

Imaging shows GT & hardware in place.

We had another long discussion re: the severity of his injury. I believe he will have significant loss of ROM and function of this shoulder given the amount of trauma and debris. Our concern at this point is to have the GT heal and eradicate/control any infection. In the future, pt may benefit from further procedures to help with ROM however that is something that will have to be addressed down the road.

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F/u 3 wks.
Referral to OT.Cont abx per ID.

43 y.o. male now approximately 4 weeks s/p ORIF R greater tuberosity fx, approximately 2 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline. Seen about 1 week ago in clinic; no acute events since that time, has not self-d/c'd sutures, no increase in pain, no fevers/chills, decreasing amount of serous drainage. He has been going to hyperbaric O2 treatments. He has been doing pendulum exercises only. States percocet makes his stomach hurt. No other complaints.

Filed Vitals:

	06/(
BP:	116/
Pulse:	
Temp:	°F (36.5 °C)
Resp:	19

Physical exam:
Gen: AOx3, NAD
RUE:
Sutures in place in surgical incision, which is healing well. One < 0.5cm area of small granulomatous exudate on lateral aspect of incision. No purulent drainage.
Minimal external rotation past neutral
About 30 degrees of passive abduction and FF.
SILT to deltoid
NVI distally

Imaging: XRs obtained in clinic today show no change in position of fragments or hardware fixation since prior study.

Other Orders

Ambulatory Referral to Occupational Therapy Evaluation and Treat Ordered

Ordering User:	1317	Authorized by:	
Frequency:			
Electronically signed by:	1317		
Diagnoses:	Post-operative state [V45.89]		
Questions:	Clinical History Relevant to this Referral GSW to R shoulder s/p repair of greater tuberosity 4 weeks ago c limitation of passive ER, FF, ABD Indicate Reason for Referral Fracture, unspecified		

All Results

Xray Ext/Int Rotation or Min 2 views (Shoulder) [30349115] Resulted: 1306, Result Status: Final result

Resulted by: Resulting Lab: GE RIS

Specimen: 1045

Narrative: Axillary, scap Y, and grashey viewLaterality->Right Ordering:
Clinical History
Post op.
Additional history: Right scapular and proximal humeral fractures secondary to gunshot wound.

Comparison
Views of the right shoulder dating back to most recently those of

Findings
Two screws with washers are again noted in the proximal humerus, apparently stabilizing a fracture of the proximal humerus involving predominantly the greater tuberosity. Fractures of the scapular spine and acromion process are again noted. Position and alignment do not appear to have changed significantly since previous postoperative images of Metallic opacities consistent with bullet fragments are again noted about the shoulder.

Impression
Posttraumatic and postoperative findings as described.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	'10 1245 - Present

Notes

Progress Notes

Physician 1:52 PM Signed
I have reviewed the notes, assessments, and/or procedures performed by , I concur with her/his documentation of

43yM now 4 wks sp ORIF R GT fx and 2 wks sp I&D. Refused IV abx treatment and abandoned hospital at last

Notes (continued)

Progress Notes (continued)

stay. At this point, attempting to be compliant with PO abx and our instructions. Continues hyperbaric O2 treatments that he initiated. Asking again to get back to working out, running, lifting, etc.

Today has some hypertrophic granuloma at incision. Rest of incision looks quite good. Sutures removed without incident.

ROM: ER neutral, IR to hip, abd to 30 deg.

Imaging shows GT & hardware in place.

We had another long discussion re: the severity of his injury. I believe he will have significant loss of ROM and function of this shoulder given the amount of trauma and debris. Our concern at this point is to have the GT heal and eradicate/control any infection. In the future, pt may benefit from further procedures to help with ROM however that is something that will have to be addressed down the road.

Encouraged pt to make wise decisions re: his activities.
May start some gentle ROM beyond pendulums.
F/u 3 wks.
Referral to OT.Cont abx per ID.

Resident 1:17 PM Signed

43 y.o. male now approximately 4 weeks s/p ORIF R greater tuberosity fx, approximately 2 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline. Seen about 1 week ago in clinic; no acute events since that time, has not self-d/c'd sutures, no increase in pain, no fevers/chills, decreasing amount of serous drainage. He has been going to hyperbaric O2 treatments. He has been doing pendulum exercises only. States percocet makes his stomach hurt. No other complaints.

Filed Vitals:

BP:	116/68
Pulse:	80
Temp:	97.7 °F (36.5 °C)
Resp:	19

Physical exam:
Gen: AOx3, NAD
RUE:
Sutures in place in surgical incision, which is healing well. One < 0.5cm area of small granulomatous exudate on lateral aspect of incision. No purulent drainage.
Minimal external rotation past neutral
About 30 degrees of passive abduction and FF.
SILT to deltoid
NVI distally

Imaging: XRs obtained in clinic today show no change in position of fragments or hardware fixation since prior study.

Other Orders

Ambulatory Referral to Occupational Therapy Evaluation and Treat Ordered

Ordering User: 1317 Authorized by:
Frequency:
Electronically signed by: 1317
Diagnoses: Post-operative state [V45.89]
Questions: Clinical History Relevant to this Referral GSW to R shoulder s/p repair of greater tuberosity 4 weeks ago c limitation of passive ER, FF, ABD
Indicate Reason for Referral Fracture, unspecified

All Results

Xray Ext/Int Rotation or Min 2 views (Shoulder) [30349115] Resulted: 1306, Result Status: Final result

Resulted by: Resulting Lab: GE RIS
Specimen: 1045
Narrative: Axillary, scap Y, and grashey viewLaterality->Right Ordering
Clinical History
Post op.
Additional history: Right scapular and proximal humeral fractures secondary to gunshot wound.

Comparison
Views of the right shoulder dating back to most recently those of

Findings
Two screws with washers are again noted in the proximal humerus, apparently stabilizing a fracture of the proximal humerus involving predominantly the greater tuberosity. Fractures of the scapular spine and acromion process are again noted. Position and alignment do not appear to have changed significantly since previous postoperative images of Metallic opacities consistent with bullet fragments are again noted about the shoulder.

Impression
Posttraumatic and postoperative findings as described.

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	'10 1245 - Present

Notes

Progress Notes

Physician 1:52 PM Signed
I have reviewed the notes, assessments, and/or procedures performed by I concur with her/his documentation of

43yM now 4 wks sp ORIF R GT fx and 2 wks sp I&D. Refused IV abx treatment and abandoned hospital at last

Occupational Therapy Upper Extremity Initial Assessment

History
Diagnosis:
1. Open reduction and internal fixation of right greater tuberosity fracture.
2. Open rotator cuff repair.
3. Open treatment of scapular and acromion fractures.
4. Right shoulder irrigation and debridement.
5. Right shoulder removal of subcutaneous foreign body/bullet.

Onset date/date of surgery
Order: eval and treat. Begin gentle ROM
Precautions/contraindications: universal
Pt. has a past medical history of GSW (gunshot wound) (

Subjective
Pt. C/o pain 5/10

Patient's goals for therapy: to increase functional use of RUE and return to gym

Occupation and Activities
Prior level of function: independent in ADL's
ADL/Current functional limitations: Grooming, Dressing, Lifting, Holding and unable to lift weights
Work status: working part time
Job title/type of work: medical sales

Objective

Hand dominance: Right

Right Upper Ext	AAROM (degrees)	PROM (degrees)	MMT
Shoulder flex	100		
Shoulder ext	55		
Shoulder abd	30		
Shoulder IR	wnl s/b		
Shoulder ER	30 s/b		
Elbow flex	wnl		
Elbow ext	wnl		
Supination	wnl		
Pronation	wnl		
Wrist flex	wnl		
Wrist ext	wnl		
Wrist rad. dev	wnl		
Wrist uln. dev	wnl		

LUE WNL

Sensation:
Light touch: Intact
Proprioception: Intact

Assessment
Patient referred to OT with diagnosis of R shoulder fx and RCR for eval and treat.
Patient will benefit from skilled OT services to address RUE dysfunction

Potential for progress: good

Short-term goals (STG)Timeframe: 1 month
1. Pt. Will be independent with HEP and all upgrades
2. Pt. Will demonstrate an increase in R shoulder AROM by 30 degrees all plans for improved dressing and bathing
3. Pt. Will use RUE to reach hanging shirt in closet independently

Long-term goals (LTG)Timeframe: 3 months
\1. Pt. Will demonstrate shoulder strength 4/5 for improved performance carrying ADL objects and reaching items overhead
2. Pt. Will report pain 2/10 during ADLs

Treatment today/Patient education: Evaluation
HEP: AAROM R shoulder all planes

Treatment time: Evaluation 45 minutes

Plan of Care: The patient is to be seen 1 time(s) per week, for 12 week(s) to progress toward above goals. The following interventions will be performed as therapeutically necessary to decrease pain, increase function, increase mobility and increase independence with activities of daily living:
Manual therapy
Therapeutic exercises
Functional activities
ADL training
Therapeutic modalities
Patient Education

<< Back to Review

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	Home Or Self Care	None	None	Ilh Wound-Hyperbarics

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
	Hospital Outpatient	Outpatient	ILH WOUND-HYPERBARICS		
13 2359	Discharge	Outpatient	ILH WOUND-HYPERBARICS		

Allergies as of **Review Complete** On: By:

	Noted	Type	Reactions
DELETED: Penicillins		Allergy	Anaphylaxis
Penicillins		Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)		Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid
Given By:					

Medical as of

Past Medical History	Comments	Source
GSW (gunshot wound) [303343]	right shoulder	Provider
Gunshot wound [207566]	2 weeks ago	Provider

Problem List

	Noted	Resolved
Wound infection	by	No
Wound dehiscence		No
GSW (gunshot wound)		No
Fracture of acromion of scapula		No
Humeral head fracture		No
Greater tuberosity of humerus fracture		No
Complete rotator cuff tear of left shoulder		No

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

ED Notes

No notes of this type exist for this admission.

Progress Notes - Encounter Notes (continued)

is a 43 y.o. male patient.

