07 Jan 2015 at NH Yokosuka, Urgent Care - Atsugi by SIMS, NATHAN WILLIAM

Encounter ID: YOKS-4766275 Primary Dx: Joint pain, localized in the shoulder

Patient: Barton,Clint
Treatment Facility: **NBHC NAF ATSUGI**
Patient Status: **Outpatient**
Date: **07 Jan 2015 1531 TST**
Clinic: **URGENT CARE - ATSUGI**
Appt Type: **ACUT$**
Provider: **SIMS,NATHAN W**

Reason for Appointment: Written by HWANG,JAMES M @ 07 Jan 2015 1531 TST
chest pain

Vitals
Vitals Written by HWANG,JAMES M @ 07 Jan 2015 1532 TST
BP: 126/92, HR: 93, RR: 16, T: 98.1 °F, HT: 72 in, WT: 205 lbs, SpO_2: 98%, BMI: 27.8,
BSA: 2.153 square meters, Tobacco Use: No, Alcohol Use: Yes, Pain Scale: 8/10 Severe, Pain Scale Comments: chest/left arm

S/O Note Written by SIMS,NATHAN W @ 08 Jan 2015 1023 TST
Chief complaint
The Chief Complaint is: Left shoulder pain.
History of present illness
The Patient is a 36 year old male.
36-year-old male presents with left shoulder pain radiating down the left arm, patient came into clinic as he was concerned that it m ay be cardiac related although he denies any chest pain at this time, he states that he has had several episodes of atypical chest p ain in the past, but has always had a negative workup. Patient states that the shoulder pain increases with abduction of the arm. De nies any numbness or tingling, points to his deltoid area when asked where the most pain is. Patient states 2/10 pain sharp and rad iates down the upper arm. Denies any history of trauma no swelling or discoloration. No increased physical activity level. Patient ha s no other complaints at this time

.
Muscle aches and limb pain.
Allergies
Allergies Verified and Updated NKDA.
Current medication
Including OTC meds, vitamins, herbals, etc. Mobic 15mg, Tiazac 120mg, Effexor XR 37.5mg.
Past medical/surgical history
Reported:
Recent Events: Medication compliance.
Medical: Reported medical history
HLD, HTN.
Surgical / Procedural: Surgical / procedural history

Personal history
Social history reviewed denies alcohol, tobacco, illicits.
Behavioral: No tobacco use history.
Alcohol: Not using alcohol AUDIT-C Date:
Family history
Family medical history
Mother DMII, HTN; Father HLD.
Review of systems
Systemic: No generalized pain and not feeling tired (fatigue). No fever, no chills, no night sweats, no recent weight loss, and no recent weight gain.
Head: No headache and no facial pain.
Neck: No neck pain and no swollen glands in the neck.
Eyes: No vision problems and no blurred vision.
Otolaryngeal: No earache, no nasal discharge, no nasal passage blockage (stuffiness), and no sore throat.
Cardiovascular: No chest pain or discomfort and no palpitations.
Pulmonary: No dyspnea, no paroxysmal nocturnal dyspnea, no orthopnea, no cough, and no wheezing.
Gastrointestinal: Appetite not decreased, no pain on swallowing, and no heartburn. No nausea, no vomiting, and no abdominal pain. No jaundice, no bright red blood per rectum, no diarrhea, and no constipation.
Genitourinary: No change in urinary frequency and no feelings of urinary urgency. No dysuria.
Endocrine: No polydipsia and no temperature intolerance.
Musculoskeletal: No back pain, no localized joint pain, and no localized joint swelling.
Neurological: No dizziness, no vertigo, no lightheadedness, no fainting, no motor disturbances, and no gait abnormality. No sensory disturbances.

History of present illness
The Patient is a 36 year old male.

<<Note accomplished in TSWF-CORE>>

36yo ADM presents to clinic for RIGHT SHOULDER PAIN. PT stated that he been having pain in both shoulder for a while.
Pain currently 8/10 (awful, hard to do anything).

DoD/VA Pain Rating Scale: Past week pain severity 8/10 - Awful, hard to do anything.
....
Sleep Screener: No, I am NOT bothered by the quality of my sleep.
....
Patient has NOT received other care since their last visit with this clinic.
Patient is NOT currently on a profile/limited duty chit.
PHQ-2 Depression Screen Negative. Score: 0.
Current medication
Including OTC meds, vitamins, herbals, etc.
08MAR2021 verified with pt

Tramadol 50mg PRN severe pain
Cymbalta 30mg 1 tab po qd
meloxicam, 15 MG, TABLET, ORALTAKE ONE TABLET BY MOUTH EVERY DAY

Blood Sugar Diagnostic, (Freestyle Lite Strips), Strip,
Lancet, (Freestyle), Device, Miscellaneous
empagliflozin, 10 MG, TABLET, ORAL
Atorvastatin 10 mg oral tablet .
Past medical/surgical history
Reported:
Medical: Medical history
Breathing issues
Back Pain

Physical Trauma: Physical trauma.
Personal history

Social history reviewed drink
married
3 boys

Tobacco use: No tobacco use history.
Alcohol: Alcohol use AUDIT-C Date: 08MAR2021
Work: Occupation OCCUPATIONAL HISTORY AI
desk job
....
History ANNUAL QUESTIONS
Preferred language (written or spoken): [x] Engli
Preferred method of learning? [x] Verbal [x] Written [x] Visual [ ] Other (Specify):
Learning disability, language barrier, hearing/vision deficit? [x] Yes [ ] No (Specify): Right hearing loss
(SILS) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
[x] Never [ ] Rarely [ ] Sometimes [ ] Often [ ] Always
Advance directives completed? [ ] Yes [x] No
Is a copy of the Advance directive in the record? [ ] Yes [x] No
Do you have any cultural or religious beliefs that may affect your care? [ ] Yes [x] No
Are you enrolled in EFMP? [ ] Yes [x] No
Contact preference: 757-300-6279
PCM: Millican
.....
Annual Questions Date: 08MAR2013.
Date last updated: 08MAR2014
Administered health literacy deficit assessment:
[x] REALM-SF Reading Assessment - Number of words pronounced correctly: 7
Menopause
Antibiotics
Exercise
Jaundice
Rectal
Anemia
Behavior
[ ] Other:

Health literacy response care plan:
[ ] Referral to special needs care coordinator
[ ] Other:
.....
Family history

11 Jun 2015 at NH Pensacola FL, MIDSTH MHP by EVANS, DEVIN ALLEN

Encounter ID: PENS-15429411 Primary Dx: Pain in left shoulder

Patient: Barton,Clint	Date: **11 Jun 2016 1313 CDT**	Appt Type: **T-CON***
Treatment Facility: **NBHC NSA MID-SOUTH**	Clinic: **MIDSTH MHP**	Provider: **EVANS, DEVIN ALLEN**
Patient Status: **Outpatient**	Clinic Phone: **874-6100**	Call Back Phone: **(757) 300-6279**

Telephone Consult Comments: Written by SMITH,CATRISA A @ 11 Jun 2016 1313 CDT
POC: 757.300.6279

PCM: MILLICAN

PATIENT IS COMPLAINING OF CHEST PAIN/ TIGHTNESS, HEART RACING , AND PAIN IN LEFT ARM, HE STATED HE WAS FEELING CLAMY

S/O Note Written by EVANS, DEVIN ALLEN @ 11 Jun 2016 1415 CDT
Subjective
37 year old active duty male arrived to NMRTU-Memphis at 1309 with CC of "left shoulder pain and some chest pain since 1030 today". Pt was brought back directly to treatment and EKG was conducted and reviewed by Physician at1314. Further evaluation has been requested by Dr. Delapena and request for EMS transport of pt to nearest ER for further evaluation. Pt transfer of care at 1340 to ACLS ambulance team.

