Note for Jane Doe on 02/10/2005 - Chart 3642

Consultation was requested by Dr. Smith
Chief Complaint (1/1): This 31 year old female presents today for evaluation of difficulty with coordination.
Associated signs and symptoms: Associated signs and symptoms include morning joint stiffness lasting 5-10 minutes and physical activity decrease.
Duration: Condition has existed for 2 months.
Location: She indicates the problem location is left thigh in muscles.
Modifying factors: Patient indicates exercise worsens condition.
Quality: Quality of the pain is described by the patient as worse in the morning.
Severity: Severity of condition is worsening.
Timing (onset/frequency): Onset was gradual.
She denies any previous limb weakness, speech or vision disturbances.

Allergies: No known medical allergies.
Medication History: Patient is currently using nitrostat sublingual tablets 0.4 mg tablet (Use as Directed) usage started on 02/10/2005, Vicodin 325 mg-10 mg tablet (One or two pills q6h prn) usage started on 09/07/2004.
PMH: Unremarkable with exception of chief complaint.
PSH: No previous surgeries.
Social History: Patient admits tobacco use. She relates a smoking history of 10 pack years, Patient admits caffeine use. She consumes 6-10 servings per day, Patient denies alcohol use, Patient denies STD history, Patient denies illegal drug use.
Family History: Unremarkable.
Review of Systems: Respiratory: (+) unremarkable, **Psychiatric:** (+) unremarkable, **Neurological:** (+) balance problems, **Musculoskeletal:** (+) weakness, (+) difficulty/limited exercise, **Integumentary:** (+) unremarkable, **Hematologic / Lymphatic:** (+) unremarkable, **Genitourinary:** (+) unremarkable, **Gastrointestinal:** (+) unremarkable, **Eyes:** (+) unremarkable, **Endocrine:** (+) unusual fatigue, **Ears, Nose, Mouth, Throat:** (+) unremarkable, **Constitutional Symptoms:** (+) tiredness, **Cardiovascular:** (+) unremarkable, **Allergic / Immunologic:** (+) unremarkable.

Physical Exam: BP Sitting: 120/80 Resp: 20 HR: 72 Temp: 98.6
Patient is a female who appears alert and in no distress.
Lymphatic: No neck, supraclavicular, or axillary lymphadenopathy noted
HEENT: Inspection of head and face shows no abnormalities.
Facial strength is normal.
Neck stiffness is not present.
Fundoscopic Exam: Bilateral retinas reveal normal color, contour, and cupping.
Bilateral retinas reveals clear.
Cardiovascular: Normal S1 and S2 without murmurs, gallop, rubs or clicks.
Peripheral pulses full to palpation, no varicosities, extremities warm with no edema or tenderness bilaterally.
Carotid pulses are palpated bilaterally and are symmetric, no bruits are auscultated over the carotid and vertebral arteries.
Neurological Exam:
Mental Status: Oriented to person, place and time.
Mood and affect normal, appropriate to situation.
Stream of thought is spontaneous, abstract thought is intact and serial 3's and simple calculations are intact.
Speech is appropriate with regular rate and rhythm.
Recent and remote memory is intact; patient recalls 3 out of 3 objects at 5 and 10 minutes.
Ability of patient to name objects, repeat phrases and speak spontaneously is good.
Attention span and concentration is good.
Patient awareness of current events, past history and vocabulary is good.
Cranial Nerves: Cranial Nerves: Testing of cranial nerves reveals no deficits.
Motor Exam: Muscle tone is normal.
Muscle strength is 5/5 for all groups tested.
Kernig's sign negative.
Sensory Exam: Touch, pin, vibratory and proprioception sensations are normal.
Vestibulospinal reflexes:
Blindfold gait and straight line walking test is positive with deviation to the left.