Past Medical History

Diagnosis	Date
• GSW (gunshot wound) *right shoulder*	
• Gunshot wound *2 weeks ago*	

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• rifampin (RIFADIN) 150 MG capsule	Take 150 mg by mouth daily. Unknown dosage, but takes 2 times daily		
• minocycline (MINOCIN,DYNACIN) 100 MG capsule	Take 100 mg by mouth 2 (two) times daily.		
• oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed.	35 tablet	0

Allergies

Allergen	Reactions
• Penicillins	Anaphylaxis
• Bactrim (Sulfamethoxazole-Trimethoprim)	Rash

Active Problems:
* No active hospital problems. *

Blood pressure 111/72, pulse 73, temperature 98.8 °F (37.1 °C), temperature source Oral, resp. rate 20, height 1.651 m (5' 5"), weight 63.504 kg (140 lb).

Subjective: First visit to wound care. GSW 4/29 right shoulder in French Quarter in robbery. Taken to UH. Discharged and operated upon 1 week later. Two weeks later thought to be infected with drainage. Admit, I & D, hospitalized x 6d, one colony of staph on culture. Has two screws in humerus. Left hospital AMA on antibiotics. Came to Family Physicians Center and saw HBOT started. Wound reopened two weeks ago and suture was expressed. Has been draining since then. Slightly yellow, clear discharge. No F,C. Seen in PT on Tuesday and patient was walked over to ortho to be seen. Seen in Ortho yesterday one week before routine F/U and patient brought to wound care for appointment today. Still on antibiotics.
Objective: Right shoulder: scar with 5 x 10 mm protruding fatty/granular bubble of tissue. Slightly tender. Epithelium growing on tissue protuberance from medial aspect of wound, cleft on lateral aspect. No pus, discharge, erythema, signs of infection or necrosis. Very limited ROM of shoulder: 15 degrees active, 40 degrees passive. Distal motor normal. 2 + radial pulse. AgNO3 to tissue.
Assessment & Plan: 1. S/p right shoulder GSW with FB reaction vs. Sinus tract.
Plan: Local wound care, PT.

<< Back to Review

Visit Summary

Reason for Visit

Follow-up right shoulder

Diagnoses

Post-operative state - Primary

Problem List as of [redacted] Date Reviewed:

	Codes	Priority	Class	Noted - Resolved
GSW (gunshot wound)	879.8			- Present
Fracture of acromion of scapula	811.01			- Present
Humeral head fracture	812.09			- Present
Wound infection	958.3			- Present
Wound dehiscence	998.32			- Present

Allergies as of

	Noted	Type	Reactions
DELETED: Penicillins		Allergy	Anaphylaxis
Penicillins		Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)		Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid

Given By:

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
115/71	74	99.1 °F (37.3 °C) (Oral)	19	1.651 m (5' 5")	63.504 kg (140 lb)

BMI
23.30 kg/m2

Visit Summary (continued)

as of										
	Never Smoker	Provider		1.0	10.0				Never Used	

Alcohol Use as of	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
	No	Provider		0.0 oz	

Drug Use as of	Drug Use	Source	Types	Frequency	Comments
	No	Provider		0.00	

Sexual Activity as of	Sexually Active	Source	Birth Control	Partners	Comments
	Not Currently	Provider			

Social ADL as of	ADL Question	Response	Comments	Source
	None			

Occupational as of **None**

Medications

Medications at Start of Encounter

	Disp	Refills	Start	End
minocycline (MINOCIN,DYNACIN) 100 MG capsule				
Sig - Route: Take 100 mg by mouth 2 (two) times daily. - Oral				
Class: Historical Med				
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet (Discontinued)	35 tablet	0		
Sig - Route: Take 1 tablet by mouth every 6 (six) hours as needed. - Oral				
Class: Print				
Reason for Discontinue: **Therapy completed**				
rifampin (RIFADIN) 150 MG capsule				
Sig - Route: Take 150 mg by mouth daily. Unknown dosage, but takes 2 times daily - Oral				
Class: Historical Med				

Discontinued Medications

	Reason for Discontinue
oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Therapy completed

Ordered Medications

	Disp	Refills	Start	End
oxyCODONE-acetaminophen (ROXICET) 5-325 mg per tablet	60 tablet	0		
Sig - Route: Take 1 tablet by mouth every 8 (eight) hours as needed for Pain. - Oral				
Class: Print				

Ordered Facility-Administered Medications

Medications (continued)

Ordered Facility-Administered Medications (continued)

		Dose	Freq	Start	End
	silver nitrate applicator 75-25 % stick				

Telephone Encounter

Call Information

	Date & Time	Provider	Department	Center
	10:30 AM			

Reason for Call

Follow-up right shoulder

Call Documentation

2:34 PM Signed

43 year old male sp GSW right shoulder Underwent ORIF right greater tuberosity fracture, open rotator cuff repair, ORIF scapula and acromion fractures. Developed wound infection and underwent Irrigation and debridement on

He is currently being followed in OT and wound care for continued drainage.

The patient is still complaining of pain in the shoulder. Currently taking percocet 10/325mg for pain.

He reports he changes the bandage 3 times per day, with drainage on each bandage.

He is currently on minocycline 100mg and rifampin daily.

The patient was seen and evaluated by

The incision remains with a central area measuring approximately 1cm with tissue protruding, slight drainage. He is able to actively abduct the shoulder to approximately 45 degrees, forward flexion to approximately 90 degrees.

The plan for the patient is to continue antibiotic until course is complete.

Will refill pain medication stepping the patient down to percocet 5/325 mg.

Return to clinic in 4 weeks for re evaluation.

Care Advice Given

No Care Advice given for this encounter.

All Orders

Xray Ext/Int Rotation or Min 2 views per radiology protocol [31190984] Final result

All Results (continued)

Xray Ext/Int Rotation or Min 2 views per radiology protocol [31190984] (continued) Resulted: 1439, Result Status: Final result

humeral fragments do not appear to have changed significantly since the previous study of and are grossly satisfactory. Defect of the acromion process and fracture plane through the spine of the scapula are again demonstrated, as are multiple metallic opacities consistent with bullet fragments. The bones at the shoulder appear demineralized, particularly the proximal humerus.

Impression
Posttraumatic and postoperative findings, similar to those demonstrated on previous study of

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	

Notes

Progress Notes

Nurse Practitioner 2:34 PM Signed

43 year old male sp GSW right shoulder Underwent ORIF right greater tuberosity fracture, open rotator cuff repair, ORIF scapula and acromion fractures. Developed wound infection and underwent Irrigation and debridement on
He is currently being followed in OT and wound care for continued drainage.
The patient is still complaining of pain in the shoulder. Currently taking percocet 10/325mg for pain.
He reports he changes the bandage 3 times per day, with drainage on each bandage.
He is currently on minocycline 100mg and rifampin daily.

The patient was seen and evaluated by

The incision remains with a central area measuring approximately 1cm with tissue protruding, slight drainage. He is able to actively abduct the shoulder to approximately 45 degrees, forward flexion to approximately 90 degrees.

The plan for the patient is to continue antibiotic until course is complete.
Will refill pain medication stepping the patient down to percocet 5/325 mg.
Return to clinic in 4 weeks for re evaluation.

Disposition: (continued)

Return in about 4 weeks (around

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents -

All Orders (continued)

Xray Ext/Int Rotation or Min 2 views per radiology protocol [31190984] (continued) — Final result

Ordering User: I 1035 — Authorized by:
Frequency: -
Electronically signed by:
Diagnoses: Post-operative state [V45.89]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: pain
Comments:
3-View Right Shoulder

oxyCODONE-acetaminophen (ROXICET) 5-325 mg per tablet [31190985] — Expired

Ordering User: — Authorized by:
Frequency: Q8H PRN - 10 Days
Electronically signed by:
PRN Reasons: Pain
Diagnoses: Post-operative state [V45.89]

silver nitrate applicator 75-25 % stick [31190993] — Expired

Ordering User: — Authorized by:
Frequency: 3 1122 - 1 Occurrences
Electronically signed by: Ads Dispense Edi 1122
Medication Comments:
BORNE, KRISTIN: cabinet override

Other Orders

No orders found

All Results

Xray Ext/Int Rotation or Min 2 views per radiology protocol — Resulted:

Resulted by: — Resulting Lab: GE RIS
Specimen: 1051
Narrative: 3-View Right ShoulderLaterality->Right Ordering:
Clinical History
Pain.
Additional history: gunshot wound right shoulder, ORIF proximal humerus.

Comparison
Views of the right shoulder dating back to most recently those of

Findings
Two screws with washers placed to stabilize a fracture of the proximal humerus involving the greater tuberosity and a portion of the humeral head, are again noted. Position and alignment of major

<< Back to Review

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
None	Home Or Self Care	None	None	Ilh Wound-Hyperbarics

Final Diagnoses (ICD-9-CM)

	Principal	Code	Name	POA	CC	HAC	Affects DRG
	[P]	880.10	Open wound of shoulder region, complicated				

Events

	Event	Pt Class	Unit	Room/Bed	Service
	Hospital Outpatient	Outpatient	ILH WOUND-HYPERBARICS		
	Discharge	Outpatient	ILH WOUND-HYPERBARICS		

Allergies as of **Review Complete** On: By:

	Noted	Type	Reactions
DELETED: Penicillins		Allergy	Anaphylaxis
Penicillins		Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)		Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid
Given By:					

Medical as of

Past Medical History	Date	Comments	Source
GSW (gunshot wound) [303343]		right shoulder	Provider
Gunshot wound [207566]		2 weeks ago	Provider

Problem List

	Noted	Resolved
Wound infection		No
Wound dehiscence		No
GSW (gunshot wound)		No
Fracture of acromion of scapula		No
Humeral head fracture		No
Greater tuberosity of humerus fracture		No
Complete rotator cuff tear of left shoulder		No

Continue local wound care. Return in 2 weeks or sooner if develop infection again.

is a 43 y.o. male patient. Here for regularly scheduled f/u for L shoulder wound. No new c/o. States he is healed.

Past Medical History

Diagnosis	Date
• GSW (gunshot wound) *right shoulder*	
• Gunshot wound *2 weeks ago*	

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• DISCONTD: minocycline (MINOCIN,DYNACIN) 100 MG capsule	Take 100 mg by mouth 2 (two) times daily.		
• DISCONTD: rifampin (RIFADIN) 150 MG capsule	Take 150 mg by mouth daily. Unknown dosage, but takes 2 times daily		

Allergies

Allergen	Reactions
• Penicillins	Anaphylaxis
• Bactrim (Sulfamethoxazole-Trimethoprim)	Rash

Active Problems:
* No active hospital problems. *

Blood pressure 106/69, pulse 75, temperature 97.8 °F (36.6 °C), temperature source Oral, resp. rate 14.