Note Written by EVANS,DEVIN @ 11 Jun 2015 1419 CDT
Vital Signs
T: 99 axillary
P : 78 upon arrival, 109 discharge
R:16
BP: 167/88
Pain:8/10 Left Shoulder
Meds; Unable to recall
POCT; Blood sugar 219

A/P Written by EVANS,DEVIN @ 11 Jun 2015 1415 CDT
1. Pain in left shoulder M25.512

Disposition Written by EVANS,DEVIN @ 11 Jun 2015 1415 CDT
Disposition: Referred to ER

Signed By EVANS,DEVIN (Mr. Devin Evans RN, NBHC NSA Mid-South) @ 11 Jun 2015 1420 CDT

Skin: No pruritus. No skin lesions and no rash. Nails are normal.

Physical findings

General:

• Physical examination Left shoulder: Patient has full range of motion in, increased pain with abduction, harkens maneuver and slight increased pain with nears impingement test. Neurovascular intact, pulses 2+ cap refill less than 2 seconds sensation to light touch intact.

Vital Signs:

• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.

General Appearance:

° Well developed. ° Well nourished. ° In no acute distress.

Neck:

Appearance: ° Of the neck was normal.
Palpation: ° No tenderness of the neck.
Thyroid: ° Showed no abnormalities.

Eyes:

General/bilateral:
Pupils: ° PERRL.
External: ° Conjunctiva exhibited no abnormalities.
Sclera: ° Normal.

Ears:

General/bilateral:
Tympanic Membrane: ° Normal.

Nose:

General/bilateral:
Cavity: ° Deviated Septum R Side causing trouble breathing

Pharynx:

Oropharynx: ° Posterior pharyngeal wall was normal.

Lymph Nodes:

° Cervical lymph nodes were not enlarged. ° Submandibular lymph nodes were not enlarged. ° Supraclavicular lymph nodes were not enlarged.

Lungs:

° Respiration rhythm and depth was abnormal. ° Clear to auscultation. ° Mild wheezing was heard. ° No rhonchi were heard. ° Mild rales/crackles were heard. Recommend follow up with ENT due to Patient's history of working near Burn Pits.

Cardiovascular:

Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal S1 and S2. ° No S3 heard. ° No gallop was heard. ° No click was heard. ° No pericardial friction rub heard.
Murmurs: ° No murmurs were heard.
Apical Impulse: ° Positioned normally.
Thrill: ° No thrill.
Edema: ° Not present.

Abdomen:

Visual Inspection: ° Abdomen was not distended.
Auscultation: ° Bowel sounds were not diminished or absent.
Palpation: ° Abdominal non-tender. ° No mass was palpated in the abdomen.
Liver: ° Normal to palpation.
Spleen: ° Normal to palpation.

Musculoskeletal System:

Shoulder:
Left Shoulder: • Shoulder was tender on palpation. • Pain was elicited on motion patient has increased pain with abduction. • Pain was elicited during a Neer impingement test slight pain with neers. • Pain was elicited during a Hawkins-Kennedy impingement test patient has increased pain with Hawkins. ° No swelling. ° No erythema. ° No warmth. ° No misalignment. ° Motion was normal. ° No instability was noted.

Neurological:

° Oriented to time, place, and person.

Psychiatric:

Mood: ° Euthymic.
Affect: ° Normal.

Practice Management

Patient does moderate exercise for 30 minutes most days of the week.

A/P Written by SIMS,NATHAN W @ 08 Jan 2015 1029 TST

1. Joint pain, localized in the shoulder: 36-year-old well-appearing male with left shoulder pain that radiates down the upper arm. Positive Hawkins and equivocal Neer's. No chest pain this time, a normal EKG replaceable shoulder pain on exam. Very unlikely that the shoulder pain is cardiac in nature. Discussed condition and treatment options with patient he agreed to ibuprofen 800 mg t.i.d., and protonic 40 mg q.d. to prevent GERD and reflux. Patient agreed to follow up in one to 2 weeks if no improvement, or

Viagra (sildenafil) Prior Authorization Request Form

5669

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	to the prescription and	• The provider may **call**: 1-866-684-4488 or the completed form may be **faxed** to: 1-866-684-4477 • The patient may attach the completed form **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at **http://pec.ha.osd.mil/forms_criteria.php**. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (please print):

Patient Name:	Barton, Clint	Physician Name:	Mark G. Moore
Address:		Address:	
Sponsor ID #	1240615580	Phone #:	734-9973
Date of Birth:	01/11/1977	Secure Fax #:	804-734-9969

Step 2 Please consider the following:

- Patients taking nitrates, either regularly or intermittently, should not receive PDE-5 inhibitors. Patients should be informed of the consequences should they initiate nitrate therapy while taking a PDE-5 inhibitor.
- Please see product labeling precautions for concurrent use with alpha blockers.

Step 3 1. Please indicate the patient's gender.

Female	Please go to **Section 1** for **Female patients** on this page
(Male)	Please go to **Section 2** for **Male patients** on page 2

Section 1 -- Female patients

1. Is the PDE-5 inhibitor being prescribed for the treatment of sexual dysfunction?	Yes **Coverage not approved**	No **Proceed to Question 2**
2. Is the PDE-5 inhibitor being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	Yes **Proceed to Question 4**	No **Proceed to Question 3**
3. Is the PDE-5 inhibitor being prescribed for a diagnosis of Raynaud's phenomenon?	Yes **Proceed to Question 4**	No **Coverage not approved**
4. What is the dosing regimen?		

Please go to **Step 4** on Page 2.

