Dr. Yan's EPIC Smart Phrases Contents:

- **22MODIFIERSTATEMENTYAN**

Statement of Justification of 22 Modifier:

This procedure was considerably more difficult than the standard procedure. The procedure was more difficult for several reasons:

- Serious Medical Comorbidities: The patient's comorbidities include ***, which increase both the preoperative and postoperative complexity of the procedure in order to avoid serious medical complications.
- Increased Time: Due to the complexity of the pathology, approximately twice the routine length-of-time was required in order to perform the procedure.
- Increased dissection was required in order to obtain adequate exposure due to the configuration and location of the pathoanatomy.
- Increased intraoperative complexity and expertise was required in order to perform the procedure due to the complexity of the pathoanatomy.
- This procedure should significantly benefit the patient by improving both stability, range of motion and pain relief for the patient.
- A *** procedure was done in this case so that ***

Given the above factors, I estimate that the case was 50% more difficult than the standard procedure.

- **ABNMLLABSNOTEYAN**

Please note your abnormal labs. Touch base with your primary care doctor to review.

ASISTYAN

*** was asked by Dr. Yan to assist with surgery. The assistant helped position and prep the patient. The assistant retracted soft tissue for operative exposure. The assistant suctioned fluids and provided traction for dissection. The assistant helped Dr. Yan identify and protect vital structures. The procedure was medically necessary for an assistant because the physician needed the operative exposure and assistance that provided. This allowed a safe and efficient procedure. It was also important that I help with hemostatic control and reduce the bleeding risk. The assistance provided reduced operative time which meant less general anesthetic for the patient and a safer procedure.

@ME@ @TD@, @NOW@

- **ATTESTNOTEYAN**

I have personally seen and examined this patient. I reviewed all the related lab examination and imaging studies. I agree with the documentation and plan.

- **AVSNOTEYAN**

Thank you for taking the time to come to our office today. I hope you had a chance to have your condition diagnosed and explained.

Please visit my website at 52BonesMD.com. Under the "Patient Education Resource" tab, you will find general and specific information on foot and ankle conditions and procedures. This can provide you with further insight into your condition.

Under the "Patient Education Resources" tab, there is also links for patient instructions. Here, you will find information on:

- Caring for your splint & cast
- Steroid and/or other injections
- Crutch and cane instructions
- Instructions for caring for diabetic feet
- Surgical after care instructions
- Smoking cessation/Quit smoking

Here, you will also find YouTube links to surgical videos of a variety of cases of mine.

Feel free to contact my office with any questions:

For Appointments: 412-232-9080 (phone)
For General Questions: *** (phone)

- **BONESTIMNOTEYAN**

The patient has demonstrated delayed union vs nonunion with relevant clinical signs and symptoms as well as imaging findings.

With the patient history of prolonged process of healing of the bone(s) and risk factors of the patient previous and current history. The patient will be beneficial for a bone stimulator to promote bone healing and avoid potential further surgical intervention.

The patient was fit for a bone stimulator device and instructed on the usage of this device.

All questions were answered.

- **BOOTINSTRUCTIONYAN**

Nonop management discussed in detail with patient.

CAM boot protection for the foot ankle.

Advised walking imbalance may incur with boot wearing and if not tolerable with boot wearing or pressure over the foot ankle then need to contact us without delay and will change modalities accordingly.

Will follow up one month and wean off boot likely at that point.

If no improvement at that time then PT or advanced imaging like MRI or CT will be needed.

- **BRIEFOPNOTEYAN**

BRIEF OP NOTE:

@TD@
@NOW@

PRE-OP DIAGNOSIS: @ORPREDX@

POST-OP DIAGNOSIS: ***

SURGEON: @ORSURROLE@

ASSISTANT: *

ANESTHESIA: @ORANEST@

PROCEDURE: @ORPROCALL@

ESTIMATED BLOOD LOSS: {misc; ebl:31738}

TOURNIQUET TIME: ***

DRAINS: ***

TOTAL IV FLUIDS: {MEDS; IV FLUIDS OR:22148}

SPECIMENS:
@ORSPECIMEN@

IMPLANTS:
@ORIMPLANT3@

COMPLICATIONS: ***

CONDITION: {stable/unstable:60080}

- **BULKYJONESSPLINTYAN**

A short leg Bulky Jones Splint was placed in the clinic with sufficient soft cushion protection of the foot and ankle in neutral *** degree position of ankle foot with posterior and U shape side support of Plaster of Paris.

Patient tolerated procedure well and comfortable in the splint.

Patient is instructed for elevation, ice under the popliteal region with skin protection 20 mins every 2 hrs for the following 3 to 5 days.

Patient is instructed to keep dry and clean and do not take the splint off unless increasing pain, increasing pressure, tightness, numbness, discoloration of toes or any other concerns. Patient is instructed to call our office for any discomfort or concerns. Patient is instructed to go to ER without delay for any urgent issues and or concerns.

- **CASTSLCASTINGNOTE**

A short leg cast was placed in the clinic with sufficient soft cushion protection of the foot and ankle in neutral *** degree position of ankle foot with fiberglass casting material.

Patient tolerated procedure well and comfortable in the cast.

Patient is instructed for elevation, ice under the popliteal region with skin protection 20 mins every 2 hrs as needed.

Patient is instructed to keep dry and clean and do not attempt to take the cast off. Patient need to watch for any increasing pain, increasing pressure, tightness, numbness, discoloration of toes or any other concerns. Patient is instructed to call our office for any discomfort or concerns. Patient is instructed to go to ER without delay for any urgent issues and or concerns.

- **COAGDCSUMMARYNOTEYAN**

The patient {DOES/NOT:5000306} have a personal or family history of DVT/PE. They will likely be on {BLANK - MULTIPLE CHOICE:13251::"162mg Aspirin","Coumadin","Plavix and Aspirin", "Lovenox and Aspirin"} following surgery for DVT prophylaxis. @CAPHE@ {DOES/NOT:5000306} have adequate help at home following the surgery and likely {GYN WILL/WILL NOT:12071} have to be transitioned to a care facility upon discharge.

- **CTYAN**

CT is ordered for further evaluation of the area of concern.

Patient is notified and understand that approval of CT may take time pending insurance approval and we will keep track of the progress however the timing is not dictated by our office.

We will monitor and follow up with the result of CT and will notify the patient on any urgent issues by our clinical staff for the conditions which may require immediate attention or changing of the current treatment course.

The patient is otherwise notified to follow up within one week with me in the clinic soon as they finished MRI exam so we can explain the often complex details of the findings face to face in clinic with our clinical correlation for definitive care plan.

The patient understands and will follow up.

- **DCSUMMARYYAN**

DC SUMMARY INPATIENT

Orthopedic Discharge Note

Patient Name: @NAME@
Medical Record Number: @MRN@
Date of Birth: @DOB@

Admit Date/Time: @ADMITDT@
Discharge Date: @DISCHDTTM@

Service: Orthopedics
Attending MD: Alan Yan, MD

Admitting Diagnosis: @ADMITDX@
Discharge Diagnosis: ***

Operations/Procedures: ***

Consults: Medicine, PT, Endocrinology
Complications: ***

Patient Active Hospital Problem List: @MEDICALHX@

Allergies : @ALG@

@PSH@

@PMH@

Brief History : @NAME@ was followed in the orthopedic clinic by Dr. Pittman for chronic *** hip pain. @CAPHE@ was diagnosed with osteoarthritis and treatment options were discussed. After trying various treatment modalities, the patient decided to proceed with total joint replacement.

Hospital Course: Patient was admitted on @ADMITDATE@ and on that date underwent *** by Dr. Yan. There were no complications. The patient was admitted to the Orthopaedic Service and followed by the medicine service for multiple co-morbidities. The patient was started on pharmaceutical and mechanical DVT prophylaxis as well as prophylactic antibiotic therapy. The patient progressed well and was discharged to {Discharge Destination:18313} in stable condition.

Discharge Medications: @PTMEDDISCHARGE@

DVT Prophylaxis: ***

Discharge Disposition: {Discharge Destination:18313}

Follow Up: The patient will follow up with *** in 2 weeks.
At follow up, *** xrays are needed.

This note completed by: Alan Yan, MD, Pager *** *** ****

- **DENTALPLANLIFELONGYAN**

@CAPHE@ was informed of the need for life-long prophylactic antibiotics prior to any dental work and will call and get the antibiotic prescription from our office.

- **DENTALRECOMMENDATIONYAN**

Dental Antibiotic Recommendations:

DO NOT UNDERGO ANY DENTAL PROCEDURES FOR 3 MONTHS BEFORE YOUR JOINT REPLACEMENT OR 6 MONTHS AFTER

You have undergone a total joint replacement and there are instances when infection in one part of your body may cause bacteria to circulate in your blood, possible resulting in infection at the site of your implant. Therefore, it is essential that your personal physician and dentist be informed of your surgery.

It is important to maintain good dental hygiene and visit your dentist for routine care, whether you are experiencing a dental problem or not. Prompt treatment of infections, particularly involving the skin and urinary tract are also important.

It is recommended by the American Dental Association and the American Academy of Orthopaedic Surgeons that some patients be considered to receive antibiotic treatment in preparation for certain dental procedures as outlined below. ***This antibiotic precaution should be performed for the first 2 years after your surgery.***

You will need antibiotics for the following procedures:

- ***Routine Dental CLEANINGS***
- Dental extractions
- Periodontal procedures including surgeries, subgingival placement of antibiotic fibers/strips, scaling, root planting
- Dental implant placement and reimplantation of avulsed teeth
- Endodontic instrumentation or surgery only beyond the apex
- Initial placement of orthodontic bands, but not brackets
- intraligamentary local anesthetic injections
- Prophylactic cleaning of teeth or implants where bleeding is anticipated

Suggested antibiotics:
Not allergic to penicillin: cephalexin or amoxicillin 2 grams orally 1 hour prior to procedure

Allergic to penicillin:
Clindamycin 600mg 1 hour prior to procedure

PLEASE CALL YOUR DENTIST PRIOR TO DENTAL CLEANINGS/PROCEDURES TO RECEIVE THE PRESCRIPTIONS FOR THE MEDICATIONS

- **DISCUSSIONCLINCPATIENTYAN**

Discussed in detail with patient and/or family on the clinical history, current presentation, exam findings and imaging findings in the language that patient and/or family can clearly understand.

- **DOPPLERRULEOUTDVT**

Complain of calf pain and swelling with current WB restriction:

Will have Doppler venous of the involved lower extremity today STAT to rule out DVT.

If positive for DVT, the patient is instructed to go to ER to be evaluated. The patient will start anticoagulation per ER recommendation and protocol and proper PCP follow up thereafter.

The patient and/or family understand and will follow instructions.