Subjective:
Symptoms: Resolved. No shortness of breath, chest pain or chest pressure.
Diet: Adequate intake.
Activity level: Normal.
Pain: He reports no pain.

Objective:
General Appearance: Comfortable, well-appearing, in no acute distress and not in pain.
Vital signs: (most recent): Blood pressure 106/69, pulse 75, temperature 97.8 °F (36.6 °C), temperature source Oral, resp. rate 14. Vital signs are normal. No fever.
Output: Producing urine and producing stool.
Lungs: Normal respiratory rate and normal effort.
Skin: Warm and dry. No ulceration.
Pulses: Distal pulses are intact.

Assessment:

Condition: In stable condition. (L anterior shoulder healed.
No fluctuance, no warmth, no TTP.
No erythema.).

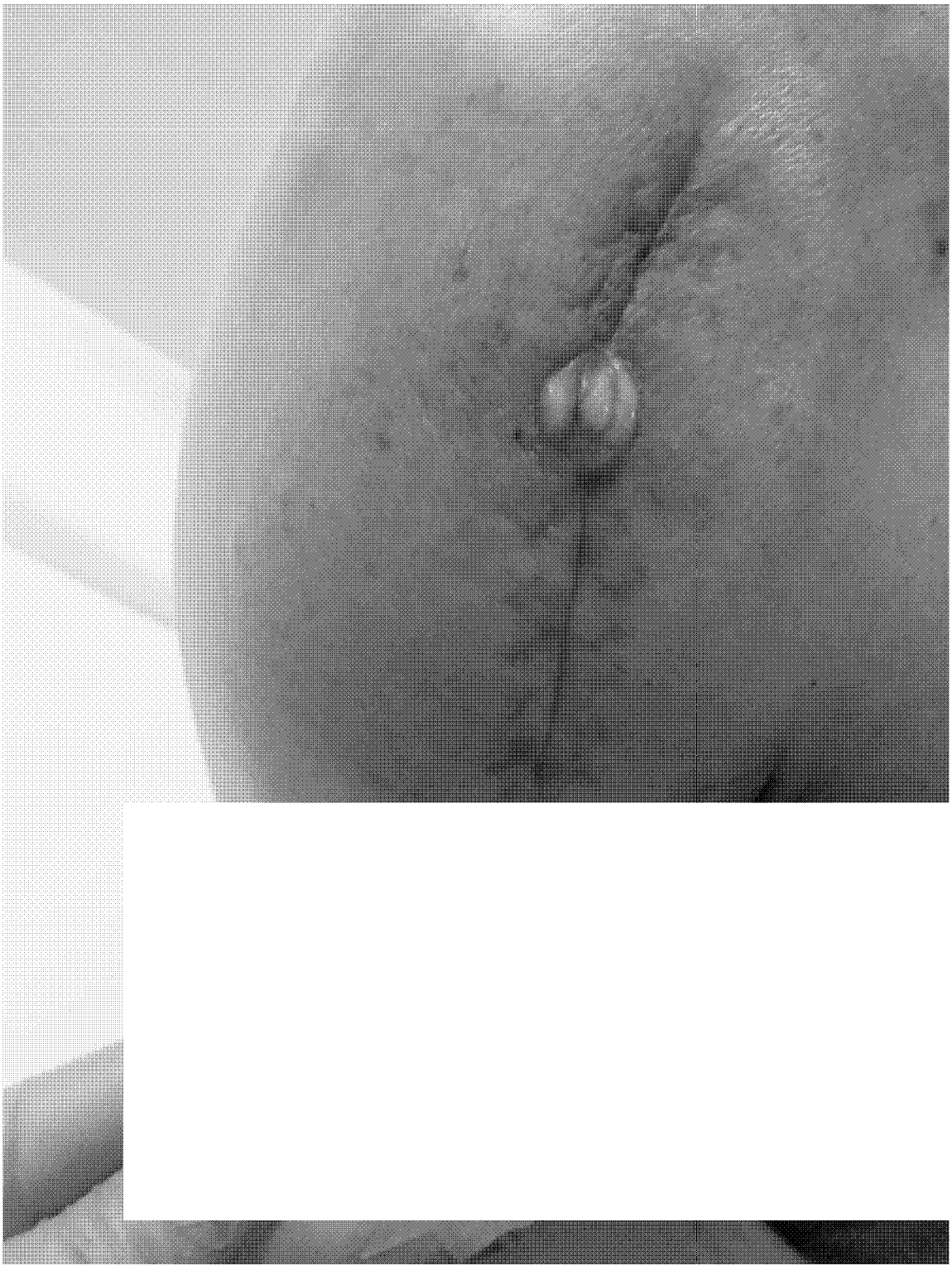
Plan:

Discharge home. (Healed.
discharge home in good condition.).

Pt in clinic for f/u visit
Denies any fever or chills
R shoulder wound OTA, new epithelium noted
No drainage
Cleaned with wound cleaner, patted dry
bedside
Pt evaluated by
Pt instructed on s/s of infection
Instructed to f/u with wound care as needed
Pt verbalizes understanding
Discharged from clinic

Patient evaluated by to wound per Patient tolerated well.
Mepilex with border to wound. Instructed by to leave dressing in place for next 3-4 days, then resume self care as he as been doing previously. Patient states he is using aquacel at home daily.
No other complaints. Discharged to home. Will return to clinic in one week to see Appt given

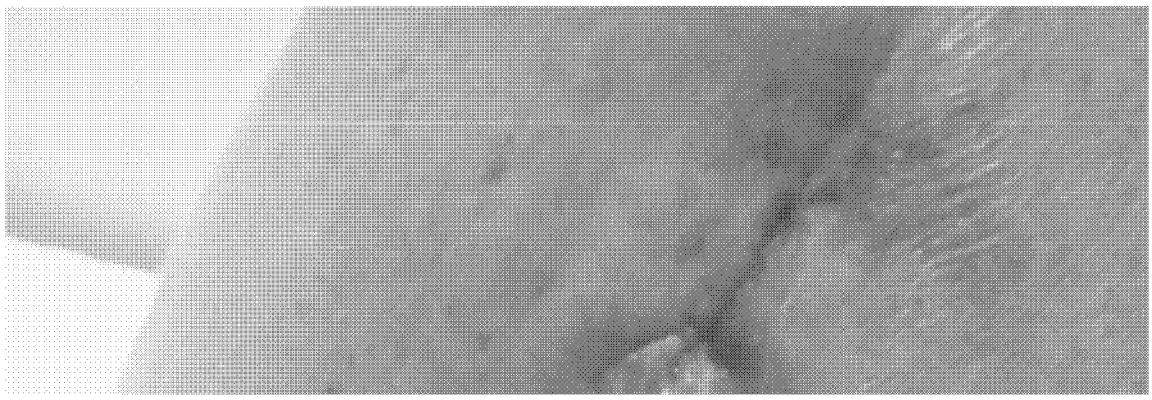
Patient presents to wound clinic for initial visit for evaluation of right shoulder wound.
AAOx3, original injury for GSW with subsequent surgery at UH to repair shoulder injury. Has received approximately 14 HBO treatments at Family Physician center on westbank.
States approx 2 weeks ago he noticed a suture coming from wound and removed it while in shower.
Wound approximated 1.0cm x 0.5cm. Wound appears raised pink wound area with yellow wound center.
Patient reports he has had yellow,clear and bloody drainage at various times since injury. Reports changes dressing 3-4 times a day and usually saturated gauze. Patient seen in ortho clinic yesterday.
No other complaints. Denies fever or chills. Awaiting evaluation



Progress Notes - Encounter Notes (continued)

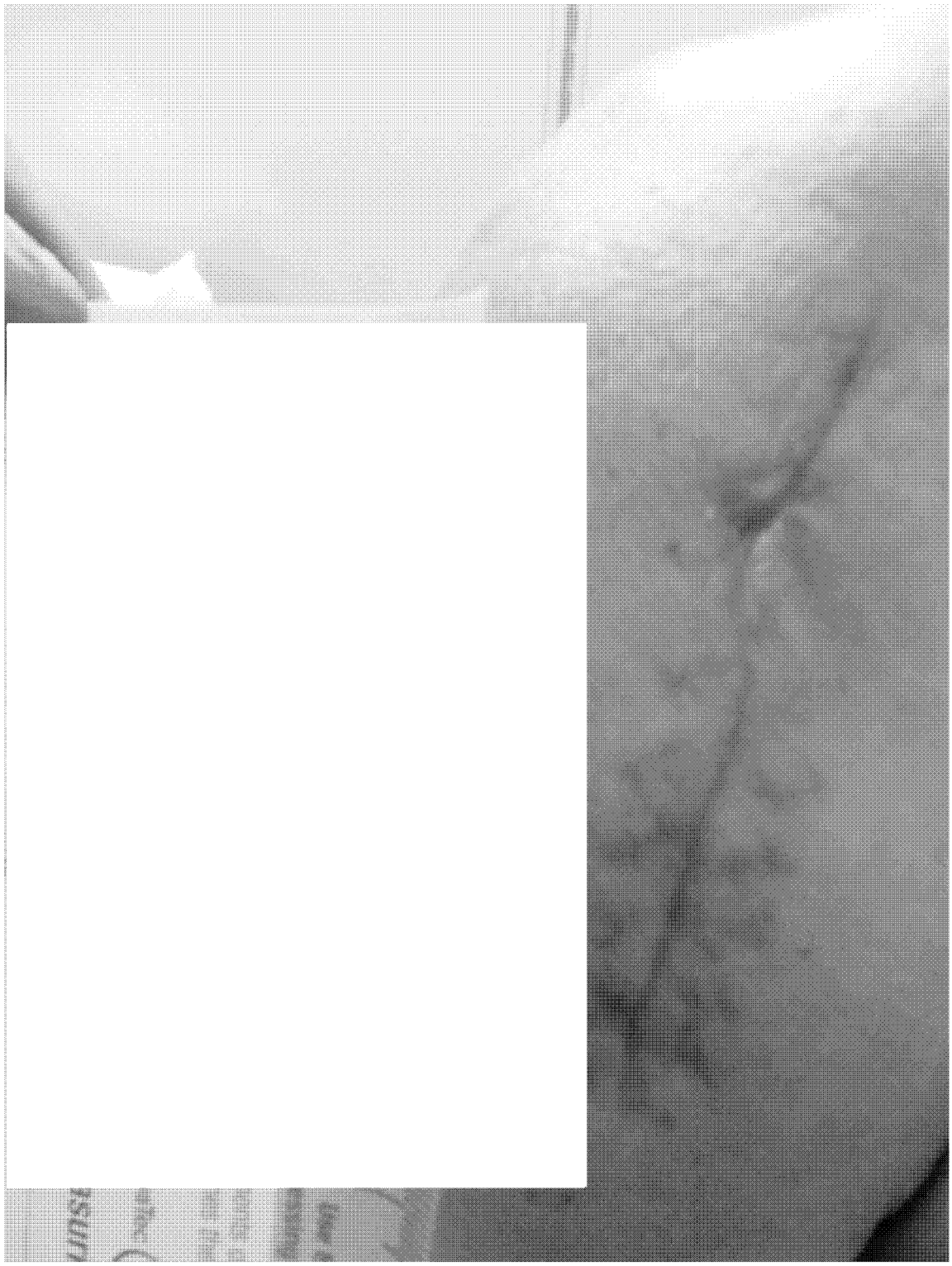
Instructed on s/s of infection
Pt verbalizes understanding
F/u scheduled

Pt in clinic for f/u visit
Denies any fever or chills
drsg remove from R shoulder, small amount of serous drainage, no odor
Full thickness wound to R shoulder surgery site
Peri wound intact with scar noted
Cleaned with wound cleaner, patted dry, awaiting



Discharge home. (Healed.
discharge home in good condition.).