Viagra (sildenafil) Prior Authorization Request Form

5670

Section 2 – Male patients

1. Is the patient 18 years of age or older?	Yes Proceed to Question 2	No Proceed to Question 7
2. Is the patient 40 years of age or older?	Yes Do not submit form. Prior authorization is not required for males 40 years or older.	No Proceed to Question 3
3. Is Viagra being prescribed for the treatment of erectile dysfunction of organic origin or mixed organic/psychogenic origin?	Yes Sign and date below	No Proceed to Question 4
4. Is Viagra being prescribed for the treatment of drug-induced erectile dysfunction where the causative drug cannot be altered or discontinued?	Yes Sign and date below	No Proceed to Question 5
5. Is Viagra being prescribed for preservation or restoration of erectile function following prostatectomy?	Yes SKIP to Question 8	No Proceed to Question 6
6. Is Viagra being prescribed for a diagnosis of Raynaud's phenomenon?	Yes SKIP to Question 8	No Proceed to Question 7
7. Is Viagra being prescribed for a diagnosis of pulmonary arterial hypertension (PAH)?	Yes Proceed to Question 8	No Coverage not approved

8. What is the dosing regimen? VIAGRA 25mg 1 capsule 1 hour before sexual activity

Step 4

I certify the above is correct and accurate to the best of my knowledge. Please sign and date:

Prescriber signature

Mark G. Moore, MMS, PA-C
Physician Assistant
Active Duty Clinic, Ft. Lee, VA
804-734-9973

03/22/2016
Date

[18 April 2012]

Previous Encounters

22 Oct **2016** *at NH Pensacola FL, MIDSTH MHP by LOWE, AYISHIA K*

Encounter ID: PENS-15622323 Primary Dx: Migraine

Patient: Barton,Clint
Treatment Facility: **NBHC NSA MID-SOUTH**
Patient Status: **Outpatient**

Date: **22 Oct 2016 0730 CDT**
Clinic: **MIDSTH MHP**
Clinic Phone: **874-6100**

Appt Type: **24HR**
Provider: **LOWE, AYISHIA**

Reason for Appointment:
POSSIBLE PINK EYE/ MIGRAINE/ COUGH AND SORE THROAT 757.300.6279
Appointment Comments:
CAS

Screening Last Updated by WESTERVELT,TREVOR J @ 22 Oct 2016 0836 CDT

Allergen information verified by WESTERVELT, TREVOR J @ 22 Oct 2016 0836 CDT

Vitals Written by WESTERVELT,TREVOR J @ 22 Oct 2016 0806 CDT
128/83; 123; 16; 99.3 °F; HT: 175.3 cm (69.02 in); WT: 92.5 kg (203.93 lbs); 96%; BMI: 30.10; BSA: 2.083 square meters; No; Yes; No; No; No; No; 4/10 Moderate; Headache

S/O Note Last Updated by LOWE, AYISHIA @ 25 Oct 2016 1612 CDT
Chief complaint
The Chief Complaint is: PINK EYE/ COUGH,SORE THROAT,MIGRAINE.
Reason for Visit
Visit type: face to face.
History of present illness
The Patient is a 37 year old.

<<Note accomplished in TSWF-CORE>>

37 yo ADM reports to the clinic with a chief compliant of pink eye, sore throat with cough and migraine. Pt reports he started experiencing a cough 7 days ago. Pt reports a headache and sore throat have been consistent with the cough and are not alleviated with cough drops, Robitussin or ibuprofen. Pt reports nasal and chest congestion. Pt reports he was seen on day 6 of his symptoms and received a covid test that resulted negative.

Patient reports adherence with medication regimen.
Current medication
Including OTC meds, vitamins, herbals, etc.
26May2021 verified with pt

Tramadol 50mg PRN severe pain

meloxicam, 15 MG, TABLET, ORALTAKE ONE TABLET BY MOUTH EVERY DAY

Blood Sugar Diagnostic, (Freestyle Lite Strips), Strip,
Lancet, (Freestyle), Device, Miscellaneous
empagliflozin, 10 MG, TABLET, ORAL
Atorvastatin 10 mg oral tablet
Metformin 1000mg
Zyrtec
Flonase

VENLAFAXINE HCL ER (venlafaxine HCl), 75 MG 1 tab po qd
Buspirone 15mg 1 tab po bid; Multivitamin.
Past medical/surgical history
Reported:
Medical:

23 Aug 2012 at USAMEDDAC Ft Drum NY, Optometry Clinic Dr by PELLETIER, DANIELLE KATHRYN

Encounter ID: DRUM-4995098 Primary Dx: Migraine

Patient: Barton,Clint
Date: **23 Aug 2012 1000 EDT**
Appt Type: **INITIAL SPECIALTY CARE APPT**
Treatment Facility: **A1011**
Clinic: **OPTOMETRY CL DR**
Provider: **PELLETIER, DANIELLE K**
Patient Status: **Outpatient**

Autocites Refreshed by PELLETIER,DANIELLE KATHRYN @ 23 Aug 2012 1019 EDT

Allergies
No Allergies Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
CETIRIZINE HCL, 10 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY	1 of 1	02 Jul 2012
PYRIDOXINE HCL, 50 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH EVERY DAY	1 of 1	31 May 2012
SIMVASTATIN (SIMVASTATIN), 40 MG, TABLET, ORAL, TEVA USA, 30 ea. BOTTLE	Active		NR	21 Apr 2009

Reason for Appointment:
cee

Appointment Comments:
gcg

A/P Last updated by PELLETIER,DANIELLE KATHRYN @ 23 Aug 2012 1035 EDT
1. ASTIGMATISM
Procedure(s): -Ophthalmological Prior Patient Start Comprehensive Care x 1
-Determination Of Refractive State x 1
-Spectacles Services Fitting Monofocals (Not For Aphakia) x 4
2. PSEUDOPHAKIA POSTERIOR CHAMBER LEFT EYE

Disposition Written by PELLETIER,DANIELLE KATHRYN @ 23 Aug 2012 1038 EDT
Released w/o Limitations
Follow up: as needed in 12 month(s) in the OPTOMETRY CL DR clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note (Draft) Written by PELLETIER,DANIELLE KATHRYN @ 23 Aug 2012 1019 EDT
Name: Barton,Clint Date of birth: 1/11/1977
Chief complaint:
pt is a 35 yr old male, established pt. Pt states that he is here for an updated exam and new glasses. Pt states no change in vision. Pt wears NVO and DVO glasses. Pt has a hx of cat sx OS 2009. Pt states he gets headaches from sinuses every day. Pt states no red eyes. NKDA.
LEE: 6/2010 **Last DFE**:
Pain: 0
Current medications: vytorin, B6
Ocular Medications: None
Medication History: was reviewed and updated in patient medication list.
General health: No history of: Diabetes, High blood pressure, Arthritis, Thyroid, Pregnant/Nursing
Ocular health: Positive history of:
No history of: Glaucoma, Cataracts, Keratoconus, Lazy eye, Double vision, Eye injury, CL wear
Family history: Family history of: Diabetes (sister)
No family history of: Glaucoma, Keratoconus, High blood pressure

SCREENING:

	DVA sc	NVA sc	**SPECTACLE RX:** (Habitual)	DVA cc	Add:	NVA cc
OD	20/50	20/	PL-1.50x017	20/20		20/