- **DVTRISKCHECKLISTYAN**

Venous Thromboembolism Prophylaxis Risk Assessment Checklist

1. Chronic Anticoagulation	Date	Yes/No
Atrial fibrillation		{Yes/No:1}
Heart valve replacement: {:19601}		{Yes/No:1}
Other (specify): ***		{Yes/No:1}

2. Anticoagulation Contraindicated	Date	Yes/No
Thrombocytopenia (platelets < 50,000/mm3) Platelet count = ***		{Yes/No:1}
Coagulopathy due to liver disease (INR > 1.5) INR = ***		{Yes/No:1}
Recent gastrointestinal bleed (within 1 month)		{Yes/No:1}
Recent genitourinary bleed (within 1 month)		{Yes/No:1}

Von Willebrand's hemophilia or other inherited bleeding disorder		{Yes/No:1}
Uncontrolled hypertension (SBP > 200 or DBP > 120)		{Yes/No:1}
Recent surgery/procedure		
TURP (within 6 weeks)	***	{Yes/No:1}
ERCP, biliary or pancreatic stents (within 72 hrs)	***	{Yes/No:1}
Craniotomy (within 2 weeks)	***	{Yes/No:1}
Intraocular surgery (within 2 weeks)	***	{Yes/No:1}
Epidural catheter insertion (within 24 hours)	***	{Yes/No:1}
Epidural catheter removal (within 12 hours)	***	
Recent cerebral or intracranial hemorrhage or aneurysm (within 1 yr)	***	{Yes/No:1}

3. Hypercoagulable States	Date	Yes/No
Personal history of venous thromboembolism		{Yes/No:1}
Deep vein thrombosis (leg blood clot)	***	
Pulmonary embolus (lung blood clot)	***	
Primary family member with history of venous thromboembolism		{Yes/No:1}
Deep vein thrombosis (leg blood clot)		{Yes/No:1}
Specify family member(s): ***		
Deep vein thrombosis (leg blood clot)		{Yes/No:1}
Specify family member(s): ***		
Specific known factors		
Factor V Leiden		{Yes/No:1}
Anti-phospholipid syndrome (lupus anti/ant-cardiolipin/glycoprotein Beta 2 6Pi antibodies)		{Yes/No:1}
Anti-thrombin III deficiency		{Yes/No:1}
Prothrombin mutations		{Yes/No:1}
Protein C deficiency		{Yes/No:1}
Protein S deficiency		{Yes/No:1}
Active cancer		{Yes/No:1}

4. Current Use of Antiplatelet Medications		Yes/No

clopidogrel (Plavix) Reason: {:19602}		{Yes/No:1}
ticlopidine (Ticlid) Reason: ***		{Yes/No:1}
dipyridimole + aspirin (Aggrenox) Reason: ***		{Yes/No:1}
aspirin (ASA) Reason/dose: ***		{Yes/No:1}
pasugrel, ticagrelor		{Yes/No:1}

5. Venous Thromboembolism Risk Factors		Yes/No
Morbid obesity (BMI > 40) and restricted weight bearing @BMIP@ and {:19603}		{Yes/No:1}
Hormone replacement therapy (HRT) or OCP		{Yes/No:1}
Polycythemia vera or essential thrombocytosis, Hemoglobin = ***		{Yes/No:1}
Bilateral joint replacements		{Yes/No:1}
ICU admission/acute respiratory failure during current hospital admission		{Yes/No:1}
Inflammatory bowel disease		{Yes/No:1}
Nephrotic syndrome		{Yes/No:1}
Rheumatoid/collagen vascular disorder, specify disorder: ***		{Yes/No:1}
Pulmonary co-morbidity risk factors		
Chronic obstructive pulmonary disease (COPD)		{Yes/No:1}
Congestive heart failure (CHF)		{Yes/No:1}
Home oxygen therapy		{Yes/No:1}
Other (specify): ***		{Yes/No:1}

6. No Venous Thromboembolism Risk Factors

- **DVTYAN**

The patient has increased risks of DVT and/or PE related to the weight bearing restrictions and impaired mobility due to the injury. Risks and benefits of anti-coagulation DVT prophylaxis are discussed in detail with patient and/or family. All questions answered. Instructed to avoid long hours of long-distance driving or air flights during the period of limited weight bearing. If there

will be any signs and symptoms like chest pain, shortness of breath or persistent leg swelling, the patient will need to go to ER without delay.

For the risk factors the patient has, the patient is advised to be on Aspirin daily or other anticoag medication or leg sequential squeeze or being active and isometric squeezing of muscle exercise as long as they will remain on the current mobility status and also following surgery for DVT prophylaxis.

The patient is also fully informed after discussion for any other risk factors for blood clots due to the injury or surgery including and not limited to the factors like family, personal history of DVT and/or PE, medications especially birth control pills in females or other medications with risks, obesity, and cancer history. The patient is advised to contact his or her primary care physician to stop any high-risk medications which is non-essential for his or her current health status until he or she can resume full weight bearing and much reduced risks for blood clots during recovery.

The patient and/or family fully understand the discussion and will follow up our recommendation. Additional written information and Informed consent form for blood clots are available for patient and/or family to sign.

- **EDUCATIONTOTALJOINTSYAN**

PATIENT TOTAL JOINT EDUCATION NOTE

Blood thinning medications: Continue on {BLANK - MULTIPLE CHOICE:13251::"162 mg Aspirin","Plavix and Aspirin","Coumadin"} for {NUMBER:8768} more weeks.

Incision: There are several layers of dissolvable stitch under the skin. Medical-grade super-glue vs non-dissolvable stitches was used on the skin surface. The glue will flake off over the next few weeks and the stitches will dissolve over the next month or two. If non-dissolvable stitches used, they will be typically removed in between 2 to 4 weeks. As long as the incision is intact and dry (no drainage or oozing for over 3 days), you may get it wet in the shower. No soaking or scrubbing until the incision is completely healed. This typically occurs 4-6 weeks following surgery.

Exercise: Work on the exercises given by your therapist. Long, slow stretching several times throughout the day is important. Prop your leg up on a stool or chair and let it hang to work on extension. The sooner you can get your range of motion (ROM) back, the better you will feel and the better the long-term result. Increase activities slowly and gradually, walking is one of the best therapies. The sooner you can transition to out-patient PT, the better.

Walker/cane: Wean off of the walker to the cane as you are able, and then off of the cane over the next 2 to 4 weeks. The primary goal is safety: it is better to have the walker/cane with you and not need it then to be stuck somewhere without it. Work towards walking with a normal gait, without any limp. This may take a few months to achieve.

Driving: You must be off of all narcotic pain medications before you can consider driving. Then, again, it is a matter of safety. If you can get in and out of the car safely, try a test drive around your neighborhood. Take someone with you on this first outing and practice using the brakes for sudden stops without hesitation. If this goes well, you can gradually increase the length of your trips.

Dental work: We recommend NO dental work for three months following a total joint replacement. It is recommended that antibiotics be take prior to ANY dental work in anyone with a total joint replacement. Call us and we will give you a prescription.

Follow up care: in general, we like to see total joint replacement patients at 2, 6 and 12 weeks after surgery and then annually after that. Xray's will be taken at your 6 week appointment and at your annual appointment.

This is a big surgery!
At 3 months out from a total joint replacement we consider you to be about 70-80% healed. Take it slow, be patient, and be smart. Let your pain be your guide.

Please call us if you have any additional questions or concerns.

- **GENCONSENTYAN**

Risks, Benefits and Alternatives to proposed procedures were discussed in detail with patient and/or family by me. Risks of bleeding, infection and nerve damage were specifically discussed. Risks of nonunion, malunion and hardware failure were discussed as were possible need for removal of hardware in the future. The possibility of chronic pain and permanent loss of range of motion were also discussed. All questions were answered in detail. Patient elects to proceed with proposed operative procedures. Signed informed consent was obtained and placed on chart.

- **GENDCSTATEMENTYAN**

Upon DC, the patient was medically stable, and vitals were within normal parameters. His pain was well controlled on oral medications. There were no postoperative surgical incision complications. All questions were answered, and the patient was comfortable with postoperative home care.

- **GENOPNOTEYAN**

Orthopaedic Operative Note

@NAME@
@MRN@

Date of Surgery: ***
Procedure(s) Performed: ***

Pre-operative Diagnosis: ***
Post-operative Diagnosis: ***Same

Attending Surgeon: Dr. Alan Yan, MD
Assistant(s): ***

FIRST ASSISTANT: {ORTHO ASSIST:14225} was required as a first assistant to assist with positioning of the patient, prepping and draping of the patient, positioning of the extremity throughout the procedure allowing for retraction and implantation of the components. The assistant also assisted with closure of the wound, placement of the dressings and transferring the patient to the recovery room in addition to entering postoperative orders.

Complications: ***Nonapparent
Estimated Blood Loss: ***

Implants: @ORIMPLANTWACT@

Indications for Procedure: @M@ @NAME@ is a @AGE@ @SEX@ who ***. History, examination, and imaging were consistent with ***. @M@ @NAME@ was determined to be a candidate for ***. A detailed discussion pertaining to the operative plan and the potential risks and benefits of the procedure was had with @M@ @NAME@ and the family. Following this discussion, their informed consent for the procedure was obtained.

Description of Procedure: The patient was greeted in the ***pre-operative holding area, the patient's identity was verified, consent was ***obtained, and the operative site on the *** was marked. The patient was then brought back to the operating room, where ***anesthesia was administered, and the patient was placed *** on the ***table. All bony prominences were well-padded. The *** was then prepped and draped in the standard sterile fashion using ***. Once we had all the drapes in place, all operating room personnel took a pause and a time out for surgical safety was performed in a standardized manner.

Antibiotic Ancef/Vancomycin*** was given via IV within 1/2 hour prior to skin incision.

We then turned our attention to exposure. ***

***

We then turned our attention to closure. ***the wound was thoroughly irrigated with normal saline. ***we ensured adequate hemostasis with Bovie electrocautery. ***We then proceeded to close the deep fascial layers ***and deep subcutaneous layers with ***0 Vicryl in an ***interrupted figure of eight fashion. We then used ***-0 Vicryl in an inverted fashion to reapproximate the deep dermal layers. ***were used for skin closure.

A dressing consisting of *** was applied. ***

***All needle, sponge, and instrument counts were correct at the conclusion of the case. ***The patient was awakened from anesthesia and brought to ***the recovery room having tolerated the procedure well without any apparent complications.

Plan:

Weight bearing status: ***
PT/OT consult:
Drain: ***None
Foley: ***remove on POD1 or when can safely get to commode.
DVT prophylaxis: ***
Antibiotic: ***24 hours of ***Ancef
Dressing: ***change post-operative day *** with ***.
Closure: ***removal at clinic visit in 10-14 days.
Return to OR: ***None planned
F/U: In ***weeks with *** with ***x-rays prior to appointment

Alan Y. Yan, MD

- **GENPOSTOPFOLLOWUPNOTEYAN**

DATE OF SERVICE: @TD@

CHIEF COMPLAINT:
@NAME@ is a @AGE@ old @SEX@ present for *** {Blank multiple:19196::"DAYs", "WEEKs", "MONTHs", "YEARs"} follow up of {{Blank multiple:19196::"RIGHT", "LEFT", "BILATERAL"} ***. Patient is doing well. No complications. No sign of infection. Denies fever or chills. Denies numbness and tinging. Patient is taking *** for pain. Patient {{Blank multiple:19196::"HAS", "HAS NOT"} been attending physical therapy. Patient has been {Blank multiple:19196::"NWB", "PWB", "TTWB", "WBAT"}. Patient is here with ***.

OBJECTIVE:
@VITALS@
On examination, the patient is a healthy and pleasant {Blank multiple:19196::"LADY", "GENTLEMAN"}, {Blank multiple:19196::"MILD", "MODERATE", "SEVERE"} distress.
HEENT: Examination normal.

Extremities: Incision healed. No signs for infection. Nerve intact distally.

X-RAYS: ***

IMPRESSION AND PLAN:
@NAME@ is a @AGE@ old @SEX@ here for *** {Blank multiple:19196::"DAYs", "WEEKs", "MONTHs", "YEARs"} follow up of {{Blank multiple:19196::"RIGHT", "LEFT", "BILATERAL"} ***. Sutures removed. Steri-Strip application done. Patient is indicated to is to be {Blank multiple:19196::"NWB", "PWB", "TTWB", "WBAT"} and return in *** {Blank multiple:19196::"with", "without"} X-Rays ***.

The patient is happy with this plan and all questions are answered today.

@ME@

- **GRAVITYCLAMPYAN**

If put to gravity leave on gravity x 3 hours then back to suction. If clamped then leave clamped x 3 hours then to gravity x 3 hours then back to suction.

- **INJECTIONFOOTANKLEYAN**

We discussed treatment options including physical therapy and corticosteroid injection into foot ankle. Risks and benefits were discussed with the patient. The patient would like to proceed with foot and/or ankle injection today.

PROCEDURE:
The {R/L:11001476} foot vs ankle was prepped in a sterile fashion. The proper side for injection was verbally confirmed prior to injection. A 21-gauge needle was steadily introduced into the {left/right/bilateral:22167} ankle joint /subtalar joint /midfoot joint(s) of ***/ forefoot joint(s) of *** /plantar fascia. 1ml of 1% Lidocaine without epi, 1ml of 0.5% Marcaine without epi, and 1ml of 40mg/ml Depomedrol was injected. Patient tolerated the procedure well. There were no complications. The area was cleaned, and a band-aid was placed over the injection site.

The patient will follow up as needed if @HIS@ foot ankle pain does not improve.

The patient was instructed to wait for 15 mins before leaving the clinic with no discomfort or uncontrolled pain.