Pt in clinic for f/u visit
Denies any fever or chills
R shoulder wound OTA, new epithelium noted
No drainage
Cleaned with wound cleaner, patted dry
Wyatt at bedside
Pt evaluated by
Pt instructed on s/s of infection
Instructed to f/u with wound care as needed
Pt verbalizes understanding
Discharged from clinic



<< Back to Review

Occupational Therapy Daily Note/Reassessment

Subjective
"I want to go back to the gym."
Objective
Pt. Seen for scheduled outpatient OT appointment.

Treatment:
Modalities:MH to R shoulder x 15 min
Ther ex: pulleys x 20, B sander with 5# x 10 reps ea direction on incline,UBE x 8 min, abduction with 2# cuff and skateboard while supine x 20 reps, wall slides for flex with 2# cuff wt., shoulder arc x 30 rings
Manual: PROM for shoulder flex, ER, abd x 10 ea, subscapularis release x 10

Right Upper Ext	AROM (degrees)	PROM (degrees)	MMT
Shoulder flex	85	120	3-/5
Shoulder ext	55		nt
Shoulder abd	62		3-/5
Shoulder IR	wnl s/b; lower lumber		nt
Shoulder ER	30 s/b		nt

Assessment:
Pt. With improved AROM measurements this date, but Pt. continues to have limited R shoulder AROM and PROM all planes and would benefit from continued OT.
Pt. Demonstrated improved AROM, but did not meet goals. Continue with goals as follows.
Short-term goals (STG)Timeframe: 1 month
1. Pt. Will be independent with HEP and all upgrades
2. Pt. Will demonstrate an increase in R shoulder AROM by 30 degrees all plans for improved dressing and bathing
3. Pt. Will use RUE to reach hanging shirt in closet independently
Long-term goals (LTG)Timeframe: 3 months
1. Pt. Will demonstrate shoulder strength 4/5 for improved performance carrying ADL objects and reaching items overhead
2. Pt. Will report pain 2/10 during ADLs

Plan
Continue OT 2 x week x 12 weeks
Follow Up
Follow up in: 1 week
Treatment time
Therapeutic Exercise 30 minutes
MH x 15
Manual 15 min

Visit Summary

Reason for Visit

Arm Injury/Fracture	Pt. here for f/u of his R Humerus fracture.

Diagnoses

Post-operative state - Primary

Problem List as of Date Reviewed:

	Codes	Priority	Class	Noted - Resolved
GSW (gunshot wound)	879.8			- Present
Fracture of acromion of scapula	811.01			- Present
Humeral head fracture	812.09			- Present
Wound infection	958.3			- Present
Wound dehiscence	998.32			- Present

Allergies as of

	Noted	Type	Reactions
DELETED: Penicillins		Allergy	Anaphylaxis
Penicillins		Allergy	Anaphylaxis
Bactrim (Sulfamethoxazole-Trimethoprim)		Allergy	Rash

Immunizations

Name	Date	Dose	VIS Date	Route	Site
TDAP		0.5 mL		Intramuscular	Left deltoid

Given By:

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
121/85	74	97 °F (36.1 °C) (Oral)	20	1.651 m (5' 5")	62.234 kg (137 lb 3.2 oz)

BMI
22.83 kg/m2

Patient History

Medical as of

Past Medical History	Date	Comments	Source
GSW (gunshot wound) [303343]	4/29/13	right shoulder	Provider
Gunshot wound [207566]		2 weeks ago	Provider

Surgical as of

Past Surgical History	Date	Comments	Source
KIDNEY STONE SURGERY [SHX686]	2007		Provider

Family as of

Problem	Relation	Name	Age of Onset	Comments	Source
Cancer	Father			colon	Provider

Family Status as of

Relation	Name	Status	Death Age	Comments	Source
Father		Deceased			Provider

Tobacco Use

Smoking Status	Source	Types	Packs/day	Years Used	Comments	Smoking Start Date	Smoking Quit Date	Smokeless Tobacco Status	Smokeless Tobacco Quit Date

Visit Summary (continued)

as of										
	Never Smoker	Provider		1.0	10.0			[redacted]	Never Used	

Alcohol Use as of	Alcohol Use	Source	Drinks/Week	Alcohol/Wk	Comments
	No	Provider		0.0 oz	

Drug Use as of	Drug Use	Source	Types	Frequency	Comments
	No	Provider		0.00	

Sexual Activity as of	Sexually Active	Source	Birth Control	Partners	Comments
	Not Currently	Provider			

Social ADL as of	ADL Question	Response	Comments	Source
	None			

Occupational as of **None**

Reason for Call

Arm Injury/Fracture Pt. here for f/u of his R Humerus fracture.

Call Documentation

2:53 PM Signed

Patient seen and examined with the resident physician. All pertinent physical findings were addressed. I agree with the resident's plan of care on

We will discuss with then contact the patient.

Signed by on 2:53 PM

2:39 PM Signed

43 y.o. male now approximately 10 weeks s/p ORIF R greater tuberosity fx, approximately 9 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline, finished course. Reports he completed approximately 12 Hyperbaric oxygen sessions. He has been seeing PT once a week. Pt continues to ask him he can return to the gym and restart weight lifting exercises. He has also been seeing wound care

Telephone Encounter (continued)

Call Documentation (continued)

and his wound has now fully granulated in. He is frustrated and believes he never had an infection. He reports pain with exercises and reports that he has been actively ranging his shoulder.

Filed Vitals:

	07/
BP:	121/85
Pulse:	74
Temp:	97 °F (36.1 °C)
Resp:	20

Physical exam:
Gen: AOx3, NAD
RUE:
Lateral incision well healed

Right Upper Ext	AROM (degrees)	PROM (degrees)	
Shoulder flex	30	90	
Shoulder ext	30		
Shoulder abd	30	80	
Shoulder IR	wnl s/b; lower lumber		
Shoulder ER	30		

No Tenderness to palpation
Full ROM at elbow, wrist, hand
5/5 strength in PIN/AIN/M/U/R
SLT M/U/R
2+ Radial Pulse, <2 sec cap refill

Imaging: XRs obtained in clinic today resorption of the greater tuberosity. The screws remain unchanged in length and are in the same position distally, however the washers have now advanced.

- encouraged ROM exercises and to post-pone strengthening exercises at this time
- told we could provide an ultram script today but the patient has declined
- will discuss case with for possible ATS, scar debridement and possible HWR
- continue OT
- will schedule outpatient CT for evaluation of bone resorption
- RTC in 4 weeks after CT, cell phone number is

Care Advice Given

No Care Advice given for this encounter.

All Results (continued)

Xray Ext/Int Rotation or Min 2 views (Shoulder) (continued) Resulted: 0904, Result Status: Final result

2. Right acromionectomy
3. Healing right scapular spine
4. Osteopenia

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - GE	GE RIS	Unknown	Unknown	'10 1245 - Present

Notes

Progress Notes

Patient seen and examined with the resident physician. All pertinent physical findings were addressed. I agree with the resident's plan of care on

We will discuss with and then contact the patient.

43 y.o. male now approximately 10 weeks s/p ORIF R greater tuberosity fx, approximately 9 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline, finished course. Reports he completed approximately 12 Hyperbaric oxygen sessions. He has been seeing PT once a week. Pt continues to ask him he can return to the gym and restart weight lifting exercises. He has also been seeing wound care and his wound has now fully granulated in. He is frustrated and believes he never had an infection. He reports pain with exercises and reports that he has been actively ranging his shoulder.

Filed Vitals:

	07/
BP:	121/85
Pulse:	74
Temp:	97 °F (36.1 °C)
Resp:	20

Physical exam:
Gen: AOx3, NAD
RUE:
Lateral incision well healed

Right Upper Ext	AROM (degrees)	PROM (degrees)	
Shoulder flex	30	90	
Shoulder ext	30		
Shoulder abd	30	80	

Notes (continued)

Progress Notes (continued)

Shoulder IR	wnl s/b; lower lumber		
Shoulder ER	30		

No Tenderness to palpation
Full ROM at elbow, wrist, hand
5/5 strength in PIN/AIN/M/U/R
SLT M/U/R
2+ Radial Pulse, <2 sec cap refill

Imaging: XRs obtained in clinic today resorption of the greater tuberosity. The screws remain unchanged in length and are in the same position distally, however the washers have now advanced.