28 Jan 2016 at Carl R Darnall Medical Center Ft Hood, TX, AMH S01A Strykr by GONZALEZ, RAFAEL R

Encounter ID: HOOD-6960081 Primary Dx: Encounter for issue of repeat prescription

Patient: Barton,Clint
Treatment Facility: **BENNETT FAMILY CARE CLINIC-HOOD**
Patient Status: **Outpatient**

Date: **28 Jan 2016 0923 CST**
Clinic: **AMHS01ASTRYKR**

Appt Type: **T-CON***
Provider: **GONZALEZ,RAFAEL RODRIGUEZ**
Call Back Phone: **(315)-771-5470**

Reason for Telephone Consult: Written by GONZALEZ,RAFAEL RODRIGUEZ @ 28 Jan 2016 0923 CST
medrefill

S/O Note Written by GONZALEZ,RAFAEL RODRIGUEZ @ 28 Jan 2016 0924 CST
Subjective
med refill

A/P Written by GONZALEZ,RAFAEL RODRIGUEZ @ 28 Jan 2016 0943 CST
1. Encounter for issue of repeat prescription: SM requesting refill for medication for chronic condition (headaches).Medication refilled without further exam due to history of medication use without adverse effects. Pt instructed to f/u with PCM as needed.
Medication(s): -SUMATRIPTAN (IMITREX)--PO 50MG TAB - TAKE ONE TABLET BY MOUTH AT ONSET OF HEADACHE AS NEEDED MAY REPEAT AFTER 2 HOURS #18 RF1
2. Hyperlipidemia, unspecified: Labs ordered. Will call pt with any abnormal results.
Laboratory(ies): -LIPID PANEL (Routine)

Disposition Last Updated by GONZALEZ,RAFAEL RODRIGUEZ @ 28 Jan 2016 0937 CST
Follow up: as needed with PCM and/or in the AMHS01ASTRYKR clinic.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By GONZALEZ, RAFAEL RODRIGUEZ (Physician) @ 28 Jan 2016 0943

Note Written by ZUCKERMAN,STEPHANIE
Verified name/DOB: YES
Consent form signed/Limits of Confidentiality Discussed: YES - This encounter was completed as a telephone visit. The provider was located at the MTF. Risks and benefits of care delivered via VH were discussed with the patient. The patient was verbally informed about their right to refuse care via telehealth. Patient verbalized understanding and provided verbal consent to continue with the telephone visit.
Voluntary: Yes
Deployment Related: NO
Type of Visit: Follow-up
Session #: 04 w/this provider
Duration: 30 minutes

Preferred Language: English
Language/Cultural Barriers: None
Barriers to Learning: No
Domestic Abuse Screening: Pt denied that he is currently in a situation in which he is being verbally or physically hurt, threatened, or made to feel afraid.
Nutrition Screening:
1 Allergies: .No
2. During the last 3 months, have you:
a. ..without wanting to, gained 10 or more pounds? **No**
b. ..had a recent significant decrease in food intake and/or appetite? **No**
c. ..had any recent dental problems? **No**
d. ..had any episodes or excessive overeating? **No**
e. ..intentionally tried to lose weight by inducing vomiting? **No**
Based on questionnaire and clinical interview, nutritional referral: is not indicated at this time.

Pain Assessment/Rating: 7/10 at intake. Pt. advised this pain is ongoing due to Lumbosacral Strain

ID/Referral Source/Chief Complaint: Pt is a 36 y/o, Married, male, ARMY, E-6. Pt was a self-referral. Pt's chief complaint at intake was "wanting an evaluation." He is being seen today for follow-up after recent d/c from Lakeside inpatient and outpatient programming.

Current Report/Update: Pt. seen today for follow-up and reports to still be doing well though he noted some ongoing work related stressors. He advised Lumbosacral Strain continues flare up and he is still working to get this managed. He advised he continues to see a psychiatric nurse practitioner monthly for medication management and he recently had Buspar added for anxiety management. Pt. reported no significant ongoing symptoms and denied any suicidal ideation currently or recently.

History of Present Illness/Symptoms: Pt. reported he had three days approximately 1 month ago when he experienced fleeting thoughts of wanting to die. He advised he wanted to schedule an appointment to discuss this and expressed belief it may have been related to increased Lumbosacral Strain at the time and he noted he also discontinued some of his medication at the time due to being concerned he was on too many medications. He noted no other current symptoms of concern. He reported a history of sleep difficulty over the past two years but advised he began taking melatonin and Benadryl for sleep as prescribed by his PCM approximately 1-2 weeks ago, which has helped him sleep better. He noted some prior incidents in which he has experienced suicidal thoughts including in 2001 considering overdose on Tylenol but "becoming scared" due to stressful deployment experience and family stressors. He noted that on approximately two other occasions he had fleeting thoughts of wishing he was dead. He advised he thinks of his family and the thoughts go away. He denied present thoughts of suicide during this encounter and noted no other significant history of mental health concerns. He denied current significant symptoms of depression or anxiety.

				(moderate severity) 22–28 = Clinical insomnia (severe)			

Measurement results today reflect an increase in both depression and anxiety scores since the last encounter, with both still falling in the mild range.

- ***C-SSRS-S Screener Recent*:** Score: 0 (6/3/21). Pt. denied current or recent with to be dead or suicidal ideation, intent, plan, or behaviors during today's encounter.

Clinical Impression/Summary: Pt. is a 44 year old male presenting to BH initially requesting to have an assessment given passive thoughts of suicide (desire to be dead) occurring approximately 1 month ago. He advised he was not taking all of his medications at the time due to feeling he was on too many medications . He noted he did not engage in any suicidal behaviors nor have thoughts, plan, or intent of engaging in self-harm. He advised he made an appointment with his medical provider and had his medications changed, which has significant improved his sleep. He noted not current mental health symptoms of concern and expressed desire to discuss his experience. Based on pt. report, it appears he may have been experiencing some depressive symptoms secondary to medical condition (Lumbosacral Strain). Pt. not provided diagnosis at intake but presents for follow-up reporting ongoing significant depressive symptoms which appear linked to ongoing Lumbosacral Strain. Pt. appears to meet criteria for Depressive Disorder Due to Known Physiological Condition (Lumbosacral Strain). Pt. was referred for treatment at Lakeside BH after second appointment and is now r eporting to be doing significantly better. He will continue treatment with this provider at this time. CBT techniques will be utilized and prognosis noted as good.