Medications used in your injection today included:

- Marcaine (a long anesthetic) or
- Lidocaine (a shorter acting anesthetic)
- Depo-Medrol (a long acting form of cortisone)

The injection you have just received normally goes without incident. The injection area may be sore, throbbing or slightly swollen for one to two days. It is very important that you rest the area of the injection for 24 to 48 hours after the injection. Unless your doctor tells you otherwise, applying ice to the area (10 to 15 minutes every one to two hours) for the first day or two will help decrease the pain. In addition, you may benefit from taking acetaminophen (Tylenol™) to help reduce the pain.

Usually, a numbing medication is given with the injection, which can last for five to 12 hours. The actual Cortisone may take up to two to five days to take effect. If you develop any abnormal symptoms, such as itching, swelling, redness, rash, or shortness of breath, please call our office. Normally, these are temporary symptoms which resolve within a day, but we are more than happy to answer any questions you may have.

Diabetic Warning
If you are diabetic and using insulin, this injection may elevate your blood sugar for the next one to five days. Please monitor your sugars closely and if they fail to return to acceptable levels, please contact your primary care physician.

The doctor would like you to observe the area of the injection for redness, swelling, or increased heat. If any or all of the reactions occur, please call our office as soon as possible. This reaction may indicate the first signs of infection. This is a very rare event, but best if caught early.

The duration of pain relief from these injections varies widely between patients. Some report two or more months of relief while other patients report only a few weeks of relief.

Thank you and please follow your doctor's directions. Call us with any questions or problems.

- **INJKNEECORTISONEYAN**

We discussed the treatment options for the management of knee osteoarthritis. This includes activity modifications, non-steroidal anti-inflammatory, glucosamine, chondroitin sulfate, fish oil, bracing options, physical therapy, and injections - both corticosteroid and Visco supplementation. A handout outlining non-operative treatment modalities was provided along with a list of informational websites.

The patient would like to proceed with corticosteroid injection today. We discussed the risks and benefits regarding the injection.

PROCEDURE:
The {R/L:15932} knee was prepped in a sterile fashion. The proper side for injection was verbally confirmed prior to injection. Using sterile technique, 5 cc of Kenalog and 7 cc of 0.5% Marcaine were injected using an inferolateral portal approach. Patient tolerated the procedure well. There were no complications. The area was cleaned, and a band-aid was placed over the injection site.

The patient will follow up as needed if knee pain returns.

Medications used in your injection today included:

- Marcaine (a long anesthetic) or
- Lidocaine (a shorter acting anesthetic)
- Kenalog (a long-acting form of cortisone)

The injection you have just received normally goes without incident. The injection area may be sore, throbbing or slightly swollen for one to two days. It is very important that you rest the area of the injection for 24 to 48 hours after the injection. Unless your doctor tells you otherwise, applying ice to the area (10 to 15 minutes every one to two hours) for the first day or two will help decrease the pain. In addition, you may benefit from taking acetaminophen (Tylenol™) to help reduce the pain.

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The doctor would like you to observe the area of the injection for redness, swelling, or increased heat. If any or all of the reactions occur, please call our office as soon as possible. This reaction may indicate the first signs of infection. This is a very rare event, but best if caught early.

The duration of pain relief from these injections varies widely between patients. Some report two or more months of relief while other patients report only a few weeks of relief.

Thank you and please follow your doctor's directions. Call us with any questions or problems.

- **KNEESCOOTERMEDNECESSITYYAN**

Letter of Medical Necessity for Knee Scooter

Patient: @NAME@
Diagnosis: @DX@
Code: Crutch substitute, Code E0118
Length of need: 3-6 months

- _____Patient had ***surgery/fracture/tendon rupture*** requiring ABSOLUTE NON-WEIGHTBEARING to maximize chance for optimal healing and recovery. The patient is unable to utilize crutches effectively or is unable to perform tasks of daily living with crutches but can do so on a roll-about.

- _____Patient has an ***ulcer infection*** which requires ABSOLUTE NON-WEIGHTBEARING to maximize chance for optimal healing and recovery. The patient is unable to utilize crutches effectively or is unable to perform tasks of daily living with crutches but can do so on a roll-about.

- _____Patient has a ***neuromuscular condition*** which makes him/her unable to bear weight effectively or safely on one foot. The roll-about will greatly increase this person's ability to function independently.

I hereby certify that this device is medically necessary.

Alan Y. Yan, MD
Orthopedic Surgery

- **LETRAUMANEWYAN**

Orthopaedic Surgery Trauma Office Note

@NAME@
@MRN@
@DOB@

Date of Visit: @TODAY@
Date of Injury: ***
***Date of Surgery: ***

History of Present Illness: @M@ @NAMEBYAGE@ is a @AGE@ @SEX@ who presents to see us today as a new patient visit for ***. ***

Review of Systems: Is notable for ***. They deny ***.

@PROB@

@MED@

@ALLERGY@

Physical Examination:
@VITALSM@

Gen: ***Awake, alert, appropriate in no acute distress
HEENT: ***Normocephalic, atraumatic
Psych: ***Normal mood and affect.
CV:***Regular rate and rhythm, checked peripherally
Pulm: ***No increased work of breathing.

***Lower Extremity Exam:
Notable for ***

Skin- ***intact, ***swelling, ***erythema, ***crepitus
Compartments- ***Soft, no pain with passive ROM of the digits.

***DP pulse ***plus, ***PT pulse
Light touch sensation intact in ***SP/DP/T/S/S distribution.
Ankle dorsiflexion/plantarflexion and EHL intact.

Hip ROM- ***
Knee ROM- ***
Ankle ROM- ***

Imaging:
***Views of the *** demonstrate ***

MRI/CT scan demonstrates

Labs:
Last CBC/no differential result
@LABBRIEF(wbc,rbc,hgb,hct,mcv,mch,mchc,plts,rdw)@
@LABBRIEF(bun:1,sodium:1,k:1,chloride:1,co2:1,glucose:1,creatinine:1,gfr:1,ca:1,aniongap:1)
@
@BLOODTYPE@
@LASTLABX(inr)@

***CRP ***
***ESR ***

Assessment and Plan: @PTTITLE@ @NAME@ is a *** pleasant @AGE@@SEX@ who presents with ***. ***

Alan Yan, MD

- **LETRAUMAPOSTOPFUYAN**

Orthopaedic Surgery Trauma Office Follow-up Note

@NAME@
@MRN@
@DOB@

Date of Visit: @TODAY@
Date of Injury: ***
***Date of Surgery: *** on *** with ***.

History of Present Illness: @M@ @NAMEBYAGE@ is a @AGE@ @SEX@ who presents to see us in follow-up for ***. They are now *** status post ***. They are doing ***well. They have been working on ***.

Review of Systems: Is notable for ***. They deny ***.

@PROB@

@MED@

@ALLERGY@

Physical Examination:
@VITALSM@

Gen: ***Awake, alert, appropriate in no acute distress
HEENT: ***Normocephalic, atraumatic
Psych: ***Normal mood and affect.
CV:***Regular rate and rhythm, checked peripherally
Pulm: ***No increased work of breathing.

***Lower Extremity Exam:
Notable for ***

Skin-
***Incision is *** without any induration, erythema, or drainage.
Compartments- ***Soft, no pain with passive ROM of the digits.

***DP pulse ***plus, ***PT pulse
Light touch sensation intact in ***SP/DP/T/S/S distr
Ankle dorsiflexion/plantarflexion and EHL intact.

***Hip ROM- ***
Knee ROM- ***
Ankle ROM- ***

Imaging:
***Views of the *** demonstrate ***

Labs: ***

Assessment and Plan: @PTTITLE@ @NAME@ is a *** pleasant @AGE@@SEX@ who presents in follow-up for ***. They are doing ***well and ***. ***

- **LETTERMEDICALNECESSITYYAN**

LETTER OF MEDICAL NECESSITY

Date

Medical Director
Health Plan
Address
Fax:

Regarding:

Patient Name
Date of Birth
Insurance ID number

Greetings:

I am writing to request [insert service or equipment request] for my patient [name of patient] who has the following diagnoses relevant to this request: [list diagnoses]

This request is medically necessary for the following reasons: [choose one or more of the reasons]

It will, or is reasonably expected to, prevent the onset of an illness, condition, or disability. [Please provide details]

It will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, injury, or disability. [Please provide details]

It will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those

functional capacities that are appropriate for individuals of the same age. [Please provide details.]

Please let me know if you require additional information from my records.

Yours truly,

Alan Y. Yan, MD

- **LYPHEDEMANOTEYAN**

Patient Name: DOB:

DIAGNOSIS ASSESSMENT:
□ Secondary Lymphedema, not elsewhere classified [I89.0]
□ Both I89.0 and Q82.0 combination

SWELLING SEVERITY:
□Stage II: Mild skin conditions present: hyperpigmentation, hyperkeratosis, etc.
□ Stage III: Lymphostatic elephantiasis where pitting can be absent, and warty overgrowths have developed.

SYMPTOMS DESPITE CONSERVATIVE THERAPY:
□ Hyperpigmentation
□ Hyperkeratosis
□ Fibrosis
□ Lymphorrhea(weeping)
□ papillomatosis
□ Proximal trunk (hip, abdomen, back or buttock) swelling
□ cellulitis /infections
□ ulcerations

CONSERVATIVE TREATMENT:
Patient has tried conservative treatments >4 weeks, without significant improvement
□ compression bandaging
□ at least 20-30mm hg compression garments/Velcro wraps
□ exercise
□ elevation
□ diuretics/medication management
□ adequate diet
□ basic pneumatic compression pump, without clinical improvement
□ MLD/massage

TREATMENT PLAN:
In addition to continuing compression, elevation and exercise, pneumatic compression is now being recommended, due to lack of improvement with conservative measures :
□ basic pump
□advanced pump (flexitouch)

MEASUREMENTS: (cm) Hip:
R Thigh: L Thigh:
R Calf: L Calf:
R Ankle: L Ankle:

Clinician/MD NAME:

Clinician/MD SIGNATURE: _____DATE: _____

- **MRIYAN**

MRI is ordered for further evaluation of the area of concern.

Patient is notified and understand that approval of MRI may take time pending insurance approval and we will keep track of the progress however the timing is not dictated by our office.

We will monitor and follow up with the result of MRI and will notify the patient on any urgent issues by our clinical staff for the conditions which may require immediate attention or changing of the current treatment course.

The patient is otherwise notified to follow up within one week with me in the clinic soon as they finished MRI exam so we can explain the often complex details of the findings face to face in clinic with our clinical correlation for definitive care plan.

The patient understands and will follow up.

- **NAILCLIPYAN**

The nails and nail beds were cleansed with alcohol. A clipper was used to debride nails of the {right left bilateral:24937} foot. The patient tolerated the procedure well.

- **PHYSICALEXAMFOOTANLEYAN**

Physical Exam:
General/Constitutional: No apparent distress: well-nourished and well developed.
Eyes: Pupils equal, round with synchronous movement.
Lymphatic: No palpable axillary adenopathy.
Respiratory: Non-labored breathing
Vascular: No edema, swelling or tenderness, except as noted in detailed exam.
Integumentary: No impressive skin lesions present, except as noted in detailed exam.
Neuro/Psych: Normal mood and affect, oriented to person, place and time.
Musculoskeletal: Normal, except as noted in detailed exam and in HPI.