- encouraged ROM exercises and to post-pone strengthening exercises at this time
- told we could provide an ultram script today but the patient has declined
- will discuss case with for possible ATS, scar debridement and possible HWR
- continue OT
- will schedule outpatient CT for evaluation of bone resorption
- RTC in 4 weeks after CT, cell phone number is

Follow-up and Disposition History

	User	

Disposition:

Return in about 4 weeks (around

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

All Orders

Xray Ext/Int Rotation or Min 2 views (Shoulder) [31190996] Final result

Ordering User: , 1131 Authorized by:
Frequency:
Electronically signed by: 131
Diagnoses: Post-operative state [V45.89]
Questions: Transport Method May Walk
Laterality Right
Reason for exam: post op
Comments:
Axill and scap y included

CT Shoulder WO [31190997] Future

Ordering User: , Authorized by:
Frequency: 13 -
Electronically signed by: 1438
Diagnoses: Post-operative state [V45.89]
Questions: Transport Method May Walk
Laterality Right
Ordering Provider
Reason for exam: fx

Resulted by: Resulting Lab: GE RIS
Specimen: 1154
Narrative: Axill and scap y includedLaterality->Right Ordering:
Clinical History
post op

Findings
Frontal, transscapular, and axillary radiographic views of the right shoulder are submitted. Comparison is made to the right shoulder views on at 10:37 a.m. Two fully threaded screws with washers are again identified stabilizing the right proximal humeral fracture involving the greater tuberosity and portion of the humeral head. Remnants of the distal right acromion appear to be in similar position and alignment to the prior study. The right scapular spine fracture is again evident with decreased visibility of the fracture planes suggesting interval healing. The medial aspect of the scapular blade is less visualized suggesting demineralization. The glenohumeral junction appears to be within normal limits. Ballistic fragments are again identified in the soft tissue proximal to the right shoulder. The visualized right lung appears clear.

Impression
1. Right proximal humerus fracture with intact hardware and no evidence of loosening, defect, or complication

2. Right acromionectomy
3. Healing right scapular spine
4. Osteopenia

Testing Performed By

	Lab - Abbreviation	Name	Director	Address	Valid Date Range
	13 - GE	GE RIS	Unknown	Unknown	'10 1245 - Present

Notes

Progress Notes

Patient seen and examined with the resident physician. All pertinent physical findings were addressed. I agree with the resident's plan of care on

We will discuss with then contact the patient.

43 y.o. male now approximately 10 weeks s/p ORIF R greater tuberosity fx, approximately 9 weeks s/p I+D of superficial infection of surgical incision and initiation of rifampin and minocycline, finished course. Reports he completed approximately 12 Hyperbaric oxygen sessions. He has been seeing PT once a week. Pt continues to ask him he can return to the gym and restart weight lifting exercises. He has also been seeing wound care and his wound has now fully granulated in. He is frustrated and believes he never had an infection. He reports pain with exercises and reports that he has been actively ranging his shoulder.

Filed Vitals:

	07/
BP:	121/85
Pulse:	74
Temp:	97 °F (36.1 °C)
Resp:	20

Physical exam:
Gen: AOx3, NAD
RUE:
Lateral incision well healed

Right Upper Ext	AROM (degrees)	PROM (degrees)	
Shoulder flex	30	90	
Shoulder ext	30		
Shoulder abd	30	80	

Occupational Therapy Daily Note

Subjective
"My shoulder really hurts"
Objective
Pt. Seen for scheduled outpatient OT appointment.
Arrived with bandage to lateral shoulder
Current condition: Pt. With area of hypergranulation lateral shoulder incision. Pt. Instructed to see

Treatment:
Modalities:MH to R shoulder x 10 min
Ther ex:supine dowels for flex/abd/ER x 10, pulleys x 10, UBE x 10 min, B sander with 1# x 10 reps ea direction on incline, shoulder arc x 12 rings

Assessment:

Pt. Progressing continues to have limited R shoulder AROM all planes and would benefit from continued OT
Progress toward previous goals: Continue STG/LTG

Plan
Continue OT plan of care.

Follow Up
Follow up in: 1 week

Treatment time
Therapeutic Exercise 45 minutes
MH x 10

Occupational Therapy Daily Note

Subjective
"The doctor didn't say anything about my bone healing at my last appointment. " "I want to go back to the gym."
Objective
Pt. Seen for scheduled outpatient OT appointment.
Arrived with bandage to lateral shoulder

Treatment:
Modalities:MH to R shoulder x 15 min
Ther ex: pulleys x 20, B sander with 1# x 10 reps ea direction on incline,table top stretches for flex and abd x 10, doorway ER stretch
Manual: PROM for shoulder flex, ER, abd x 10 ea, subscapularis release x 5
Assessment:
Pt. continues to have limited R shoulder AROM and PROM all planes and would benefit from continued OT. ER significantly limited
Progress toward previous goals: Continue STG/LTG
Plan
Continue OT plan of care.
Follow Up
Follow up in: 1 week
Treatment time
Therapeutic Exercise 15 minutes
MH x 15
Manual 15 min

Occupational Therapy Daily Note

Subjective
"I may have another surgery."
Objective
Pt. Seen for scheduled outpatient OT appointment.

Treatment:
Modalities:MH to R shoulder x 15 min
Ther ex: pulleys x 20, B sander with 5# x 10 reps ea direction on incline,shoulder arc x 30 rings, supine shoulder abduction with skateboard x 20, wall slides with towel for flex and abd x 10
Manual: PROM for shoulder flex, ER, abd x 10 ea
Assessment:
AROM improving slowly, but pt. continues to have limited R shoulder AROM and PROM all planes and would benefit from continued OT.
Progress toward previous goals: Continue STG/LTG
Plan
Continue OT plan of care.
Follow Up
Follow up in: 1 week
Treatment time
Therapeutic Exercise 15 minutes
MH x 15
Manual 15 min

Occupational Therapy Daily Note

Subjective
"I think its the screws that hurt."
Objective
Pt. Seen for scheduled outpatient OT appointment.

Treatment:
Modalities:MH to R shoulder x 15 min
Ther ex: pulleys x 20, B sander with 3# x 10 reps ea direction on incline,shoulder arc x 30 rings, supine shoulder abduction x 20
Manual: PROM for shoulder flex, ER, abd x 10 ea
Assessment:
Pt. With improved AAROM for shoulder abduction this date.
Progress toward previous goals: Continue STG/LTG
Plan
Continue OT plan of care.
Follow Up
Follow up in: 1 week
Treatment time
Therapeutic Exercise 15 minutes
MH x 15
Manual 15 min

Telephone Encounter (continued)

Call Documentation (continued)

CC: Right Shoulder Pain
HPI: 43y/o M complaining of right shoulder pain that limits his range of motion. Pt is approximately 14wks s/p ORIF R greater tuberosity fx. He has been working with PT up until 2wks ago when he says that the pain increased during one session and he has not been able to move his arm well since. All incision sites have healed well. He has been seen and we have discussed possible treatment options with . The patient has attempted to follow up over the past 2-3 weeks but has not reached LSU ortho. He is very frustrated with the clinic and ease of care.

Filed Vitals:

	0842
BP:	112/73
Pulse:	70
Temp:	96.6 °F (35.9 °C)
Resp:	20

Physical Exam:
Gen: AAO x3, NAD
RUE: Incisions healed well, palpable HW at lateral shoulder
Sulcus seen at lateral shoulder
Pt refused ROM and strength due to pain
A&P:
43y/o M s/p ORIF R greater tuberosity fx
1. MRI of R shoulder
2. RTC in 2wks or after MRI obtained
3. We will consider treating this as a RCT pending results

Signed by on 2:34 PM

Care Advice Given

No Care Advice given for this encounter.

All Orders

Xray Ext/Int Rotation or Min 2 views (Shoulder) Final result
User: by:
Frequency:
Electronically

<< Back to Review

Medications

Ordered Medications

		Disp	Refills	Start	End
	oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet Sig - Route: Take 1 tablet by mouth every 4 (four) hours as needed for Pain. - Oral Class: Print	45 tablet			

Telephone Encounter

Call Information

	Date & Time	Provider	Department	Center
	8:30 AM			

Reason for Call

Shoulder Injury right

Call Documentation

4:25 PM Signed

Patient seen and examined with the resident physician. All pertinent physical findings were addressed. I agree with the resident's plan of care on

For discussion with
MRI scheduled
Tentative shoulder arthroscopy

4 views of the right shoulder.

Findings
The glenohumeral articulation is anatomical. There is fracture of the greater tuberosity which has been fixed with cancellous screws and washers. Multiple metallic fragments are noticed in the soft tissues of the posterior aspect of the right shoulder.

Impression
Healing fracture of the right femur greater tuberosity. Continue follow up.

Notes

Progress Notes

Physician 4:25 PM Signed
Patient seen and examined with the resident physician. All pertinent physical findings were addressed. I agree with the resident's plan of care on

For discussion with
MRI scheduled
Tentative shoulder arthroscopy

Electronically signed by on 4:25 PM

Physician 2:34 PM Signed
CC: Right Shoulder Pain
HPI: 43y/o M complaining of right shoulder pain that limits his range of motion. Pt is approximately 14wks s/p ORIF R greater tuberosity fx. He has been working with PT up until 2wks ago when he says that the pain increased during one session and he has not been able to move his arm well since. All incision sites have healed well. He has been seen and we have discussed possible treatment options with The patient has attempted to follow up over the past 2-3 weeks but has not reached . He is very frustrated with the clinic and ease of care.

Filed Vitals:

0842
BP: 112/73

<< Back to Review

Medical as of

Past Medical History	Date	Comments	Source
GSW (gunshot wound)]		right shoulder	Provider
Gunshot wound		2 weeks ago	Provider

Problem List

	Noted	Resolved
Wound infection	by	No
Wound dehiscence		No
GSW (gunshot wound)		No
Fracture of acromion of scapula		No
Humeral head fracture		No
Greater tuberosity of humerus fracture		No
Complete rotator cuff tear of left shoulder	,	No

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

ED Notes

No notes of this type exist for this admission.

ED Records (continued)

ED Arrival Information (continued)

ED Disposition

None

ED Notes

No notes of this type exist for this admission.

Pt requesting that he does not want a catheter during surgery and also requesting that no residents be involved in his surgery, pt states that he wants only. And that he has" f---ing issues with the residents."
Paged MD
up to speak with pt, stated that surgery is cancelled.

Pt came behind nurses station and tapped me on the shoulder stating that now he does want his surgery
Spoke with again who spoke with and instructed pt to come to the ortho clinic Monday
Appointment made and brought to pt
pt in room making several phone calls to multilple MD's and stating their names..
stated he needed to call his attorney

Surgery desk called again to state that pt was cancelled
Pt in room and upset and on the phone with MD
Appointment given, and pt left 3-west via ambulatory

Patient ID: is a 44 y.o. male.

