Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:**All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:**For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments:**We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: "*Comments***".

Indecipherable notes/date:**Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:**Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:**If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **XXXX** on **MM/DD/YYYY**, the injuries and clinical condition of XXXXX as a result of injury, treatments rendered for the complaints and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*

Injury Report:

DESCRIPTION	DETAILS
Prior injury details	*No prior history of musculoskeletal injuries*
Date of injury	09/21/YYYY
Description of injury	Patient was driving for uber and reports going through a stop light where the other car failed to yield, hitting the front part of her car, airbags deployed. Speed was between 40 and 45 mph per patient.
Injuries as a result of accident	Muscle strain Muscle spasm Lumbar region intervertebral disc disorders with radiculopathy Cervical disc disorder at C5-C6 level with radiculopathy Sprain of ligaments of lumbar/cervical/thoracic spine Bilateral sciatica Headache syndrome Muscle spasm Herniated nucleus pulposus of the cervical spine. Discogenic pain
Treatments rendered	Pain medication 12/19/YYYY: Received interlaminar injection to lumbar/sacral 01/09/YYYY: Received interlaminar epidural or subarachnoid, cervical or thoracic with imaging guidance 10/16/YYYY-04/02/YYYY: Chiropractic therapy for neck and back pain 06/13/YYYY: Underwent L4-S1 discogram 07/11/YYYY: Underwent cervical discogram at C5-6 and C6-7
Condition of the patient as per the last available record	As on 06/18/YYYY, she complained of neck and low back pain – She had restricted range of motion in her lumbar region – Recommended to proceed with TLIF and cervical disc arthroplasty at C5-6 – Follow-up visit for preoperative visit.

Patient History

Past Medical History: None listed (PDF REF: 5)

Surgical History: None listed (PDF REF: 5)

Family History: There is no family history of spinal issues (PDF REF: 5)

Social History: She is married, works production at Alpha Foods Company, and lives in College Station. She smokes 5 cigarettes a day, and drinks alcoholic beverage a day (PDF REF: 5)

Allergy: None (PDF REF: 5)

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
09/22/YYYY	XY Health	**Emergency Department (ED) Visit following Motor Vehicle Accident (MVA):**	1851-1856

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	XXX, RN XXX, M.D. XXX, RN	**@ 1308 hours: Nursing Note:** Patient was the passenger during a multiple car collision occurring by being hit by a semi on September 22, YYYY at 0200 hours. Air bag deployed. Vehicle was struck from the right side. Patient complains of pain in the head, face and left eye accompanied by blurred vision, nausea. Head injury: Yes. Loss of consciousness: Yes, don't know the amount of time. Visual acuity Right: 20/40 Left: 20/30 Both: 20/25 **Provider Note:** Patient is a X years old woman who presents today complaining of left eye pain, swelling, headache and mild nausea. Was in a serious MVA at about 02:00 when her boyfriend's car was totaled by a semi. Airbags deployed. Feels she was "in and out of it" at the scene but did climb out of the car by herself. Boyfriend sustained rib injuries. Refused ambulance or transfer to ED. Recalls being upset about them wanting to put a cervical collar on, saying "My neck is fine, it is my eye" Now thinks she was probably just in shock and that's why she didn't go. Denies any neck pain or paresthesias. Earlier today left eye was almost completely swollen shut. Has not eaten since accident. Realizes that the cut on her eyebrow keeps bleeding and she can see "meat" in the cut. Thought it might need to be stitched. Eye feels sore and irritated and she worries she might have glass in it from the windshield. **Examination:** **General:** Alert, oriented woman, good historian but seems a little drowsy. **HEENT:** Moderate edema and bruising around eye, particularly at medial upper orbital rim EOMI but painful. No nystagmus. No hyphema. Exquisitely tender at eye rim. Pulls my hand away and tears up. Eye was anesthetized and no foreign body could be located but I was not satisfied with my ability to see the whole eye due to her upper lid and orbital pain. Fluorescein stain did not reveal any obvious abrasion but again, exam compromised by pain and swelling. At this stage, I began to feel she needed more Ophthalmologist assessment and probably CT to evaluate for orbital fracture. Therefore, I did not test visual fields. Patient was given Ibuprofen for pain and sent in cab to Mertier ED, who was advised of her case. **Assessment and plan:** Eye contusion and foreign body sensation, probable moderate concussion. To Mentor ED for further post-trauma assessment. **@ 1406 hours: ED administrations:** Administered Ibuprofen 800 mg per orders. Patient tolerated procedure well. **@ 1421 hours: Patient transfer note:** Sending patient by cab. Patient was in a MVA last night. Swelling and laceration over eye. Worried about orbital fracture and eye exam needed. Probable concussion. Given some pain medications before leaving.	