Comprehensive Foot and Ankle Exam

	Left	Right

Gait	Normal	
Musculoskeletal Exam		
Deformity	No deformity	No deformity
Misalignment	None	None
Crepitation	None	None
Tenderness	None	None
Defect	None	None
Effusions	None	None
Range of Motion		
Ankle Dorsiflexion	20, Painless	20, Painless
Ankle Plantarflexion	50, Painless	50, Painless
Subtalar Joint Inversion	35, Painless	35, Painless
Subtalar Joint Eversion	25, Painless	25, Painless
Transverse Tarsal Joints Abduction	Painless	Painless
Transverse Tarsal Joints Adduction	Painless	Painless
Contractures	None	None
Crepitation	None	None
Stability		
Dislocations	None	None
Subluxations or Laxity	None	None
Muscle Strength		
Atrophy	None	None
Abnormal Movements	Normal	Normal
Anterior Tibial Muscle	5/5	5/5
Posterior Tibial Muscle	5/5	5/5
Peroneals	5/5	5/5
Gastroc-soleus Muscle	5/5	5/5
Single Heel Raise	Able	Able
Neurologic		
Coordination	Concordant	
Reflexes	Normal	Normal
Sensation		
Sural Nerve Dist.	Normal	Normal
Saphenous Nerve Dist.	Normal	Normal
Tibial Nerve Dist.	Normal	Normal
Deep Peroneal Nerve Dist.	Normal	Normal
Superficial Peroneal Nerve Dist.	Normal	Normal
Cardiovascular		
Edema	None	None
Ecchymosis	None	None
Varicosities	None	None
DP Artery Pulse	Palpable	Palpable
PT Artery Pulse	Palpable	Palpable
Capillary Refill	Brisk, less than 2 secs	Brisk, less than 2 secs
Special Tests		
Anterior Drawer at Neutral	Not tested	Not tested
Anterior Drawer in PF	Not tested	Not tested

Calcaneal Compression	Not tested	Not tested
Peroneal Subluxation/Dislocation	Not tested	Not tested
Tinel's	Not tested	Not tested
Pitting edema sign	Not tested	Not tested
Too Many Toe Signs	Not tested	Not tested

- **PLANACHILLESSURGERY**

Today we discussed Achilles tendon surgery, the risks, benefits, and alternatives. We also discussed the general course of care including preoperative, and post-operative rehabilitation. We discussed the general time course for milestones with Achilles surgery and that there is considerable variability in this course from individual to individual.

Risks discussed included, but were not limited to infection, bleeding, and blood clots, anticoagulation, pneumonia, heart attack, stroke, pulmonary embolism, and death. More unique risks were discussed as they relate to Achilles tendon surgery. Continued pain, wound healing problems, and possible future surgery. Future surgery could be necessary for infection, wound healing problems. We also discussed risks to the structures around the tendon including the arteries, nerves, ligaments, tendon, bone, and skin. These risks were understood, questions were addressed, and an informed consent was signed. The patient will need pre-operative clearance from PCP.

- **PLANANKLEORIF**

Today we discussed ORIF ankle, the risks, benefits, and alternatives. We also discussed the general course of care including preoperative, and post-operative rehabilitation. We discussed the general time course for milestones with ankle ORIF and that there is considerable variability in this course from individual to individual.

Risks discussed included, but were not limited to infection, bleeding, and blood clots, anticoagulation, pneumonia, heart attack, stroke, pulmonary embolism, and death. More unique risks were discussed as they relate to ankle fixation. Continued pain, wound healing problems, nonunion and malunion, ankle stiffness, and possible future surgery. Future surgery could be necessary for stiffness, infection, wound healing problems, nonunion and malunion, posttraumatic arthritic changes, instability. We also discussed risks to the structures around the ankle including the arteries, nerves, ligaments, tendon, bone, and skin. These risks were understood, questions were addressed, and an informed consent was signed. The patient will need pre-operative clearance from PCP.

- **PLANANKLERECONSURGERY**

Today we discussed ankle reconstruction with hardware screw, plate nail with and without osteotomy or soft procedures, the risks, benefits, and alternatives. We also discussed the

general course of care including preoperative, and post-operative rehabilitation. We discussed the general time course for milestones with ankle ORIF and that there is considerable variability in this course from individual to individual.

Risks discussed included, but were not limited to infection, bleeding, and blood clots, anticoagulation, pneumonia, heart attack, stroke, pulmonary embolism, and death. More unique risks were discussed as they relate to ankle fixation. Continued pain, wound healing problems, nonunion and malunion, ankle stiffness, and possible future surgery. Future surgery could be necessary for stiffness, infection, wound healing problems, nonunion and malunion, posttraumatic arthritic changes, instability. We also discussed risks to the structures around the ankle including the arteries, nerves, ligaments, tendon, bone, and skin. These risks were understood, questions were addressed, and an informed consent was signed. The patient will need pre-operative clearance from PCP.

- **PLANANKLEFOOTSCOPE**

Today we discussed ankle foot arthroscopy surgery, the risks, benefits, and alternatives. We also discussed the general course of care including preoperative, and post-operative rehabilitation. We discussed the general time course for milestones with arthroscopic surgery and that there is considerable variability in this course from individual to individual.

Risks discussed included, but were not limited to infection, bleeding, and blood clots, anticoagulation, pneumonia, heart attack, stroke, pulmonary embolism, and death. More unique risks were discussed as they relate to arthroscopic surgery. Continued pain, wound healing problems, and possible future surgery. Future surgery could be necessary for infection, wound healing problems. We also discussed risks to the structures around the tendon joint including the arteries, nerves, ligaments, tendon, bone, and skin. These risks were understood, questions were addressed, and an informed consent was signed. The patient will need pre-operative clearance from PCP.

- **PLANFOOTSURGERY**

Today we discussed foot reconstruction fixation surgery, the risks, benefits, and alternatives. We also discussed the general course of care including preoperative, and post-operative rehabilitation. We discussed the general time course for milestones with foot reconstruction fixation and that there is considerable variability in this course from individual to individual.

Risks discussed included, but were not limited to infection, bleeding, and blood clots, anticoagulation, pneumonia, heart attack, stroke, pulmonary embolism, and death. More unique risks were discussed as they relate to foot reconstruction fixation surgery. Continued pain, wound healing problems, nonunion and malunion, and possible future surgery. Future surgery could be necessary for infection, wound healing problems, nonunion and malunion, posttraumatic arthritic changes, instability. We also discussed risks to the structures around the

ankle including the arteries, nerves, ligaments, tendon, bone, and skin. These risks were understood, questions were addressed, and an informed consent was signed. The patient will need pre-operative clearance from PCP.

- **POSTINJECTIONNOTEYAN**

Medications used in your injection today included:

- Marcaine (a long anesthetic) or
- Lidocaine (a shorter acting anesthetic)
- Depo-Medrol (a long-acting form of cortisone)

The injection you have just received normally goes without incident. The injection area may be sore, throbbing or slightly swollen for one to two days. It is very important that you rest the area of the injection for 24 to 48 hours after the injection. Unless your doctor tells you otherwise, applying ice to the area (10 to 15 minutes every one to two hours) for the first day or two will help decrease the pain. In addition, you may benefit from taking acetaminophen (Tylenol™) to help reduce the pain.
Usually, a numbing medication is given with the injection, which can last for five to 12 hours. The actual Cortisone may take up to two to five days to take effect. If you develop any abnormal symptoms, such as itching, swelling, redness, rash, or shortness of breath, please call our office. Normally, these are temporary symptoms which resolve within a day, but we are more than happy to answer any questions you may have.

Diabetic Warning
If you are diabetic and using insulin, this injection may elevate your blood sugar for the next one to five days. Please monitor your sugars closely and if they fail to return to acceptable levels, please contact your primary care physician.

The doctor would like you to observe the area of the injection for redness, swelling, or increased heat. If any or all the reactions occur, please call our office as soon as possible. This reaction may indicate the first signs of infection. This is a very rare event, but best if caught early.
The duration of pain relief from these injections varies widely between patients. Some report two or more months of relief while other patients report only a few weeks of relief.

Thank you and please follow your doctor's directions. Call us with any questions or problems.

- **POSTOPPLANYAN**

Post Op Plan:

Allergies: @ALG@:

Hemovac/JP drain: ***
Anesthesia: General
Fluid: ***cc Crystalloid, ***cc Hextend
UOP: ***cc
Tourniquet: *** min at 300***mmHg

Disposition: Patient tolerated the procedure well and was transported to the PACU in stable condition. Thereafter to ***

Pain control
WB status: *** x *** weeks
Antibiotics: Ancef*** x 24*** hours
DVT Prophylaxis: *** and mechanical while in hospital, D/C on ***ASA 325mg x 4 weeks
Drains: ***Document per shift, dc when <15cc/shift
X-rays: *** POD#1
PT/OT: *** ROM, ADL's.
Bracing/Splinting: ***
Elevation: ERLE pillow***
Cultures: Pending***
Hbg: POD# 1, 2, 3***
Dressings: Keep clean, dry, intact until post-op clinic appointment.
Pin care: ***
Diet: Begin with fluids and progress DAT
Consults: case management

F/U: Clinic with Dr. Yan in 2 weeks with *** x-rays needed.

@ME@ @TD@, @NOW@

- **PREOPCHECKLISTYAN**

Orthopaedic Surgery Preoperative Checklist:

PreOP Diagnosis:

Procedure:

Surgeon: Alan Y. Yan, MD

NPO after Midnight: yes

Consent:

Clearance:

DVT Prophylaxis Held: not receiving chemical DVT ppx

Radiographic Studies:

Labs: ordered for tomorrow AM.

Type and Screen:

Blood Products:

OR Booked: yes

Phases of care orders placed: Yes

- **PREOPHANDOFFNOTEYAN**

PREOPERATIVE HANDOFF NOTE

[ ] informed consent
[ ] pre-op labs
[ ] pre-op orders
[ ] case requested
[ ] OR called
[ ] additional imaging
[ ] H&P/consult note
[ ] medicine clearance
[ ] other (NPO, AC held, etc)

- **PREOPTOTALJOINTSHOWERYAN**

Shower instruction:

You are planning on having surgery. These are the bathing instructions to prepare your body: Starting 2 days before surgery, take your normal shower with soap and shampoo. You will do this daily for the 2 days prior to surgery and the morning of surgery. Rinse well. Turn off the water. Then, using the 16 oz Hibiclens foam pump soap, apply 3-5 pumps of the Hibiclens foam to all 14 areas shown on the instruction form. The soap is to be left on the skin for 30 seconds before rinsing. After that time, rinse well, dry off with a clean, dry towel, put on clean clothes and pajamas each day. Change the bedding the night before surgery. Do NOT apply cream, lotions, powders or deodorants after the showers. Document your showers on the form provided and bring this form with you to surgery.

- **PREOPWORKSHEETFOOTANKLESURGERYYAN**

Dr. Alan Yan's PreOperative F&A Worksheet

Patient Name: @NAME@	**Age: @AGE@**	**DOS:**
MRN: @MRN@	**DOB: @DOB@**	**PCP: @PCP@**

Allergies: @ALLERGY@

Past Medical History: @PMH@

Medications: @MED@

BMI: @BMI@

Ht: (last Encounter) @FLOWAMB(11)@

Wt: (Last Encounter) @FLOWAMB(14)@

Hgb: @RESUFAST(HGB)@

WBC: @RESUFAST(WBC)@

HGB A1C: @RESUFAST(HGBA1C)@
INR: @RESUFAST(INR:3,PROTIME:3)@

CR: @RESUFAST(CREATININE)@
CRP: @RESUFAST(CRP)@
ESR: @RESUFAST(SEDRATE)@

GFR: @GFRCG@
Pre-Op antibiotics: Ancef _____ Vancomycin _____
Post-op antibiotics: SCIP Until cultures final/discharge per ID
Anticoagulation: 1 2 3 4 5 6 Other:
Post-op pain meds: Std Other:
Disposition: Home with OPPT Home with home PT/nursing TCU_____
Procedure: Left/Right
Position: Supine Lateral Decubitus Prone
Vendor: Wright Arthrex Stryker Synthes Zimmer/biomet Other:

Special Instruments:

Brief History:

- **PREOPWORKSHEETTAAYAN**

Dr. Alan Yan's PreOperative TAA Worksheet

Patient Name: @NAME@	**Age: @AGE@**	**DOS:**
MRN: @MRN@	**DOB: @DOB@**	**PCP: @PCP@**

Allergies: @ALLERGY@

Past Medical History: @PMH@

Medications: @MED@

BMI: @BMI@

Ht: (last Encounter) @FLOWAMB(11)@

Wt: (Last Encounter) @FLOWAMB(14)@

Hgb: @RESUFAST(HGB)@

WBC: @RESUFAST(WBC)@

HGB A1C: @RESUFAST(HGBA1C)@
INR: @RESUFAST(INR:3,PROTIME:3)@

CR: @RESUFAST(CREATININE)@
CRP: @RESUFAST(CRP)@
ESR: @RESUFAST(SEDRATE)@

GFR: @GFRCG@
Nasal Culture: MSSA negative MSSA positive MRSA positive
Pre-Op antibiotics: Ancef _____ Vancomycin _____
Post-op antibiotics: SCIP Until cultures final/discharge per ID
Anticoagulation: 1 2 3 4 5 6 Other:
Post-op pain meds: Std Other:
Disposition: Home with OPPT Home with home PT/nursing TCU_____
Templating:
Procedure: TAA Left/Right Primary/Revision
Position: Supine
Vendor: Wright Infinity Wright Prophecy Wright Inbone Salto Zimmer STAR