DSM-5 Diagnosis: Unspecified Anxiety Disorder

Suicide Risk Factors

Static: History of childhood physical/verbal abuse
Dynamic: History of medical conditions with no current symptoms of concern
Protective Factors: Responsibility to family/children; future orientation; strong support network; no current report of significant distress or anxiety/depression related symptoms

Suicide Risk Assessment: After considering variables that influence suicide risk including prior suicide attempts, psychiatric diagnoses that elevate risk, age, gender, family background, quality of interpersonal relationships, physical health, suicide risk variables regarding lethality/access/ planning, affective control, degree of hope, family history of completed suicide, degree of willingness to seek help, connection with therapist, and degree of psychosocial support for dealing with current life stressors, current suicide risk is judged to be: [X] LOW [ ] MODERATE

Acute Suicide Risk Level: **Low Risk for Suicide**

Treatment Plan:

1) Safety Plan/Crises Response: Pt briefed on walk-in hours/local emergency services. The patient was provided a copy? N/A.
2) Problem 1: Depression - Intervention/Modality: CBT, Goal/Outcome Measures: Screening measures & patient report, Progress: Significantly Improved
3) Patient verbalized goal for treatment: Pt. noted today desire to not have further suicidal thoughts and not feel so much pain.
4) Referrals: Psychiatry referral placed for medication management.
5) Next Follow-up/Scheduled Session: Pt. to schedule f/u with this provider in approximately 1 month via telephone or earlier as needed.
6) Prevention Discussed: None
7) Patient agrees with plan: Yes

Appearance: Good grooming and hygiene, appropriately dressed, overweight
Gait & Station: Unremarkable, no abnormality noted
Behavior: Cooperative
Speech: Grossly within normal limits in terms of rate, rhythm, volume and prosody
Eye contact: Good
Mood: Grossly euthymic with congruent and restricted affect
Thought process: Linear and goal-directed
Thought content: No suicidal, homicidal or assaultive ideations. No delusions, auditory or visual hallucinations, or other psychotic thought content.
Judgment: Intact
Insight: Intact
Impulse control: Intact

Risk Assessment

Self harm risk:low
Harm to others:low
AWOL risk:low

Assessment:
34-year-old Caucasian male with genetic loading for mental illness and alcoholism complains of depressed mood and depressive symptoms including irritability and initial insomnia improved since restarting an increasing Zoloft. Complains of anger issues.
Axis I: Adjustment disorder with anxiety and depressed mood; alcohol dependence in early full remission
Axis II: Deferred
Axis III: Deferred
Axis IV: Occupational and marital stressors, moderate
Axis V: GAF 70

Plan:
Refer to anger management. At our next encounter, will consider referral to psychotherapy and will consider increasing Zoloft again.
1. Medications: No changes.
2. Followup: RTC 4 weeks
3. Laboratory studies ordered/reviewed: none
4. Other recommendations: Referred to anger management. SM signed up for Wednesday morning courses.
5. Profile: 90 day temporarily non-deployable due to medication change profile in place through January 14, 2014.
6. Medical Category: 2
7. Patient is aware of all emergency services.
8. Risks versus benefits of treatment and medications were explained to the patient, who understood and agreed with the plan.

2015

2015

Barton,Clint 2015

16 Mar 2015 at NH Yokosuka, ATS Medical Home by LYNN, JESSE HARRISON

Encounter ID: YOKS-4905264 Primary Dx: Respiratory

Patient: Barton,Clint
Treatment Facility: **NBHC NAF ATSUGI**
Patient Status: **Outpatient**
Date: **16 Mar 2015 0830 TST**
Clinic: **FPC MEDICAL HOME ATSUGI**
Appt Type: **ACUT**
Provider: **LYNN,JESSE H**

AutoCites Refreshed by LYNN,JESSE H @ 16 Mar 2015 1433 TST

Allergies
No Allergies Found.

Reason for Appointment:
back/side pain/ f/u xray/ 3933
Appointment Comments:
alg

Vitals
Vitals Written by RANGEL,ASHLEY M @ 16 Mar 2015 0846 TST
BP: 124/82, HR: 86, RR: 16, HT: 69 in, WT: 99.6 kg, BMI: 32.43, BSA: 2.149 square meters, Tobacco Use: No, Alcohol Use: Yes,
Alcohol Comments: Socially, Pain Scale: 8/10 Severe, Pain Scale Comments: lumbar spine, L Shoulder

Questionnaire AutoCites Refreshed by LYNN,JESSE H @ 16 Mar 2015 1433 TST
Questionnaires

S/O Note Written by LYNN,JESSE H @ 16 Mar 2015 1433 TST
History of present illness
The Patient is a 36 year old male.

<<Note accomplished in TSWF-CORE>>

36yo AD Male presents to follow up on concerns for his breathing and shoulder pain. PT has history of working near burn pits and is concerned that they have started to effect his breathing. Will follow up with a FeNO test for asthma.

Allergies
Allergies Verified and Updated.
Current medication
Including OTC meds, vitamins, herbals, etc.

Motrin, effexor, protonix.
Past medical/surgical history
Reported:
Medical: Reported medical history
Shoulder Pain, Headaches, shortness of breathe
Personal history
Social history reviewed Works on a computer (galley).
Family history
Family medical history
Mother diabetes type 2/HBP, father high colesterol, grandfather bypass surgery.
Review of systems
Systemic: No fever and no chills.
Otolaryngeal: No earache, no nasal discharge, and no sore throat.
Cardiovascular: No chest pain or discomfort.
Pulmonary: No dyspnea and no cough.
Physical findings

Are you enrolled in EFMP? [ ] Yes [x] No
Do you use a Personal Health Record (PHR)? [ ] Yes [x] No Specify:
Contact info:

Family history

Family medical history

No Cancer
No Heart Disease
No High Blood Pressure
No High Cholesterol
YES DIABETES: Paternal

Review of systems

Systemic symptoms: No recent weight loss.
Gastrointestinal symptoms: No fecal incontinence.
Genitourinary symptoms: No urinary loss of control.
Neurological symptoms: No numbness of the legs.

Physical findings

Vital signs:

Vital Signs/Measurements Value
Blood pressure: Reviewed
• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

General appearance:
° Normal. ° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.

Back:
• Tenderness on palpation increased tenderness to soft tissue over right SI joint with some guarding secondary to deep palpation. ° No muscle spasm.

Musculoskeletal system:
Thoracolumbar Spine (Motion):
General/bilateral: • Thoracolumbar spine did not demonstrate full range of motion moderately reduced with flexion, can obtain approximately 50-60?.
Lumbar / Lumbosacral Spine:
General/bilateral: • Lumbosacral spine exhibited muscle spasms questionable. ° A straight-leg raising test was negative.

Neurological:
° A mini-mental status exam score was not recorded : out of 30. ° Remote memory was not impaired. ° Recent memory was not impaired. ° Judgement was not impaired.
Sensation: ° No sensory exam abnormalities were noted. ° No decreased response to tactile stimulation of both entire legs.
Motor (Motor Strength): ° No weakness of the right knee was observed. ° No weakness of the left knee was observed. ° No weakness of the right ankle was observed. ° No weakness of the left ankle was observed.
Balance: ° Normal.
Gait And Stance: • Abnormal Slightly guarded with ambulation.
Reflexes: ° Deep tendon reflexes were normal. ° Knee jerk was normal. ° Ankle jerk reflex was normal.