Pronator drift test reveals upward drift.
Reflexes: Bilateral brachioradialis reflex, bilateral patellar reflex, bilateral achilles reflex, bilateral biceps reflex and bilateral triceps reflex is 2/4.
Ankle clonus, Hoffman's sign, Trommer's sign and Babinski reflex is absent.
Superficial reflexes are within normal limits.
Cerebellar Exam: Coordination is normal for finger/nose testing, normal for heel/knee/shin testing, normal for rapid alternating movements and negative for truncal or gait ataxia.
Gait and station examination reveals normal arm swing, with normal heel-toe and tandem walking.
Parkinson's scoring:
I. Metation, Behavior, Mood
Intellectual impairment is noted as mild, consistent forgetfulness with partial recollection of events with no other difficulties (score = 1).
No thought disorder (score = 0).
Patient experiences sustained depression for > 1 week (score = 2).
Patient is experiencing loss of initiative or disinterest in day to day (routine) activities (score = 3).

II. Activities of Daily Living
Speech is mildly affected, no difficulty being understood (score = 1).
No increase in salivation (score = 0).
Patient rarely chokes with swallowing (score = 1).
Handwriting: slightly small or slow (score = 1).
Patient can cut most foods, some help needed (score = 2).
When dressing, she needs occasional help with buttons or arms in sleeves (score = 2).
She is somewhat slow but no help needed with self-care (score = 1).
Patient can turn alone or adjust sheets but with great difficulty (score = 2).
She falls occasionally, less than once per day (score = 2).
Has occasional falls from freezing (score = 2).
Moderate difficulty walking, requires no assistance (score = 2).
Tremors are moderate, bothersome to patient (score = 2).
Patient complains of frequent painful sensations (score = 3).

III. Motor Exam
Speech is noticed to have slight loss of expression, dictation and volume (score = 1).
Facial expression is normal (score = 0).
Facial tremors are absent (score = 0).
Right upper extremity tremors are slight and infrequent (score = 1).
Left upper extremity tremors are slight and infrequent (score = 1).
Right lower extremity tremors are mild and present most of the time (score = 2).
Left lower extremity tremors are moderate and present most of the time (score = 3).
Tremors present in right upper extremity are slight, present with action (score = 1).
Tremors present in left upper extremity are slight, present with action (score = 1).
Rigidity in neck is absent (score = 0).
Rigidity in RUE is absent (score = 0).
Rigidity of LUE is absent (score = 0).
Rigidity of right lower extremity is mild/moderate (score = 2).
Rigidity of left lower extremity is marked, full range of motion (score = 3).
Right finger taps are normal (score = 0).
Left finger taps are normal (score = 0).
When asked to open and close right hand in rapid succession demonstrates mild slowing, and/or reduction in amp (score = 1).
When asked to open and close left hand in rapid succession movement is moderately impaired - definite and early fatiguing, may have occasional arrests (score = 2).
Able to move right hand pronate and supinate with no hesitation (score = 0).
Able to move left hand pronate and supinate with no hesitation (score = 0).
When asked to tap right heel on ground there is mild slowing, and/or reduction in amp (score = 1).
When asked to tap left heel on ground movement moderately impaired - definite and early fatiguing, may have occasional arrests (score = 2).
Patient pushes self up from arms or seat of chair (score = 2).
Posture is slightly stooped, could be normal for older person (score = 1).
Gait is noted as difficult, little or no assistance needed, some festination, short steps or propulsion (score = 2).
Patient recovers from instability unaided (score = 1).

Minimal slowness, could be normal, deliberate character (score = 1).

Rating:
70% - Not completely independent. More difficulty with chores. 3 to 4 times along on chores for some. May take large part of day for chores.

Test Results: Visual-evoked potentials (VER): P100 is greater than 100 msec (abnormal).

Impression:
Parkinson's disease.

Plan: Ordered CT scan of the head or brain without then with contrast.
PTT ordered.
Ordered antigenic protein C.
Ordered total protein S.
Antiphospholipid antibodies ordered.
Physical therapist was given orders to evaluate patient's condition and treat accordingly.
Scheduling: Return to clinic in 2 week(s).

Patient Instructions:
Therapy ordered for patient

Prescriptions:
levodopa Dosage: 100 mg capsule Sig: One PO QD Dispense: 30 Refills: 2 Allow Generic: Yes

_____ A. Neurologist, M.D.
Digitally Signed on 02/10/2005 By: A. Neurologist, M.D.

MediNotes
Simply the right choice
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02/10/2005

Dr. Smith
1025 Ashworth Road, Suite 222
West Des Moines, IA 50265

Dear Dr. Smith:

Jane Doe was seen in my office in consultation as requested by you for evaluation and care. The following is a summary of my findings and recommendations:

Impression:
Parkinson's disease.