Tibia: Size:

Talus: Size:

Special Instruments:

Brief History:

ROM: R Ankle: _____ L Ankle: _____

- **PREOPWORKSHEETTKAYAN**

Dr. Alan Yan's PreOperative TKA Worksheet

Patient Name: @NAME@	**Age: @AGE@**	**DOS:**
MRN: @MRN@	**DOB: @DOB@**	**PCP: @PCP@**

Allergies: @ALLERGY@

Past Medical History: @PMH@

Medications: @MED@

BMI: @BMI@

Ht: (last Encounter) @FLOWAMB(11)@

Wt: (Last Encounter) @FLOWAMB(14)@

Hgb: @RESUFAST(HGB)@

WBC: @RESUFAST(WBC)@

HGB A1C: @RESUFAST(HGBA1C)@
INR: @RESUFAST(INR:3,PROTIME:3)@

CR: @RESUFAST(CREATININE)@
CRP: @RESUFAST(CRP)@
ESR: @RESUFAST(SEDRATE)@

GFR: @GFRCG@

Nasal Culture: MSSA negative MSSA positive MRSA positive
Pre-Op antibiotics: Ancef _____ Vancomycin _____
Post-op antibiotics: SCIP Until cultures final/discharge per ID
Anticoagulation: 1 2 3 4 5 6 Other:
Post-op pain meds: Std Other:
Disposition: Home with OPPT Home with home PT/nursing TCU_____
Templating:
Procedure: TKA Left/Right Primary/Revision
Position: Supine
Vendor: Zimmer Persona NexGen LCCK

Femur: Size: **Femoral cut:**
Tibia: Size: **Tibial cut:**
Special Instruments:

Brief History:

ROM: R knee: _____ L knee: _____

Brief history:

- **PREOPWORKSHEETTRAUMAYAN**

Dr. Alan Yan's PreOperative Trauma Worksheet

Patient Name: @NAME@	**Age: @AGE@**	**DOS:**
MRN: @MRN@	**DOB: @DOB@**	**PCP: @PCP@**

Allergies: @ALLERGY@

Past Medical History: @PMH@

Medications: @MED@

BMI: @BMI@

Ht: (last Encounter) @FLOWAMB(11)@

Wt: (Last Encounter) @FLOWAMB(14)@

Hgb: @RESUFAST(HGB)@

WBC: @RESUFAST(WBC)@

HGB A1C: @RESUFAST(HGBA1C)@
INR: @RESUFAST(INR:3,PROTIME:3)@

CR: @RESUFAST(CREATININE)@
CRP: @RESUFAST(CRP)@
ESR: @RESUFAST(SEDRATE)@

GFR: @GFRCG@
Pre-Op antibiotics: Ancef _____ Vancomycin _____
Post-op antibiotics: SCIP Until cultures final/discharge per ID

Anticoagulation: 1 2 3 4 5 6 Other:
Post-op pain meds: Std Other:
Disposition: Home with OPPT Home with home PT/nursing TCU_____
Procedure: Left/Right
Position: Supine Lateral Decubitus Prone
Vendor: Stryker Synthes Zimmer/biomet

Special Instruments:

- **PROGRESSNOTEYAN**

Orthopedic Progress Note

Patient Name: @NAME@
Medical Record Number: @MRN@
Date of Birth: @DOB@
Date of service: @TD@

Admission Date: @ADMITDT@
Admission Diagnosis: @ADMITDX@ .admit
Post-Operative Date: ***
Surgical Procedure: {RIGHT LEFT BILATERAL:22876} ***
Attending: @ATTPROV@

Subjective: Patient lying in bed, NAD. Denies SOB, CP, HA, N/V. Pain *** controlled.
***
HV output: ***

@V@

EXAM: The patient is a pleasant adult in no acute distress. Examination of the patient's right lower extremity shows the splint dressing remains clean, dry and intact. Distal sensation is present to light touch in all dermatomes including DP, SP, Saphenous, Sural and Tibial nerves. The patient has 4/5 distal strength in plantar and dorsiflexion as well as extensor hallucis longus and flexor hallucis longus. The patient's foot is well perfused with brisk capillary refill. There is no calf tenderness to palpation in bilateral lower extremity.

Lab:
@LASTLAB(GLU:1,ANIONGAP:1,CO2:1,CREATININE:1,K:1,NA:1,CL:1,BUN:1,LABIL2:1,CALCIUM:1,OSMOLALITY:1,BCR:1,GFRAA:1,GFRNONAA:1,PROT:1,ALBUMIN:1,GLOB:1,AST:1,ALKPHOS:1,BILITOT:1,ALT:1)@

@RESUFAST(WBC,HGB,HCT,MCV,PLT)@
@RESUFAST(INR:3,PROTIME:3)@
@RESUFAST(PTT)@
@RESUFAST(SEDRATE)@
@RESUFAST(CRP)@

Plan:
{ortho post-op:17905}

@ME@
Pager: 412-958-6490

- **PTACHILLESTENDONITISYAN**

  Physical Therapy Prescription

  Diagnosis:
  Achilles Tendonitis

  Foot/Ankle Physical Therapy
  -ROM and stretching foot and ankle.
  -Strengthening program for gastrocnemius-soleus complex using Therabands.
  -Eccentric strengthening program for the gastrocnemius-soleus.
  -Instruct in home strengthening program to be performed daily using Therabands.
  -Modalities PRN.
  -Home exercise program.
  -Iontophoresis and Graston technique as needed

Frequency/Duration: 2- 3 times per week for 6 weeks

- **PTACHILLESFHLTRANSFERYAN**

  ANKLE REHABILITATION GUIDELINES: ACHILLES TENDON REPAIR WITH FHL/FDL TENDON TRANSFER

  RX:

  Physical Therapy: 3 times/ week for 6 weeks

  1. ROM and stretching foot and ankle

  2. Strengthening program for intrinsic and extrinsic muscles of the foot and ankle, with particular attention to inversions with plantarflexed foot.

  3. Instruct in home strengthening program to be performed daily with Theraband

  4. Modalities PRN

  PHASE 1 (start 4-6 weeks post-op; start time will vary)

1) Visit 1 – Patient is evaluated
   a) Begin ankle ROM exercises: AROM, alphabet, and ankle circles.
   b) Gait training, in CAM walker WBAT.
   c) Ice ankle and use compressive stockinette for edema control, and educate patient on icing at home.
2) Visits 2 and 3
   a) Continue with ankle ROM exercises as needed (full ROM should be achieved by 10 weeks post-op; caution in over-stretching the repair into excessive DF beyond neutral to 5 degrees in the first several weeks, not to exceed 10 degrees by week 10, full symmetric DF by 12 to 14 weeks post-op).
   b) Begin gentle ankle strengthening including manual resistance exercises, 4-direction theraband exercises, and seated DF/PF.
   c) Begin proprioceptive exercises such as the seated BAPS board.
   d) Begin aerobic conditioning such as the bike.
3) Visits 4 and 5
   a) Progress the strengthening exercises to include the leg press in CAM walker.
   b) Address additional strengthening deficits of the involved extremity using machines that may include knee extension machine, hamstring curl machine and multi hip machine.

PHASE 2 (8 to 12 weeks post-op)

4) Visits 6 and 7
   a) Begin progressive weight bearing without the CAM walker, with the use of heel lift.
   b) Discontinue use of CAM walker in therapy.
   c) Begin weight bearing proprioceptive exercises on static and dynamic surfaces to include single limb stance exercises, plyoball and 4-way theraband exercises standing on involved limb.
   d) Address additional gait deficits and abnormalities.
   e) Advance strengthening activities to include standing heel raises, squats, lunges and step-ups.
5) Visits 8 and 9
   a) Continue exercise progression with increased weight bearing with activities in single limb stance and with additional weight.
   b) Advance aerobic conditioning to include the treadmill, stepper, etc.

PHASE 3 (14+ weeks post-op)

6) Visits 10 and 11
   a) Begin sports specific training with sport cord activities including lunges and semicircles.
   b) Progress difficulty of proprioceptive exercises done on dynamic surfaces only.
7) Visits 12, 13, 14
   a) Begin hopping and jumping drills and other plyometric training for return to sports as appropriate.
   b) Begin running based on MD clearance.
   c) Discharge with HEP (to include goal of single heel raise by 6 to 12 months post-op).

DISCHARGE CRITERIA (10-14 visits)

1) Normal gait without assistive device or bracing.
2) Minimal to no pain with ADLs.
3) Minimal to no joint effusion.
4) Adequate neuromuscular control and proprioceptive awareness based on ability to perform stabilization exercises and ability to participate in recreational/sport activities.

- **PTACHILLESREPAIRYAN**

ANKLE REHABILITATION GUIDELINES: PRIMARY ACHILLES TENDON REPAIR

RX:

Physical Therapy: 3 times/ week for 6 weeks

1. ROM and stretching foot and ankle

2. Strengthening program for intrinsic and extrinsic muscles of the foot and ankle, with particular attention to inversions with plantarflexed foot.

3. Instruct in home strengthening program to be performed daily with Theraband

4. Modalities PRN

PHASE 1 (start 2-4 weeks post-op; start time will vary)

1) Visit 1 – Patient is evaluated
   a) Begin ankle ROM exercises: AROM, alphabet, and ankle circles.
   b) Gait training, in CAM walker WBAT.
   c) Ice ankle and use compressive stockinette for edema control, and educate patient on icing at home.
2) Visits 2 and 3
   a) Continue with ankle ROM exercises as needed (full ROM should be achieved by 10 weeks post-op; caution in over-stretching the repair into excessive DF beyond neutral to 5 degrees in the first several weeks, not to exceed 10 degrees by week 10).
   b) Begin gentle ankle strengthening including manual resistance exercises, 4-direction theraband exercises, and seated DF/PF.
   c) Begin proprioceptive exercises such as the seated BAPS board.
   d) Begin aerobic conditioning such as the bike.
3) Visits 4 and 5
   a) Progress the strengthening exercises to include the leg press in CAM walker.
   b) Address additional strengthening deficits of the involved extremity using machines that may include knee extension machine,

hamstring curl machine and multi hip machine.

PHASE 2 (6 to 10 weeks post-op)

4) Visits 6 and 7
   a) Begin to discontinue use of CAM walker in therapy as tolerated.
   b) Begin weight bearing proprioceptive exercises on static and dynamic surfaces to inlcude single limb stance exercises, plyoball and 4-way theraband exercises standing on involved limb.
   c) Advance strengthening activities to include standing heel raises (note single heel rise will usually not be possible until 6-12 months post-op), squats, lunges and step-ups.
5) Visits 8 and 9
   a) Begin progressive weight bearing without the CAM walker (8 weeks post-op), with the use of heel lift (5/16 inch).
   b) Address additional gait deficits and abnormalities.
   c) Continue exercise progression with increased weight bearing with activities in single limb stance and with additional weight.
   d) Advance aerobic conditioning to include the treadmill, stepper, etc.

PHASE 3 (12+ weeks post-op)

6) Visits 10 and 11
   a) Begin sports specific training with sport cord activities including lunges and semicircles.
   b) Progress difficulty of proprioceptive exercises done on dynamic surfaces only.
7) Visits 12, 13, 14
   a) Begin hopping and jumping drills and other plyometric training for return to sports as appropriate.
   b) Begin running based on MD clearance.
   c) Discharge with HEP (to include goal of single heel raise by 6 to 12 months post-op).

DISCHARGE CRITERIA (10-14 visits)

1) Normal gait without assistive device or bracing.
2) Minimal to no pain with ADLs.
3) Minimal to no joint effusion.
4) Adequate neuromuscular control and proprioceptive awareness based on ability to perform stabilization exercises and ability to participate in recreational/sport activities.