Psychiatric Exam:
Mood: ° Euthymic.
Affect: ° Normal.

A/P Written by HARDY,JAY MITCHELL @ 11 Jun 2012 1018 WEDT
1. SACROILIAC REGION SPRAIN: Patient instructed to apply heat to the affected area twice daily as needed. Patient also instructed on stretching exercises to relieve symptoms of SI joint syndrome. Patient placed on reduced activity profile x20 days.

Medication(s): -INDOMETHACIN--PO 25MG CAP - T 1 CAP TID WITH FOOD OR MILK #50 RF0 Qt: 50 Rf: 0
2. insomnia: Medications have been refilled.
Medication(s): -ZOLPIDEM--PO 10MG TAB - T 1/2 TO 1 TAB PO HS AS DIRECTED DS15 #15 RF0 Qt: 15 Rf: 0
3. DEPRESSION: Stressed importance to patient to followup with behavioral health, we'll refill current medication i.e. Zoloft for 30 days pending followup.
The patient's master problem list has been reviewed and updated.
Medication(s): -SERTRALINE--PO 100MG TAB - T1 TAB PO QHS #30 RF0 Qt: 30 Rf: 0

Disposition Written by HARDY,JAY MITCHELL @ 11 Jun 2012 1019 WEDT
Released w/ Work/Duty Limitations
Follow up: as needed with PCM and/or in the HHF PRIMARY CARE clinic. - Comments: Followup With Non-resolution Or Increased Symptoms.
Medication Reconciliation Complete; Med List Reviewed With Patient (parents). Patient Instructed To Obtain Updated Med List From Pharmacy And To Destroy Old Med List.
Education Appropriate To The Patients Needs Was Provided Regarding The Care/treatment/services Provided. The Patient Voices Understanding And All Questions Were Answered. Parent/patient Has No Barriers To Learning.

673d MDG PAIN MANAGEMENT CLINIC
POST-PROCEDURE PAIN DIARY
Fax Number: 907-580-1048

Date of Procedure: 20 Feb 2018 **Physician Name:** Cartier

Patient Name: Barton,Clint **DOB:** 01-11-1977 **Last Four SS#:** 2006

Type of Block: Left / Right / (Bilateral) (Lumbar) / Thoracic / Cervical / Other _____

(Facet) MBB SI Joint **Other Block** _____

Pain Score Prior to Procedure: No Pain 0 1 2 3 (4) 5 6 7 8 9 10 Severe Pain

Pain score After Procedure: 4 /10 @ 0805

Time	Pain Level	Function/Range of Motion**
0835	0 1 2 3 (4) 5 6 7 8 9 10	limited / still functional
0905	0 1 2 3 (4) 5 6 7 8 9 10	limited / still functional
0935	0 1 2 3 4 (5) 6 7 8 9 10	limited / still functional
10:10	0 1 2 3 4 (5) 6 7 8 9 10	limited / " "
10:40	0 1 2 3 4 (5) 6 7 8 9 10	limited / " "
11:15	0 1 2 3 4 5 (6) 7 8 9 10	minimal / tense / aches
11:45	0 1 2 3 4 (5) 6 7 8 9 10	.
12:15	0 1 2 3 4 (5) 6 7 8 9 10	
12:45	0 1 2 3 4 5 6 (7) 8 9 10	tense / minimal / worse its been
13:15	0 1 2 3 4 5 6 (7) 8 9 10	tense / minimal / worse its been
13:45	0 1 2 3 4 5 6 (7) 8 9 10	tense / minimal / worse its been.
14:15	0 1 2 3 4 5 (6) 7 8 9 10	took Ibuprofen. tense.

Fill out this diary EVERY 30 MINUTES for 6 hours after the procedure and DROP IT OFF AT OUR CLINIC THE NEXT DAY. Bringing this diary to the clinic is MANDATORY for eligibility for procedures.

****Range of Motion/Function: Are you able to move better? Has your ability to function or range of motion improved? DO NOT SLEEP THE FIRST 6 HOURS AFTER THE PROCEDURE.**

Please keep in mind this is a diagnostic procedure and pain relief is not expected to last for an extended period of time.

Please complete the other side of this sheet in the morning prior to returning it to clinic

Do you feel that the procedure went well?	**(YES)/NO**
Pain score prior to the procedure?	4 /10
Pain score post-procedure?	4 /10
Average Pain on pain diary?	6 /10
Current Pain Level?	7 /10
Was the procedure effective?	**YES/(NO)**
Was there greater than a 50% reduction in pain?	**YES/(NO)**
How long did the relief last?	_____ **HOURS** **(N/A)**
Improved/Worsened ROM/Function?	worsened.
Have you used Ice for injection site soreness?	**YES/(NO)**
Have you used Heat for any muscle spasm?	**YES/(NO)**
Current pain medications utilized? If yes, what kind?	Ibuprofen
Injection site appearance (any redness/swelling/heat sensation/drainage)?	clear

Medical Records - CONFIDENTIAL

FROM: VA - Interventional Pain and Spine Speci
Ann C
12230 BRANDERS CREEK DRIVE, CHESTER, VA 23831-1626
Phone: (804) 715--4709
Fax: (804) 715--4714

TO:

Name: Barton,Clint

DOB: 01-11-1977

Date Range: 06/01/1995 - 04/08/2018

This document contains the following records of the patient:
- **Encounters and Procedures**

Note: Barton,Clint

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 04-08-18

Patient

Name Barton,Clint M) ID# **Appt. Date/Time** 04/08/2018 09:20AM

DOB 01/11/1977 **Service Dept.** OFFICE

Provider HASSAN ZAKARIA

Insurance Med Primary: TRICARE EAST - HUMANA MILITARY TRICARE (TRICARE)
Insurance # : 436517512
PCP : BUCHANAN, CYNTHIA
Referring Provider Name : BUCHANAN, CYNTHIA
Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details

Chief Complaint

Low back/L-spine problem

Left EMG/Nerve Conduction Study of Lower Limbs

Patient's Care Team

Primary Care Provider (Primary Insurance): BUCHANAN, CYNTHIA: KENNER ARMY HEALTH CLINIC, 70024TH ST BLDG 8130, FORT LEE, VA 23801, Ph (804) 734-2273, Fax (887) 874-1008
Referring Provider (Primary Insurance): BUCHANAN, CYNTHIA: KENNER ARMY HEALTH CLINIC, 70024TH ST BLDG 8130, FORT LEE, VA 23801, Ph (804) 734-2273, Fax (887) 874-1008

Patient's Pharmacies

DOD FT LEE EPHCY (ERX): 700 24TH ST BLDG 8130, FT LEE VA 23801, Ph (804) 734-9137, Fax (804) 734-9658

Vitals

Ht:	6 ft 08/28/2018 09:12 am	**BP:**	139/80 sitting L wrist 08/28/2018 09:27 am	**Pulse:**	77 bpm regular 08/28/2018 09:27 am
Pain Scale:	3 08/28/2018 09:27 am	**Pain Scale Type:**	Numeric 08/28/2018 09:12 am		