Plan: Ordered CT scan of the head or brain without then with contrast.
PTT ordered.
Ordered antigenic protein C.
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Scheduling: Return to clinic in 2 week(s).

Patient Instructions:
Therapy ordered for patient

If I may be of any further assistance in the care of your patient, please let me know. Thank you for providing me the opportunity to participate in the care of your patients.

Sincerely,

A. Neurologist, M.D.

Patient Instructions for Jane Doe on 02/10/2005

PRESCRIPTION FORM

Patient Name: Jane Doe
Patient Phone Number: 123-555-1234
Diagnosis: Parkinson's disease
Next Physician Appointment: 02/24/2005
Date of Onset/Surgery: 02/24/2005 Type of Surgery: _____
Area to be Treated: _____
Precautions: falls easily

Goals:
_x___Improve Gait/Mobility __x__Improve Strength
__x__Improve Balance and Coordination ____Improve ROM
____Decrease Pain ___x_Improve ADL Skills
____Improve Cognition-Linguistic Skills

Frequency of Treatment:
_3___ x / week for _6___ weeks
__x__ Evaluation and treatment
____ Evaluation and call referring physician

PHYSICAL THERAPY
____Aquatic Therapy Exercise
____Therapeutic Exercise Strengthening
____ Active
____ PRE
____Therapeutic Exercise ROM
____ Active
____ Active Assistance
____Gait/Transfer Training
____Home Exercise Instruction
____Stabilization Exercise
____ Lumbar
____ Thoracic
____ Cervical
____McKenzie Exercise
____Neuromuscular Facilitation
____Spinal Mobilization
____Orthotic Training
____Prosthetic Training
____Massage
____MFR
____Modalities
____ E-Stimulation
____ US
____ Iontophoresis
____ Phonophoresis
____Other _____

OCCUPATIONAL THERAPY
____Evaluate & Treat
____ADL/Self Care Training
____Ther. Exercise
____Splinting
____Community Integration
____Hand Therapy
____Other _____

SPEECH THERAPY
____Evaluate & Treat
____Motor Speech Ther. Ex
____Dysphagia
____Voice Ex/Breath Support Training
____Cognitive - Linguistic Training
____Aural Rehab. Training
____Other _____

COMPREHENSIVE PROGRAMS
____Physical Reconditioning / Work Simulation
____Physical Impairment Testing
____Onsite Work Rehabilitation

I certify that therapy is required and medically necessary.

02/10/2005

_____ A. Neurologist, M.D.

Billing Statement - Thursday, February 10, 2005

Provider: A. Neurologist, M.D.
Patient: Jane Doe, Chart 3642
123 Main Street
West Des Moines, IA 50265

Diagnoses

1. 332 Parkinson's Disease
2. 332.0 Paralysis Agitans

Treatments

1. 85302 Clotting Inhibitors Or Anticoagulants; Protein C, Antigen
Related Diagnoses: Parkinson's disease
Modifiers:
Units:
2. 85305 Clotting Inhibitors Or Anticoagulants; Protein S, Total
Related Diagnoses: Parkinson's disease
Modifiers:
Units:

Referring Physician:
Date Last Seen: 02/10/2005

Medical Clinic

1025 Ashworth Road, Suite 222
West Des Moines IA 50265

PRESCRIBER: A. Neurologist, M.D.
TELEPHONE: (515)327-8850
DEA: 123456789

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PATIENT: Jane Doe
ADDRESS: 123 Main Street
West Des Moines, IA 50265

TELEPHONE: 515-327-8854
DOB: 04/09/1973
DATE: 02/10/2005

Rx levodopa, 100 mg capsule

Disp: 30
Sig: One PO QD
Refills: 2

__ DISPENSE AS WRITTEN
X GENERIC SUBSTITUTION PERMITTED

_____
SIGNATURE OF PRESCRIBER