- **PTALLAMERICANPTTDYAN**

ANKLE REHABILITATION GUIDELINES: POSTERIOR TIBIAL TENDON RECONSTRUCTION WITH FDL TRANSFER AND CALCANEAL OSTEOTOMY

RX:

Physical Therapy: 2-3 times/ week for 6 weeks

1. ROM and stretching foot and ankle

2. Strengthening program for intrinsic and extrinsic muscles of the foot and ankle, with particular attention to inversions with plantarflexed foot.

3. Instruct in home strengthening program to be performed daily with Theraband

4. Modalities PRN

PHASE 1 (start 2-4 weeks post-op; start time will vary)

1) Visit 1 – Patient is evaluated
   a) Begin ankle ROM exercises: AROM, alphabet, and ankle circles.
   b) Begin intrinsic foot musculature strengthening with towel scrunch.
   c) Gait training, in
2) Visits 2 and 3
   a) Continue with ankle ROM exercises as needed.
   b) Begin gentle ankle strengthening including manual resistance exercises, 4-direction theraband exercises, and seated DF/PF.
   c) Instruct patient in PF/INV to isolate the transferred tendon not the anterior tibial tendon, strengthening with manual resistance, progressing to theraband.
   d) Begin proprioceptive exercises such as the seated BAPS board.
   e) Continue with intrinsic foot musculature exercises including use of marble pick up.
   f) Begin aerobic conditioning such as the bike.
3) Visits 4 and 5
   a) Progress the strengthening exercises to include the leg press in CAM walker.
   b) Address additional strength deficits of the involved extremity using machines that may include knee extension machine, hamstring curl machine and multi hip machine.

PHASE 2 (6 to 10 weeks post-op)

4) Visits 6 and 7
   a) Begin to discontinue use of CAM walker in therapy as tolerated.
   b) Begin weight bearing proprioceptive exercises on static and dynamic surfaces to include single limb stance exercises, plyoball and 4-way theraband exercises standing on involved limb.
   c) Advance strengthening activities to include standing heel raises, squats, lunges and step-ups.
5) Visits 8 and 9
   a) Begin progressive weight bearing without the CAM walker (12 weeks post-op), and assess the need for orthotics to maintain appropriate arch alignment.
   b) Address additional gait deficits and abnormalities.
   c) Continue exercise progression with increased weight bearing with activities in single limb stance and with additional weight.

d) Advance aerobic conditioning to include the treadmill, stepper, etc.

PHASE 3 (14+ weeks post-op)

6) Visits 10 and 11
   a) Begin sports specific training with sport cord activities including lunges and semicircles.
   b) Progress difficulty of proprioceptive exercises done on dynamic surfaces only.
7) Visits 12, 13, 14
   a) Begin hopping and jumping drills and other plyometric training for return to sports as appropriate.
   b) Begin running based on MD clearance.
   c) Discharge with HEP (emphasize goal of single heel raise by 9 to 12 months post-op).

DISCHARGE CRITERIA (10-14 visits)

1) Normal gait without assistive device or bracing.
2) Minimal to no pain with ADLs.
3) Minimal to no joint effusion.
4) Adequate neuromuscular control and proprioceptive awareness based on ability to perform stabilization exercises and ability to participate in recreational/sport activities.

- **PTANKLEINSTABPERONEALTENDONIITISYAN**

Physical Therapy Prescription

Diagnosis:
Ankle Instability, Peroneal Tendonitis

Foot/Ankle Physical Therapy
-ROM and stretching foot and ankle.
-Instruct in home strengthening program to be performed daily using Therabands.
-Modalities PRN.
-Strengthening program for intrinsic and extrinsic muscles of the foot and ankle, with particular attention to peroneal strengthening using Therabands.
-B.A.P.S. board for strengthening and proprioception.
-Home exercise program.

Frequency/Duration: 2-3 times per week for 6 weeks

- **PTBUNIONCHEVRONAKINYAN**

BUNIONIECTOMY REHABILITATION GUIDELINES
STATUS POST CHEVRON OR AKIN

RX:

Physical Therapy: 3 times/ week for 6 weeks

1. ROM and stretching foot and ankle

2. Instruct in home strengthening program to be performed daily

3. Modalities PRN

PHASE 1 (start 2-4 weeks post-op; start time will vary)

1) Visit 1 – Patient is evaluated
   a) Gait training, WBAT with “heel to toe gait.” Review bracing/toe splint. Discuss appropriate shoe wear.
   b) Begin first MTP joint ROM exercises: AROM, PROM, and towel stretch for ankle dorsiflexion.
   c) Ice ankle and use compressive stockinette for edema control and educate patient on icing at home.
2) Visits 2 and 3
   a) Continue with ankle ROM exercises as needed.
   b) Begin toe strengthening exercises, seated PF, and towel scrunch.
   c) Address ankle strength issues; ankle strengthening including manual resistance exercises, and 4-direction theraband exercises.
   d) Begin weight bearing proprioceptive exercises on static surfaces to include single limb stance exercises, plyoball and 4-way theraband exercises standing on involved limb.
   e) Begin aerobic conditioning such as the bike.

PHASE 2 (6 to 8 weeks post-op)

3) Visits 4 and 5
   a) Address additional gait deficits and abnormalities. Begin wearing sneakers with toe spacer.
   b) Progress the strengthening exercises to include the leg press, calf press, and standing heel raises.
   c) Progress ankle stretches to include standing gastrocnemius and soleus stretches.
   d) Progress proprioceptive exercise to dynamic surfaces such as: foam, rocker board and balance disc.
4) Visits 6 and 7
   a) Begin standing heel raises.
   b) Progress difficulty of proprioceptive exercises to be done on dynamic surfaces only.
   c) Advance aerobic conditioning to include the treadmill, stepper, etc.

PHASE 3 (sports specific - 8 to 10 weeks)

5) Visits 8 and 9
   a) Begin sports specific training with sport cord activities including lunges and semicircles.
   b) Begin hopping and jumping drills and other plyometric training for return to sports as appropriate.

c) Begin running based on MD clearance.
d) Discharge with HEP.

DISCHARGE CRITERIA

1) Normal gait without assistive device or bracing.
2) Minimal to no pain with ADLs.
3) Minimal to no joint effusion.
4) Adequate neuromuscular control and proprioceptive awareness based on ability to perform stabilization exercises and ability to participate in recreational/sport activities.

- **PTPFYAN**

Physical Therapy Prescription

Diagnosis:
Plantar Fasciitis

Foot/Ankle Physical Therapy
-ROM and stretching foot and ankle.
-Eccentric strengthening program for the gastrocnemius-soleus.
-Instruct in home strengthening program to be performed daily using Therabands.
-Home exercise program.
-Whirlpool, ultrasound, iontophoresis, graston technique as needed to plantar fascia insertion.
-Modalities PRN. Keep forefoot adducted when stretching.

Frequency/Duration: 2-3 times per week for 6 weeks

- **PTPTTDYAN**

Physical Therapy Prescription

Diagnosis:
Posterior Tibial Tendonitis

Foot/Ankle Physical Therapy
-ROM and stretching foot and ankle.
-Instruct in home strengthening program to be performed daily using Therabands.
-Modalities PRN.
-Home exercise program.
-Strengthening program for intrinsic and extrinsic muscles of the foot and ankle, with particular attention to inversions with plantarflexed foot.
-Iontophoresis and Graston Technique as needed

Frequency/Duration: 2-3 times per week for 6 weeks

- **PTSCOPEOCDYAN**

ANKLE REHABILITATION GUIDELINES: POST ANKLE ARTHROSCOPY WITH OCD DRILLING

RX:
Physical Therapy: 3 times/ week for 6 weeks

1. ROM and stretching foot and ankle

2. Instruct in home strengthening program to be performed daily

3. Modalities PRN

PHASE 1 (start 2-4 weeks post-op; start time will vary)

1) Visit 1 – Patient is evaluated
   a) Begin ankle ROM exercises: AROM, alphabet, and ankle circles.
   b) Gait training, in CAM walker NWB (patient has option to not use
   c) Ice ankle and use compressive stockinette for edema control and educate patient on icing at home.
2) Visits 2 and 3
   a) Continue with ankle ROM exercises as needed.
   b) Begin gentle ankle strengthening including manual resistance exercises, 4-direction theraband exercises, and seated DF/PF.
   c) Begin proprioceptive exercises such as the BAPS board, seated only.
   d) Begin aerobic conditioning such as the bike.
3) Visits 4 and 5
   a) Progress the strengthening exercises.
   b) Address additional strength deficits of the involved extremity using machines that may include knee extension machine,
   hamstring curl machine and multi hip machine.

PHASE 2 (6 to 10 weeks post-op)

4) Visits 6 and 7
   a) Gait training in CAM walker WBAT at 6 weeks.
   b) Begin to discontinue use of CAM walking in therapy as tolerated.
   c) Begin weight bearing proprioceptive exercises on static and dynamic surfaces to include single limb stance exercises,
   plyoball and 4-way theraband exercises standing on involved limb.
   d) Advance strengthening activities to include standing heel raises, squats, lunges and step-ups.
5) Visits 8 and 9

a) Continue exercise progression with increased weight bearing with activities in single limb stance and with additional weight.
b) Advance aerobic conditioning to include the treadmill, stepper, etc.

PHASE 3 (12+ weeks post-op)

6) Visits 10 and 11
   a) Begin sports specific training without the CAM walker (12 weeks post-op).
   b) Address additional gait deficits and abnormalities.
   c) Begin sports specific training with sport cord activities including lunges and semicircles.
   d) Progress difficulty of proprioceptive exercises done on dynamic surfaces only.
7) Visits 12, 13, 14
   a) Begin hopping and jumping drills and other plyometric training for return to sports as appropriate.
   b) Begin running based on MD clearance (3 months post-op).
   c) Discharge with HEP.

DISCHARGE CRITERIA (10-14 visits)

1) Normal gait without assistive device or bracing.
2) Minimal to no pain with ADLs.
3) Minimal to no joint effusion.
4) Adequate neuromuscular control and proprioceptive awareness based on ability to perform stabilization exercises and ability to participate in recreational/sport activities.

- **RISKWARNINGBMIYAN**

@CAPHE@ understands that with a BMI of ***, the risk of surgery significantly increases and that improved overall health and well -being can drastically improve the outcome of @HIS@ surgery.

- **RISKWARNINGDMYAN**

@CAPHE@ understands that with a history of diabetes, the risk of surgery and recovery of surgery including but not limited to soft tissue and bone healing and risk for infection significantly increases and that well controlled diabetic status throughout and after the recovery with an improved overall health and well -being by reducing this significant risk can drastically improve the outcome of @HIS@ surgery. We require less than 8 % of HbA1C level before any elective surgery and immediate consult and coordinated care for patients with uncontrolled diabetic status from primary care or medical team for any emergent, urgent surgery.

- **RISKWARNINGSMOKINGYAN**

@CAPHE@ understands that with a history of smoking, the risk of surgery and recovery of surgery including but not limited to soft tissue and bone healing and risk for infection significantly increases and that stop smoking immediately and continue to remain non-smoking status throughout and after the recovery. Therefore an improved overall health and well -being by reducing this significant modifiable risk can drastically improve the outcome of @HIS@ surgery. We require 8 weeks of stop smoking completely before any elective surgery and immediate stop smoking completely and continue to stop smoking for any emergent, urgent surgery. We require urine nicotine test to confirm normalized value one week before any elective surgery. Please seek any help from your primary care to help with your smoking cessation.

- **ROSYAN**

Review of Systems _____
Constitutional: Negative for fever, chills, appetite change, fatigue and unexpected weight change. ____
HENT: Negative for sore throat and trouble swallowing. _____
Respiratory: Negative for cough, chest tightness, shortness of breath and wheezing. ____
Cardiovascular: Negative for chest pain, palpitations and leg swelling. ____
Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea, constipation and blood in stool. ____
Endocrine: Negative for cold intolerance. ____
Genitourinary: Negative for dysuria, urgency, frequency, hematuria and difficulty urinating. ____
Musculoskeletal: Negative for back pain, gait problem, joint swelling, myalgias, neck pain and neck stiffness. ____
Skin: Negative for rash and wound. _____
Neurological: Negative for dizziness, syncope, weakness, light-headedness, numbness and headaches. ____
Hematological: Does not bruise/bleed easily. ____
Psychiatric/Behavioral: Negative for confusion and sleep disturbance. The patient is not nervous/anxious.