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

Bayer Back and Body 500 mg-32.5 mg tablet	06/05/18	entered
cyclobenzaprine 10 mg tablet	06/05/18	entered
hydroCHLOROthiazide 25 mg tablet	06/05/18	entered
metoprolol succinate	06/05/18	entered
Pain Relief PM	06/05/18	entered

Problems

Reviewed Problems

Family History

Reviewed Family History

Social History

Reviewed Social History

4. Left tibial F-wave and H-reflex were WNL.

5. Left LE needle EMG showed normal membrane stability , MUAP morphology and recruitment.

**NO evidence of radiculopathy, plexopathy or peripheral neuropathy.

Assessment / Plan

1. Pain in left lower limb
M79.605: Pain in left leg

2. Lumbosacral radiculitis
M54.17: Radiculopathy, lumbosacral region

Discussion Notes

*MRI reviewed. There is significant narrowing at L4-5. Luckily no signs of denervation / instability on EMG today

*Will schedule for a left S1 epidural today

Return to Office
None recorded.

Encounter Sign-Off
Encounter signed-off by Hassan Zakaria, 08/28/2018.

Encounter performed and documented by Hassan Zakaria
Encounter reviewed & signed by Hassan Zakaria on 08/28/2018 at 9:54am

Encounter Date: 06/05/2018 (Last amended by Hassan Zakaria on 06/05/2018 at 5:13pm)

Patient

Name	Barton,Clint	ID# **Appt. Date/Time**	06/05/2018 09:20AM
DOB	01/11/1977	**Service Dept.**	OFFICE
Provider	HASSAN ZAKARIA		
Insurance	Med Primary: TRICARE EAST - HUMANA MILITARY TRICARE (TRICARE) Insurance # : 436517512 PCP : BUCHANAN, CYNTHIA Referring Provider Name : BUCHANAN, CYNTHIA Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Low back/L-spine problem

Patient being seen for back pain

Patient's Care Team

Primary Care Provider (Primary Insurance): BUCHANAN, CYNTHIA: KENNER ARMY HEALTH CLINIC, 70024TH ST BLDG 8130, FORT LEE, VA 23801, Ph (804) 734-2273, Fax (887) 874-1008
Referring Provider (Primary Insurance): BUCHANAN, CYNTHIA: KENNER ARMY HEALTH CLINIC, 70024TH ST BLDG 8130, FORT LEE, VA 23801, Ph (804) 734-2273, Fax (887) 874-1008

Patient's Pharmacies

DOD FT LEE EPHCY (ERX): 700 24TH ST BLDG 8130, FT LEE VA 23801, Ph (804) 734-9137, Fax (804) 734-9658

Vitals

Ht:	6 ft 06/05/2018 09:01 am	**Wt:**	191 lbs 06/05/2018 09:01 am	**BMI:**	25.9 06/05/2018 09:01 am
BP:	130/80 sitting L wrist 06/05/2018 09:01 am	**Pulse:**	80 bpm regular 06/05/2018 09:01 am	**Pain Scale:**	6 06/05/2018 09:01 am

Patient reports **back pain** but reports no muscle aches, no muscle weakness, no arthralgias/joint pain, no neck pain, and no swelling in the extremities. He reports no fever, no night sweats, no significant weight gain, and no significant weight loss. He reports no change in vision and no change in hearing. He reports no frequent nosebleeds and no nasal drainage/sinus problems. He reports no sore throat, no dry mouth, and no mouth ulcers. He reports no chest pain on exertion, no palpitations (no irregular heart beats), no shortness of breath on exertion, no shortness of breath when lying down, no light-headedness upon standing, and no known heart murmur. He reports no cough, no wheezing, and no shortness of breath. He reports no abdominal pain, no nausea/vomiting, no diarrhea, no constipation, no black or tarry stools, and no bowel incontinence. He reports no urinary incontinence, no difficulty urinating, no increased urinary frequency, and no blood in urine. He reports no rash, no areas of red patches, no discoloration, no itchy skin, and no dry skin. He reports no weakness, no numbness, no seizures, no dizziness, and no headaches/migraines. He reports no depression, no sleep disturbances/insomnia, no alcohol abuse, and no substance abuse. He reports no fatigue, no cold intolerance, no heat intolerance, and no hair growth/hair loss.

Physical Exam

Patient is a 38-year-old male.

Constitutional: General Appearance: Healthy-appearing, NAD, and Normal body habitus.

Psychiatric: Orientation: Oriented to person, place, time. Mood and Affect: normal mood and affect and active and alert.

Gait and Station: Appearance: Normal gait.

Cardiovascular System: Edema Right: None. Edema Left: None.

Skin: Evidence of injury or surgery normal skin.

Lumbar Spine: Inspection: normal alignment, (normal) appearance: lordosis, and no swelling, induration or echymosis. Bony Palpation of the Lumbar Spine: **Mild Tenderness at the bilateral paramidline area at Lower lumbar**. Bony Palpation of the Right Hip: no tenderness of the SI joint. Bony Palpation of the Left Hip: no tenderness of the SI joint. Soft Tissue Palpation on the Right: no tenderness of the sciatic nerve or the piriformis, no tenderness gluteal region, and **tenderness of the paraspinal region at lower lumbar level**. Soft Tissue Palpation on the Left: no tenderness gluteal region or of the sciatic nerve and **tenderness of the paraspinal region at lower lumbar level**. Lumbar Range of Motion: flexion within functional limits with pain and extension within functional limits without pain.

Motor Strength: L1 Motor Strength on the Right: hip flexion iliopsoas 5/5. L1 Motor Strength on the Left: hip flexion iliopsoas 5/5. L2-L4 Motor Strength on the Right: knee extension quadriceps 5/5. L2-L4 Motor Strength on the Left: knee extension quadriceps 5/5. L5 Motor Strength on the Right: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. L5 Motor Strength on the Left: ankle dorsiflexion tibialis anterior 5/5 and great toe extension extensor hallucis longus 5/5. S1 Motor Strength on the Right: plantar flexion gastrocnemius 5/5. S1 Motor Strength on the Left: plantar flexion gastrocnemius 5/5.

Neurological System: Special Tests: no clonus of the ankle/knee. Ankle Reflex Right: normal (2). Ankle Reflex Left: normal (2). Knee Reflex Right: normal (2). Knee Reflex Left: normal (2). Sensation on the Right: L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, normal distal extremities, and No Allodynia / Hyperesthesia. Sensation on the Left: L1 normal, L2 normal, L3 normal, L4 normal, L5 normal, S1 normal, and No Allodynia / Hyperesthesia. RIGHT Dural tension / sacroilliac joint manuvers straight leg raise test negative, SI joint testing negative (Patrick, Yeomans, Gaenslens), Piriformis Manuvers Negative, and Waddell's test of non organic physical signs are negative. Left Dural tension / Sacroilliac joint manuvers SI joint testing negative (Patrick, Yeomans, Gaenslens), Piriformis Manuvers negative, and **straight leg raising test positive Leg and low back pain**.