HPI Comments: is a 44 y.o. male s/p GSW to his R shoulder in May with ORIF who presents to the Urgent Care Clinic requesting a refill of his pain meds complaining of continuing pain in his right shoulder. The pain is at a 4/10 and sharp during complete rest. It prevents him from moving his shoulder completely. He states that he was supposed to receive a third surgery this past Friday, but due to disagreement with surgeons, he will be seeing a new doctor next Tuesday. He has come for a refill of his Percocet prescription until that time. Also requesting something for sleep

Constitutional: Negative for fever, chills and appetite change.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for palpitations and chest pain.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea, constipation, blood in stool and abdominal distention.
Genitourinary: Negative for dysuria, urgency and frequency.
Musculoskeletal: Positive for joint swelling.
Skin: Negative for wound.
Neurological: Negative for dizziness, weakness and headaches.

Reviewed past medical/surgical/social history
BP: 131/94 Pulse: 80 Temp: 97.2 °F (36.2 °C) Resp: 18 Height: 1.651 m (5' 5") SpO2: 98 Weight: 63.504 kg (140 lb)

Objective:

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat: No oropharyngeal exudate.
Eyes: Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.
Neck: Normal range of motion.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. He has no wheezes. He has no rales. He exhibits no tenderness.
Abdominal: Soft. Bowel sounds are normal. He exhibits no distension. There is no tenderness. There is no

Reason For Visit
Right shoulder pain.

HPI
Mr. is a 44 year old right hand dominant male who presents with right shoulder pain and weakness. In late April 2013, he sustained a gunshot wound to the right shoulder. The shot resulted in fractures of the greater tuberosity, acromion, and scapula as well as a rotator cuff tear. He underwent ORIF of the greater tuberosity, open treatment of the acromion and scapula fractures, and open repair of the rotator cuff. The procedure was done through an anterolateral approach. He underwent a second operation on the right shoulder several weeks later due to possible infection. The patient states that a significant amount of the deltoid had to be debrided during the second surgery. In addition, the operative report states that the acromion was necrotic. After surgery, the patient was doing okayuntil about two months ago. He correlates his worsening to discontinuation of hyperbaric oxygen treatments that he was having at the time. He was recently scheduled to undergo surgery at ILH but the surgery was cancelled.

Today, the patient reports pain and weakness. The pain is superior and lateral. The pain is worse with attempted elevation of the shoulder and rolling onto his side. He denies any current relieving factors. He reports some occasional numbness and paresthesias in the volar aspect of the extremity but none around the shoulder.

Allergies
Bactrim SOLN
Penicillins.

Current Meds
Rec: 17Sep2013. List Reconciled and Reviewed.
Oxycodone-Acetaminophen 5-325 MG Oral Tablet;TAKE 1 TABLET EVERY 6 HOURS AS NEEDED.; Rx
Diazepam 5 MG Oral Tablet;TAKE 1 TABLET 3 TIMES DAILY AS NEEDED.; Rx.

Active Problems
Pain in the right shoulder joint(s) (719.41).

PMH
Kidney stones.

PSH
Lithotomy.

Family Hx
Family history of Cancer.

Personal Hx
Former Smoker (V15.82).

ROS
Review of systems have been reviewed and noted on the intake form dated

Results

I have reviewed the plain x-rays of the right shoulder that were performed in late August. There are retained metallic fragmenets about the shoulder. There are two screws with washers along the greater tuberosity. The screws have not backed out. There is some resorption of the greater tuberosity beneath the screws. There is irregularity of the acromion and scapula spine consistent with prior fracture/trauma/surgical removal. The humeral head relationship to the glenoid is well-maintained.

Vital Signs

Recorded by Cousin,Andrea on 08:28 AM
BP:118/79, LUE, Sitting,
HR: 74 b/min,
Temp: 97.4 F, Oral,
Height: 65 in, Weight: 135 lb, BMI: 22.5 kg/m2,
Pain Scale: 4,
BSA Calculated: 1.67 ,
BMI Calculated: 22.46.

Physical Exam

General:
Alert male in no acute distress. Alert and oriented x 3. He appears stated age of 44 year.

Cervical:
Nontender in the midline. Range of motion is within normal limits.

Skin:
No rashes or cellulitis present about the right shoulder girdle. The surgical incision is healed.

Lymphatics:
No generalized lymphedema in the right upper extremity.

Musculoskeletal:
Right shoulder exam:
Upon inspection of the right shoulder, there is evidence of deltoid muscle loss and atrophy. The acromion and humeral head are prominent. There are multiple areas that are prominent and sensitive to palpation. I believe these areas include the screw heads/washers, the edge of the remaining acromion, and the edge of the scapula spine.

Range of motion testing reveals the following (R/L)
Forward elevation: Active 70/170, Passive 100/170
External rotation at the side: 5/30
Internal rotation at the side: T11/T5

Rotator strength testing reveals the following
Forward elevation: 3/5
External rotation: 4/5
Internal rotation: 5/5

Rotator cuff provocative testing reveals the following:
There is a Positive Neer Impingement sign
There is a Positive Hawkins Impingement sign

Biceps-labral provocative testing reveals the following:
There is a Negative Speeds test
There is a Negative Yergusons test
There is a Negative Obriens test

AC joint provocative testing reveals the following:
There is a Negative Cross-Body Adduction test
There is a Negative Obriens test

Neurological:
Intact light touch sensation in the axillary, musculocutaneous, radial, ulnar, and median nervous distributions of the right upper extremity. Gross motor exam intact in right upper extremity. I have closely examined his deltoid. He has decent strength with testing of the anterior and posterior deltoid.

Vascular:
2+ radial pulse right wrist.

Assessment

1. Right shoulder pain and weakness status post gunshot wound, ORIF greater tuberosity, open repair rotator cuff, open treatment of acromion and scapula spine fractures, and irrigation/debridement

2. Anger.

Orders

Oxycodone-Acetaminophen 5-325 MG Oral Tablet;TAKE 1 TABLET EVERY 6 HOURS AS NEEDED; Qty60; R0; Rx.
Diazepam 5 MG Oral Tablet;TAKE 1 TABLET 3 TIMES DAILY AS NEEDED; Qty45; R0; Rx.

Plan

I had a long discussion with the patient regarding his shoulder. First, I explained to him that the shoulder will probably never be normal again. He has lost a significant portion of the deltoid musculature and acromion. I stressed the importance of the deltoid for normal deltoid function. I also entertained with him the possibility of the there being involvement of the axillary nerve and his current shoulder weakness. His physical exam today does not support involvement of the axillary nerve.

I have offered him the following surgical approach: right shoulder arthroscopy with possible removal of any retained metallic fragments, possible debridement of any prominent bony regions, hardware removal, and possible repair of the rotator cuff. We will plan to proceed with surgery at ILH the next time that I am there.

The patient has also asked for a Psychiatric consult for anger issues. We will place a consult into the .

Signature

Electronically signed

PROGRESS NOTES:

9-15-2021

HT: 65 WT: 135 TMP: 97.4 PULSE: 74 B/P: 118/79 REFERRING MD:

GSW (R) shoulder 4/10 pain scale

44 y.o. M c̄ h/o (R) shoulder GSW in late April. Taken to UH. ORIF one wk. later & HWR was cancelled @ UH recently. Now c̄ pain, want HWR & needs some pain meds.

Med Hx - kidney stones
Surg Hx - (R) shoulder
(R) kidney stones
All - PCN -> anaphylaxis
Bactrim -> rash
Soc - ø Tob
EtOH occas.
ø drugs
Fam Hx - CA
Meds - Percocet

Pain — 2 months ago ↓ started worsening

Loc = superior lateral

Agg → rolling over on side
→ lifting

(+) N/P → intermittent volar/ulnar

Relief →

FF - 70/100° (© → 30°)
Ext - 5° (© → T5)
Int - T11

Psych Consult

~~ORIF GT~~
Open RCR
Open tx scapula + acromion fx's
- Synthes 3.5 mm cortical screws with washers x2
x2

<< Back to Review

All Orders

No orders found

Other Orders

No orders found

All Results

CBC and differential **(Abnormal)** : Final result

Resulting Lab: HCSD SUNQUEST Specimen: Blood; BLOOD [illegible] 1316

Component	Value	Ref Range	Flag	Comment
CBC PROFILE	RESULTS:			-
WBC	6.6	4.5 - 11.0 10^3/UL		-
Red Blood Cell Count	4.90	4.50 - 5.90 10^6/UL		-
Hemoglobin	14.4	13.5 - 17.5 GM/DL		-
Hematocrit	41.6	40.0 - 51.0 %		-
MCV	85.0	80.0 - 100.0 FL		-
MCH	29.3	26.0 - 34.0 PG		-
MCHC	34.5	31.0 - 37.0 G/DL		-
RDW	19.0	11.5 - 14.5 %	**H**	-
Platelet Cnt	290	130 - 400 10^3/UL		-
MPV	8.7	7.4 - 10.4 FL		-
DIFFERENTAL	RESULTS:			-
Differential Type	AUTO			-
Neutrophils Absolute	3.9	1.8 - 8.0 10^3/UL		-
Lymphocytes Absolute	1.8	1.1 - 5.0 10^3/UL		-
Monocytes Absolute	0.6	0.2 - 1.1 10^3/UL		-
Eosinophils Absolute	0.2	0.0 - 0.6 10^3/UL		-
Basophils Absolute	0.0	0.0 - 0.2 10^3/UL		-
Neutrophils Relatives	58	%		-
Lymphocytes Relative	28	%		-
Monocytes Relative	10	%		-
Eosinophils Relative	3	%		-
Basophils Relative	1	%		-

Comprehensive metabolic panel [36789117] (Abnormal) Resulted: 1611, Result Status: Final result

Resulting Lab: HCSD SUNQUEST Specimen: Blood; BLOOD [illegible] 1316

Component	Value	Ref Range	Flag	Comment
Sodium	141	135 - 146 MMOL/L		-
Potassium	4.1	3.6 - 5.2 MMOL/L		-
Chloride	107	96 - 110 MMOL/L		-
CO2	23	24 - 32 MMOL/L	**L**	-
Glucose	76	65 - 99 MG/DL		-
BUN	18	7 - 25 MG/DL		-
Creatinine	0.89	0.70 - 1.40 MG/DL		-

D/C Summaries - Encounter Notes (continued)

Discharge Exam:
Dressing c/d/i, NVI, pain controlled. Tolerating PO.