- **SKINCALLOUSDEBRIDEYAN**

The skin was cleansed with alcohol. A 15 blade was used to debride the skin/Callous over the {left/right/bilateral:22167} {Dorsum/Plantar/Sole:20304} {Ort FA Tenderness:26641}. The patient tolerated the procedure well.

- **SMOKECESSTIONADVICEYAN**

The patient is a current smoker and/or tobacco product user. The patient is advised to stop smoking for 6 to 8 weeks before we can proceed with surgical planning. A urine nicotine test will be tested one week before surgery. Risks for smoking in surgery was discussed with the patient in details. Resources for smoking cessation was discussed. The patient is encouraged to seek

help from primary care also. No nicotine product should be used at all prior to surgical planning. The patient understands and will follow up instructions.

- **SOCIALMEDIANOTEYAN**

Today we discussed with our patient for potential use of the patient's clinical information and all related digital media of preoperative, intraoperative and postoperative photos and or videos containing information of the history, exam, surgical or nonsurgical management and recovery in professional social medial platforms and professional publications and conferences.

The consent for digital medical imaging (photography and/or video recording) to be made of the patient related to the patient's specific health conditions under the care of Dr. Alan Y. Yan and his care team was presented and signed.

Patient understands that the information may be used in the medical record, for purposes of medical teaching, publication in medical textbooks, journals, and social media as the patient has consented.

The patient's refusal to consent to photographs and video recordings will in no way affect the medical and/or surgical care the patient will receive. If the patient have any questions or wish to withdraw the consent in the future, the patient may contact the hospital and Dr. Alan Y. Yan's care team.

The patient is hereby consent to the use of the photographs and video recordings in medial publications, including but not limited to medical journals, textbooks, electronic publications, and social media. The patient understands that the photographs and videos may be seen by members of the public. Although the photographs and video recordings will be used without identifying information such as the patient's name or any unique identifying features (i.e., tattoo or scars), the patient understand that it is possible that someone may recognize the patient. The patient also agrees for the images to be used for teaching purposes and to be used in the patient's medical record.

- **SURGERYASSISTANTNOTEYAN**

***, PA was asked by Dr. Yan to assist with surgery. The assistant helped position and prep the patient. The assistant retracted soft tissue for operative exposure. The assistant suctioned fluids and provided traction for dissection. The assistant also helped with wound closuring dressing, splint placement, VAC and Xray positioning. The assistant helped Dr. Yan identify and protect vital structures during the procedure. The procedure was medically necessary for an assistant because the physician needed the operative exposure and assistance that provided. This allowed a safe and efficient procedure. It was also important that I help with hemostatic control and reduce the bleeding risk. The assistance provided reduced operative time which meant less general anesthetic for the patient and a safer procedure.

This was medically necessary as the resident and fellow were not available for this part of the case.

I confirm that I was present for the key and critical portions of the service including a review of the patient's history and other pertinent data. I personally examined the patient and formulated the evaluation and treatment plan.

@ME@ @TD@, @NOW@

I reviewed the note of my documentation.

- **SURGERYSCHEDULEDNOTEYAN**

Surgery Schedule:

Alan Yan, MD
Please schedule @NAME@ for the following procedure {:8292} within {:7911} {:7012} at {:8293}. Length of time needed {:33002} hour(s). Anesthesia needed {:8294}.

Pre-op Diagnoses: ***
Position: ***
@BMI@
Pre-op scheduled: {:16960}
NPO: {:16960}
Latex Allergy: {:16960}
Comments: ***
Primary Care Provider: @PCP@

- **UEINJURYDETAILNOTEYAN**

Date of Service: @TD@

History: The patient is a @AGE@ old {RIGHT/LEFT:5002175}-hand dominant @SEX@ who presents to the orthopedic clinic for follow-up of a {RIGHT/LEFT:5002175} *** sustained on *** while ***.

Please see the intake form for addition details regarding history, medications, social history and ROS.

Physical Examination:
@BMI@

@CAPHE@ is a pleasant adult @SEX@ in no acute distress. @CAPHE@ is well dressed and well-groomed with appropriate affect. @CAPHE@ is alert and oriented x 3.

NEUROVASCULAR: Radial pulse is palpable; sensation to light touch is intact to median, ulnar and radial nerve distributions in both upper extremities.

SKIN: Right upper extremity: {SKIN:14137}. Left upper extremity: {SKIN:14137}.

SHOULDER EXAM	**RIGHT**	**LEFT**
Forward flexion	***	***
Abduction	***	***
External Rotation	***	***
Internal Rotation	***	***
Tenderness to Palpation	***	***
Muscle Strength		
Abduction	***/5	***/5
External Rotation	***/5	***/5
Internal Rotation	***/5	***/5
Impingement Test (Hawkins, Neer)	{POSITIVE/NEGATIVE 2:9720}	{POSITIVE/NEGATIVE 2:9720}
Elbow Exam		
Flexion	***	***
Extension	***	***
Supination	***	***
Pronation	***	***
Tenderness to palpation	***	***
Muscle Strength		
Biceps	***/5	***/5
Triceps	***/5	***/5
WRIST EXAM		
Dorsiflexion	***	***
Palmarflexion	***	***
Supination	***	***
Pronation	***	***
Tenderness to palpation	***	***
Muscle Strength		
Grip strength	***, ***, ***	***, ***, ***
Wrist extension	***	***
Wrist flexion	***	***

Radiographic Evaluation: *** views of the {RIGHT/LEFT:5002175} *** were obtained at this visit, reviewed, and compared to previous films. They reveal interval healing of the fracture with stable alignment. Hardware is intact with no evidence of loosening or breakage.

Assessment and Plan: The patient is a @AGE@ old {RIGHT/LEFT:5002175}-hand dominant @SEX@ who presents to the orthopedic clinic for follow-up of a {RIGHT/LEFT:5002175} ***. The patient is now {WEEKS/MONTHS/YEARS:13790} out. ***. The patient will return to clinic in {WEEKS/MONTHS/YEARS:13790}, at which time *** views of the {RIGHT/LEFT:5002175} *** will be obtained. Patient agrees with this plan.

This is @ME@ scribing for @ENCPROVNMTITLE@.

@ME@ @TD@, @NOW@

- **UEINJURYFUnoteYAN**

ORTHO TRAUMA UE FU

Orthopaedic Surgery Trauma Office Follow-up Note
@NAME@
@MRN@
@DOB@

Date of Visit: @TODAY@
Date of Injury: ***
***Surgery: *** on *** with Dr. ***.

History of Present Illness: @M@ @NAMEBYAGE@ is a @AGE@ @SEX@ who presents to see us in follow-up today for ***. They are *** status-post ***. They are doing ***well. ***

Review of Systems: Is notable for ***. They deny ***.
@PROB@
@MED@
@ALLERGY@

Physical Examination:
@VITALSM@

Gen: ***Awake, alert, appropriate in no acute distress
HEENT: ***Normocephalic, atraumatic
Psych: ***Normal mood and affect.
CV:***Regular rate and rhythm, checked peripherally
Pulm: ***No increased work of breathing.

***Upper Extremity Exam:
Notable for ***

Skin- ***intact, ***swelling, ***erythema, ***crepitus
Compartments- ***Soft, no pain with passive ROM of the digits.

***+ radial pulse
Light touch sensation intact in ***Ax, LAB, R, M, U distribution
Grip/IO/FPL/EPL/WE intact.

Shoulder ROM- ***
Elbow ROM- ***
Wrist ROM- ***

Imaging:
***Views of the *** demonstrate ***

Labs: ***

Assessment and Plan: @PTTITLE@ @NAME@ is a *** pleasant @AGE@@SEX@ who presents with ***. ***

- **UEINJURYNEWNOTEYAN**

ORTHO TRAUMA UE NEW OFFICE

Orthopaedic Surgery Office Note

@NAME@
@MRN@
@DOB@

Date of Visit: @TODAY@
Date of Injury: ***
***Date of Surgery: ***

History of Present Illness: @M@ @NAMEBYAGE@ is a @AGE@ @SEX@ who presents to see us today as a new patient visit for ***. ***

Review of Systems: Is notable for ***. They deny ***.

@PROB@

@MED@

@ALLERGY@

Physical Examination:
@VITALSM@

Gen: ***Awake, alert, appropriate in no acute distress
HEENT: ***Normocephalic, atraumatic
Psych: ***Normal mood and affect.
CV:***Regular rate and rhythm, checked peripherally
Pulm: ***No increased work of breathing.

***Upper Extremity Exam:
Notable for ***

Skin- ***intact, ***swelling, ***erythema, ***crepitus
Compartments- ***Soft, no pain with passive ROM of the digits.

***+ radial pulse
Light touch sensation intact in ***Ax, LAB, R, M, U distribution
Grip/IO/FPL/EPL/WE intact.

Shoulder ROM- ***
Elbow ROM- ***
Wrist ROM- ***

Imaging:
***Views of the *** demonstrate ***

MRI/CT scan demonstrates

Labs:
Last CBC/no differential result
@LABBRIEF(wbc,rbc,hgb,hct,mcv,mch,mchc,plts,rdw)@
@LABBRIEF(bun:1,sodium:1,k:1,chloride:1,co2:1,glucose:1,creatinine:1,gfr:1,ca:1,aniongap:1)@
@BLOODTYPE@
@LASTLABX(inr)@

Assessment and Plan: @PTTITLE@ @NAME@ is a *** pleasant @AGE@@SEX@ who presents with ***. ***

Alan Yan, MD

- **VACDRESSINGNOTEYAN**

A VAC dressing was placed on the wound today with setting of continuous suction pressure of *** mmHg. The patient was instructed on the usage of this device. All questions were answered.

- **WBPROGRESSIONINSTRUCTION**

WB progression instructions given: start with 20 to 25% WB in 1 to 2 weeks and then 50% in another 1 to 2 weeks. At 4 weeks 100% WBAT in boot.

- **WEANOFFBOOTINSTRUCTION**

Wean off boot starting this week:

Instructions given: 1 hr each in morning and by the end of day without boot WBAT. If goes well no pain for one to 2 days then progress to 2 hrs in the morning and 2 hrs by the end of the day in another one to 2 days. Then progress to 3 and 3 hrs in that pattern until rid of the boot completely without discomfort.

The patient will use regular comfortable protective sports shoes during the time that patient is out of boot.

Patient understands and will follow up instructions.

- **WHEELCHAIRMEDNECESSITY**

Patient's fracture limited her MRADLs and manual wheelchair will be helpful. The patient has good upper extremity function and she has family or other assistant who is available willing and able to provide assistance for wheelchair.

- **WORKNOTEYAN**

WORK NOTE

A workability note {WAS:5003766} needed, the patient {WORK:8068}. Typical work duties include ***, ***, and ***. We will plan on reassessing @HIS@ workability at the clinic next visit.

- **YANADDENDUMNOTENEW**

ATTENDING NOTE:

I personally performed a history and physical examination on @NAME@. I reviewed the fellow/resident/PA's findings and plan and note and agree and link my note. I discussed the plan with the patient and/or family.

***
F/U in *** weeks with repeat Xray of ***

Alan Yan, MD

- **YANCONSULTNOTE**

Orthopedic Physician Consult Note

@NAME@
Code Status: @RRCODESTATUS@
Primary Care Physician: @PCP@
DOB: @DOB@ **Age:** @AGE@

Consulting Physician:@ME@

Date of Service: @FDATE@

Admit Date: @ADMITDT@ **Admitting Diagnosis**: @ADMITDX@

Subjective:

Time consult called: *
Time at patient bedside: *

Requesting Physician: staff MD

Reason for Consultation: ***

Chief Complaint: *

History of present illness: @**NAME**@ is a @AGE@ @SEX@ who ***

Review of Systems

Review of systems: All 14 systems are reviewed with the patient. Significant positives include the past medical history as stated above and the recent *** injury. Significant negatives include no issues of chest pain, lightheadedness, dizziness, nausea or vomiting, bowel or bladder problems, syncope, or loss of consciousness.