Hips: Right Hip: Passive ROM are normal. Left Hip: Passive ROM are normal.

Knees: Right Knee: Range of motions are normal both actively and passively, patellar apprehension negative, and joint effusion is absent. Left Knee: joint effusion negative, no pain with motion, and patellar apprehension negative.

Assessment / Plan

1. Lumbosacral spondylosis without myelopathy

M47.817: Spondylosis without myelopathy or radiculopathy, lumbosacral region

- MRI, LUMBAR SPINE, W/O CONTRAST - Note to Imaging Facility: PLEASE FAX RESULTS TO OUR OFFICE AND GIVE PATIENT A COPY OF DISC. THANK YOU

  Height (ft.): 6 ft 0 in Weight (lbs): 190
- XR, LUMBAR SPINE

XR, LUMBAR SPINE

Review of xr, lumbar spine taken on 06/05/2018 at IN-OFFICE ORDER shows:

Lumbar Spine:

Radiographic Findings: **There is disc space narrowing at L5-S1 of 25-50% and There is mild facet joint arthritis at L4-5** but No spondylolisthesis is seen. and No compression deformities are seen.

Discussion Notes

*back pain since 2014 , no identifiable injury.

*He says he has pain across the low back when he sits and has pain that radiates down the left leg.

*He says if he stand for prolonged periods , bends or does sit ups he will also get the symptoms.

*He had MRI at Ft. Hood in 2014. I do not have this for review. he was told he has 3 bulging discs.

*I did take xrays today. They look fairly normal except for some DDD at l5-S1. there is very mild facet arthritis.

*I will need a lumbar MRI prior to procedures. He has been in therapy recently and there does not seem to be any progress. He uses some OTC NSAIDs for pain.

*I will also schedule him for a left LE EMG.

*After abo ve we can decide on what procedure may benefit him the most.

*Neuro exam WNL in he LE today.

*Mild neural tension signs on left.

Return to Office

- Hassan Zakaria for Zakaria EMG at OFFICE on 07/10/2018 at 08:40 AM

Amendment Sign-Off

Encounter signed-off by Hassan Zakaria, 06/05/2018.

Encounter performed and documented by Hassan Zakaria
Encounter reviewed & signed by Hassan Zakaria on 06/05/2018 at 10:01am
Amendment closed by Hassan Zakaria on 06/05/2018 at 5:13pm

Medical Records - CONFIDENTIAL

FROM: VA - Interventional Pain and Spine Speci
HASSAN ZAKARIA
12230 BRANDERS CREEK DRIVE, CHESTER, VA 23831-1626
Phone: (804) 715--4709
Fax: (804) 715--4714

TO: KENNER ARMY HEALTH CLINIC
700 24TH ST, FORT LEE, VA 23801
Phone: (804) 734-2273
Fax: (877) 874-1008

Name: Barton,Clint

DOB: 01/11/1977

Date Range: 06/01/1995 - 04/08/2018

This document contains the following records of the patient:
- **Imaging Results**

Barton,Clint DOB 01/11/1977 SSN: 011-25-2006

Imaging Results

Barton,Clint DOB 01/11/1977 SSN: 011-25-2006

MRI, LUMBAR SPINE, W/O CONTRAST

(#753448, 06/12/2018 12:00am)

TO: 11/30/18
Zakaria,Hassan MD

FROM: APPOMATTOX IMAGING CENTER
. Radiology

Pages including cover sheet: 3

Comments:

Appomattox Imaging Center
930 South Avenue
Suite 1
Colonial Heights, VA 23834
Phone #: (804)524-2340
FAX #: (804)520-6202

Name: Barton,Clint
Phys: Zakaria,Hassan MD
DOB: 01/11/1977 Age: 38 Sex: M
Acct: M00001902865 Loc: M.MRI
Exam Date: 06/12/2018 Status: DEP CLI
Rad No: URN: F404770
Unit No: M000077030

EXAMS: CPT CODE:
000222158 MRI LSPINE WO IV CON 72148

Reason for Visit: SPONDYLOSIS W/O MYELOPATHY
Reason for Exam: SPONDYLOSIS W/O MYELOPATHY
Exam: - MRI LSPINE WO IV CON

Comparison: None.

Clinical History: Back pain, left leg pain and weakness.

Technique: T1 and T2 weighted images were obtained in the axial and sagittal planes. 3-D myelographic images were obtained and projection images were rendered at the MR console and provided for interpretation.

L1-L2 level: Normal.

L2-L3 level: Normal.

L3-L4 level: Normal.

L4-L5 level: Disc desiccation is present. There is a left posterior paramedian annular tear with posterior disc bulge. Facet joint degenerative change and hypertrophy of the ligamentum flavum also contribute to a focal canal stenosis with AP canal dimension reduced to 5 mm. There is also narrowing of the left lateral recess due to the disc bulge, facet joint degenerative change, and hypertrophy of the ligamentum flavum, compressing the left L5 nerve root.

L5-S1 level: Disc desiccation, posterior disc bulge, facet joint degenerative change, and hypertrophy ligamentum flavum are present. AP canal dimension remains about 9 mm, and there is no foraminal narrowing.

There is normal signal in the lumbar vertebral bodies and conus medullaris which terminates at the lower T12 level.

Impression:
1. Degenerative changes in L4-5 and L5-S1 discs and facet joints, including small annular tear in the L4-5 disc.
2. Focal canal stenosis at the L4-5 interspace (AP canal dimension 5

Appomattox Imaging Center
930 South Avenue
Suite 1
Colonial Heights, VA 23834
Phone #: (804)524-2340
FAX #: (804)520-6202

Name: Barton,Clint
Phys: Zakaria,Hassan MD
DOB: 01/11/1977 Age: 38 Sex: M
Acct: M00001902865 Loc: M.MRI
Exam Date: 06/12/2018 Status: DEP CL
Rad No: URN: F404770
Unit No: M000077030

EXAMS: CPT CODE:
000222158 MRI LSPINE WO IV CON 72148
<Continued>

mm), and narrowing of the left lateral recess which compresses the left L5 nerve root.

** Electronically Signed by Nathaniel W Cuthbert MD **
** on 04/08/2018 at 2030 **
Reported and signed by: Nathaniel W Cuthbert, MD

CC: Hassan Zakaria MD

Dictated Date/Time: 06/13/2018 (2018)
Techs: Constance S Mitchell, RT(R) MR
Transcribed Date/Time: 06/13/2018 (2018)
Transcriptionist: DR.CUTNA
Electronic Signature Date/Time: 06/13/2018 (2030)
Orig Print D/T: S: 06/13/2018 (2031)
BATCH NO: N/A