Disposition: Home or Self Care

Patient Instructions:
Discharge Medication List as o 3 PM

START taking these medications

	Details
clindamycin (CLEOCIN) 150 MG capsule	Take 1 capsule by mouth See Admin Inst., Starting , Until Discontinued, Print

CONTINUE these medications which have CHANGED

	Details
!! oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed., Starting Until Discontinued, Print
!! oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed for Pain., Starting Until Thu 10/24/13, Print

!! - Potential duplicate medications found. Please discuss with provider.

Activity: pendulum exercises R shoulder, AROM elbow/wrist/hand
Diet: regular diet
Wound Care: dressing change after 3 days, keep clean/dry, ok to shower once dry

sustained a GSW to his right shoulder on fter he underwent an armed robbery.
On , the patient underwent the following procedures

1. Open reduction and internal fixation of right greater tuberosity fracture.
2. Open rotator cuff repair.
3. Open treatment of scapular and acromion fractures.

4. Right shoulder irrigation and debridement.
5. Right shoulder removal of subcutaneous foreign body/bullet.

Reports self d/c'ing the sutures around POD # 7-9 and having hyperbaric wound care treatments which was arranged by one of his friend which performs hyperbaric wound care. Reports continued mechanical pain and irritation from implanted hardware

Filed Vitals:

	1029
BP:	98/68
Pulse:	80
Temp:	98.2 °F (36.8 °C)
Resp:	19

Physical Exam:
NAD, Alert
RUE:
Incision well healed with no fluctuance/erythema/warmth
Skin intact; no significant swelling
+ Ax/EPL/FPL/OP/EDC/FDP/IO
LTSI Ax/R/M/U
2+ RP

Radiology:
HW shows evidence of loosening

Assessment:
43 y/o M s/p ORIF Right Shoulder Greater Tuberosity fx w/ RTC repair
Plan:
-- To OR for shoulder arthroscopy, I&D with possible HWR and RTC repair

Post op check
44 y/o M s/p R shoulder arthroscopy, limited synovectomy, and open rotator cuff repair

Patient doing well post op, no acute isuess. Awake and alert in PACU, able to comply with exam. Awaiting anesthesia for local block.

Awake alert NAD
R shoulder sling in place
Surgical dressing in place, CDI
Light touch and sensation intact axillary, radial, median, ulnar, musculocutaneus
Activates deltoid
5/5 AIN/PIN/Ulnar

Other Orders

Anesthesia Block Standing

Ordering User:	1253	Ordering Provider:			
Authorized by:		Frequency:	Once	1254 - 1	Occurrences
Electronically signed by:	1253				

Comments:
This order was created via procedure documentation

right interscalene nerve block

Laterality: Right

Prep: ChloraPrepPatient Location is post-op and PACU.
Needles
Injection technique: Single-shot
Needle: 20 G
Preanesthetic Checklist
Completed: patient identified, site marked, surgical consent, pre-op evaluation, timeout performed, IV checked, risks and benefits discussed, monitors and equipment checked, at surgeon's request, post-op pain management and anesthesia consent given
Procedures
Procedures: ultrasound guided
Monitoring with cardiac monitor, continuous pulse oximetry, heart rate and blood pressure.
Narrative
Start time: 12:30 PM
End time: 12:45 PM
Performed by: Personally
Anesthesiologist: Salinas

Encounter-Level Documents:

There are no encounter-level documents.

Order-Level Documents:

There are no order-level documents.

Pre-Operative Diagnosis:
1. Gunshot wound right shoulder status post prior ORIF greater tuberosity fracture and rotator cuff repair
2. Retained metallic foreign bodies right shoulder

Indication:
To improve pain and function

Post-Operative Diagnosis:
1. Right complete rotator cuff tear (chronic)
2. Gunshot wound right shoulder status post prior ORIF greater tuberosity fracture and rotator cuff repair

Procedure:
1. Right open rotator cuff repair (chronic)
2. Right arthroscopic limited debridement of labrum and synovium
3. Removal deep hardware right shoulder

Implants:
Arthrex 5.5 Biocorkscrew suture anchors x 3

Narrative:
The patient was first identified in the pre-operative holding area. The correct extremity was marked with a surgical pen. Informed consent was verified. The patient was taken into the operating room. General anesthesia was administrated. The patient was placed into a lateral decubitus position on a bean bag. All bony prominences were well padded. The head was secured with the neck in a neutral position. The right shoulder was prepped and draped in the usual sterile fashion. A surgical timeout was performed to verify the correct extremity and pre-op administration of IV antibiotics within 1 hour of surgical start time.

The arthroscopic portion of the procedure was commenced. The posterior portal was established in the usual manner. The scope was introduced into the glenohumeral joint. Using an outside in technique, the anterior portal was established. Diagnostic arthroscopy was performed. The chondral services were found to be smooth

without any evidence of chondral injury or wear. There was extensive synovitis of the capsule. The biceps tendon was intact. The articular aspect of the rotator cuff demonstrated tearing in the supraspinatus and infraspinatus. An arthroscopic shaver was introduced into the anterior portal and utilized to debride the synovium and multiple frayed areas of the labrum. The scope was then removed from the joint and redirected into the subacromial space.

Once in the subacromial space, maneuverability was difficult because the overlying skin was puckered into the subacromial space. I was able to maneuver enough to confirm that there was full thickness tearing of the supraspinatus and infraspinatus. I started to perform a subacromial bursectomy but kept encountering the overlying skin. At this point, I made the decision to proceed to the open portion of the procedure.

The lateral aspect of the shoulder demonstrated a significant amount of deltoid muscle loss in the region where the prior skin incision had been made. The overlying skin in the middle of the old incision was puckered as mentioned previously. The incision was made through the old scar. The anterior and posterior skin was meticulously elevated from what was left of the underlying deltoid. Once these skin flaps were developed, the deltoid was split. The deltoid was very flimsy and atrophic in the region of the split. After the split, the remaining anterior and posterior portions of the deltoid were tagged with 0 vicryl and carefully protected for later repair. As the split in the deltoid was made, I had to be very meticulous because the deltoid was adhered to the underlying greater tuberosity and cuff. After splitting the deltoid, the screws and the rotator cuff tear were revealed. The screws were still in place but the underlying greater tuberosity had resorbed. The cuff was torn medial to the screws. It appeared that the cuff tore medially along the screws and did not avulse off of the tuberosity. The screws were easily removed. After removing the screws, I prepared the remaining bony bed down to a bleeding surface with a rongeur and a bur. The rotator cuff edge was tagged. In order to obtain a repair with the least possible tension, I released the capsule between the labrum and the cuff. I released the bursal tissue on its superior surface and released the coracohumeral ligament to the base of the coracoid. The cuff now had good mobility. However, the cuff that was remaining was not very good tissue. It appeared that the bullets may had compromised a large portion of the infraspinatus and supraspinatus in their respective muscle bellies and musculotendinous junctions. Nonetheless, I attempted to reattach as much of the remaining cuff tissue. This was accomplished by placing three Arthrex double loaded 5.5 Biocorkscrew anchors along the medial aspect of the rotator cuff footprint. Each suture pair was passed in a horizontal mattress fashion. The sutures were then sequentially tied from posterior to anterior. Next, the interval between the supraspinatus and the subscapularis was closed with multiple No 2 Fiberwire in a figure of eight fashion. Upon completion of the repair, there was excellent approximation of the remaining cuff tissue to the humerus. The wound was irrigated. Hemostasis was achieved. The deltoid was then meticulously repaired using multiple 0 vicryl sutures. The subcutaneous layer was closed with interrupted 2-0 vicryl. The skin was closed with interrupted 3-0 nylon. A sterile dressing was apllied. An ultrasling was applied.

I was present for this entire procedure.

EBL:
150 ml

Complication:
None known

Drains:
None

SURGICAL PATHOLOGY CONSULTATION REPORT

Clinical History:
Right shoulder pain

Specimen:
Surgical hardware, removal, gross ID only

Gross Description:
Received fresh, labeled with the patient's name and medical record number,
and designated as "hardware from right shoulder", are two metallic screws
and two metallic washers. The screws measure 5.5 and 6 cm in length x 0.5
cm in diameter. Both washers measure 0.7 cm in diameter. This specimen is
submitted for gross identification only.

Surgical pathology | **(continued)** Resulted: 1331, Result Status: Final result

FINAL DIAGNOSIS
GROSS & MICROSCOPIC:
GROSS DIAGNOSIS ONLY.
Hardware, right shoulder, removal:
Two metallic screws and washers (medical devices) identified.

ZX/jc

ED Records (continued)

ED Arrival Information (continued)

ED Disposition

None

ED Notes

No notes of this type exist for this admission.

D/C Summaries - Encounter Notes

D/C Summaries signed by . **1658**

Author:

Filed: 1658 Note Time: 1651 Cosigner: 2000

Physician Discharge Summary

Patient ID:

1001042387
44 y.o.

Admit date:

Discharge date and time: 3:45 PM

Admitting Physician:

Discharge Physician: same

Admission Diagnoses: 1. Right Shoulder GSW
2. Right Shoulder post-traumatic stiffness, RCT

Discharge Diagnoses: same

Admission Condition: good

Discharged Condition: good

Indication for Admission: day surgery

Hospital Course: Evaluated post-op, NVI, pain controlled. Able to be discharged home same day.

Consults: none

Significant Diagnostic Studies: none

Treatments: surgery: R shoulder Dx ATS, Limited synovectomy, Open R shoulder RCR

Discharge Exam:
Dressing c/d/i, NVI, pain controlled. Tolerating PO.

Disposition: Home or Self Care

Patient Instructions:
Discharge Medication List as of 2:13 PM

START taking these medications

	Details
clindamycin (CLEOCIN) 150 MG capsule	Take 1 capsule by mouth See Admin Inst., Starting Until Discontinued, Print

CONTINUE these medications which have CHANGED

	Details
!! oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed., Starting Until Discontinued, Print
!! oxyCODONE-acetaminophen (PERCOCET) 10-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed for Pain., Starting Until Thu Print

!! - Potential duplicate medications found. Please discuss with provider.

Activity: pendulum exercises R shoulder, AROM elbow/wrist/hand
Diet: regular diet
Wound Care: dressing change after 3 days, keep clean/dry, ok to shower once dry

Follow-up with in 2 weeks.