{CHI Findings ROS:30410068}

Past medical history: @PMH@

Past surgical history: @PSH@

Medications: @MEDS@

Allergies: @ALLERGY@

Social history: @SOC@

@ACTMED@

Family History

@FAMHX@

Reviewed and updated Past Medical History? {yes no:314532}

Objective:

Vital signs in last 24 hours:
@VSRANGES@
@TMAX(24)@
Intake/Output last 3 shifts:
@IOLAST3SHIFTS@
Intake/Output this shift:
@IOTHISSHIFT@

General: @NAME@ is a well-developed well-nourished @AGE@ @SEX@ who appears stated age and weight. Patient is resting comfortably in their hospital bed. Alert and oriented x3.

HEENT: Head appears normocephalic and atraumatic. PERRLA, EOMI. I do not appreciate any significant oropharynx, external auditory canal, or nasal passage drainage today. Nasal mucosa appears moist. Neck supple, trachea midline.

Cardiovascular: Regular rate and rhythm, equal chest rise bilaterally.

GU: Deferred

Abdomen: Soft and nontender.

Musculoskeletal: Full active motion, 2/4 pulses, SILT, with 5/5 strength in unaffected extremity(ies).

Examination of the {Blank single:19197::"Left","Right"} {Blank single:19197::"Upper","Lower"} Extremity reveals
***

Diagnostic Findings:
Pertinent Labs: @LABRCNTIP(WBC,HEMATOCRIT,HEMOGLOBIN,MCV,PLATELETS)@
@LABRCNTIP(SODIUM,POTASSIUM,CHLORIDE,CALCIUM,BUN,GLUCOSE,CREATININE,CO2,ANION GAP2,GFR MDRD AF AMER)@
@LABRCNTIP(AST,ALT,ALK PHOS,BILIRUBIN TOTAL,BILIRUBIN DIRECT,PROTEIN TOTAL,ALBUMIN,GLOBULIN)@
@LABRCNTIP(CHLPL,TRIG,HDL PML,VLDL CALC,LDL CALC,CHOL/HDL RATIO,LDL/HDL RATIO,NON-HDL CHOLESTEROL)@
@LABRCNTIP(CK TOTAL,TROPONIN I,CK MB)@
@LABRCNTIP(APTT)@
@LABRCNTIP(INR,PROTHROMBIN TIME)@

@LASTIMAGING(img1050509:4)@

Additional comments: {comments:30782}
Extensive review of previous medical records completed.

Imaging:

***

Assessment:

***

Plan:

***

Signed:
@MECRED@ @TD@ @NOW@

- **YANDIFFICULTDECISIONSTATEMENT**

As we discussed today, the patient has a very difficult case situation which may lead to unpredictable consequences of surgery. We may decide not to proceed with surgery by the surgeon after a complete and prudent consideration up to the day right before surgery. Patient and family is aware of that and agreed with the statement for the safety and benefit over risk ratio consideration.

- **YANDMFOOTDAILYCAREnote**

Patient is diabetic on medication. There is compromised peripheral nerve and vascular condition. The patient will need to observe daily care precautions as follows:
1. Daily exam of foot by patient and or patient assistant at home. Check for blisters, cuts or sores.
2. Wash feet daily with lukewarm water and soap. Dry well especially in between toes.
3. If using moisture please do not use between the toes.
4. Keep toenails at reasonable length.
5. Wear clean socks not too big or small.
6. Keep feet warm and dry with shoes that fit comfortably.
7. Never walk barefoot indoors or outdoors.
8. Exam shoes for things might hurt feet.

- **YANFANEGATIVENOTE**

Not diabetic and non-smoker.
No CP or SOB.
No fever chills.
No red hot swelling joint.
No open lesion, drainage or ulceration

- **YANFOLLOWUPCLINICNOTE**

PATIENT: .@NAME@
DOB: @DOB@
MRN: @MRN@

PRIMARY CARE PROVIDER: @PCP@

REFERRING PHYSICIAN: @REFPROV@

DIAGNOSIS:

- ***

HISTORY OF PRESENT ILLNESS: @NAME@ presents back and following up in our clinic. The patient's condition has been ***

Of note, the following was the record from this patient first visit.

No acute event during the interim.

PAST MEDICAL HISTORY: @PROB@

@PMH@

PAST SURGICAL HISTORY: @PSH@

SOCIAL HISTORY: @SOC@

FAMILY HISTORY: @FAMHX@

MEDICATIONS: @MED@

ALLERGIES TO MEDICATIONS: @ALLERGY@

REVIEW OF SYSTEMS:
Constitutional: Otherwise negative. No unexplained weight loss/gain, no fevers/chills.
HENT: Otherwise negative. No ringing in the ears, no headache.
Respiratory: Otherwise negative. No shortness of breath, no cough.
Cardiovascular: Otherwise negative. No chest pain, no palpitations.
Gastrointestinal: Otherwise negative. No current stomach problems, no diarrhea.
Genitourinary: Otherwise negative. No urinary frequency, no painful urination.
Musculoskeletal: Otherwise negative. No myalgia, no other joint pains.
Skin: Otherwise negative. No lesions reported, no rashes.
Neurological: Otherwise negative. No blurred vision or unilateral weakness.
Hematological: Otherwise negative. No anemia, no recurrent infections.
Psychiatric/Behavioral: Otherwise negative. No current depression or behavioral issues.

PHYSICAL EXAMINATION:
@VITALS@

@CAPHE@ is a @AGE@ year-old well-developed, well-nourished @SEX@ alert and oriented X3 with normal station, mood, affect, coordination, and balance with a BMI of @BMI@. Cardiovascular - pulses are normal and symmetric. Respiratory - no signs of respiratory distress. Wheezing is not evident. Neck - Appropriate motion, no tenderness. Skin - no significant lacerations, abrasions, or ecchymosis noted. Neurologic - cranial nerves II-XII grossly intact.

***

RADIOGRAPHIC STUDIES: X-rays of the ***

PLAN: Anatomy and diagnoses were discussed in full detail with @NAME@.

***

Alan Y. Yan, MD
@NOW@
@TD@

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- **YANFOOTANKLECOMPEXAM**

Comprehensive Foot and Ankle Exam

	Left	Right
Gait	Normal	
Musculoskeletal Exam		
Deformity	No deformity	No deformity
Misalignment	None	None
Crepitation	None	None
Tenderness	None	None
Defect	None	None
Effusions	None	None
Range of Motion		
Ankle Dorsiflexion	20, Painless	20, Painless
Ankle Plantarflexion	50, Painless	50, Painless
Subtalar Joint Inversion	35, Painless	35, Painless
Subtalar Joint Eversion	25, Painless	25, Painless
Transverse Tarsal Joints Abduction	Painless	Painless
Transverse Tarsal Joints Adduction	Painless	Painless
Contractures	None	None
Crepitation	None	None
Stability		
Dislocations	None	None
Subluxations or Laxity	None	None
Muscle Strength		
Atrophy	None	None
Abnormal Movements	Normal	Normal
Anterior Tibial Muscle	5/5	5/5
Posterior Tibial Muscle	5/5	5/5
Peroneals	5/5	5/5
Gastroc-soleus Muscle	5/5	5/5
Single Heel Raise	Not tested	Not tested
Neurologic		
Coordination	Concordant	
Reflexes	Normal	Normal
Sensation		

Sural Nerve Dist.	Normal	Normal
Saphenous Nerve Dist.	Normal	Normal
Tibial Nerve Dist.	Normal	Normal
Deep Peroneal Nerve Dist.	Normal	Normal
Superficial Peroneal Nerve Dist.	Normal	Normal
Cardiovascular		
Edema	None	None
Ecchymosis	None	None
Varicosities	None	None
DP Artery Pulse	Palpable	Palpable
PT Artery Pulse	Palpable	Palpable
Capillary Refill	Brisk, less than 2 secs	Brisk, less than 2 secs
Special Tests		
Anterior Drawer at Neutral	Not tested	Not tested
Anterior Drawer in PF	Not tested	Not tested
Calcaneal Compression	Not tested	Not tested
Peroneal Subluxation/Dislocation	Not tested	Not tested
Tinel's	Not tested	Not tested
Pitting edema sign	Not tested	Not tested
Too Many Toe Signs	Not tested	Not tested

- **YANNEWCLINICNOTE**

PATIENT: .@NAME@
DOB: @DOB@
MRN: @MRN@

PRIMARY CARE PROVIDER: @PCP@

REFERRING PHYSICIAN: @REFPROV@

DIAGNOSIS:

- ***

HISTORY OF PRESENT ILLNESS: @NAME@ is a very pleasant @AGE@-year-old @SEX@ patient of @PCP@ who presents with a chief complaint of *** which has been going on for ***

PAST MEDICAL HISTORY: @PROB@

@PMH@

PAST SURGICAL HISTORY: @PSH@

SOCIAL HISTORY: @SOC@

FAMILY HISTORY: @FAMHX@

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RADIOGRAPHIC STUDIES: X-rays of the ***

PLAN: Relevant anatomy and diagnoses were discussed in full detail with @NAME@.

***

Alan Y. Yan, MD
@NOW@
@TD@

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- **YANPFEXAM**

No localized swelling, redness or warmth or fluctuation.

Squeeze heel no sharply increased pain.

TTP at the medial calcaneal tubercle.

No lesions plantar foot. No corns, callus or ulceration.

Mild to moderate calf tightness on Silfverskiold DF test.

STLT present at SP, DP, T, S.

Cap refill 2 seconds

ROM of ankle and foot no pain.

- **YANPFHX**

The patient is experiencing pain over the medial calcaneal tubercle of the PF insertion without obvious injury. Pain is mostly pronounced in the morning as getting up and pain with the first few steps after getting off the bed. Pain gets better after warming up. Pain also returns after short period of rest and resuming WB ambulation. No radiating pain to the distal toes or proximally to the ankle, calf or thigh. No open lesions or corns or callus over the plantar heel.

- **YANPFPLAN**

The patient has clinical signs and symptoms of plantar fasciitis.

Details of management and timing of progress have been discussed with the patient.

The progress usually takes longer than 3 months or even up to or over half a year.

Nonoperative management will be the main stay and will be tried systematically.

If the pain is over 5/10 and acute, then a CAM boot will be given, and patient will be strictly use CAM boot as much as they can for most of the time during the day.

Night splint is also recommended for prevention of plantar flexion during the night relating to the morning first few steps of pain.

Home stretching exercises demonstration instructed to the patient also.

Formal PT will start now if pain is tolerable at the moment otherwise start at one month after CAM boot wearing.

Encourage Vit D 3 oral intake.

Rolling of chilled bottle under plantar foot demonstrated and recommended.

If all above fails, then one time corticosteroid injection can be given for pain relief but warning of plantar fascia tear or chronic fat pat atrophy with chronic pain risks explained.

Local injection also includes PRP or other type of stem cells which are not covered by insurance.

If all nonop fails, then will get MRI rule out other pathology mimicking plantar fasciitis and surgical options of partial PF release vs gastroc release will be discussed and carried if over one year of non-op fails.

Patient understands and will follow up instructions.

NSAIDS orally for symptomatic relief if no contraindications.

In Summary:

The patient is instructed and given the following:

***

Follow up in 6 to 8 weeks.

- **YANPOSTOPCLINICNOTE**

PATIENT: .@NAME@
DOB: @DOB@
MRN: @MRN@

PRIMARY CARE PROVIDER: @PCP@

REFERRING PHYSICIAN: @REFPROV@

DIAGNOSIS:

- **S/P**

DOS:

HISTORY OF PRESENT ILLNESS: @NAME@ presents back in clinic *** weeks after the surgery.

***

No acute event during the interim.

PAST MEDICAL HISTORY: @PROB@

@PMH@

PAST SURGICAL HISTORY: @PSH@

SOCIAL HISTORY: @SOC@

FAMILY HISTORY: @FAMHX@

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- **YANPOSTOPEXAM**

Surgical incision C, D, I.

No sign of infection.

STLT present at SP, DP, T, S.

Cap refill 2 secs.

Moving toes and ankle.

- **YANPOSTOPHX2WEEKS**

The patient is 2 weeks after surgery. Doing reasonably well. Pain well tolerated. No fever chills. On DVT prophylaxis and NWB in splint.

- **YANTELEMEDFOOTankleEXAM**

Normal color of skin pink good perfusion.
No sign of infection.
No open lesion.
Moving toes, foot, ankle without pain.
ROM within normal limit.
No obvious swelling.
STLT by patient present all distal N distribution.
Alignment neutral.
Able to WBAT.