4:51 PM

37 yo M sustained a GSW to his right shoulder on after he underwent an armed robbery.
On the patient underwent the following procedures

1. Open reduction and internal fixation of right greater tuberosity fracture.
2. Open rotator cuff repair.
3. Open treatment of scapular and acromion fractures.

All Results (continued)

Urine, Microscopic **(continued)** Resulted: Result Status: Final result

Bacteria, UA	NEGATIVE	0 /HPF	-
Casts	0 TO 2	0 - 2 /LPF	-
Ca Oxalate Crys, UA	PRESENT	/HPF	-

Urine culture Resulted: Result Status: Final result

Resulting Lab: HCSD SUNQUEST Specimen: Urine; URINE 0630

Component	Value	Ref Range	Flag	Comment
SPECIMEN DESCRIPTION	URINE			-
SPECIAL REQUESTS	NONE			-
CULTURE RESULTS	NO GROWTH			-
REPORT STATUS	FINAL			-

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
16 - HCSDLAB	HCSD SUNQUEST	Unknown	Unknown	1428 - Present

Notes

Progress Notes

6:46 AM Signed

I have reviewed the notes, assessments, and/or procedures performed by the resident, I agree with her/his documentation of ' I was present during the exam/ procedure , and discussed and approved the treatment plan for this patient.

Electronically signed by 6:46 AM

H&P Notes

6:37 PM Signed

History and Physical Exam:

' is a 44 y.o. male who presents requesting ESWL for treatment of a large R renal calculus, noted on CT scan from He is an xray technologist, and he reports having had ~16-18x stone episodes, less recently as he has been following the paleo diet for the past year. He endorses L>R pain, which he describes as severe.

Presented with a CT stone protocol from which was reviewed with Pt has a R lower pole calculus of ~12mm in greatest dimension, some punctate hyperdensities in L calyces, no

Notes (continued)

H&P Notes (continued)

hydro or evidence of obstruction bilaterally.

Recently was shot in the R shoulder while being mugged in the french quarter, had open surgery for this.

Pt became agitated during the encounter, threatening to leave several times, left prior to PAT appointment being scheduled.

AUASS - 18/35, bother 4 "mostly dissatisfied"
IIEF - 16/25

Past Medical History

Diagnosis	Date
• GSW (gunshot wound) *right shoulder*	
• Gunshot wound *2 weeks ago*	

Past Surgical History

Procedure	Date
• Kidney stone surgery	2007
• Shoulder arthroscopy	

Family History

Problem	Relation	Age of Onset
• Cancer *colon*	Father	

History

Social History	
• Marital Status:	Single
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

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:	Not Currently

Other Topics	Concern
• Not on file	

Notes (continued)

H&P Notes (continued)

Social History Narrative

*** Merged History Encounter ***

Medications Reviewed

Allergies

Allergen	Reactions
• Penicillins	Anaphylaxis
• Bactrim (Sulfamethoxazole-Trimethoprim)	Rash

Filed Vitals:

	10/
BP:	118/78
Pulse:	58
Temp:	97.6 °F (36.4 °C)
Resp:	16

ROS:

A comprehensive Review of System was performed and is as per the patients HPI and otherwise negative.

General: Alert, cooperative, no distress, appears stated age
Head: Normocephalic, without obvious abnormality, atraumatic
Eyes: PERRL, conjunctiva/corneas clear
Lungs: Respirations unlabored
CV: Warm and well perfused
Abdomen: Soft, non-tender, no CVA tenderness
Genitalia: Patient refused
DRE: Not done
Extremities: R arm in sling, surgical dressings on R shoulder, Extremities otherwise normal and atraumatic, no cyanosis or edema
Skin: Skin color, texture, turgor normal, no rashes or lesions
Psych: Appropriate
Neurologic: Non-focal

Body mass index is 21.63 kg/(m^2).

Labs:

Recent Results (from the past 336 hour(s))

SURGICAL PATHOLOGY

Collection Time

:00 AM

Component	Value	Range
Histology		

rt

Notes (continued)

H&P Notes (continued)

Value:

SURGICAL PATHOLOGY CONSULTATION REPORT

Specimen:
Surgical hardware, removal, gross ID only

Gross Description:
Received fresh, labeled with the patient's name and medical record number, and designated as "hardware from right shoulder", are two metallic screws and two metallic washers. The screws measure 5.5 and 6 cm in length x 0.5 cm in diameter. Both washers measure 0.7 cm in diameter. This specimen is submitted for gross identification only.

FINAL DIAGNOSIS
GROSS & MICROSCOPIC:
GROSS DIAGNOSIS ONLY.
Hardware, right shoulder, removal:
Two metallic screws and washers (medical devices) identified.

ZX/jc

No results found for this basename: PSA

Assessment/Diagnosis:

1. **Renal calculus, right**

   Case Request: URETEROSCOPY/STONE MANIPULATION, Full Code, Vital signs, Notify physician, Up as tolerated, Diet NPO except medications, Height and weight, Intake and output, Verify modification of diabetic agents, Verify lab results available, POCT glucose, Verify surgical site confirmation documentation completed, Verify discontinuation of anti thrombotics, Insert and maintain IV line, Verify informed consent, Urine culture, Urinalysis, sodium chloride 0.9 % flush 3 mL, Place sequential compression device, Place patient in outpatient bed (outpatient status), CBC and differential, Basic metabolic panel, Protime-INR, ciprofloxacin (CIPRO) 400 mg in dextrose 200 ml IVPB, tamsulosin (FLOMAX) 0.4 mg 24 hr capsule, ketorolac (TORADOL) 10 mg tablet, Case Request: URETEROSCOPY/STONE MANIPULATION, Full Code, Diet NPO except medications, Place sequential compression device

2. Recurrent kidney stones

Pts CT scan from OSH was reviewed. Copied onto osirix on chief computer.
Pt with R lower pole renal calculus, nonobstructing. 2 small L hyperdensities with the appearances of randall's plaques. No hydro bilaterally. No stranding.

Notes (continued)

H&P Notes (continued)

Pt endorses severe pain, requests treatment of his stones urgently. No

Plans:

Flomax
Toradol 10mg PO q6 hours x 4 days
Pt consented and scheduled for URS/HLL of R renal calculus on
Labs ordered, preop visit scheduled
Urine cx and urinalysis obtained today

6:37 PM

Follow-up and Disposition History

	User	Date & Time
	MITCHELL, GREGORY	6:37 PM

Disposition:

Return for surgery.

Follow-up:

N/A

Instructions:

N/A

Check-out Note:

N/A

Send Reminder:

N/A

Encounter-Level Documents -

Scan on)

<< Back to Review

Reason For Visit
Surgical aftercare status post right shoulder arthroscopy with hardware removal, mini open rotator cuff repair.

HISTORY OF PRESENT ILLNESS: Mr. returns today for his suture removal. He reports that he is doing fairly well. His pain today is 3/10.

PHYSICAL EXAMINATION
GENERAL: Alert male in no acute distress.
SKIN: Surgical incision clean, dry, and intact with sutures in place.

IMPRESSION: Two weeks status post right shoulder arthroscopy with open rotator cuff repair and hardware removal.

PLAN: The patient will participate in pendulum supine passive forward elevation to 90 and supine passive external rotation to 20 degrees. He will return in 1 month..

Vital Signs

BP:122/70,
HR: 86 b/min,
Temp: 97.8 F, Oral,
Height: 65 in, Weight: 135 lb, BMI: 22.5 kg/m2,
Pain Scale: 3,
BSA Calculated: 1.67 ,
BMI Calculated: 22.46.

Orders
Renew Oxycodone-Acetaminophen 7.5-325 MG Oral Tablet;TAKE 1 TO 2 TABLETS EVERY 6 HOURS AS NEEDED FOR PAIN; Qty60; R0; Rx.

Signature
Electronically signed by :

Reason For Visit
Follow-up s/pRight shoulder ATS with hardware removal, mini open RTC repair.

HPI
The patient returns today for evaluation of the right shoulder. He rates his pain as 4/10. He has only been performing pendulum exercises up to this point..

Vital Signs

N

BP:135/86, LUE, Sitting,
HR: 93 b/min,
Height: 65 in, Weight: 135 lb, BMI: 22.5 kg/m2,
Pain Scale: 4,
BSA Calculated: 1.67 ,
BMI Calculated: 22.46.

Physical Exam
Right shoulder skin incisions healed. Passively, I can elevate him to 100 degrees and externally rotate him to 20 degrees. No strength exam was performed today..

Assessment
One month s/p right shoulder ATS with hardware removal, mini open RTC repair.

Orders
Renew Oxycodone-Acetaminophen 7.5-325 MG Oral Tablet;TAKE 1 TO 2 TABLETS EVERY 6 HOURS AS NEEDED FOR PAIN; Qty60; R0; Rx.
Renew Diazepam 5 MG Oral Tablet;TAKE 1 TABLET 3 TIMES DAILY AS NEEDED; Qty45; R0; Rx.

Plan
I have agreed to renew his pain medications. In addition, I have instructed him in passive supine forward elevation and passive supine external rotation exercises. In addition, he is going to perform some active assisted wall climbs. Return in 4-6 weeks..

Signature
Electronically signed by

Reason For Visit
Follow-up status post right ATS with hardware removal, mini open RTC repair.

HPI
The patient returns today for evaluation of the right shoulder. He rates his pain as 4/10. He has only been performing pendulum and passive range of motion exercises. He reports a sharp pain toward the distal end of his incision.

Physical Exam
Right shoulder skin incisions healed. Passively, I can elevate him to 110 degrees and externally rotate him to 20 degrees. He has weakness in elevation and external rotation.

Assessment
Three month s/p right shoulder ATS with hardware removal, mini open RTC repair.

Plan
I have advised the patient to start gentle rotator cuff and deltoid strengthening exercises. We will see how he does after working on strengthening. I don't know how much active motion he will get back given the deltoid and acromion loss present. I will see him back in about three months.

Vital Signs
Recorded by Cousin,Andrea on 14 12:06 PM
BP:124/83, LUE, Sitting,
HR: 110 b/min,
Height: 65 in, Weight: 145 lb, BMI: 24.1 kg/m2,
Pain Scale: 4,
BSA Calculated: 1.72 ,
BMI Calculated: 24.13.

Orders
Renew Diazepam 5 MG Oral Tablet;TAKE 1 TABLET 3 TIMES DAILY AS NEEDED; Qty45; R0; Rx.

Signature
Electronically signed by :